



**ASSESSMENT OF MOOD, FAMILY ENVIRONMENT, AND
COPING STRATEGY OF OPIOID DEPENDENTS AND
ALCOHOL DEPENDENTS**

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

BY
ELANGBAM PRIYOKUMAR SINGH
Ph. D. REGN NO. PhD/PSY/00866

DEPARTMENT OF PSYCHOLOGY
SCHOOL OF SOCIAL SCIENCES
MAY, 2026



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In partial fulfilment of the requirements for the Degree of Doctor of Philosophy in
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NAGALAND UNIVERSITY
(A Central University Established by the Act of Parliament No. 35 of 1989)

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CERTIFICATE

This is to certify that the present research work titled, “**Assessment of mood, family environment, and coping strategy of opioid dependents and alcohol dependents**” is the original research work carried out by Mr. **Elangbam Priyokumar Singh**, Ph.D. Regd. No. PhD/PSY/00866 under my supervision. The work done is being submitted to the Nagaland University for the degree of Doctor of Philosophy in Psychology.

This is to further certify that the research conducted by Mr. Elangbam Priyokumar Singh has not been submitted to any other University/ Institute.

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DECLARATION

I, Elangbam Priyokumar Singh, 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 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. This is being submitted to the Nagaland University for the degree of Doctor of Philosophy in Psychology.

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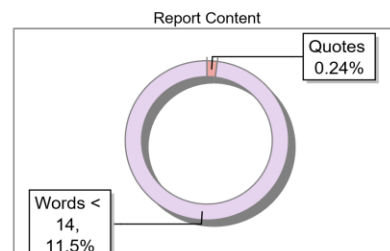
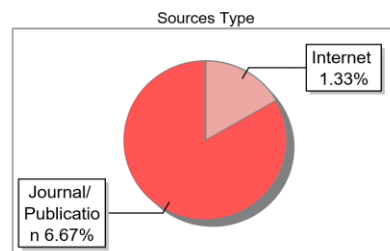
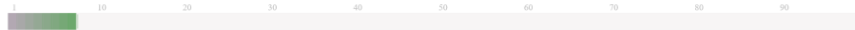
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Abstract

Substance dependence, particularly opioid and alcohol dependence, represents a pressing public health concern due to its complex interplay with psychological, familial, and coping dimensions. These are a premier global public health challenge, with opioids and alcohol being the most widely abused substances. The World Health Organization (2023) reports that approximately 296 million people used illicit drugs in 2021, with opioids accounting for two-thirds of drug-related fatalities. Similarly, harmful alcohol use contributes to 5.1% of the global disease burden, resulting in over three million annual deaths (WHO, 2018). These figures underscore the urgent need to understand the psychosocial factors driving dependence.

The primary objective of this research was to conduct a comparative analysis of depression, anxiety, stress, family environment, and coping styles between individuals with opioid and alcohol dependence. Adopting a cross-sectional, correlational, and comparative research design, the study sampled 200 male participants (100 opioid-dependent and 100 alcohol-dependent) through purposive sampling. Data collection focused on five core hypotheses regarding the significant differences and internal relationships among the variables. Standardized measures were employed, including the Depression Anxiety Stress Scales (DASS-42), Family Environment Scale (FES), and Coping Inventory for Stressful Situations (CISS). Descriptive statistics (mean, standard deviation, and percentages) were used to summarize the socio-demographic characteristics of the participants, as well as their scores on measures of mood, family environment, and coping strategies. Following normality testing via the Kolmogorov-Smirnov test, the study utilized independent sample t-tests for group comparisons and Pearson's correlation coefficient to evaluate the associations among the variables.

No significant sociodemographic differences were found, indicating comparable study groups; however, subtle patterns in demographic profiles were observed between groups. While opioid dependence typically affects younger, unmarried individuals from lower socioeconomic backgrounds, alcohol dependence is more frequent among older, married, and better-educated populations.

Regarding family dynamics, Opioid-dependent families reported significantly higher independence ($p<0.05$), organization and control ($p<0.01$) than alcohol-dependents, which may suggest greater rigidity and structured family functioning among opioid users. In contrast, alcohol dependents reported lower scores in these dimensions, indicating comparatively more flexible but less structured family patterns.

Psychologically, the study found that alcohol dependents exhibit significantly higher depression levels ($p<0.05$) than opioid dependents, suggesting that alcohol dependence may have a more severe impact on mood stability. Furthermore, alcohol dependents utilized significantly more task-oriented coping than opioid dependents ($p<0.01$).

These psychological outcomes are deeply intertwined with the family environment. Family cohesion was negatively significant with depression ($p<0.05$) and anxiety ($p<0.01$), while acceptance & caring and active recreational orientation in the family were found significantly correlated with lower anxiety ($p<0.05$). Conversely, family control was positively significant with heightened anxiety ($p<0.05$).

The influence of the family also extends to coping mechanisms, as family cohesion was negatively significant with social diversion coping ($p<0.05$). Further, family organization was negatively significant with distraction coping ($p<0.05$). However, family control was positively significant with task-oriented coping ($p<0.01$).

Further, emotion-oriented coping was positively significant with stress ($p<0.01$). Similarly, both distraction and social diversion forms of avoidance coping were positively significant with higher depression ($p<0.01$). In contrast, family expressiveness, acceptance, and caring were negatively significant with anxiety ($p<0.05$).

Finally, Independence, acceptance & caring, and organization within the family environment were positively significant with task-oriented coping. Independence was specifically negatively correlated with social diversion ($p<0.01$). Conversely, Further, control was negatively significant with emotion-oriented coping ($p<0.05$).

Future research can expand to include both genders and diverse socio-economic backgrounds, utilizing qualitative methods to capture the complex psychosocial dynamics of substance dependence.

Keywords: *Opioid dependence, Alcohol dependence, Family environment, Depression, Anxiety, Stress, Coping strategies, Substance use disorders*

CHAPTER I

INTRODUCTION

1.1. Substance Dependence: Global and National Context

Substance use disorders (SUDs) are among the most challenging global public health issue, with opioids and alcohol constituting two of the most widely abused substances. The World Health Organization (WHO, 2023) reports that approximately 296 million people used illicit drugs globally in 2021, with opioids accounting for nearly two-thirds of all drug-related deaths. Similarly, alcohol, one of the most socially accepted psychoactive substances, continues to pose a major threat to health worldwide, with harmful use contributing to 5.1% of the global burden of disease and above three million deaths annually (WHO, 2018). These alarming figures highlight the gravity of the problem and the urgent need for an indepth understanding of the psychosocial factors underlying substance dependence.

Globally, opioid misuse has emerged as a serious public health issue, contributing to significant morbidity, mortality, and socioeconomic costs. World Health Organization (WHO, 2023), estimated 61 million people worldwide engaged in opioid use, with more than 30 million affected by opioid use disorders. The opioid crisis is particularly severe in North America, where synthetic opioids like fentanyl have driven unprecedented rates of overdose deaths. Between 1999 and 2021, nearly 645,000 people died from overdoses involving opioids in the United States alone (Centers for Disease Control and Prevention [CDC], 2022). In India, the situation is equally alarming. The *Magnitude of Substance Use in India* report (Ambekar et al., 2019) estimated that around 0.7% of the Indian population, or approximately 8.5 million people, were opioid users, with heroin being the most highly used opioid, followed by pharmaceutical opioids and opium. The Punjab Opioid Dependence Survey further highlighted the disproportionate burden in specific regions, reporting that more than 230,000 people in the state were dependent on opioids, underscoring the localized epidemic within India (Ambekar et al., 2015). These figures reflect the

urgency for comprehensive understanding and intervention strategies addressing opioid dependence both globally and nationally.

India's geographic location further compounds this challenge, as it lies between the two largest illicit opium-producing regions of the world: the "Golden Crescent" (Afghanistan, Iran, and Pakistan) and the "Golden Triangle" (Myanmar, Laos, and Thailand). Both regions are notorious for large-scale opium cultivation and trafficking, and their proximity makes illicit opioids easily accessible in India (UNODC, 2005). Complicating the situation, India is also one of the world's largest legal producers of opium for pharmaceutical purposes, creating risks of diversion into illicit markets. Together, these factors make India uniquely vulnerable, both as a consumer and a transit hub in the global opioid trade.

Although opioids are essential in medicine for their potent analgesic properties, their non-medical use produces powerful reinforcing effects- euphoria and stress relief, which significantly increase the risk of dependence. Prolonged or repeated use alters brain reward circuits, leading to tolerance, withdrawal, and compulsive drug-seeking behaviors characteristic of opioid use disorder (Koob, 2016; Volkow et al., 2019).

Similarly, on a global scale, alcohol-related mortality and morbidity remain substantial. In 2019, alcohol consumption caused around 2.6 million deaths worldwide, including 1.6 million deaths from noncommunicable diseases, 700,000 from injuries, and 300,000 from communicable diseases. Men accounted for nearly 2 million of these deaths, compared to 600,000 among women (WHO, 2019). In 2018, it accounts for approximately 5.3% of all deaths and 5.1% of the global burden of disease (WHO, 2018). Approximately 400 million people—7% of the world's adult population—live with alcohol use disorders, with 209 million suffering from alcohol dependence (Griswold et al., 2018). It is a causal factor in over 200 diseases and injury conditions, including liver cirrhosis, cancers, cardiovascular diseases, depression, anxiety, and suicide (Rehm et al., 2017). Chronic alcohol misuse contributes to systemic health complications, including hypertension, cardiomyopathy, stroke, cirrhosis, and pancreatic disorders (Fuller et al., 2007).

Beyond individual health, alcohol misuse contributes significantly to family dysfunction, workplace absenteeism, violence, and accidents, amplifying its societal costs. It also exerts broader social costs, most notably its association with road traffic fatalities. Alcohol accounts for nearly 40% of traffic-related deaths in the United States (McGwin, 1999). Similarly, Gururaj (2004) estimated that in 2000, approximately one million people were killed globally in road accidents, with nearly 75% of these deaths occurring in developing countries, almost half of them in Asia.

Alcohol use, while often normalized in social and cultural contexts, is no less concerning. Harmful drinking patterns have been linked to a wide range of physical, psychological, and social consequences. In India, alcohol consumption patterns have shown a marked increase over the last two decades, with national surveys indicating that around 14.6% of the population aged 10–75 years are current users of alcohol, and nearly 5.2% qualify as individuals with alcohol dependence (Ambekar et al., 2019). According to the *Magnitude of Substance Use in India: Executive Summary* (2019), alcohol is the most commonly used psychoactive substance in the country. The prevalence of alcohol use is higher among men, though women increasingly show rising patterns of risky drinking, indicating changing social dynamics (Prasad, 2009; Gururaj et al., 2022). Furthermore, regional variations reveal higher prevalence rates in states such as Chhattisgarh, Tripura, Punjab, and Arunachal Pradesh, where alcohol-related harms impose heavy social and economic burdens.

India plays a unique role in the regional alcohol landscape, being the dominant producer of alcohol in South-East Asia, contributing nearly 65% of the region's production and about 7% of total beverage imports (Mathur, 2014). Alcohol use disorders (AUDs) are a growing concern in the Indian context. Findings from the National Mental Health Survey of India (2015–2016) revealed that the prevalence of AUDs among adult men was 9%. Household expenditure on alcohol is found to be significant, ranging from 3% to 45% of family income (Gururaj et al 2016,) reflecting health and also socioeconomic burdens.

The National Survey on Extent and Pattern of Substance Use in India (2019) estimated that 57 million Indians are dependent on alcohol and nearly 7.7 million individuals require help for opioid dependence. Among the Northeastern states, including Manipur and Nagaland, substance use has become a serious social and health issue, influenced by unique sociocultural dynamics, porous borders, and political instability (Armstrong, et al. 2014). Opioids, particularly heroin and synthetic variants, have found widespread availability in these regions, while alcohol consumption—both licensed and illicit—remains a major contributor to health and social problems.

In this way, both opioids and alcohol—despite their different pharmacological mechanisms—share the potential to create profound psychological, physiological, and social consequences for individuals and communities. Thus, opioid and alcohol dependence not only pose significant health risks but also impair psychosocial functioning, disrupt family structures, and exacerbate psychiatric comorbidities. The impact of these substances must be studied in comparative terms, especially in regions such as Northeast India, where their use is intertwined with cultural practices, economic constraints, and social instability.

1.2. Conceptual and Diagnostic Framework of Dependence

Opioids, in particular, represent a diverse group of substances that include natural, semi-synthetic, and fully synthetic compounds acting primarily on opioid receptors in the central nervous system and gastrointestinal tract (National Institute on Drug Abuse [NIDA], 2024). These receptors regulate vital functions such as pain perception, respiratory control, mood, and gastrointestinal activity. Natural opioids, or opiates, such as morphine, codeine, and thebaine, are derived from the opium poppy. Semi-synthetic opioids, such as heroin, oxycodone, and hydrocodone, are produced by modifying natural opiates, while fully synthetic opioids, including fentanyl and methadone, are manufactured in laboratories (Pathan & Williams, 2012).

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines alcohol as a psychoactive substance commonly found in beverages such as beer, wine, and liquor, which exerts a wide range of physical and psychological effects, including intoxication and dependence. According to the World Health Organization (WHO), ethanol, the active ingredient in alcoholic beverages, is both toxic and addictive, contributing substantially to the global burden of disease (WHO, 2011). While alcohol is often consumed for socialization, relaxation, or stress reduction (Maxwell, 2002), its widespread availability and cultural acceptance make it one of the most significant public health concerns worldwide.

In context of clinical diagnosis, the 12-month prevalence of opioid use disorder (OUD) in the general adult population (18 years and older) is estimated at 0.37% according to the *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition* (DSM-5; American Psychiatric Association, 2013). According to the *Magnitude of Substance Use in India: Executive Summary* (2019), In India, about 0.7% of individuals aged 10–75 years are affected by OUD, with a dependence rate of 0.26% at the national level. Alarming, the prevalence in Manipur is substantially higher at 1.8%, underscoring the disproportionate burden of opioid dependence in this region. The risk of developing OUD is multifactorial, shaped by individual vulnerabilities, family and peer influences, and broader sociocultural stressors. Genetic predisposition plays a particularly salient role, exerting both direct and indirect effects on susceptibility to dependence (American Psychiatric Association, 2013). This highlights the need to conceptualize opioid dependence not merely as a behavioral or social issue but as a complex biopsychosocial disorder requiring multidimensional interventions.

From a classificatory perspective, the *International Classification of Diseases, 11th Revision* (ICD-11) defines opioid and alcohol dependence as disorders of regulation of substance use arising from repeated or continuous consumption (World Health Organization, 2019). A hallmark feature is a strong internal drive or compulsion to use the substance, manifesting in impaired control over initiation, termination, or level of use. Dependence is further characterized by the prioritization of substance

use over other responsibilities, persistence of use despite adverse consequences, and the presence of cravings, tolerance, and withdrawal. Typically, a diagnosis requires persistence of these features for at least 12 months, though earlier recognition is possible in cases of continuous daily or near-daily use.

Similarly, the DSM-5 conceptualizes opioid and alcohol use disorders within the broader category of Substance Use Disorders (SUDs), defined by a maladaptive pattern of use leading to clinically significant impairment or distress. Diagnostic criteria span impaired control (e.g., unsuccessful attempts to cut down), risky use, social dysfunction, tolerance, and withdrawal. Severity is determined by the number of criteria endorsed, ranging from mild (2–3 symptoms) to severe (6 or more symptoms) (American Psychiatric Association, 2013).

Integrating ICD-11 and DSM-5 perspectives highlights that substance dependence is best understood as a biopsychosocial condition rather than a purely physiological process. It encompasses neurobiological adaptations, psychological vulnerabilities such as mood disturbances and stress reactivity, and social disruptions including family conflict and maladaptive coping. These dimensions directly inform the present study's comparative focus on mood, family environment, and coping strategies among alcohol- and opioid-dependent individuals, emphasizing the importance of examining both shared and distinct psychosocial determinants across these groups.

1.3. Psychological Correlates of Substance Dependence

Psychological distress is one of the most critical concerns in understanding the impact of substance dependence. Among the many mental health complications, depression, anxiety, and stress are widely reported in individuals with both opioid and alcohol dependence. These disorders not only exacerbate the severity of dependence but also interfere with treatment outcomes, recovery, and quality of life.

Depression is commonly observed among individual dependent on substances. Studies showed that depressive symptoms may act both as a risk factor and as a consequence of substance abuse. Alcoholics frequently experience episodes of

sadness, hopelessness, and diminished interest in daily activities, with nearly one-third reporting major depressive episodes lasting several weeks (Brown & Schuckit, 1988; Winokur, 1983). Similarly, opioid users often present with depressive symptoms linked to neurochemical changes in the brain and the psychosocial consequences of chronic use (Schuckit, 1996).

Anxiety is another common comorbidity among substance-dependent individuals. Defined as apprehension or uneasiness stemming from anticipated danger (APA, 2013), anxiety often manifests as excessive worry, panic attacks, and autonomic arousal. In alcohol dependence, anxiety tends to increase during withdrawal and hangover phases, while opioid dependence is strongly associated with heightened future-oriented worry and panic states (Kushner et al., 1990; Horwitz et al., 1986). Freud's psychoanalytic perspective, behavioral theories, and personality-based explanations (e.g., Eysenck's model of neuroticism and extraversion) all contribute to understanding how vulnerability to anxiety interacts with substance dependence.

Stress also plays a significant role in substance dependence. According to Selye's General Adaptation Syndrome (1956), prolonged exposure to stressors leads to physical and psychological exhaustion, increasing susceptibility to maladaptive coping behaviors, including substance use. Stress not only acts as a precipitating factor for initiating substance use but also exacerbates withdrawal symptoms and relapse. Studies have consistently shown that individuals with alcohol and opioid dependence exhibit higher stress reactivity compared to non-dependent populations (Brady & Sinha, 2005).

Collectively, depression, anxiety, and stress function as both causal factors and outcomes of substance dependence, creating a vicious cycle that perpetuates maladaptive behaviors. Understanding their differential manifestations in opioid and alcohol dependence provides critical insight for individualized interventions and treatment planning.

1.4. Depression in the Context of Substance Dependence

Depression is one of the most prevalent psychiatric comorbidities in individuals with substance dependence, including opioid and alcohol dependence, and it significantly influences clinical outcomes. Both the International Classification of Diseases, 11th Revision (ICD-11), and the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), provide frameworks for understanding depressive disorders, which share overlapping but distinct diagnostic features. According to the ICD-11, depression may occur as a single-episode depressive disorder, characterized by one episode of depressed mood with no prior history, or as a recurrent depressive disorder involving repeated episodes of low mood, diminished energy, and loss of interest lasting at least two weeks (ICD-11, BlockL2-6A7). Core symptoms include impaired concentration, feelings of worthlessness or excessive guilt, hopelessness, appetite or sleep disturbances, psychomotor agitation or retardation, fatigue, and recurrent thoughts of death or suicide. Episodes are further classified as mild, moderate, or severe, depending on both the number and intensity of symptoms as well as the degree of functional impairment. The DSM-5 adopts a similar approach, defining major depressive disorder (MDD) as the presence of five or more depressive symptoms during the same two-week period, with at least one symptom being either depressed mood or loss of interest or pleasure (American Psychiatric Association, 2013). Symptoms mirror those described in ICD-11 and include significant weight or appetite changes, insomnia or hypersomnia, psychomotor changes, fatigue, diminished concentration, inappropriate guilt or feelings of worthlessness, and suicidal ideation. DSM-5 further specifies severity (mild, moderate, severe), course specifiers (single or recurrent episodes), and additional features such as melancholic or atypical presentations. Together, these frameworks emphasize that depression is not merely a transient emotional state but a clinically significant mood disorder associated with marked distress and impairment in daily functioning. In the context of substance use disorders, comorbid depression exacerbates craving, worsens coping, and increases relapse risk, underscoring the need for integrated assessment and treatment approaches that address both mood pathology and substance dependence.

From a theoretical perspective, several explanatory models have been advanced to understand the etiology and persistence of depression, many of which offer insights into its co-occurrence with substance dependence. Biological theories highlight the role of neurobiological mechanisms, including imbalances in neurotransmitters such as serotonin, norepinephrine, and dopamine, as well as dysregulation of the hypothalamic–pituitary–adrenal (HPA) axis (Nestler et al., 2002). Genetic vulnerability is also recognized, with heritability estimates suggesting that 30–40% of the risk for depression may be inherited (Sullivan, et al, 2000). Cognitive theory, most notably Beck’s Cognitive Model, posits that depression arises from distorted thought processes and negative schemas about the self, the world, and the future, often referred to as the “cognitive triad” (Beck, 1967). These maladaptive cognitions reinforce feelings of hopelessness and helplessness, which may be further intensified in individuals struggling with addiction-related stigma and repeated relapse. Complementing this, Seligman’s (1975) learned helplessness theory suggests that depression emerges when individuals perceive a lack of control over life events, resulting in passivity and hopelessness, a phenomenon frequently observed in those battling substance dependence.

Equally important are psychosocial and family systems perspectives, which highlight the role of dysfunctional family environments. High conflict, low cohesion, and poor emotional expressiveness within families have been shown to correlate strongly with depressive symptoms (Moos & Moos, 1984; Mattoo et al., 2013). Substance dependence itself, conceptualized as a “family disease” (O’Farrell & Fals-Stewart, 1999), can exacerbate these dynamics, perpetuating cycles of stress and depression within households. Finally, stress–coping models emphasize that depression often arises when individuals perceive stressors as overwhelming while lacking effective coping mechanisms. According to Lazarus and Folkman’s (1984) transactional model, inadequate coping strategies such as avoidance or emotion-focused responses can heighten vulnerability to depression, a finding echoed in substance-dependent populations where ineffective coping is common (Endler & Parker, 1999). Collectively, these perspectives underscore that depression in individuals with

alcohol and opioid dependence is rather a complex interplay of biological, cognitive, psychosocial, and stress-related processes that demand integrated theoretical and clinical attention.

1.5. Anxiety in the Context of Substance Dependence

Anxiety disorders are among the most common psychiatric comorbidities associated with alcohol and opioid dependence, and they significantly complicate diagnosis, treatment, and recovery outcomes. According to the International Classification of Diseases, 11th Revision (ICD-11), anxiety disorders are classified under *fear- and anxiety-related disorders (BlockL1-6B0)* and are characterized by excessive fear, anxiety, and related behavioral disturbances causing significant distress or impairment in personal, social, educational, occupational, or family functioning (World Health Organization [WHO], 2019). Fear generally reflects a response to imminent threat, whereas anxiety is more future-oriented, involving apprehension of anticipated threat. Similarly, the American Psychiatric Association (APA, 2013) defines anxiety as apprehension, tension, or uneasiness stemming from the anticipation of danger where the source may be vague or unrecognized. Anxiety encompasses both subjective states of worry and nervousness and physiological reactions mediated by the autonomic nervous system (Horwitz, et al, 1986). In line with this, Scovel (1978) described anxiety as a “vague fear” that is only indirectly associated with an object.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), provides a structured framework, defining Generalized Anxiety Disorder (GAD) as excessive anxiety and worry occurring more days than not for at least six months, accompanied by difficulty controlling the worry and three or more associated symptoms such as restlessness, fatigue, impaired concentration, irritability, muscle tension, and sleep disturbances (American Psychiatric Association, 2013). DSM-5 further emphasizes that anxiety disorders, including panic disorder, social anxiety disorder, and phobias, must result in clinically significant distress or impairment in functioning.

Several theoretical perspectives help explain the etiology and persistence of anxiety. Freud (1926) proposed a psychoanalytic model in which anxiety arises from repressed libido, identifying three forms: realistic anxiety (fear of real dangers), neurotic anxiety (disproportionate fear without clear external threat), and moral anxiety (guilt or fear of violating internalized codes). Behavioral theories conceptualize anxiety as a conditioned response, acquired through classical conditioning and maintained through reinforcement and avoidance learning (Mowrer, 1960), a mechanism highly relevant to substance dependence, where alcohol or opioids may be used to avoid withdrawal-induced anxiety. Personality-based theories, such as Eysenck's model, link anxiety vulnerability to neuroticism and introversion, suggesting that highly neurotic individuals are especially prone to developing anxiety disorders (Schuckit, 1996). Cognitive theories emphasize maladaptive thought patterns, including catastrophic misinterpretations of bodily sensations (Clark, 1986) and exaggerated beliefs about perceived threats, which maintain a cycle of worry, hypervigilance, and avoidance. Biological models implicate dysregulation of neurotransmitters such as GABA, serotonin, and norepinephrine, alongside overactivation of the amygdala and hypothalamic–pituitary–adrenal (HPA) axis (Nutt, 2005). Genetic factors also contribute substantially, with heritability estimates ranging between 30–50% (Hettema, et al 2001).

The clinical overlap of anxiety with alcohol and opioid dependence is well documented. Alcohol-dependent individuals frequently report drinking as a means of self-medicating feelings of nervousness or sadness (Brown & Schuckit, 1988). Although alcohol's sedative effects may initially reduce anxiety, chronic and excessive use exacerbates mood disturbances, with high doses inducing depressive symptoms during intoxication and heightened anxiety during withdrawal (Winokur, 1983). Studies indicate that nearly 80% of alcohol-dependent individuals report episodes of sadness or anxiety, around one-third experience severe depressive episodes lasting weeks, and approximately 40% report panic attacks, often accompanied by palpitations and shortness of breath (Brown & Schuckit, 1988;

Kushner et al., 1990). Similarly, opioid withdrawal is strongly associated with heightened anxiety, restlessness, and autonomic hyperarousal, all of which significantly increase relapse risk (Kosten & George, 2002).

Taken together, anxiety in substance-dependent populations emerges as a multifactorial condition shaped by neurobiological, psychological, and social-environmental influences. Its strong bidirectional relationship with alcohol and opioid dependence not only complicates clinical management but also heightens relapse risk, underscoring the need for integrative interventions that address both anxiety pathology and substance use disorders simultaneously.

1.6. Stress in the Context of Substance Dependence

Stress is a multidimensional concept with roots in both physics and behavioral sciences. Originally described in physics as an external pressure or force applied to a structure (Hinkle, 1974), the term was later popularized in biology by Hans Selye in the 1930s as a bodily response to circumstances that place physical or psychological demands on an individual (Selye, 1976). The American Psychiatric Association (2014) defines stress as feelings of being overwhelmed, pressured, exhausted, or lethargic, while Lazarus (1993) emphasizes its psychological dimension, describing it as a state that arises when demands exceed an individual's personal and social resources. Stress may also be conceptualized as pressure from external situations interacting with internal anxieties (Malhotra, 2009) or as the body's reaction to changes requiring physical, mental, or emotional adjustment (Morrow & Lynne, 2010). In this sense, stress is both inevitable and integral to life—serving as a motivating force in manageable amounts but becoming maladaptive when excessive.

Clinically, the International Classification of Diseases, 11th Revision (ICD-11), categorizes stress-related disorders under *disorders specifically associated with stress* (BlockL1-6B4), which include conditions such as post-traumatic stress disorder (PTSD) and adjustment disorders that directly result from stressful or traumatic experiences (World Health Organization [WHO], 2019). While stress itself is not a disorder, its manifestations—cognitive, emotional, physical, and

behavioral—are recognized as risk factors for psychopathology. Typical signs include worry, irritability, loneliness, dizziness, chest pain, rapid heartbeat, disrupted sleep or eating patterns, and neglect of responsibilities (McGrath, 1982; Sinha, 2001, 2008). Similarly, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), recognizes stress as a major precipitating or exacerbating factor in the onset and course of mental disorders, including depression, anxiety, and substance use disorders (American Psychiatric Association, 2013).

Theories of stress highlight two broad perspectives: physiological models of systemic stress and cognitive models of psychological stress. From a physiological standpoint, Hans Selye's (1976) General Adaptation Syndrome (GAS) describes stress as a stereotypical three-stage response pattern. The *alarm stage* involves sympathetic nervous system activation and the “fight-or-flight” response, releasing adrenaline and increasing heart rate, respiration, and blood pressure. In the *resistance stage*, the body attempts to adapt, outwardly appearing normal while enduring persistent hormonal strain, which may lead to “diseases of adaptation.” Finally, in the *exhaustion stage*, coping resources are depleted, parasympathetic functioning deteriorates, and the individual may experience fatigue, depression, or even mortality. Psychological perspectives, on the other hand, emphasize cognitive appraisal. Lazarus and Folkman (1984) argued that stress results when environmental demands exceed coping resources, with outcomes shaped by whether individuals employ adaptive or maladaptive coping.

Further psychological frameworks highlight the role of individual and social resources in buffering stress. Resource-based theories, such as Antonovsky's (1979) sense of coherence, Kobasa's (1979) hardiness, Bandura's (1992) self-efficacy, and Scheier and Carver's (1985) optimism, emphasize internal resilience and external support systems. Hobfoll's (1989) Conservation of Resources (COR) theory extends this view, positing that stress arises when valued resources—whether material (shelter, finances), relational (employment, family), personal (skills, confidence), or energetic (time, knowledge)—are threatened, lost, or invested without sufficient gain.

Biological models complement these perspectives by linking stress to dysregulation of the hypothalamic–pituitary–adrenal (HPA) axis and sympathetic nervous system activation, resulting in elevated cortisol levels and autonomic hyperarousal (McEwen, 2007). Chronic stress exposure alters brain regions central to emotional regulation and addiction, including the amygdala, hippocampus, and prefrontal cortex, thereby increasing vulnerability to psychiatric disorders and maladaptive substance use.

Although mild to moderate stress can be adaptive by fostering resilience and mastery (Levine, 2005; Selye, 1976), excessive or prolonged stress overwhelms coping abilities and increases the risk of psychopathology (McEwen, 2007; Sinha, 2008). This is especially significant in the context of substance dependence. Stress functions as both a precipitant and consequence of alcohol and opioid use disorders. Many individuals report initiating or escalating substance use to self-medicate stressful experiences (Sinha, 2001). While alcohol may temporarily reduce tension due to its sedative effects, chronic use dysregulates stress pathways, leading to heightened reactivity during withdrawal (Koob & Volkow, 2016). Similarly, opioid withdrawal is characterized by restlessness, irritability, autonomic hyperarousal, and dysphoria, all of which intensify relapse risk (Kosten & George, 2002). Occupational and chronic life stressors—such as high job demands, inflexibility, and prolonged interpersonal strain—are also strongly linked with alcohol-related problems (Seeman & Seeman, 1992).

Overall, stress is a dynamic biopsychosocial construct that interacts with genetic predispositions, cognitive appraisals, and environmental demands. Within the framework of alcohol and opioid dependence, stress should be understood not merely as an external trigger but as an ongoing process that undermines coping, exacerbates psychiatric comorbidities, and perpetuates cycles of dependence and relapse.

1.7. Coping Strategies and Substance Dependence

Coping strategies represent the behavioural and cognitive efforts individuals employ to manage stressors, internal conflicts, and environmental challenges. It is defined as constantly changing strategies aimed at addressing external or internal demands appraised as exceeding available resources (Lazarus & Folkman, 1984). They categorized coping into problem-focused coping, aimed at resolving or altering the source of stress, and emotion-focused coping, which seeks to regulate the emotional response to stress. Later frameworks expanded this classification to include avoidance-oriented coping, distraction, and social diversion strategies (Endler & Parker, 1999). Building on this conceptualization, Higgins and Endler (1995) categorized coping into three broad types: task-oriented coping, which directly addresses stressors; emotion-oriented coping, which regulates emotional responses through reframing or self-regulation; and avoidance-oriented coping, which involves denial, withdrawal, or distraction. Similarly, Cohen and Lazarus (1979) identified five common coping strategies: information seeking, direct action, inhibition of action, intrapsychological efforts, and turning to others. Schafer further summarized coping under the “three A’s”: action, acceptance, and avoidance. Carver et al. (1989) expanded this taxonomy with problem-focused strategies such as active coping, planning, suppression of competing activities, restraint coping, and seeking instrumental social support.

Coping styles can be broadly adaptive or maladaptive. Adaptive strategies, such as planning and problem-solving, reduce distress and enhance resilience, while maladaptive ones—such as denial, disengagement, or self-blame—exacerbate psychological and functional impairments (Taylor & Stanton, 2007; Mahmoud et al., 2012). Emotion-focused coping is frequently linked with heightened psychological disturbance (Ireland et al., 2005), whereas avoidance strategies are consistently associated with greater distress, physical illness, and mortality (Eisenbarth, 2012).

In the context of substance dependence, coping assumes critical importance, as it mediates the relationship between stress, family environment, and psychological outcomes. Individuals with opioid or alcohol dependence often face heightened stress, recurrent mood disturbances, and significant family or social dysfunction, all of which strain their coping resources. Research indicates that opioid-dependent individuals report higher levels of stress, diminished adaptive coping, and similar or greater reliance on maladaptive strategies compared to non-dependent controls (Hyman et al., 2009). Likewise, alcohol-dependent individuals display deficits in coping, especially when encountering situations that pose a high risk of relapse (Monti & Rohsenow, 1999). More recent evidence further underscores that the severity of alcohol dependence is positively correlated with maladaptive coping, suggesting that poor coping not only contributes to the initiation and maintenance of dependence but also predicts poorer outcomes in treatment and recovery (Venkateswaran & Thirumalai, 2024).

Studies indicate that persons with alcohol and opioid dependence frequently rely on maladaptive coping strategies, such as avoidance, denial, and emotion-oriented coping, which exacerbate psychological distress and perpetuate substance use (Cooper et al., 1992). In contrast, adaptive strategies—such as task-oriented coping, planning, and active problem-solving—are often underutilized in dependent populations (Wills & Hirky, 1996).

Among alcohol dependents, coping tends to revolve around tension reduction and avoidance of distress. Drinking often becomes a maladaptive mechanism to regulate emotions, temporarily alleviating anxiety and depression but ultimately worsening psychological well-being. Studies have consistently shown that alcohol-dependent individuals exhibit lower use of problem-solving coping and higher reliance on emotion-oriented and avoidance coping (Holahan et al., 2001).

For opioid dependents, coping mechanisms are often influenced by both physiological dependence and social stigma. Avoidance and emotion-oriented strategies are common, with individuals seeking temporary escape from withdrawal symptoms, social rejection, and emotional distress (Shiffman, 1985). However, task-oriented coping, when present, has been linked to greater treatment adherence and better psychological adjustment (Hasking & Oei, 2002).

The relationship between coping and psychological outcomes is further compounded by the family environment. Dysfunctional family contexts—marked by poor cohesion, conflict, and rigid control—have been associated with greater reliance on maladaptive coping (Moos & Moos, 2009). Conversely, supportive family structures encourage the development of problem-focused strategies, thereby enhancing resilience and recovery.

Therefore, understanding coping styles in alcohol- and opioid-dependent groups is essential, as it offers insights into their psychological functioning and informs the development of targeted therapeutic interventions. The current study seeks to examine how coping strategies differ between these groups and how they relate to family environment and psychological outcomes such as depression, anxiety, and stress. Taken considering these findings, coping is a critical mediator in the relationship between mood disturbances, stress, and substance dependence. While depression, anxiety, and stress increase vulnerability to alcohol and opioid use, the ways in which individuals cope with these challenges determine whether they manage distress adaptively or resort to substance use as a maladaptive coping mechanism. Thus, examining coping alongside mood and family environment provides a comprehensive understanding of the psychosocial factors that underlie dependence.

1.8. Family Environment and Its Role in Substance Dependence

The family, as the most fundamental social unit where parents and children live together, plays a central role in shaping personality, behaviour, and coping mechanisms (Bhatia & Chadha, 1993). They identified eight key components: cohesion (commitment and support), expressiveness (sharing feelings openly), conflict (anger and disharmony), acceptance and caring (unconditional support), independence (encouragement of autonomy), active recreational orientation (shared leisure activities), organization (structured roles and responsibilities), and control (regulation and limits). It is within this environment that children first learn how relationships function, how to navigate the physical and social world, and how to manage challenges—primarily by observing parents, grandparents, siblings, and other family members. Beyond social learning, the family provides material, emotional, and physical support, fostering emotional security, stability, and wellbeing. Family is also widely regarded as the basic institution of society, responsible for the survival, protection, and holistic development of children. A nurturing and supportive family environment provide a strong foundation for healthy psychosocial growth, whereas a dysfunctional family environment can predispose members—especially children—to emotional and psychiatric difficulties (Bracik et al., 2012). A balanced family environment across these dimensions fosters emotional security, resilience, and healthy coping. Conversely, dysfunction—such as low cohesion, poor communication, high conflict, or rigid control—has been linked with greater vulnerability to substance dependence. In alcohol and opioid dependence, strained family relationships often exacerbate stress, impair coping strategies, and contribute to relapse, highlighting the family’s role as both a potential protective factor and a significant risk factor in addiction trajectories.

In the context of substance dependence, the quality of family environment has consistently been identified as both a protective factor and a risk factor. The presence of drug addiction or alcoholism within the family can severely undermine stability, strain relationships, and threaten the very foundations of family functioning (Singh et al., 2012).

A healthy family environment characterized by cohesion, expressiveness, acceptance, and support fosters resilience and adaptive functioning in individuals. On the contrary, dysfunctional environments—marked by conflict, lack of organization, poor communication, and rigid control—are strongly associated with the development and persistence of substance dependence (Moos & Moos, 2007; Velleman et al., 2005). Family stressors such as marital discord, parental neglect, domestic violence, and poor role modeling have been widely reported in individuals with alcohol and opioid dependence (McCrary & Epstein, 1999).

Substance dependence is often described as a “*family disease*” (O’Farrell & Fals-Stewart, 1999), as the presence of a substance-dependent individual in the family tends to affect almost all aspects of family life. It disrupts interpersonal and social relationships, creates financial strain, increases conflicts, and places a heavy burden on the family system (Bush et al., 1996). Barry and Fleming reported that addicts’ families typically show poor cohesion and expressiveness, alongside elevated levels of conflict. Similarly, empirical studies have consistently found that families of alcoholics tend to have lower cohesion, independence, and expressiveness, but higher conflict compared to families without substance dependence (Filstead et al., 1981; Moos & Moos, 1984). Such disturbances in family environment may exacerbate stress, negatively affect mood, and foster maladaptive coping strategies.

Eventually, this can result in heightened psychological distress, financial instability, domestic violence, and family dysfunction. Familial alcoholism is one of the basic factors contributing to such dysfunctionality, further aggravating relational and emotional difficulties (Mattoo et al., 2013).

In alcohol dependence, families often exhibit patterns of denial, enabling behaviors, and high conflict, which perpetuate the cycle of abuse. Individuals from families with poor cohesion and weak communication skills are more likely to adopt maladaptive behaviors such as alcohol misuse (Jackson et al., 1996). Similarly, opioid-dependent individuals often report growing up in environments where family conflict and lack of parental support were prevalent (Johnson & Leff, 1999).

Furthermore, family organization and control exert significant influence on coping strategies. Excessive control or rigid structures may suppress healthy expression of emotions, pushing individuals toward maladaptive outlets such as substance use. Conversely, a supportive and well-structured family fosters problem-solving skills and adaptive coping, reducing vulnerability to dependence.

Thus, the family environment acts both as a context for the development of dependence and as a potential resource in recovery. Family-based interventions, including family therapy, psychoeducation, and support groups, have been shown to significantly improve outcomes for individuals undergoing treatment for alcohol and opioid dependence (O'Farrell & Fals-Stewart, 1999).

Importantly, disturbances in family functioning intersect directly with mood regulation and coping mechanisms. Dysfunctional family dynamics often heighten stress and emotional instability, contributing to prolonged negative mood states such as depression, anxiety, or irritability (Watson & Clark, 1997). In turn, individuals in such environments may resort to maladaptive coping strategies—including substance use—as a means of managing distress. This reciprocal relationship suggests that family environment not only shapes emotional well-being but also influences the coping styles adopted by substance-dependent individuals.

Within the context of alcohol and opioid dependence, these interactions become particularly critical. The strain of disrupted family cohesion and conflict may aggravate negative mood states, while ineffective coping strategies may perpetuate dependence and hinder recovery. Therefore, examining family environment, mood,

and coping strategies together provides a comprehensive insight into how these variables interact in individuals struggling with alcohol or opioid dependence.

1.9. Psychological Outcomes: Depression, Anxiety, and Stress in Substance Dependence

Substance dependence is strongly associated with a range of adverse psychological outcomes, most notably depression, anxiety, and stress. These conditions not only co-occur with dependence but also play a major role in the maintenance and relapse of addictive behaviors. The relationship is bidirectional—psychological distress may predispose individuals to substance use, while chronic substance dependence exacerbates emotional dysregulation and mental health issues (Kessler et al., 2005).

Depression is frequently reported among both alcohol- and opioid-dependent populations. Alcohol dependence is linked to persistent low mood, hopelessness, and anhedonia, which might be both a consequence of prolonged use and a motivator for continued consumption as a maladaptive means of coping (Boden & Fergusson, 2011). Similarly, opioid dependence is associated with high rates of depressive symptoms, often compounded by withdrawal experiences and psychosocial stressors (Martins et al., 2012). Untreated depression in these populations increases relapse risk, complicates treatment, and diminishes overall quality of life.

Anxiety disorders are also common among individuals with substance dependence. Alcohol-dependent individuals often report generalized anxiety, panic, and social anxiety, sometimes triggered or worsened during withdrawal phases (Kushner et al., 2000). Opioid dependents, on the other hand, commonly experience heightened anxiety due to physiological dependency, fear of withdrawal, and social stigma. Anxiety not only sustains substance-seeking behavior but also interferes with rehabilitation by undermining confidence in coping without substances (Ziedonis et al., 2009).

Stress plays a central part in the onset and continuation of substance dependence. High stress levels are linked to increased vulnerability to substance use initiation, escalation, and relapse (Sinha, 2008). Stress activates the hypothalamic–pituitary–adrenal (HPA) axis, increasing physiological arousal and emotional instability, which in turn drive individuals to seek substances as a form of relief. Alcohol dependents often use alcohol to blunt stress responses, whereas opioid dependents turn to opioids for both physiological and emotional escape. Chronic stress further disrupts coping processes, making adaptive strategies less likely to be utilized.

Importantly, these psychological outcomes do not occur in isolation but are strongly influenced by family environment and coping strategies. Dysfunctional families tend to amplify psychological distress, whereas supportive environments mitigate symptoms of depression, anxiety, and stress. Likewise, maladaptive coping mechanisms—such as avoidance or emotional suppression—exacerbate distress, while task-oriented coping promotes better emotional regulation and resilience.

By exploring these psychological outcomes in relation to family environment and coping strategies, this study aims for a comprehensive understanding of how depression, anxiety, and stress interact with the psychosocial dimensions of substance dependence, with particular focus on differences between alcohol- and opioid-dependent groups.

1.10. Interlinking Family Environment, Coping, and Psychological Outcomes in Substance Dependence

The interrelationship between family environment, coping strategies, and psychological outcomes forms a critical framework for understanding substance dependence. Family environment not only influences the onset of dependence but also shapes the coping strategies individuals adopt to manage stress and emotions. In turn, these coping strategies directly affect the severity of psychological outcomes such as depression, anxiety, and stress.

A dysfunctional family environment—characterized by high conflict, poor cohesion, lack of expressiveness, and rigid or inconsistent control—can create conditions of emotional instability. Individuals raised in such environments often report higher levels of psychological distress and are more vulnerable to maladaptive coping styles, such as avoidance or emotional suppression (Moos & Moos, 2009). Conversely, families that provide support, warmth, and encouragement foster resilience, enabling dependents to utilize adaptive coping strategies like problem-solving, planning, and seeking social support (McCrary & Epstein, 2013).

Coping mechanisms act as mediators between family environment and psychological health. For example, dependents from supportive families may rely on task-oriented coping, reducing depression and stress levels, while those from high-conflict families may lean toward avoidance-oriented coping, increasing vulnerability to psychological disturbances. Studies have consistently highlighted that reliance on maladaptive coping styles correlates with higher depression, anxiety, and stress among substance-dependent individuals (Litman, 2006; Annis, 1992).

The interaction between these three domains—family environment, coping, and psychological outcomes—is particularly important when comparing alcohol and opioid dependence. Alcohol dependence, often socially and culturally normalized, may develop in families with permissive or enabling attitudes, leading to distress when maladaptive coping fails. Opioid dependence, in contrast, is frequently accompanied by stigma, social rejection, and strained family relationships, intensifying anxiety and reliance on dysfunctional coping strategies. Despite differences, both groups demonstrate how family structures and coping skills act as crucial determinants of psychological well-being.

Thus, examining these interconnections provides an in depth understanding of the psychosocial dimensions of dependence. It also underscores the importance of integrative treatment approaches address medical detoxification and family dynamics, coping interventions, and emotional regulation strategies.

1.11. A Brief Overview of Manipur (Operational Area)

Manipur is one of the eight north-eastern states of India, with a geographical area of 22,327 sq. km. According to the 2011 Census, the state has a population of 27.2 lakhs, comprising approximately 16.5 lakhs males and 13.5 lakhs females (Census of India 2011). Geographically, Manipur occupies a strategic location, sharing a 367.5 km-long porous international border with Myanmar, which makes it highly vulnerable to drug trafficking and the associated challenges of substance use. The state also serves as a crucial transit point for illicit drugs entering India from the Golden Triangle region, thereby intensifying its exposure to narcotics-related issues. Manipur has been grappling with a high incidence of substance use disorders, a problem that escalated significantly during the 1980s with the influx of heroin, often referred to as “No. 4 heroin” (UNODC, 2005). Substance use in the state is not limited to opioids but extends to alcohol, cannabis, sedatives, inhalants, and other psychoactive substances. This multidrug use pattern has compounded public health concerns and contributed to the spread of HIV/AIDS, particularly through injecting drug use (Sarkar et al., 1993).

According National Survey on the Extent, Pattern and Trends of Drug Abuse in India (2004), alcohol is the most commonly used substance in most north-eastern states, with the exception of Mizoram. Interestingly, despite prohibition of alcohol in Manipur, Mizoram, and Nagaland, alcohol users continue to form the second largest group seeking treatment, after opioid users. This suggests that prohibition policies, while well-intentioned, have not been entirely effective in curbing consumption, and in many cases have led to illicit brewing and unsafe consumption practices.

In Manipur, the Manipur Liquor Prohibition Act (MLPA), 1991 formally banned the sale and consumption of alcohol. However, exemptions were provided in certain areas such as Andro, Sekmai, Phayeng, and some tribal-populated regions of Imphal, where traditional and customary practices were recognized. Over time, enforcement challenges and the growth of illicit alcohol markets raised questions about the effectiveness of prohibition. Consequently, the state government officially withdrew

prohibition on 6th December 2023, citing the need to regulate production, ensure safety, and address revenue concerns.

Today, Manipur stands at a critical juncture: while grappling with long-standing issues of opioid dependence, alcohol misuse, and poly-substance abuse, it also faces the social and health consequences of shifting drug policies. The unique geopolitical location, porous borders, and sociocultural dynamics make it a particularly relevant context for studying the interplay of mood, family environment, and coping strategies among individuals with substance dependence.

CHAPTER II

REVIEW OF LITERATURE

This chapter is an attempt made to review the research findings with regard to the areas of the present study.

2.1. Mood & Psychiatric Comorbidities in Substance Dependence

Chhetri et al. (2023) investigated the prevalence and severity of major depressive disorder (MDD) and associated risk factors among Bhutanese adults with alcohol use disorder (AUD). The study reported an overall prevalence of depression, defined as a PHQ-9 score of ≥ 10 , in 38% of participants. Individuals with a family history of alcohol and substance use disorders demonstrated significantly higher rates of depression ($p = .03$). Multivariate binary logistic regression analysis further revealed that female participants (AOR = 2.19, 95% CI [1.01, 4.75]) and those with a family history of psychiatric illness (AOR = 4.63, 95% CI [1.17, 18.44]) were more likely to develop MDD.

Allah et al. (2022) examined the relationship between opioid addiction and comorbid major depressive disorder (MDD) among 229 patients aged 15–50 diagnosed with opioid use disorder. Major depressive disorder was the most common psychiatric comorbidity, affecting 32.8% of the sample. Comorbid MDD patients had significantly more rates of suicide attempts, overdose history, number of treatment trials, and previous admissions for addiction problems compared with those without comorbidity.

Santo Jr. et al. (2022) conducted a meta-analysis by searching Embase, MEDLINE, and PsycInfo for observational studies published between 1990 and 2021 on mental disorders among individuals with opioid use disorder (OUD). Using random-effects meta-analyses with 95% confidence intervals (CIs), they pooled current and lifetime prevalence estimates of depression, anxiety, bipolar disorder, personality disorders, and other specified conditions. Among individuals with OUD, the prevalence of depression was 36.1% (95% CI [32.4, 39.7]), anxiety was 29.1% (95% CI [24.0,

33.3]), attention-deficit/hyperactivity disorder was 20.9% (95% CI [15.7, 26.2]), post-traumatic stress disorder was 18.1% (95% CI [15.4, 20.9]), and bipolar disorder was 8.7% (95% CI [6.7, 10.7]). The lifetime prevalence of antisocial personality disorder was 33.6% (95% CI [29.1, 38.0]) and borderline personality disorder was 18.2% (95% CI [13.4, 23.1]).

In this cross-sectional study of 61 patients with opioid dependence (28 abstinent, 33 relapsed), Kailash et al. (2021) examined psychosocial predictors of relapse: high-risk situations, negative mood states, undesirable stressful life events, self-efficacy, coping behaviour, social support. They found that more high-risk situations and negative mood states and stressful life events significantly increased odds of relapse, whereas higher self-efficacy was protective. This highlights the importance of psychosocial variables (coping, mood, stress) in relapse among opioid dependents.

Chan et al. (2020) investigated the association between non-medical prescription opioid use (NMPOU) and psychological distress using the Kessler Psychological Distress Scale (K6). Their findings indicated that NMPOU was significantly associated with higher levels of psychological distress. Among adults aged 50 years and older, NMPOU was linked to a 224% increase in the odds of meeting the clinical threshold for serious mental illness.

Sharma et al. (2019) assessed 100 opioid-dependent individuals in treatment centres in Sikkim, India. Mean age was about 29.6 years, majority male, from urban areas. Very high rates of depression (82%) with mild to moderate severity, anxiety (56%), and some cases of mania was found. Sociodemographic factors (urban locality, education, socioeconomic status) were also considered. The study underscores how common psychiatric comorbidity is among opioid dependence in an Indian context, suggesting that treatment must address not just dependence but also mood disorders.

Kaundal, Sharma, and Jha (2016) studied alcohol-dependent patients who relapsed, assessing psychosocial factors retrospectively. They found various psychosocial correlates of relapse include stressors, family issues, psychological distress etc. This adds more evidence for coping, relapse, and family environment as important domains.

Fooladi and colleagues (2014) compared depression, anxiety, stress, and quality of life between individuals with drug dependence and a control group. Using the DASS-21 and the SF-36 questionnaire, they found that drug-dependent individuals reported significantly higher depression, anxiety, and stress, along with poorer quality of life, compared to the normal population. Furthermore, depression, anxiety, and stress were negatively correlated with quality of life.

Gros and colleagues (2013) investigated psychiatric comorbidities prevalence among individuals with prescription opioid dependence. In their study, diagnosed 47.1% of participants with a comorbid mood or anxiety disorder. Those with such comorbidities exhibited more severe alcohol use, heightened psychiatric symptoms, and greater sleep impairments compared to individuals without comorbidity. These findings underscore the complex interplay between prescription opioid dependence and co-occurring mental health conditions, highlighting the need for integrated treatment approaches. This supports the broader evidence that substance dependence often coexists with psychiatric disorders, complicating both the clinical presentation and recovery process.

Keys et al. (2012) examined the relationship between stress and alcohol use, emphasizing how stress contributes to the development and progression of alcohol use disorders (AUDs). They identified four main categories of stressors that influence alcohol consumption: general life stress, catastrophic or fateful stress, childhood maltreatment, and minority stress. Findings indicates that individuals with a history of AUDs are more likely to use alcohol as a coping mechanism in response to traumatic or stressful events. Additionally, early initiation of drinking during adolescence and a higher likelihood of adult AUDs were observed among individuals

exposed to childhood maltreatment. This study highlights the critical role of stress exposure, particularly in formative years, in shaping vulnerability to problematic alcohol use across the life span.

Fatséas et al. (2010) investigated the prevalence of anxiety disorders among individuals receiving treatment for opiate dependence. The study reported a high lifetime prevalence of anxiety disorders, ranging from 26% to 35% among this population. Findings suggest that anxiety disorders are a common psychiatric comorbidity in opioid-dependent individuals, which complicates treatment outcomes and recovery trajectories. The co-occurrence of anxiety not only exacerbates psychological distress but may also contribute to maladaptive coping mechanisms and relapse vulnerability. This highlights the importance of incorporating mental health assessments and integrated interventions into substance use disorder treatment programs.

Saatcioglu et al (2008) investigated the relationship between psychiatric comorbidity and quality of life in a sample of 150 hospitalized patients with alcohol dependence. The study specifically assessed the severity of anxiety and depression symptoms and their influence on patients' overall functioning. It showed that higher levels of anxiety and depression were strongly associated with greater severity of alcohol-related problems and significantly reduced quality of life. It indicated that psychological distress not only accompanies alcohol dependence but also amplifies its adverse consequences, making recovery more difficult. The study underscores the need of screening for and addressing co-occurring anxiety and depressive symptoms in the treatment of alcohol dependence, as untreated psychiatric comorbidities may hinder improvement in both clinical outcomes and quality of life.

Seeman and Seeman (1992) examined the relationship between stressful experiences and drinking problems, emphasizing that alcohol-related issues are strongly associated with stress irrespective of whether the stressors are acute, severe, or chronic. In the context of occupational stress, the study highlighted that men working in highly demanding jobs, particularly those characterized by rigid or inflexible ways

of fulfilling job responsibilities, exhibited the highest levels of alcohol consumption and alcohol-related problems. Results indicate occupational stress acting as a significant risk factor for problematic drinking, and that the rigidity of workplace demands can exacerbate vulnerability to alcohol misuse. The study thus underscores the importance of addressing workplace-related stressors in the prevention and treatment of alcohol dependence.

2.2. Family Environment & Substance Use Disorders

Rathee et al. (2022) conducted a cross-sectional study of the family burden experienced by caregivers of individuals with alcohol dependence. The study revealed a high level of burden, especially in the areas of financial strain, disruption of family interactions, and routine activities. The findings emphasize that alcohol dependence not only affects the individual but also places significant strain on family members, highlighting the need for family-focused interventions in treatment.

Sarkar et al. (2022) reviewed the interrelationship between substance use disorders (SUDs) and family functioning. Their findings indicated that domestic violence and adverse familial circumstances frequently emerge as consequences of substance use. Spouses of individuals with SUDs were reported to experience elevated rates of psychopathology and psychological distress, while children of affected individuals exhibited higher levels of behavioral disturbances. The review also highlighted the development of codependence within families, which may perpetuate the cycle of substance use. Overall, substance use was shown to place a significant burden on families, both psychologically and in terms of resources.

Soni et al. (2021) directly compared quality of life among patients diagnosed with alcohol dependence syndrome versus opioid dependence syndrome. Results indicate that while both groups exhibit impaired QoL, specific domains (e.g., social relationships, psychological health) may be more severely affected in one group than the other, suggesting substance-specific patterns of impact. Such comparative QoL data complement studies of family burden and coping by documenting how

dependence translates into everyday functional impairment for the patient and, by extension, for family members.

Nalven et al. (2020) examined the influence of peer, family, and school factors on opioid use among American Indian (AI) youth. The study found that greater peer substance use, lower levels of family disapproval, and poorer school performance were significantly associated with a higher likelihood of lifetime opioid misuse. These findings underscore the need of incorporating peer, family, and educational contexts into intervention strategies for heroin and other opioid misuse among AI adolescents.

Singh and Gupta (2017) highlighted the multifaceted consequences of drug abuse within the family system, including economic strain, interpersonal violence, disruption of family dynamics, and the emergence of psychological problems among family members. Their review emphasized adolescent drug abuse as a particularly pressing concern, more than half of individuals with substance dependence are introduced to substances before the age of 15. The study also underscored the broader social implications of substance abuse, particularly the burden it imposes on families on finances, emotional well-being, and stability of relationships. Result showed that early prevention and intervention strategies targeting adolescents and family systems are crucial in mitigating the long-term psychosocial consequences of drug abuse.

Vaishnavi Et al (2017) assessed 200 patients with alcohol dependence and their caregivers on severity of dependence and the pattern of burden on caregivers. The caregivers of alcohol dependent patients reported significant objective burden and subjective burden. High significance was found between the severity of alcohol dependence and the domains of burden such as financial burden, disruption of family interaction, and disruption of family routine activities.

Sarkar, et al (2016) discussed the significant impact of substance dependence on family members, particularly in societies such as India where families tend to be close-knit. They emphasized that family members provide crucial social support in

the treatment of substance dependence, and their role should be acknowledged and respected. The authors also noted that changing social structures may influence both the effects of substance dependence on families and the role families play in treatment-seeking processes.

Lander et al (2013) emphasized the significant impact of substance dependence on family systems. They found that substance dependence disrupts emotional and behavioral patterns within families from the very beginning, often leading to negative outcomes for both children and adults. The study highlighted that the family context plays an important role in how substance dependence develops and are maintained, and determining the course of treatment. By examining the family's influence, the authors suggested that interventions targeting family dynamics can improve result for individuals with substance dependence.

Mattoo, et al (2013) investigated the burden experienced by family caregivers of individuals with alcohol or opioid dependence at a de-addiction centre in North India. The study, which included 120 male patients, reported that almost all caregivers (95–100%) experienced moderate to severe burden. The most affected domains were disruption of family routine, financial strain, disruption of family interaction, and restriction of family leisure activities. Family burden was significantly higher among caregivers from low-income and rural backgrounds, whereas no significant associations were found with patient age, education, duration of dependence, family size, type of caregiver, or caregiver's educational or occupational status. These findings highlight that socioeconomic and environmental factors contribute more to caregiver burden than individual demographic variables.

Singh et al. (2012) examined how parents, spouses, and siblings of individuals with alcohol dependence perceive the quality of the family environment. The study included 90 alcohol dependent participants (30 parents, 30 spouses, and 30 siblings), using a socio-demographic data sheet, the Family Environment Scale (FES), and the General Health Questionnaire-12. Findings revealed that spouses reported significantly lower levels of expressiveness in the family environment compared to

parents and siblings. Moreover, both parents and spouses experienced more negative perceptions in the domain of control than siblings. These results highlight the disproportionate emotional and relational strain faced by those most directly involved in caregiving, particularly spouses, who are often primary caregivers. The study reinforces that alcohol dependence does not only affect the individual but also creates systemic stressors within the family, contributing to family burden and potentially influencing coping strategies and relapse risk.

Barry and Fleming (1990) investigated family cohesion, expressiveness, and conflict in a primary care sample consisting of alcoholics and non-alcoholics, both with and without a family history of alcoholism. Their findings revealed that alcoholics with a family history of alcoholism reported significantly lower levels of family cohesion and expressiveness, alongside higher levels of family conflict, when compared with non-alcoholics from either group. Interestingly, non-alcoholics who had grown up in alcoholic families did not differ significantly from non-alcoholics without such a family history in their perceptions of present family relationships. These results suggest that a family history of alcoholism alone does not necessarily predict negative family dynamics; rather, it is the combination of personal alcoholism and family history that is associated with greater dysfunction in current family relationships.

2.3. Stress, Coping Strategies in Alcohol and Opioid Dependents

Venkateswaran and Thirumalai (2024) examined the severity of alcohol dependence & coping styles among 127 alcohol-dependent participants aged 18 years and above. The sample had a mean age of 38.24 years ($SD = 15.75$). Findings indicated that individuals who had relapsed scored significantly higher on denial ($p = .005$), substance use ($p = .024$), and self-blame ($p = .012$). Furthermore, a positive correlation was observed between the severity of alcohol dependence and maladaptive coping strategies ($p < .01$).

Taziki and colleagues (2015) compared opioid-dependent individuals ($n = 149$) with controls ($n = 221$) on coping strategies using the Jalowiec Coping Scale and various

socioeconomic factors. Significant differences were found in 10 out of 15 coping strategies ($p < .05$), though the combined scores of problem-oriented and affective-oriented coping items did not differ significantly between groups. Opioid dependence was significantly associated with cigarette smoking ($p < .001$), lower education ($p = .002$), employment status ($p < .001$), having children ($p < .001$), and being married ($p < .001$). The authors suggested that educational programs aimed at improving problem-solving and coping skills could help reduce opioid dependence and smoking.

Hyman et al. (2009) conducted a comparative study between opioid-dependent individuals entering naltrexone treatment ($n = 57$) and healthy controls ($n = 75$) to assess stress, coping, and social support. Findings revealed that opioid-dependent participants experienced significantly greater stress and made less use of adaptive coping strategies compared to controls. Interestingly, no differences emerged between the two groups in the use of maladaptive or avoidant coping strategies, suggesting that opioid dependence is more strongly characterized by a deficit in adaptive coping rather than an excess of maladaptive responses. Additionally, levels of social support did not differ significantly between the groups. Regression analysis indicated that perceived stress was predicted by group membership, lower levels of social support, and greater reliance on maladaptive coping strategies. These findings highlight that while social support may remain intact, ineffective stress management and limited adaptive coping skills play a critical role in the persistence of opioid dependence, underscoring the need for therapeutic interventions that strengthen adaptive coping mechanisms.

Benegal et al. (2009) examined alcohol dependent caregivers' burden in India. Their findings indicated that caregivers frequently reported high levels of stress, financial strain, and disruption of family relationships due to the individual's drinking behavior. The study emphasized that alcohol dependence not only impacts the patient but also extends significant psychological and social consequences onto the family system. This underlines the need for family-centered approaches in the management and rehabilitation of alcohol-dependent individuals.

Maulik et al (2002) assessed coping behaviors and reasons for lapse and relapse among individuals with substance dependence in the Indian context. The study revealed that environmental influences, such as peer pressure and availability of substances, played a major role in the initiation of first use, while physiological experiences related to drug consumption were more important in driving regular use. Significant differences were also found between currently abstinent and currently using individuals in terms of their coping strategies during abstinence, with abstinent participants employing more adaptive coping behaviors compared to those who relapsed. The findings underscore the relevance of environmental triggers in initiating substance use and the importance of coping mechanisms in determining the course of abstinence or relapse. By situating these patterns within an Indian sociocultural framework, the study provides valuable insights for designing relapse prevention interventions tailored to local contexts

2.4. Comparative Studies: Alcohol vs. Opioid Dependence

Kaur & Kaur (2024) conducted a comparative study among 100 patients (50 with alcohol dependence, 50 with opioid dependence) admitted to selected hospitals in Ludhiana, Punjab, to identify factors contributing to relapse. The study used a self-structured checklist covering sociodemographic data and five sub-factors (each with 10 items) to assess relapse risk. Among opioid-dependent patients, 84% reported the effect of all examined factors as “severe” while 16% reported them as “moderate”; among alcohol-dependent patients, 68% reported “severe” and 32% “moderate” effects. Personal, family, and psychological factors were the main reasons associated with relapse in both groups. Interestingly, age, marital status, and area of residence did not show statistically significant relationship with relapse in alcohol-dependent patients; similarly, family type and area of residence showed non-significant association in opioid-dependent patients. These findings suggest that while relapse risk is high in both groups, the severity and perception of contributing factors differ somewhat by dependence type, and certain sociodemographic variables may be less predictive of relapse in this sample.

Kadam et al. (2017) compared sociodemographic factors and correlates of relapse in alcohol dependent (n = 30) and opioid dependent (n = 30). The opioid-dependent group was more likely to be single, unemployed, from a lower socioeconomic background, and to have a criminal record ($p = .025$). In terms of relapse factors, the opioid group reported significantly higher craving, greater perceived criticism ($p = .0001$), and lower self-efficacy ($p = .016$). Across both groups, the most common reason cited for relapse was the desire for a positive mood.

Mattoo et al (2013) compared individuals with opioid dependence and alcohol dependence to examine differences in socio-demographic characteristics and family burden. They found that those with alcohol dependence were generally older, married, employed, and earning higher incomes, with wives often serving as primary caregivers. In contrast, family burden was reported as moderate to severe in 95–100% of cases across both groups, with the most significant effects observed in disruption of family routine, financial strain, strained family interactions, and loss of leisure activities. Importantly, family burden was strongly associated with low income and rural residence but was not significantly related to patient age, education, duration of dependence, family size, caregiver type, or caregiver's education and occupation. This highlights importance of socioeconomic status and rural background in shaping the extent of family burden in substance dependence.

Mattoo et al. (2009) conducted a structured assessment to examine clinical and demographic parameters, relapse precipitants, coping strategies, self-efficacy, stressful life events, and perceived social support among patients with alcohol or opioid dependence. The sample consisted of 60 participants, including 30 who had relapsed and 30 who had remained abstinent. Comparisons were also made within the alcohol and opioid subgroups. This showed patients who relapsed were significantly more likely to report a positive family history of substance use, a greater number of previous relapses, reliance on maladaptive coping strategies, higher exposure to “high-risk” situations, and a greater number of undesirable life events. In contrast, abstinent patients employed a significantly larger number of coping strategies—primarily adaptive ones—and scored higher on all measures of

self-efficacy. Importantly, the factors influencing relapse were largely consistent across both alcohol and opioid dependence groups. These findings underscore the critical role of coping strategies and self-efficacy in sustaining recovery, while also highlighting how family history and life stressors serve as potent risk factors for relapse.

Subramaniam et al. (2009) examined differences between adolescents with opioid use disorder (OUD; $n = 94$) and those with non-OUD substance use disorders involving cannabis or alcohol ($n = 74$). It was found that adolescents with OUD were dropped out of school, and residing in suburban areas, though pattern were not uniformly significant. The OUD group demonstrated greater severity of substance use, with higher proportions reporting sedative use and multiple substance use disorders. While both groups showed high rates of psychiatric comorbidity (83% for OUD vs. 78% for non-OUD), adolescents with OUD reported significantly higher levels of depressive symptoms, generally in the moderate range. Moreover, injection drug use and needle sharing were reported almost exclusively in the OUD group, highlighting a unique risk profile. Both groups, however, exhibited similarly elevated rates of risky sexual behaviors. These findings emphasize the heightened vulnerability of adolescents with OUD, not only due to greater psychiatric burden and depressive symptoms but also because of the associated severe health risks.

Thomas et al. (2004) compared individuals with alcohol dependence ($n = 63$) and those with opioid dependence ($n = 34$) to identify socio-demographic and clinical differences between the two groups. Most participants in both groups were aged 30–50 years, but the onset of dependence differed significantly: opioid users became dependent at a younger age (mean = 25.88 years) compared to alcohol users (mean = 30.59 years). The alcohol-dependent group tended to be older overall (mean age = 41.48 years vs. 33 years in the opioid group) and showed a higher prevalence of physical comorbidities (79.3% vs. 29.4%). In context of social characteristics, alcohol-dependent individuals were more often from rural areas (73%), whereas opioid users predominantly came from urban settings (88.2%), suggesting a growing urban risk profile for opioid misuse. Religious background also showed variation,

with Hindus comprising the majority in the alcohol-dependent group (86%) and Muslims forming the majority in the opioid-dependent group (85%). A family history of substance use was commonly observed alcohol-dependent participants (54%). Collectively, these findings highlight distinct socio-demographic and clinical profiles for alcohol- versus opioid-dependent populations, emphasizing the need for context-specific prevention and intervention strategies.

Priyanka and Ankita (2016) reviewed the risk factors for adolescent drug abuse, highlighting multiple contributors such as biological predisposition, weak social bonding, low socioeconomic status, poor family relationships and parental guidance, history of abuse or neglect, psychiatric vulnerabilities, stress, and inadequate coping skills. Peer influences, rejection due to poor communication, academic failure, and antisocial behaviors were also identified as significant risk factors. The authors emphasized that the path to drug abuse is complex, making simple solutions ineffective. Their review also examined the extent and demographics of drug abuse in India, concluding that preventive strategies must be developed, and more empirical studies are needed to address the current situation.

Nattala et al. (2010) compared three interventions in alcohol dependence treatment: individual relapse prevention, dyadic relapse prevention (participant + family member), and treatment as usual. Over 6 months follow-up in Indian inpatient sample, dyadic relapse prevention produced better outcomes in reduced drinking days, lower quantity intake, and fewer family, occupational, financial dysfunctions. This demonstrates that including family environment in relapse prevention improves outcomes, reinforcing your thesis focus on family environment and coping.

Rationale of the study

Existing literature provides extensive evidence on the psychosocial and clinical aspects of substance dependence, but notable gaps remain. Research has consistently demonstrated a high prevalence of depression, anxiety, and stress among individuals with alcohol or opioid dependence (Chhetri et al., 2023; Gros et al., 2013; Hyman et al., 2009). However, lack of comparative focus restricts our understanding of whether mood disturbances manifest differently in alcohol-dependent versus opioid-dependent individuals, despite clinical evidence suggesting potential variations in severity and symptom profiles.

Studies have also highlighted the significant family environment of individuals with substance dependence, including reduced cohesion, increased conflict, and overall disruptions in family functioning (Barry & Fleming, 1990; Mattoo et al., 2013; Singh et al., 2012). While these findings underscore the importance of the family environment, there is limited comparative research examining whether the familial impact differs between alcohol and opioid dependence. In India, family takes a very important part in caregiving and recovery, such comparative insights are particularly valuable yet understudied.

Similarly, coping strategies and relapse risk are strongly linked, with maladaptive coping associated with poorer treatment outcomes across both alcohol and opioid dependence (Hyman et al., 2009; Kadam et al., 2017; Mattoo et al., 2009). Nonetheless, most research has assessed coping strategies within a single group of patients, leaving unclear whether alcohol- and opioid-dependent individuals employ different coping mechanisms that may require tailored therapeutic interventions.

Finally, the majority of studies tend to examine individual domains—mood, family environment, or coping—in isolation. Few have adopted an integrated framework that simultaneously evaluates all three dimensions. Moreover, found paucity of comparative research in the Indian context, where cultural and socioeconomic factors strongly influence substance use and recovery. Therefore, there is a clear gap in the literature regarding a comprehensive, comparative assessment of mood, family

environment, and coping strategies among alcohol- and opioid-dependent populations in India. Addressing this gap will help generate evidence to guide context-specific, holistic treatment approaches.

Significance of the Study

The present study holds significance at multiple levels. At the clinical level, it will provide comparative insights into the role of mood disturbances, family environment, and coping strategies in alcohol and opioid dependence. Such knowledge will enable mental health professionals to develop more precise, substance-specific therapeutic interventions and relapse prevention strategies.

At the family and community level, the study will shed light on how dependence affects family functioning and coping mechanisms, particularly in the Indian cultural context where families are deeply involved in caregiving. These findings may guide the design of family-based interventions and psychoeducation programs, thereby reducing caregiver burden and strengthening support systems for individuals with substance dependence.

At the policy and programmatic level, the study can contribute to evidence-based decision-making by highlighting areas that require resource allocation, such as integrating family support services within de-addiction programs or developing specialized modules for alcohol versus opioid users.

Finally, at the academic level, this research will enrich the existing literature by addressing gaps in comparative studies of alcohol and opioid dependence. It will serve as a valuable resource for future researchers interested in the psychosocial dimensions of substance use disorders in India.

CHAPTER III

METHODOLOGY

3.1. Aim & Objectives:

Aim: The present study aimed to explore and compare the depression, anxiety, stress, family environment, and coping styles of opioid dependents and alcohol dependents.

Objectives:

1. To assess and compare the family environment of opioid dependent and alcohol dependent groups.
2. To assess and compare depression, anxiety, stress, of opioid dependent and alcohol dependent groups.
3. To explore and compare coping style of opioid dependent and alcohol dependent groups.
4. To explore the relationship among family environment, depression, anxiety, stress, coping style of opioid dependence.
5. To explore the relationship among family environment, depression, anxiety, stress, coping style of alcohol dependence.

3.2 Hypotheses: Based on the objectives set forth for the present study, the following Hypotheses were developed:

1. The family environment of opioid dependent and alcohol dependent groups will be significantly different.
2. There will be significant differences on depression, anxiety, stress of opioid dependent and alcohol dependent groups.
3. Significant difference will be observed on coping style of opioid dependent and alcohol dependent groups.
4. Significant relationship among family environment, depression, anxiety, stress, coping style of opioid dependence will be observed.
5. Family environment, depression, anxiety, stress, coping style of alcohol dependence will be significantly related.

3.3 Research Design

The present study employs a cross-sectional, correlational, and comparative research design using a two-group framework. A cross-sectional approach enables the assessment of mood, family environment, and coping strategies among individuals at a single point in time, thereby capturing existing differences and associations without the influence of temporal variation. The correlational element facilitates the exploration of relationships between mood states, family dynamics, and coping mechanisms within each group, offering insights into the psychological and social factors that contribute to dependence. The comparative design allows for a systematic evaluation of similarities and differences between opioid-dependent and alcohol-dependent individuals across these domains. By adopting a two-group design, the study ensures that both groups are assessed under equivalent conditions, thereby enhancing the validity of group comparisons.

3.4 Sample

A total of 200 male participants (100 opioid-dependent and 100 alcohol-dependent) was selected for this study. Participants were selected through purposive sampling, strictly based on the inclusion and exclusion criteria outlined for the study.

Due to the clinical nature of the population and the specific inclusion/exclusion criteria, a non-probability purposive sampling approach was adopted.

The sample size was predetermined at 100 per group (N=200) to ensure estimation precision and statistical stability. This size aligns with methodological precedents in Indian psychiatric literature (Kadam et al., 2017; Kailash et al., 2021; Kaur & Kaur, 2024; Sharma et al., 2019; Singh et al., 2012), ensuring results are consistent with regional research norms.

3.5 Inclusion and exclusion criteria

Inclusion Criteria

1. Male participants diagnosed with either opioid dependence or alcohol dependence.
2. Participants with a history of opioid or alcohol dependence for a duration not exceeding two years.
3. Participants aged between 18 and 45 years.
4. Minimum educational qualification of up to Class XII and adequate proficiency in English to ensure comprehension of study instruments.

3.6 Exclusion Criteria

1. Female participants were excluded from the study.
2. Individuals below 18 years or above 45 years of age.
3. Individuals with chronic medical conditions, neurological disorders, or comorbid psychiatric illnesses.

4. Participants currently in a state of intoxication or undergoing acute withdrawal at the time of data collection.
5. Individuals with an educational level below Class XII or lacking proficiency in English sufficient to comprehend study tools.

3.7 Operational Definitions

Substance Dependence (Screening and Inclusion/Exclusion Criteria): Substance dependence in this study specifically refers to alcohol dependence or opioid dependence. Screening for multiple substance use/dependence was conducted using the World Health Organization Alcohol, Smoking and Substance Involvement Screening Test (WHO ASSIST, 2002), and only participants with primary alcohol or opioid dependence without multiple substance dependence were included.

Mood: In the present study, mood refers to the level of depression, anxiety, and stress as assessed by the Depression Anxiety Stress Scale-42 (DASS-42; Lovibond & Lovibond, 1995). Higher scores indicate greater severity of the respective negative emotional states.

Family Environment: Family environment refers to the social and interpersonal climate within the family system, as assessed by the Family Environment Scale (FES; Bhatia & Chadha, 1993). The scale evaluates domains such as cohesion, expressiveness, conflict, and control, reflecting the overall relational patterns within the family.

Coping Strategy: Coping strategy is defined as the patterns of cognitive and behavioral responses used to manage stress in difficult or challenging situations, as measured by the Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1999). The tool categorizes coping into task-oriented, emotion-oriented, and avoidance-oriented strategies.

3.8 Tools used in the study:

1. **Socio-demographic profile:** A semi-structured proforma was developed to collect necessary background information. It included variables such as age, educational level, occupation, religion, marital status, type of family, and monthly family income. This tool was used to document the socio-demographic profile of participants and to check the baseline comparability of the opioid-dependent and alcohol-dependent groups through statistical analysis.

The WHO- Alcohol, Smoking and Substance Involvement Screening Test (ASSIST-Version 3.0) is an 8-item screening tool used to assess substance use and related risks; items 2–7 generate involvement scores for risk levels, while items 1 and 8 identify substances used and associated problems, with strong reliability and validity across populations. Scores from items 2–7 are summed to calculate a Specific Substance Involvement Score (SSIS). Total scores categorize risk into three levels: Low (0–3), Moderate (4–26), and High (27+). Moderate scores indicate a need for brief intervention, while high scores suggest a likely dependence requiring specialist referral. It was the primary tool for the Magnitude of Substance Use in India report (Ambekar et al., 2019), which specifically highlighted substance use patterns in Manipur.

3. Family environment scale (FES: Bhatia H& Chadha N.K, 1993): The scale is based on the family environment scale by Moos (1974) and it consists of 69 items. The scale measures mainly three dimensions of family environment viz. Relationship (cohesion, expressiveness, conflict, acceptance and caring), Personal Growth (independence, active-recreational orientation) and System maintenance (organization and control). Items are rated on a 5-point scale (Strongly Agree to Strongly Disagree, including a Neutral option), incorporating both positive and reverse-coded items. Subscale scores are summed and interpreted as High, Average, or Low; with reported reliability ranging from .48 to .92. The FES is a standard tool in Manipuri social

research, used to study student well-being (Singh & Kumar, 2022) and educational aspirations in districts like Churachandpur (Lalsanhim, 2018).

4. The Depression Anxiety Stress Scale (DASS)-42 (Lovibond & Lovibond, 1995) is a 42-item self-report scale assessing depression, anxiety, and stress for people 17 years and above via three 14-item subscales, demonstrating high reliability ($\alpha = .88, .82, .90$). Items are rated on a 4-point scale (0–3) based on the past week. Subscale scores (0–42) are calculated by summing relevant items, with higher scores indicating greater severity across five levels: Normal, Mild, Moderate, Severe, and Extremely Severe. This tool has been extensively utilized in Manipur, including studies on higher secondary students in Imphal (Kumar & Akoijam, 2017) and medical students at JNIMS (Singh et al., 2021).

5. Coping Inventory for Stressful Situations (CISS); (CISS; Endler & Parker, 1999): The CISS is a self-report paper and pencil measure of coping, consisting of 48 items. Sixteen items each assess Task-oriented coping, Emotion-oriented coping, and Avoidance-oriented coping: i. distraction (eight items), and ii. Social Diversion (five items). Participants are asked to rate each item on a 5-point frequency scale ranging from (1) Not at all to (5) very much. The CISS can usually be completed in about 10 minutes. The task and emotion scales had the highest reliabilities, above or equal to .68 for males and females. The avoidance scale and the two subscales of distraction and social diversion had moderate reliabilities ranging from .51 to .60. Total scores for each dimension range from 16 to 80. Higher scores reflect a stronger preference for that coping style, with the Avoidance scale providing further sub-scores for Distraction and Social Diversion. Local researchers have utilized this scale to document coping mechanisms among adolescents and general populations in Imphal West and surrounding conflict zones (Devi & Singh, 2018).

3.9 Procedure

After the approval of the study in the 37th Academic Council Meeting following the recommendations from the Departmental Research Committee and Board of Studies; Ethical clearance was obtained to ensure compliance with ethical research standards. And formal permissions were secured from the relevant authorities at the Jawaharlal Nehru Institute of Medical Sciences (JNIMS) hospital and the Department of Social Welfare, Govt. of Manipur as well as rehabilitation centres. Further, concerned authorities were briefed on study objectives and protocols to facilitate site access.

Prospective participants were provided with a comprehensive briefing regarding the nature and purpose of the study, including specific expectations, time requirements, and their right to voluntary withdrawal. Any queries raised by the participants were clarified to ensure full comprehension. Following this disclosure, written informed consent was systematically obtained from each individual prior to their inclusion. To protect participant privacy, strict protocols for confidentiality and anonymity were maintained throughout the study.

To ensure the cohort strictly aligned with the research objectives The World Health Organization Alcohol, Smoking and Substance Involvement Screening Test (WHO ASSIST, 2002) was utilized to screen for multiple substance use or dependence. Eligibility was restricted to participants presenting with primary alcohol or opioid dependence without comorbid multiple substance dependence. Final inclusion was determined by these screening results in conjunction with the predefined inclusion and exclusion criteria.

Participants were selected from a hospital and different deaddiction and rehabilitation centres located in different valley districts of Manipur viz. Jawaharlal Nehru Institute of Medical Sciences (JNIMS), Porompat, Imphal East and Kha Manipur Yoga & Nature Cure Association and Phidam (IRCA) located in Kakching district; Rural Development Society De-Addiction Centre in Thoubal district; Manipur Rural Institute Society, New Life De-Addiction Centre, Galaxy Club–Divine Light De-Addiction Centre, Renaissance Anti-Drug Movement in Imphal

West; and Kripa Foundation, Korengei, CMC Road, Awakening Foundation in Imphal East.

The Semi-Structured Performa, which consisted of demographic details such as age, religion, educational qualification, marital status, and previous history of psychological or psychiatric problems, was administered to ensure the true representation of comparison groups. Following this, the following standardized tools were administered sequentially: (1) Depression Anxiety Stress Scale (DASS-42) (Lovibond & Lovibond, 1995), (2) Family Environment Scale (FES; Bhatia & Chadha, 1993), and (3) Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1999).

3.10 Statistical Analysis

To test the hypotheses formulated for the present study titled *“Assessment of Mood, Family Environment, and Coping Strategy of Opioid Dependents and Alcohol Dependents,”* a series of statistical analyses were conducted.

Descriptive statistics (mean, standard deviation, and percentages) were used to summarize the socio-demographic characteristics of the participants, as well as their scores on measures of mood, family environment, and coping strategies. Prior to conducting inferential statistics, the Kolmogorov-Smirnov test was applied to examine the normality of the data distribution, and the results indicated that the sample was normally distributed, allowing for the use of parametric tests.

For group comparisons, independent sample *t*-tests were employed to assess significant differences between opioid-dependent and alcohol-dependent participants on depression, anxiety, stress, family environment, and coping strategies. Chi-square tests were applied to analyze categorical variables such as socio-demographic factors. Pearson’s correlation coefficient was used to explore relationships among family environment, depression, anxiety, stress, and coping strategies within each group.

Statistical analyses were computed using the Statistical Package for the Social Sciences (SPSS) software, version 25. A significance level of $p < .05$ was considered statistically meaningful for all tests.

3.11 Ethical Consideration

The study was conducted with adherence to ethical guidelines for social research and with approval from the Departmental Research Ethics Committee of the University and adhered strictly to the ethical principles outlined in the *Declaration of Helsinki (2013)*. All participants were informed about the voluntary nature of their participation, assured of confidentiality, and written informed consent was obtained before inclusion. Moreover, permissions from hospitals, rehabilitation centres, and the Social Welfare Department ensured institutional oversight during the conduct of the study.

CHAPTER IV

RESULTS

The present study entitled, “Assessment of mood, family environment, and coping strategy of opioid dependents and alcohol dependents”, was conducted by following the scientific methodology which could be replicated in future to cross checking or to get more information in the selected population for framing prevention and developing intervention strategies for psychological problems.

The present study explored family environment, Anxiety, Depression, Stress and coping strategy of opioid dependents and alcohol dependents individuals. For the study, 2 groups of 100 male opioid dependents and 100 male alcohol dependents participants aged 18-45 was selected through purposive sampling method. To meet the objectives and the hypotheses set forth for the present study, the psychological tests: 1. The World Health Organization (WHO) Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) is a questionnaire to screen the levels of problem, 2. Family environment scale (FES: Bhatia H& Chadha N.K, 1993), and 3. Depression Anxiety Stress Scale (Lovibond, S.H. & Lovibond, P.F.,1995)) and 4. Coping Inventory for Stressful Situations (CISS; Endler & Parker, 1999) were employed.

The result of the study are as follows:

Table 1 Sociodemographic Characteristics with regard to Opioid Dependents and Alcohol Dependents.

Variable	Categories	Opioid dependents	Alcohol Dependents	Chi-square	d.f.	P-value
Age	18-30	57	45	2.88	1	.99
	31-45	43	55			
Educational level	XII	52	40	3.56	2	.16
	Graduate	44	52			
	Post Graduate	4	8			
Occupation	Student	27	16	5.32	2	.07
	Self employed	58	59			
	Govt. employee	15	25			
Monthly family Income (in rupees)	Up to 20,000	18	23	4.38	2	.11
	21,000-40,000	41	27			
	Above 40,000	41	50			
Marital Status	Unmarried	51	40	3.41	2	.18
	Married	39	52			
	Separated/ Divorced	10	8			
Religion	Sanamahism	38	40	3.52	3	.32
	Hindu	29	37			
	Christian	24	19			
	Muslim	9	4			
Family type	Nuclear	53	60	0.99	1	.32
	Joint	47	40			

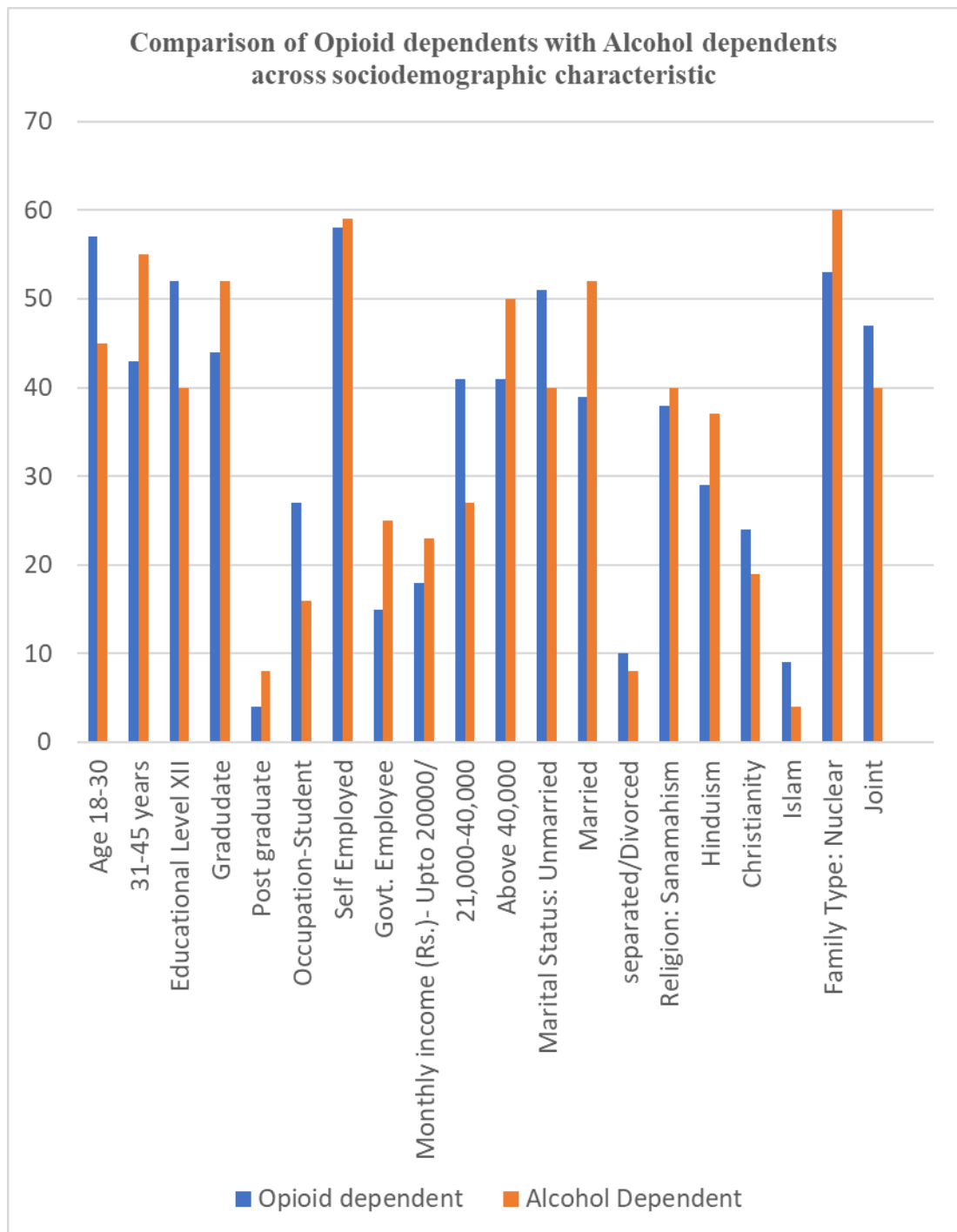


Fig. 1 showing the Sociodemographic Characteristics of the sample.

4.1 Sociodemographic Characteristics of the sample

The sociodemographic profile of opioid and alcohol-dependent participants was compared using chi-square tests (Table 1). The age distribution revealed that 57% of opioid dependents were between 18–30 years, while alcohol dependents were more concentrated in the 31–45 years group (55%). However, difference was not statistically significant ($\chi^2 = 2.88$, $df = 1$, $p = 0.99$).

In terms of educational attainment, the majority of opioid dependents had completed higher secondary education (52%), whereas alcohol dependents were relatively more represented in the graduate group (52%). Although more alcohol dependents were educated up to postgraduate level compared to opioid dependents (8% vs. 4%), the overall difference in education was not statistically significant ($\chi^2 = 3.56$, $df = 2$, $p = 0.16$).

Occupation-wise, self-employment was the most common category in both groups (58% in opioid and 59% in alcohol dependents). However, a higher proportion of alcohol dependents were government employees (25% vs. 15%), while more opioid dependents were students (27% vs. 16%). The occupational difference approached but statistically not significant ($\chi^2 = 5.32$, $df = 2$, $p = 0.07$).

With regard to income, 50% of alcohol dependents' monthly family income is more than ₹40,000 compared to 41% of opioid dependents. Conversely, a higher percentage of opioid dependents were in the family income group of ₹21,000–40,000 per month. These differences were statistically non-significant ($\chi^2 = 4.38$, $df = 2$, $p = 0.11$).

Marital status analysis showed that 52% of alcohol dependents were married compared to 39% of opioid dependents. On the other hand, opioid dependents had a slightly higher proportion of unmarried participants (51% vs. 40%). A small proportion in both groups were separated/divorced. The differences were not statistically significant ($\chi^2 = 3.41$, $df = 2$, $p = 0.18$).

With respect to religion, Sanamahism was the most common religion in both groups, followed by Hinduism, Christianity and Islam respectively. Though variation was found between the two groups, it was not statistically significant ($\chi^2 = 3.52$, $df = 3$, $p = 0.32$).

Regarding family type, nuclear families were more common among alcohol dependents (60%) compared to opioid dependents (53%), while joint families were slightly more represented among opioid dependents (47% vs. 40%). This variation was not statistically significant ($\chi^2 = 0.99$, $df = 1$, $p = 0.32$).

Overall, no significant sociodemographic differences were observed between the opioid and alcohol-dependent groups, though trends suggested that opioid dependence was relatively more common among younger, unmarried, and student populations, whereas alcohol dependence was more common among older, married, and government-employed individuals.

Table 2: Comparison of Opioid dependents and Alcohol dependents with regard to dimensions of family environment.

↓Dimensions of Family Environment	Opioid dependent Mean±SD	Alcohol dependent Mean±SD	t-value	p-value
Relationship dimension				
1. Cohesion	39.37±4.82	39.36± 4.59	0.02	.99
2. Expressiveness	28.66± 3.93	29.07± 3.93	0.74	.46
3. Conflict	36.30± 4.88	36.38±4.95	0.12	.91
4. Acceptance and caring	40.34±4.71	40.68±4.58	0.52	.61
Personal Growth Dimensions				
5.Independence	29.71±4.10	28.49± 3.99	2.13	.03*
6. Active Recreational Orientation	26.58±3.93	26.32±3.70	0.48	.63
System Maintenance Dimensions				
7. Organization	6.93±0.98	6.16±2.20	3.19	.01**
8. Control	13.07±2.49	12.18±2.32	2.61	.01**

** . P value is significant at the 0.01 level (2-tailed).

*. P value is significant at the 0.05 level (2-tailed).

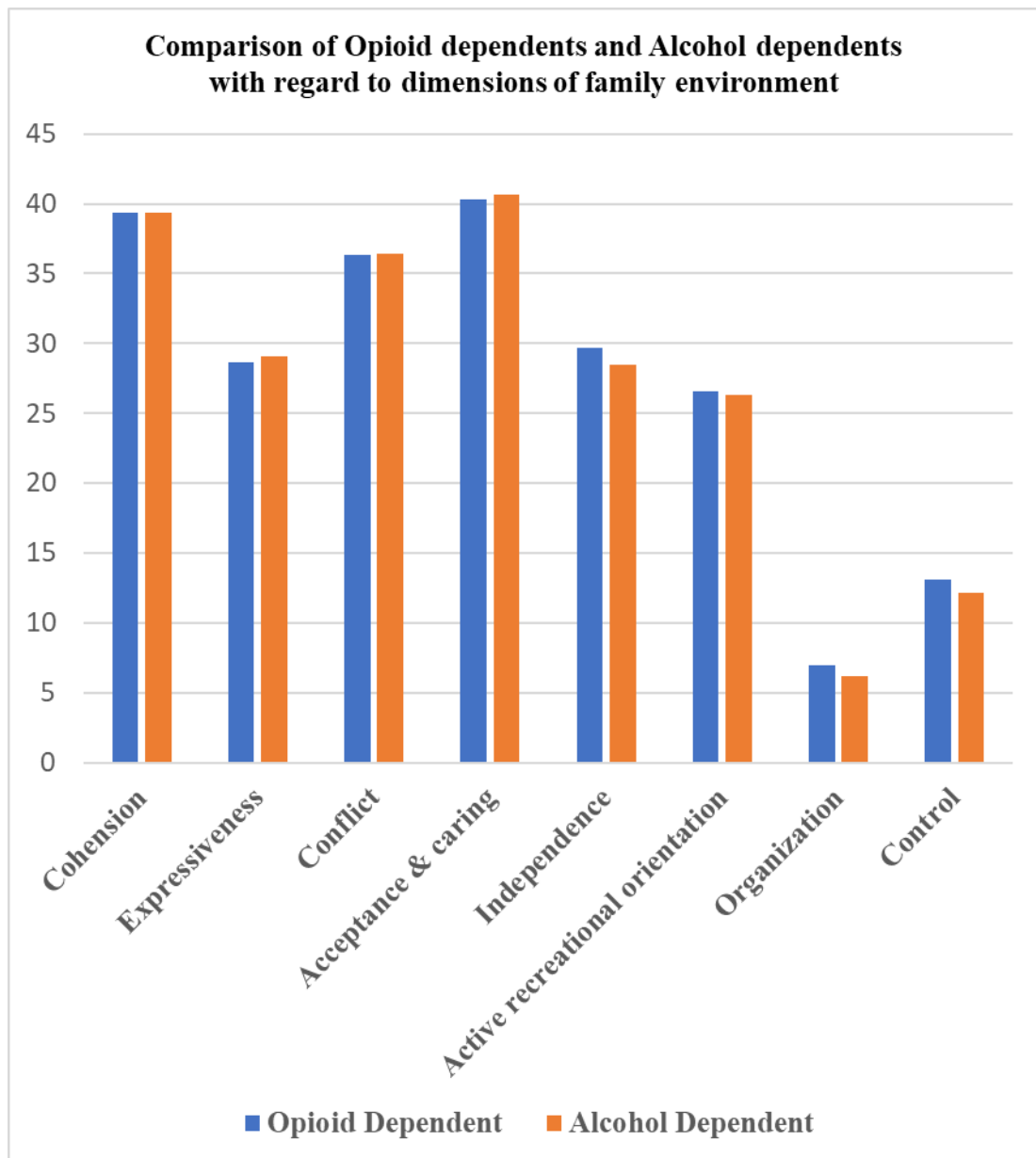


Fig.2 Differences between Opioid dependents and Alcohol dependents with regard to the dimensions of family environment.

4.2. Differences of Opioid dependents and Alcohol dependents with regard to the dimensions of family environment.

Comparison of the family environment between opioid- and alcohol-dependent groups revealed largely similar patterns across most domains. In the relationship dimensions, found no significant differences between the two groups for cohesion ($M = 39.37$, $SD = 4.82$ vs. $M = 39.36$, $SD = 4.59$; $t = 0.02$, $p = 0.99$), expressiveness ($M = 28.66$, $SD = 3.93$ vs. $M = 29.07$, $SD = 3.93$; $t = 0.74$, $p = 0.46$), conflict ($M = 36.30$, $SD = 4.88$ vs. $M = 36.38$, $SD = 4.95$; $t = 0.12$, $p = 0.91$), and acceptance and caring ($M = 40.34$, $SD = 4.71$ vs. $M = 40.68$, $SD = 4.58$; $t = 0.52$, $p = 0.61$).

Within the personal growth dimensions, independence was higher among opioid dependents ($M = 29.71$, $SD = 4.10$) than alcohol dependents ($M = 28.49$, $SD = 3.99$) and the difference was statistically significant ($t = 2.13$, $p = 0.03$). However, active recreational orientation showed no significant difference between groups ($M = 26.58$, $SD = 3.93$ vs. $M = 26.32$, $SD = 3.70$; $t = 0.48$, $p = 0.63$).

However, in the system maintenance dimensions, a significant difference emerged in the domain of organization, with opioid dependents scoring significantly higher ($M = 6.93$, $SD = 0.98$) compared to alcohol dependents ($M = 6.16$, $SD = 2.20$; $t = 3.19$, $p < 0.01$). And, control domain also differs significantly between the groups ($M = 13.07$, $SD = 2.49$ vs. $M = 12.18$, $SD = 2.32$; $t = 2.61$, $p = 0.01$).

So, the results suggest that while the two groups share similar experiences of family cohesion, expressiveness, conflict, acceptance & caring, active recreational orientation, and a notable difference exists in independence, organization & control which was higher in the opioid-dependent group.

Table 3: Comparison of Opioid Dependents and Alcohol Dependents with regard to Depression, Anxiety, and Stress.

Variables	Opioid dependent	Alcohol dependent	t-value	p value
	Mean $\pm$ S.D.	Mean $\pm$ S.D.		
Depression	17.16 $\pm$ 7.47	19.22 $\pm$ 6.93	2.02	.04*
Anxiety	16.22 $\pm$ 6.50	15.41 $\pm$ 7.32	0.83	.41
Stress	19.64 $\pm$ 7.83	21.56 $\pm$ 7.02	1.83	.07

**. P value is significant at the 0.01 level (2-tailed).

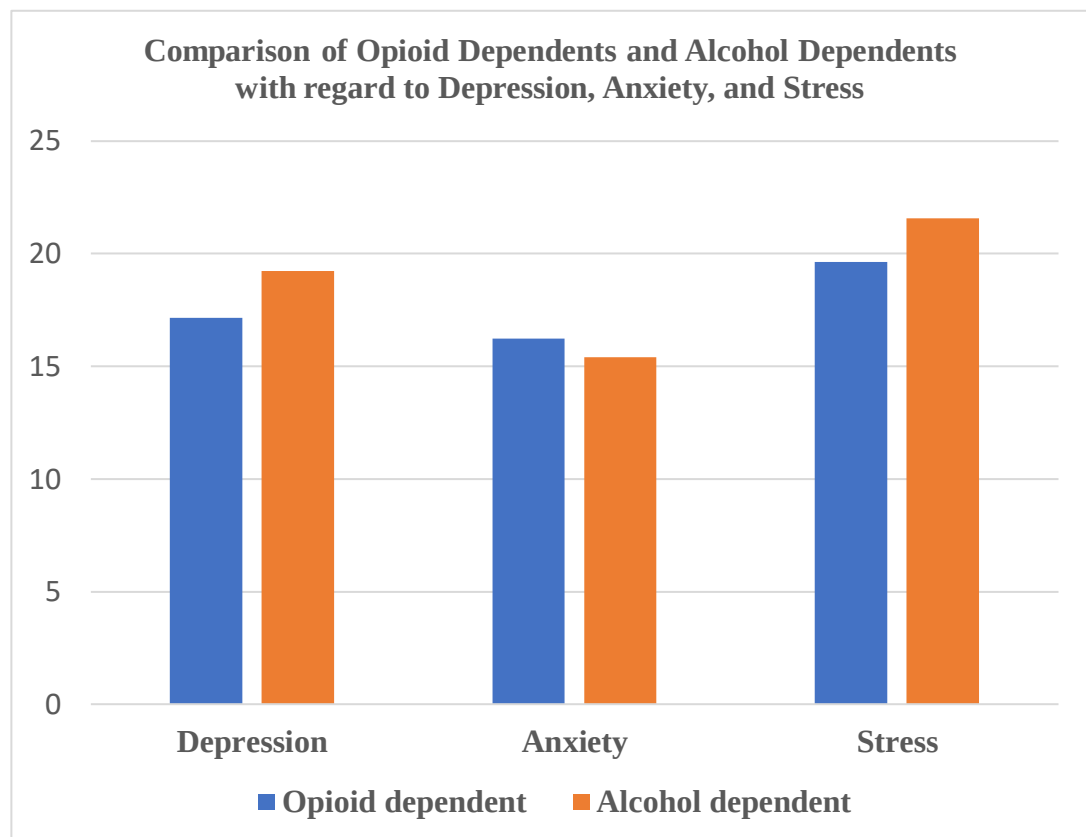


Fig. 3 Showing difference between Opioid dependent and Alcohol Dependents with regard to Depression, Anxiety, and Stress.

4.3 Differences of Opioid Dependents and Alcohol Dependents with regard to Depression, Anxiety, and Stress.

The mean score of depression, anxiety, and stress were compared between opioid dependents and alcohol dependents using independent samples *t*-test. The result indicated that there is significant difference between opioid dependents ($M = 17.16$, $SD = 7.46$) and alcohol dependents ($M = 19.22$, $SD = 6.92$) with regard to depression ($t = -2.02$, $p = .04$).

However, there was no significant difference found between the study groups with regard to anxiety and stress. Though opioid dependents reported a higher anxiety mean score ($M = 16.22$, $SD = 6.50$) as compared to alcohol dependents ($M = 15.41$, $SD = 7.32$), the difference was not statistically significant ($t = 0.83$, $p = .41$). And regarding stress, opioid dependents ($M = 19.64$, $SD = 7.83$) showed slightly lower scores than alcohol dependents ($M = 21.56$, $SD = 7.02$). However, this difference was not significant ($t = -1.83$, $p = .17$).

Table 4: Comparison of Opioid dependents and Alcohol dependents with regard to domains of Coping Inventory for Stressful Situations (CISS).

Coping Inventory for Stressful Situations	Opioid Mean± S.D.	Alcohol Mean± S.D.	t- value	p-value
Task-oriented	33.44±12.07	47.23±14.56	7.28	.01**
Emotion oriented	56.31± 9.55	56.75±10.92	.30	.76
Avoidance	56.57±11.12	57.10±11.09	.34	.74
i. Distraction	27.87±6.92	26.03±6.71	1.90	.06
ii. Social Diversion	18.28±3.82	18.90±2.81	1.31	.19

**. P value is significant at the 0.01 level (2-tailed).

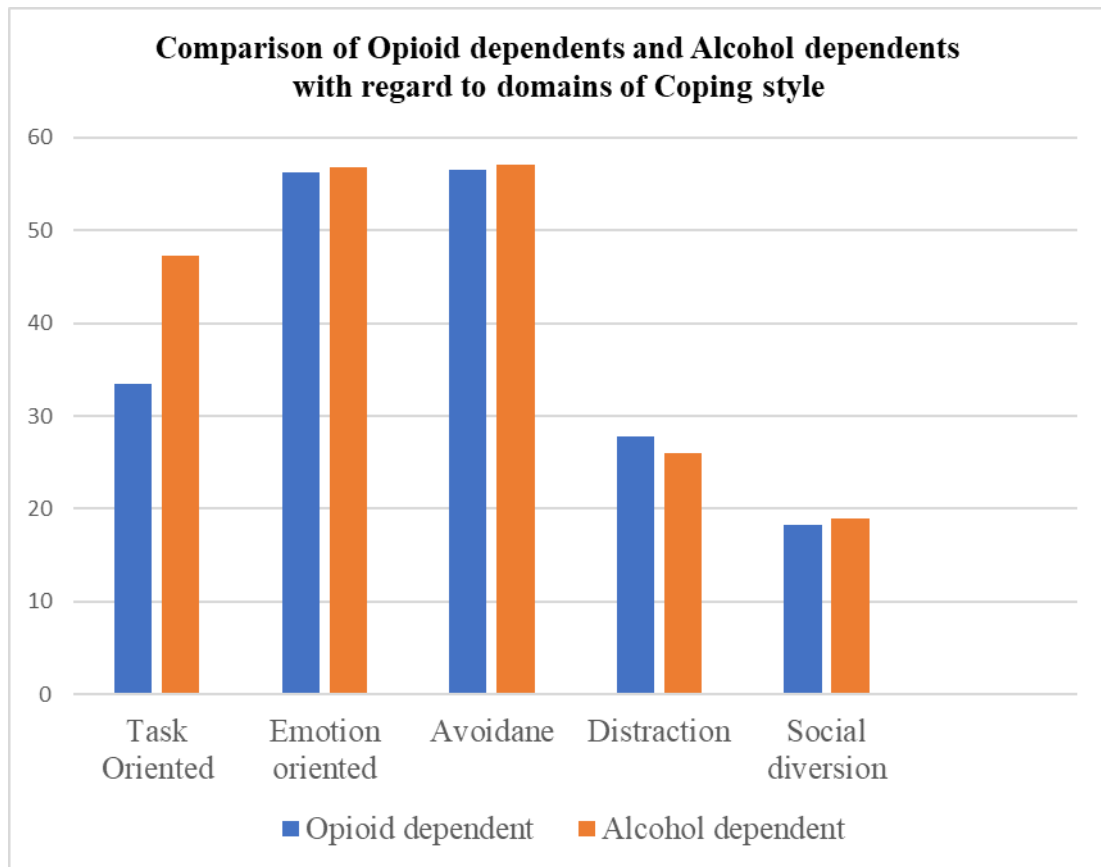


Fig.4 Differences between Opioid dependents and Alcohol dependents with regard to domains of Coping Inventory for Stressful Situations (CISS).

4.4 Differences of Opioid dependents and Alcohol dependents with regard to Coping Inventory for Stressful Situations (CISS) subtypes.

The comparison of coping strategies between opioid dependents and alcohol dependents, as assessed by the Coping Inventory for Stressful Situations (CISS), is presented in Table 4. The analysis revealed significant differences between the two groups only in task-oriented coping style and emotion-oriented, or avoidance coping styles were insignificant. Specifically, opioid dependents ($M = 33.44$, $SD = 12.07$) and alcohol dependents ($M = 47.23$, $SD = 14.56$) significantly differed in task-oriented coping ($t = 7.28$, $p < .01$). However, no significant difference was observed in emotion-oriented coping (opioid dependents: $M = 56.31$, $SD = 9.55$; alcohol dependents: $M = 56.75$, $SD = 10.92$; $t = 0.30$, $p = .76$) and avoidance coping (opioid

dependents: $M = 56.57$, $SD = 11.12$; alcohol dependents: $M = 57.10$, $SD = 11.09$; $t = 0.34$, $p = .74$).

When examining the sub-dimensions of avoidance coping, no significant difference was found in distraction coping (opioid dependents: $M = 27.87$, $SD = 6.92$; alcohol dependents: $M = 26.03$, $SD = 6.71$; $t = 1.90$, $p = .06$). And also no statistically significant difference was noted in social diversion coping, with alcohol dependents ($M = 18.28$, $SD = 2.82$) reporting higher reliance on this strategy compared to opioid dependents ($M = 18.90$, $SD = 3.82$; $t = 1.31$, $p = .19$).

These findings indicate that while both groups employ similar coping strategies overall, alcohol dependents tend to engage more in task oriented as a coping mechanism than opioid dependents.

Table 5: Relationship among dimensions of Family Environment with Depression, Anxiety, Stress of Opioid Dependents.

↓Dimensions of Family environment	Depression	Anxiety	Stress
Relationship dimension			
1. Cohesion	-.256*	-.273**	-.047
2. Expressiveness	-.188	-.195	-.048
3. Conflict	.058	.024	.079
4. Acceptance and caring	-.164	-.215*	-.042
Personal Growth Dimensions			
5. Independence	-.059	-.157	-.134
6. Active Recreational Orientation	-.166	-.220*	-.030
System Maintenance Dimensions			
7. Organization	-.168	-.173	-.025
8. Control	.176	.225*	.024

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

4.5. Relationship among dimensions of Family Environment with Depression, Anxiety, & Stress of Opioid Dependents are presented in Table 5.

Cohesion showed a significant negative correlation with depression ($r = -.256, p < .05$) and anxiety ($r = -.273, p < .01$), indicating that individuals perceiving greater family cohesion reported lower levels of depression and anxiety. Expressiveness did not show significant relation with depression ($r = -.188, p > .05$), anxiety ($r = -.195, p > .05$), and stress ($r = -.048, p > .05$).

Conflict was not significantly related to depression, anxiety, or stress, suggesting that perceived family conflict may not directly influence psychological distress in this sample. Acceptance and caring demonstrated a significant negative correlation with anxiety ($r = -.215, p < .05$), but no significant associations with depression or stress.

Within the personal growth dimensions, independence did not correlate significantly with any of the psychological variables. However, active recreational orientation was negatively correlated with anxiety ($r = -.220, p < .05$), though unrelated to depression or stress.

Among the system maintenance dimensions, organization showed no significant associations. Control was positively correlated with anxiety ($r = .225, p < .05$), but not with depression or stress.

Table 6 Relationship among dimensions of Family Environment with domains of Coping Style of Opioid Dependents

↓Dimensions of Family environment	→Domains of Coping style				
	Task oriented	Emotion oriented	Avoidance	Distract ion	Social Diversion
Relationship dimension					
1. Cohesion	.113	-.009	-.172	-.110	-.207*
2. Expressiveness	.111	-.066	-.130	-.107	-.126
3. Conflict	-.074	.082	.033	.092	.075
4. Acceptance and caring	.047	-.067	-.027	-.070	-.111
Personal Growth Dimensions					
5. Independence	.083	-.167	-.125	-.119	-.136
6. Active Recreational Orientation	.052	-.059	-.029	-.077	-.113
System Maintenance Dimensions					
7. Organization	.110	-.103	-.184	-.213*	-.096
8. Control	.319**	-.096	-.139	-.146	-.149

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

4.6 Relationship among dimensions of Family Environment and domains of Coping Style of Opioid Dependents

Correlation analysis between family environment and coping styles revealed notable patterns (Table 6). Among relationship dimensions, cohesion showed a significant negative relation with social diversion coping ($r = -.207$, $p < .05$), suggesting that individuals perceiving higher family cohesion were less likely to rely on seeking social outlets as a coping mechanism. Expressiveness and conflict, however, did not show significant relationships with any coping styles. Similarly, acceptance and caring were not significantly related with coping approaches.

Within personal growth dimensions, independence and active recreational orientation showed no significant associations with coping strategies.

Among system maintenance dimensions, organization was negatively correlated with distraction coping ($r = -.213$, $p < .05$), indicating that higher family organization reduced reliance on distraction as a coping method. Most notably, control demonstrated a significant positive correlation with task-oriented coping ($r = .319$, $p < .01$), suggesting that greater family emphasis on control was associated with stronger use of adaptive, problem-focused coping strategies.

Table 7 Relationship among domains of Coping Style with Depression, Anxiety, and Stress of Opioid Dependents

↓Domains of Coping style	Depression	Anxiety	Stress
Task oriented	-.163	-.181	-.039
Emotion oriented	.133	.013	.271**
Avoidance	.794**	.039	.107
Distraction	.558**	.086	.160
Social Diversion	.914**	-.052	-.149

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

4.7 The relationship among domains of Coping Style with Depression, Anxiety, and Stress of Opioid Dependents

The correlation analysis between coping styles and psychological outcomes revealed distinct patterns (Table 7). Task-oriented coping showed no significant relationship with depression, anxiety, or stress, though a weak negative trend with depression ($r = -.163$), anxiety ($r = -.181$) and stress ($r = -.039$) were observed.

Emotion-oriented coping was significantly positively correlated with stress ($r = .271$, $p < .01$), indicating that individuals who relied more on emotional coping strategies experienced higher levels of stress. No significant relationship was found with depression or anxiety.

Avoidance coping demonstrated a strong positive correlation with depression ($r = .794$, $p < .01$), suggesting that reliance on avoidance strategies substantially increased depressive symptoms.

Within the avoidance subcomponents, distraction ($r = .558$, $p < .01$) and social diversion ($r = .914$, $p < .01$) showed a significant positive correlation with depression. Neither distraction nor social diversion was significantly associated with anxiety or stress.

Table 8 Relationship among dimensions of Family Environment with Depression, Anxiety, and Stress of Alcohol Dependents.

↓ Dimensions of Family environment	Depression	Anxiety	Stress
Relationship dimension			
1. Cohesion	-.008	-.164	-.091
2. Expressiveness	-.031	-.208*	-.118
1. Conflict	.118	.058	.075
2. Acceptance and caring	-.007	-.201*	-.142
Personal Growth Dimensions			
3. Independence	-.192	-.049	-.062
4. Active Recreational Orientation	-.005	-.151	-.101
System Maintenance Dimensions			
5. Organization	-.052	-.167	-.005
6. Control	-.136	-.100	.029

*. Correlation is significant at the 0.05 level (2-tailed).

4.8 Relationship among dimensions of Family Environment with Depression, Anxiety, & Stress of Alcohol Dependents

Correlation analysis of dimensions of family environment domains with depression, anxiety, and stress revealed selective associations (Table 8). Within the relationship dimension, cohesion was not significantly correlated with any psychological

outcome, showing weak associations with depression ($r = -.008$), anxiety ($r = -.164$), and stress ($r = -.091$). Expressiveness demonstrated a significant negative correlation with anxiety ($r = -.208$, $p < .05$), though it was not significantly related with depression or stress. Conflict displayed weak, nonsignificant relationships across all three outcomes. Acceptance and caring showed a significant negative correlation with anxiety ($r = -.201$, $p < .05$), but no meaningful association with depression or stress.

For the personal growth dimensions, independence exhibited a weak negative association with depression ($r = -.192$), although this relationship was not statistically significant, and no meaningful links were observed with anxiety or stress. Active recreational orientation demonstrated a weak negative correlation with anxiety, depression, and stress.

In the system maintenance dimensions, organization and control showed no significant correlation with depression, anxiety and stress suggesting limited influence of this domain on psychological outcomes.

Table 9: Relationship among dimensions of Family Environment with Coping Style of Alcohol Dependents

↓Dimensions of Family environment	→Domains of Coping style				
	Task oriented	Emotion oriented	Avoidance	Distraction	Social Diversion
Relationship dimension					
1. Cohesion	.138	-.053	-.082	-.110	-.068
2. Expressiveness	.075	-.046	-.030	-.054	.027
3. Conflict	-.076	.158	.034	.060	.063
4. Acceptance & Caring	.201*	-.116	-.072	-.109	.048
Personal Growth Dimensions					
5. Independence	.258**	.020	-.018	-.109	-.257**
6. Active Recreational Orientation	.189	-.080	-.124	-.098	.066
System Maintenance Dimensions					
7. Organization	.291**	-.144	-.121	-.206*	.079
8. Control	.014	-.248*	-.111	-.087	-.129

*. Correlation is significant at the 0.05 level (2-tailed).

**. Correlation is significant at the 0.01 level (2-tailed).

4.9 Relationship among dimensions of Family Environment with domains of Coping Style of Alcohol Dependents

Correlation analysis was conducted to examine the relationships among dimensions of family environment with coping styles among opioid dependent and alcohol-dependent participants (Table 9). Within the relationship dimension, cohesion demonstrated a weak positive correlation with task-oriented coping ($r = .138$), though it was not statistically significant. No meaningful associations emerged between cohesion and other coping strategies. Expressiveness also showed no significant relationship with any coping styles. Conflict exhibited a weak, nonsignificant positive correlation with emotion-oriented coping ($r = .158$). However, acceptance and caring were found to have a significant positive correlation with task-oriented coping ($r = .201$, $p < .05$), indicating that higher levels of perceived acceptance and caring within families may encourage individuals to adopt more problem-focused coping strategies.

Regarding personal growth dimensions, independence displayed a significant positive correlation with both task-oriented coping ($r = .258$, $p < .01$) and negative relation with social diversion ($r = -.257$, $p < .01$). This suggests that individuals from families that promote independence are more likely to engage in proactive problem-solving behaviours rather than seeking social support as coping mechanisms. Active recreational orientation demonstrated a insignificant positive association with task-oriented coping, but no significant relationships with other coping strategies.

In context of system maintenance dimensions, organization was positively significant with task-oriented coping ($r = .291$, $p < .01$), though negatively significant with distraction coping ($r = -.206$, $p < .05$) suggesting that more structured and organized family environments are conducive to active coping and reduce reliance on distraction-based strategies. Finally, control showed a significant negative correlation with emotion-oriented coping ($r = -.248$, $p < .05$), implying that rigid or controlling family environments may discourage the use of emotionally focused coping strategies.

Table 10: Relationship among domains of Coping Style with Depression, Anxiety, & Stress of Alcohol Dependents

	Depression	Anxiety	Stress
Task oriented	-.139	-.025	-.056
Emotion oriented	.022	.098	.040
Avoidance	.058	.175	.006
a. Distraction	.129	.126	.057
Social Diversion	.754**	-.003	-.019

** . Correlation is significant at the 0.01 level (2-tailed).

* . Correlation is significant at the 0.05 level (2-tailed).

4.10 Relationship among domains of Coping Style with Depression, Anxiety, & Stress of Alcohol Dependents

The correlation analysis among domains of coping styles with depression, anxiety & stress outcomes revealed several noteworthy trends (Table 10). Task-oriented coping showed weak, non-significant associations with depression ($r = -.139$), anxiety ($r = -.025$), and stress ($r = -.056$), suggesting that the use of problem-focused strategies did not substantially influence levels of psychological distress among the participants. Similarly, emotion-oriented coping demonstrated only weak and non-significant correlations with depression ($r = .022$), anxiety ($r = .098$), and stress ($r = .040$), indicating that emotional coping efforts were not strongly related to these outcomes.

Avoidance coping displayed an insignificant positive correlation with depression, anxiety and stress. Further, distraction coping was positively but insignificantly related to depression ($r = .129$), anxiety ($r = .126$), and stress ($r = .057$). However, social diversion coping emerged as the most prominent pattern, showing a strong and significant positive correlation with depression ($r = .754$, $p < .01$), but insignificant negative associations with anxiety ($r = -.003$) and stress ($r = -.019$). This finding indicates that frequent reliance on social diversion is closely linked with greater depressive symptoms among opioid- and alcohol-dependent individuals.

CHAPTER V

DISCUSSION

5.1 Sociodemographic Characteristics of the sample

Referring table 1, study did not reveal statistically significant sociodemographic differences between opioid dependent and alcohol-dependent groups, although certain patterns were observed. Opioid dependence was more common among younger participants (18–30 years), whereas alcohol dependence was predominant in the 31–45 years age group. Results align with previous research indicating that opioid use disorders often begin earlier in life, particularly during late adolescence and young adulthood, while alcohol dependence typically develops later, often after years of social or occupational drinking (Kedia et al., 2007; Subramaniyan & Nadar, 2019).

With respect to education, a majority of opioid dependents had studied up to higher secondary level, whereas alcohol dependents were more often graduates or postgraduates. Earlier studies have suggested that lower educational attainment is associated with early initiation and higher vulnerability to opioid use (Ambekar et al., 2019), while alcohol use is more socially accepted across educational backgrounds, leading to dependence in both lower and higher education groups (World Health Organization [WHO], 2018).

Occupationally, self-employment was the most common in both groups; however, alcohol dependence showed higher prevalence among government employees, while opioid dependence was more common among students. This is consistent with previous findings that substance use patterns are shaped by accessibility and social context—opioids being more prevalent among unemployed youth or students, while alcohol is more entrenched among working adults (John et al., 2009).

In terms of income, alcohol dependence was somewhat more represented among the higher income group, whereas opioid dependence was relatively more common in the lower and middle-income groups. This pattern reflects earlier findings that

opioids are often used by socially and economically disadvantaged populations (Ambekar et al., 2019), while alcohol consumption cuts across income levels but dependence may be sustained by higher affordability among those with stable employment (Grant et al., 2015).

Marital status analysis revealed that alcohol dependence was more prevalent among married individuals, while opioid dependence was higher among unmarried participants. This supports earlier research suggesting that marital stress and responsibilities are often linked with problematic alcohol use (Templeton et al., 2010), whereas opioid dependence may be associated with social isolation and delayed marital commitments (Mattoo et al., 2009).

The lack of significant religious variation between the groups ($p = 0.32$) aligns with regional demographic trends where Sanamahism and Hinduism frequently overlap within the same socio-economic strata (Census of India, 2011). This homogeneity suggests that religion was not a confounding variable in the present study.

Family type did not significantly differ between the two groups, though nuclear families were more common among alcohol dependents and joint families slightly more among opioid dependents. Earlier studies have emphasized that dysfunctional family environments, irrespective of type, play a significant role in the onset and maintenance of substance dependence (Filstead et al., 1981; Moos & Moos, 1984; Bracik et al., 2012).

Overall, sociodemographic differences were not statistically significant and the observed patterns are consistent with the broader literature. Opioid dependence appears to cluster in younger, unmarried, and student populations with lower educational attainment, while alcohol dependence tends to be more prevalent among older, married, and employed individuals. The findings highlight the importance of tailoring prevention and intervention strategies to the sociodemographic context of each substance, especially given the strong role of stress, coping styles, and family environment in shaping vulnerability to addiction (Hyman et al., 2009; Monti & Rohsenow, 1999; Sinha, 2008).

5.2. The family environment of Opioid dependents and Alcohol dependents.

The findings of the present study (table 2) indicate that there are no statistically significant differences between opioid-dependent and alcohol-dependent individuals across most dimensions of family environment, including cohesion, expressiveness, conflict, acceptance and caring, and active recreational orientation. Both groups demonstrated comparable levels of relationship quality and one sub-dimension of personal growth dimensions, suggesting that substance dependence—whether opioids or alcohol—emerges in the context of similar family dynamics. This aligns with previous studies which highlighted that family dysfunction, communication difficulties, and impaired cohesion are common correlates of substance dependence, regardless of the specific substance involved (Bradshaw, et al. 2016). However, significant differences were observed in independence ($p < .05$) and the system maintenance dimension, particularly in organization and control ($p < .01$). Opioid dependents reported significantly higher levels of perceived organization within the family compared to alcohol dependents, which may suggest greater rigidity and structured family functioning among opioid users. This is consistent with the observations of Moos and Moos (2002), who emphasized that heightened levels of family organization and control may function as maladaptive mechanisms, restricting emotional openness while reinforcing rigid rules. In contrast, alcohol dependents reported lower scores in these dimensions, indicating comparatively more flexible but less structured family patterns. This finding supports earlier research that identified disorganization and lack of consistency as prevalent in families of alcohol dependents, which may exacerbate vulnerability to alcohol-related problems (Subodh et al., 2014).

The comparable levels of cohesion and acceptance across both groups suggest that while emotional bonds within families remain intact, these bonds may coexist with conflict and maladaptive coping styles. Prior literature has consistently shown that family expressiveness and conflict are critical determinants in the trajectory of addiction, with high conflict and low expressiveness being associated with greater relapse rates (Velleman et al., 2005). Interestingly, the present study did not find

significant group differences in these domains, suggesting that such relational dynamics are broadly shared across substance dependence types rather than substance-specific.

Overall, these findings indicate that while relationship-oriented dimensions of family environment do not significantly differ between opioid and alcohol dependents, structural aspects such as organization and control emerge as distinguishing features. These nuances highlight the importance of tailoring family-based interventions: for alcohol dependence, strengthening organizational consistency and boundaries may be beneficial, whereas for opioid dependence, fostering flexibility and reducing rigid control could support recovery.

5.3 Depression, Anxiety, and Stress of Opioid dependents and Alcohol Dependents

The present study compared (table 3) levels of depression, anxiety, and stress between opioid dependents and alcohol dependents. The study found that alcohol dependents exhibit significantly higher depression levels ($p < 0.05$) than opioid dependents. This suggests that alcohol dependence may have a more severe impact on mood stability, aligning with research that identifies alcohol as a primary driver for co-occurring depressive disorders (Sullivan et al., 2005). Furthermore, it supports the previous finding that chronic alcohol use significantly increases the risk and intensity of depressive symptoms (Boden & Fergusson, 2011).

In terms of anxiety, opioid dependents reported comparatively higher levels compared to alcohol dependents though not significant. However, with respect to stress, alcohol dependents reported marginally higher levels compared to opioid dependents, although this difference did not reach statistical significance. Previous research suggests that both alcohol and opioids act as maladaptive coping mechanisms in response to stress exposure (Sinha, 2008; Brady & Sonne, 1999). Alcohol dependence, however, has been particularly associated with occupational and chronic stressors (Seeman & Seeman, 1992), which might explain the slightly elevated stress levels in this group. At the same time, the comparable stress levels

across both groups underscore that stress is a core component in the development, maintenance, and relapse of substance use disorders in general (McEwen, 2007; Sinha, 2001).

Overall, these findings reinforce the biopsychosocial model of addiction, whereby mood disturbances such as depression, anxiety, and perceived stress not only coexist with substance dependence but also interact to perpetuate the cycle of use and relapse. The significantly higher depression among alcohol dependents calls for targeted psychosocial interventions—such as stress management and adaptive coping training—tailored to reduce relapse vulnerability in this group.

5.4 Comparison of Opioid dependents and Alcohol dependents with regard to Coping Inventory for Stressful Situations (CISS) domains

The study found that alcohol dependents utilized significantly more task-oriented coping than opioid dependents ($p < 0.01$). This aligns with Moos and Moos (2006), suggesting that social integration preserves instrumental problem-solving, whereas the executive deficits typical of opioid dependence often hinder such goal-directed strategies (Verdejo-García et al., 2006).

However, the present findings revealed that opioid and alcohol dependents did not differ significantly in emotion-oriented, and avoidance coping strategies. This suggests that both groups employ almost similar broad coping styles when managing stressful situations.

The lack of significant differences in emotion-oriented and avoidance coping strategies aligns with prior evidence suggesting that substance dependents, regardless of the substance, often adopt maladaptive coping such as denial, withdrawal, or emotional regulation attempts that fail to address stressors directly (Mahmoud et al., 2012; Eisenbarth, 2012). These strategies are generally associated with higher distress, poorer psychological outcomes, and increased vulnerability to relapse.

Overall, these findings reinforce the need for targeted interventions that enhance adaptive coping skills in substance-dependent populations. In particular,

strengthening problem-focused strategies particularly in opioid dependents group and reducing reliance on maladaptive mechanisms such as avoidance may improve treatment outcomes. Additionally, interventions for alcohol dependents may benefit from carefully addressing the dual role of social environments, which can function as both a protective coping resource and a potential risk factor for relapse.

5.5. Relationship among of dimensions of family environment with depression, anxiety, and stress of opioid dependents

The present study examined the relationship among dimensions of family environment with depression, anxiety, and stress among opioid dependent and alcohol-dependent individuals. Findings (table 5) revealed that family cohesion was significantly and negatively correlated with both depression and anxiety. This suggests that higher levels of perceived cohesion in the family system act as a protective factor, reducing vulnerability to depressive and anxious symptoms. These results align with earlier research which highlights the buffering role of family support in mitigating emotional distress and maladjustment (Moos & Moos, 2009). Strong family cohesion provides emotional security and adaptive coping resources, thereby reducing the likelihood of psychiatric comorbidity in substance dependence.

In contrast, family expressiveness and conflict were not significantly associated with psychological distress in this study. While earlier studies have linked high family conflict to increased emotional difficulties and relapse risk among individuals with substance dependence (Andreas et al., 2015; Velleman et al., 2005), the nonsignificant results may indicate that participants in both groups perceived conflict as a normative aspect of family life, or that other mediating factors such as coping styles and social support networks exerted a stronger influence.

The significant negative correlation between acceptance and caring and anxiety in opioid dependence indicates that higher social support acts as a direct buffer against psychological distress. This finding supports that social support acts as a primary psychosocial buffer against distress in opioid dependence (Smith & Adinoff, 2021).

Acceptance reduces the internalized stigma and social isolation that typically drive anxiety (Earnshaw et al., 2013).

Among personal growth dimensions, independence did not show significant associations, whereas active recreational orientation was negatively associated with anxiety. Result aligns with earlier evidence that recreational involvement often enhances well-being (Green et al., 2014), suggesting that in this sample, recreational orientation may reflect attempts to deal with distress.

Within system maintenance dimensions, organization did not significantly correlate with psychological distress, but control was positively related to anxiety. This supports literature indicating that rigid family control and dominance can restrict autonomy, thereby elevating anxiety levels in individuals with substance use issues (Brook et al., 1990; Velleman & Templeton, 2007).

Overall, these findings underscore the complex and multidimensional role of family environment in shaping psychological distress among substance-dependent populations. While cohesion, acceptance & caring appears, recreational orientation, to buffer against depression and anxiety, other dimensions such as control may heighten vulnerability to anxiety. This dual influence highlights the need for family-based therapeutic interventions that enhance positive family functioning (e.g., cohesion, support) while addressing maladaptive dynamics (e.g., overcontrol).

5.6 Relationship among dimensions of Family Environment with domains of Coping Style of Opioid Dependents

The findings (Table 6) highlight the nuanced interplay between family environment and coping mechanisms among individuals with opioid dependence. Family cohesion was negatively significant with social diversion coping, which may reflect that cohesive families provide sufficient internal support, reducing the need for external social outlets as a coping strategy. This supports previous findings that strong family bonds serve as protective factors against maladaptive coping and externalizing behaviors (Moos & Moos, 2009; Velleman & Templeton, 2007).

Interestingly, family expressiveness, conflict, and acceptance and caring showed no significant correlations with coping. While literature emphasizes that conflictual or poorly expressive families tend to foster maladaptive coping (Andreas et al., 2015; Velleman et al., 2005), the nonsignificant findings here could suggest cultural differences in how family members communicate and manage stress, or that coping in substance dependence is more strongly influenced by individual psychological resources than by family expressiveness.

The negative correlation between family organization and distraction coping indicates that well-structured families discourage avoidance-based strategies. This is in line with research showing that structured family systems enhance self-regulation and promote adaptive coping (Olson et al., 2019). In contrast, disorganized environments often contribute to chaotic coping styles, including reliance on distraction.

The most striking result was the positive correlation between family control and task-oriented coping. This suggests that in families emphasizing rules, discipline, and behavioral monitoring, individuals may be more inclined toward problem-focused strategies. While excessive control has been linked to anxiety and rigidity (Barber, 1996; Wood et al., 2004), it appears that moderate levels of family control can encourage structured, solution-oriented responses to stress. These findings resonate with Carver et al.'s (1989) emphasis on task-oriented coping as adaptive in managing stressful circumstances.

Overall, the results underline the dual role of family environment in shaping coping mechanisms. Cohesion and organization act as protective dimensions by discouraging maladaptive strategies such as social diversion and distraction, whereas control, when balanced, appears to strengthen adaptive coping styles. These insights suggest that family-based interventions for substance dependence should focus not only on reducing conflict but also on enhancing cohesion, structure, and adaptive control to foster healthier coping.

5.7 Relationship among domains of Coping Style with Depression, Anxiety, & Stress of Opioid Dependents

The findings (Table 7) underscore the pivotal role of coping styles in shaping psychological outcomes among substance-dependent individuals. Task-oriented coping, generally considered adaptive (Carver et al., 1989; Lazarus & Folkman, 1984), did not exhibit significant associations with depression, anxiety, or stress in this study. This could indicate that although problem-focused strategies are beneficial, their effectiveness may be undermined by the chronic stressors and emotional burdens associated with substance dependence (Hyman et al., 2009).

Emotion-oriented coping, on the other hand, was positively associated with stress. This supports earlier study that individuals who focus on regulating emotional distress without addressing underlying stressors are more prone to heightened stress levels (Taylor & Stanton, 2007). The finding highlights the limited utility of emotion-focused strategies in high-stress environments like addiction recovery.

Avoidance coping and its subcomponents—distraction and social diversion—showed the most striking results, with strong positive correlations with depression. These findings are consistent with prior research linking maladaptive coping, such as avoidance and denial, to increased risk of depressive symptoms and poorer mental health outcomes (Eisenbarth, 2012; Mahmoud et al., 2012). The particularly high correlation between social diversion and depression suggests that relying excessively on social activities to escape stress may mask underlying emotional difficulties without resolving them, thereby deepening depressive symptoms.

Together, these results reinforce the centrality of coping strategies in substance dependence. Maladaptive approaches, especially avoidance-based coping, appear to exacerbate depression, while emotion-focused coping heightens stress. Task-oriented coping, although theoretically adaptive, may require targeted skill-building interventions to become effective in populations facing chronic stressors. These insights suggest that therapeutic approaches should emphasize reducing reliance on

avoidance and emotional coping while strengthening task-oriented strategies through cognitive-behavioural and skills-based interventions.

5.8 Relationship among dimensions of Family Environment with Depression, Anxiety, & Stress of Alcohol Dependents

These findings (Table 8) highlight the relationship between family environment dimensions and psychological outcomes in individuals with alcohol dependence.

The significant negative correlations between expressiveness and acceptance and caring with anxiety indicate that these family dimensions function as robust protective factors within the context of dependence. As family members demonstrate greater emotional openness and unconditional support, there is a corresponding and significant reduction in the dependent's anxiety levels (Moos & Moos, 2007). This suggests that a supportive social climate effectively buffers the psychological distress inherent in early-stage addiction (Smith & Adinoff, 2021). While high-support environments can occasionally introduce interpersonal pressures (Latendresse et al., 2008), the primary effect observed here is that emotional warmth and clear communication significantly mitigate the internalized stigma and tension typically associated with opioid and alcohol dependence (Earnshaw et al., 2013).

The absence of significant correlations between cohesion and psychological outcomes contrasts with prior findings that stronger family bonds reduce psychological distress (Kumar & Mattoo, 2016). It is possible that in substance-dependent populations, cohesion alone is insufficient to buffer against depression, anxiety, or stress, particularly when other relational conflicts or systemic issues are present.

Similarly, the weak and nonsignificant role of conflict suggests that overt family disputes may not directly predict depression, anxiety, or stress in this group. Instead, subtler relational dynamics (such as perceived acceptance or pressure) may exert stronger psychological influences.

The personal growth and system maintenance dimensions (independence, recreational orientation, organization, control) showed only weak or nonsignificant correlations. This aligns with research indicating that structural and autonomy-related aspects of family life play a less direct role in emotional outcomes compared to relational closeness or conflict (Hetherington, 1999; Schaefer et al., 2011).

5.9 Relationship among dimensions of Family Environment with domains of Coping Style of Alcohol Dependents

The findings (Table 9) suggest that specific aspects of family environment are related with the coping strategies adopted by individuals with alcohol dependence.

The significant positive relation of acceptance and caring, independence and organization with task-oriented coping are consistent with earlier studies emphasizing the protective role of supportive and autonomy-promoting family climates (Moos & Moos, 2007). Families that provide emotional security and encourage independence may empower individuals to confront stressors directly, thereby reducing maladaptive coping tendencies.

The significant negative correlation between independence and social diversion suggests that as family environments increasingly encourage autonomy, there is a corresponding decrease in the reliance on social diversion as a primary coping strategy. This aligns with Self-Determination Theory, which posits that autonomy-supportive environments foster internal resilience and self-regulation, reducing the need for external distractions to manage psychological distress (Deci & Ryan, 2000).

The negative relationship between organization and distraction coping suggests that structured family environments may discourage avoidance or escape-oriented strategies, instead channeling individuals toward adaptive, problem-focused coping. Similar patterns have been reported in studies linking family structure and routines to healthier psychological adjustment in high-stress contexts (Fiese et al., 2002).

Interestingly, control showed a significant negative association with emotion-oriented coping, implying that rigidly controlling environments might suppress

emotional expression, forcing individuals to rely less on emotion-focused strategies. While this may reduce overt emotional reactivity, it could also limit healthy emotional processing, potentially contributing to long-term psychological strain (Barber, 1996).

Overall, these results reinforce the dual role of family environment: supportive and autonomy-promoting climates foster adaptive coping, while rigid or poorly structured environments may limit or redirect coping strategies in ways that can be maladaptive in the long run.

5.10 Relationship among domains of Coping Style with Depression, Anxiety, & Stress of Alcohol Dependents

The findings (Table 10) highlight important patterns between coping strategies and psychological distress in alcohol dependent populations.

The lack of significant associations between task-oriented coping and depression, anxiety, or stress suggests that while problem-focused coping is generally considered adaptive, it may not independently buffer against psychological distress in individuals with substance dependence. Previous studies note that the chronic nature of addiction often diminishes the protective role of task-oriented strategies when stressors are persistent and beyond immediate control (Endler & Parker, 1999).

Interestingly, avoidance coping sub-type social diversion was significantly associated with depression, aligning with prior research that links avoidance with maladaptive emotional outcomes (Cooper et al., 1992). While social diversion may provide short-term relief, its long-term effects contribute to heightened psychological vulnerability, particularly depressive symptoms.

Emotion-oriented coping and distraction coping showed no meaningful associations with depression, anxiety, or stress in this study, though literature often identifies emotion-focused strategies as risk factors for distress in addiction contexts (Litman, 2006). The absence of significant associations here may reflect the overlapping and

complex coping patterns employed by substance-dependent individuals, where multiple maladaptive strategies coexist.

Overall, the findings reinforce that maladaptive coping, particularly avoidance and unhelpful social diversion, plays a critical role in worsening depression among opioid- and alcohol-dependent individuals. These results underscore the importance of interventions that reduce reliance on avoidance and foster adaptive social support networks.

CHAPTER VI

SUMMARY & CONCLUSION

6.1 Summary

The primary objective of this research was to conduct a comparative analysis of depression, anxiety, stress, family environment, and coping styles between individuals with opioid and alcohol dependence. Adopting a cross-sectional, correlational, and comparative research design, the study sampled 200 male participants (100 opioid-dependent and 100 alcohol-dependent) through purposive sampling. Data collection focused on five core hypotheses regarding the significant differences and internal relationships among the variables. Following normality testing via the Kolmogorov-Smirnov test, the study utilized independent sample t-tests for group comparisons and Pearson's correlation coefficient to evaluate the associations among the variables.

The findings revealed that the two groups possess distinct sociodemographic and clinical profiles. Alcohol-dependent individuals reported significantly higher levels of depression ($p < 0.05$) and a greater reliance on task-oriented coping ($p < 0.01$). In contrast, opioid-dependent families demonstrated significantly higher levels of organization, control ($p < 0.01$), and independence ($p < 0.05$), suggesting a more structured yet potentially rigid family environment compared to the relatively flexible but disorganized patterns observed in alcohol-dependent households.

Correlation analyses supported the buffering hypothesis, showing that high family cohesion, expressiveness, and caring were significantly associated with lower anxiety and depression ($p < 0.05$). Conversely, maladaptive avoidance coping (distraction and social diversion) was strongly linked to increased psychological distress. Collectively, the results indicate that while family structure is a vital precursor to adaptive problem-focused coping, high levels of authoritarian control and avoidant strategies significantly exacerbate mental health challenges in both populations.

6.2 Implications of the Study

The findings of this study offer a multilevel framework for addressing the complexities of substance dependence and recovery. At the individual level, the research highlights the need for substance-specific mental health screening; specifically, alcohol-dependent individuals require intensive screening for depressive disorders to prevent the worsening of symptoms associated with chronic use (Boden & Fergusson, 2011). At the clinical and family level, the results underscore a shift toward Systemic Family Therapy. Clinicians should focus on modifying the "rigidity" found in opioid-dependent families—which can be maladaptive (Moos & Moos, 2002)—and addressing the "disorganization" prevalent in alcohol-dependent families to reduce reliance on avoidant coping mechanisms (Subodh et al., 2014).

At the community and policy level, these results suggest that public health initiatives should move beyond universal prevention programs toward targeted outreach. Policy frameworks should support the integration of family-based psychosocial support into standard addiction treatment protocols, recognizing that family cohesion acts as a critical "protective shield" against systemic anxiety and depression (Moos & Moos, 2009). By funding programs that promote family organization and emotional expressiveness, policymakers can foster environments that encourage task-oriented coping, ultimately reducing the long-term socioeconomic burden of relapse and untreated co-occurring mental health disorders.

6.3 Limitations of the Study

The study has a few limitations that must be considered while interpreting the findings. First, the sample is limited to treatment-seeking individuals, which restricts generalizability to the broader population of substance dependents. Second, as the study employed a cross-sectional design, it cannot establish causal relationships between mood, coping, and family environment. Third, data were collected through self-report measures, which may be influenced by recall bias or social desirability. Finally, the study was conducted in a specific cultural and geographical context, which may limit the applicability of results to other populations.

6.4 Recommendations

To optimize clinical outcomes, therapeutic programs could prioritize adaptive coping and family communication, specifically employing task-oriented strategies for opioid users and depression-focused care for alcohol users. Policy should align with demographic data by integrating opioid interventions into youth and employment services while focusing alcohol programs on workplace wellness and family counseling. Furthermore, public health models should shift from surveillance to non-judgmental, expressive support to better mitigate anxiety. Future research can expand to include both genders and diverse socio-economic backgrounds, utilizing qualitative methods to capture the complex psychosocial dynamics of substance dependence.

6.5 Conclusion

The study reveals that alcohol and opioid dependence are characterized by distinct sociodemographic and psychosocial topographies, necessitating tailored therapeutic approaches. Alcohol dependence is predominantly associated with an older, married, and better-educated demographic but carries a significantly higher burden of depressive symptomology and mood instability. In contrast, opioid dependence typically emerges in younger, unmarried individuals from lower socioeconomic backgrounds, characterized by family environments with high levels of organization and rigidity. While such structure promotes task-oriented coping, the findings suggest that excessive control may become maladaptive by suppressing emotional openness and fostering systemic anxiety.

Furthermore, the research highlights the critical role of family dynamics as both a risk factor and a protective "buffer." Family cohesion, expressiveness, and warmth are robustly correlated with reduced psychological distress, supporting the buffering hypothesis where familial support mitigates the impact of addiction. Conversely, family disorganization and authoritarian control are linked to maladaptive coping mechanisms, such as distraction and social diversion. Because these avoidant strategies are significantly predictive of worsened depression and stress, the study

concludes that recovery outcomes are heavily dependent on transitioning from escapist behaviors toward task-oriented, instrumental problem-solving facilitated by a supportive and autonomy-promoting family climate.

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Appendices

Appendix I

Informed Consent

I, Elangbam Priyokumar Singh, a Ph.D. research scholar from the Department of Clinical Psychology, Mizoram University, am conducting a study titled *“Assessment of Mood, Family Environment, and Coping Strategy of Opioid Dependents and Alcohol Dependents.”*

You are invited to participate in this research. If you agree, you will be asked to complete a questionnaire by providing your opinions on certain statements. Your honest responses will contribute significantly to the success of this study. The questionnaire will take approximately 30 minutes to complete.

Participation in this study is entirely voluntary, and you may withdraw at any time without any consequences. All information collected will remain strictly confidential and will be used solely for academic and research purposes.

Consent Statement

I have read and understood the information provided above. I voluntarily agree to participate in this study and understand that I may withdraw at any time without any negative consequences.

Participant’s Signature: _____

Date: _____

Appendix II

Semi-structured proforma:

1. Name (Optional):
2. Address with district:
3. Age:
4. Educational qualification:
5. Occupation:
6. Income:
7. Marital status:
8. Family type:
 - a. Nuclear
 - b. joint
9. History of dependence:
 - a. Duration
 - b. Treatment history:
10. Any history of chronic illness:
11. Any other information:

Appendix III

Depression Anxiety and Stress Scale (DASS)

The DASS is a 42-item questionnaire which includes three self-report scales designed to measure the negative emotional states of depression, anxiety and stress. Each of the three scales contains 14 items, divided into subscales of 2-5 items with similar content. The Depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia, and inertia. The Anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect. The Stress scale (items) is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive and impatient. Respondents are asked to use 4-point severity/frequency scales to rate the extent to which they have experienced each state over the past week.

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you *over the past week*. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

Did not apply to me at all

Applied to me to some degree, or some of the time

Applied to me to a considerable degree, or a good part of time 3 Applied to me very much, or most of the time

1	I found myself getting upset by quite trivial things	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3

5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (eg, legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg, lifts, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3
<i>Reminder of rating scale:</i> Did not apply to me at all Applied to me to some degree, or some of the time Applied to me to a considerable degree, or a good part of time 3 Applied to me very much, or most of the time					

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

Appendix IV

Family environment scale (Dr. Harpreet Bhatia & Dr. N.K. Chadha) (English)

Instruction: this booklet contains some statements. These statements are about your family, you have to decide which of these statements are applicable to you about your family and which are not. Alongside the statements have FIVE options. If you **strongly agree** with the statement, mark tick (✓) under the ‘**Strongly Agree**’. If you **strongly disagree** with the statement, mark tick (✓) under the ‘**Strongly Disagree**’ column. For in between preferences mark accordingly ‘**Agree**’, ‘**Neutral**’ or ‘**Disagree**’.

Give us your general impression of your family. There is no right or wrong answers to any statement. Your responses will be kept in strict confidence and will be used only for research purposes. Please respond to each statement and do not leave any statement unanswered. Your help will be duly acknowledged.

Statements	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. We enjoy doing things together.					
2. Family members often do not express their feelings.					
3. Breaking things in anger is quite common in our family.					
4. Making decisions independently is strongly encouraged in our family.					
5. In our family everyone is encouraged to play and interact with neighbours.					
6. Responsibilities are not taken seriously in our family.					
7. All members of the family are expected to be together for at least one meal in a day.					
8. Affection is expressed openly, quiet often in our family.					
9. Togetherness is the basic feeling of our family.					
10. Our feelings of happiness are shared openly with others in our family.					

11. Beating up people in anger is not seen in our family.					
12. There are a lot of restrictions in our family.					
13. Friends and guests are always welcome in our family.					
14. Everyone in our family is well aware of their responsibilities.					
15. Nobody in our family bothered about rules of any kind.					
16. Everyone in our family listens to what each one of us has to say.					
17. Whenever any work comes up, everyone tries to get out of the situation.					
18. It is difficult to express ourselves openly for fear of some one reacting to it angrily.					
19. Everyone tries to sort things out if there is a disagreement in the family.					
20. Thinking for ourselves is not encouraged in our family.					
21. We often go out together for movies in our family.					
22. Going for programmes without informing at home is not accepted in our family.					
23. Nobody bothers to look after anyone else in our family.					
24. Any new situation that arises is discussed openly in the family in order to get ideas and suggestions from everybody.					
25. We talk about our personal problems to each other in our family.					
26. When members are angry, they do not talk to each other for days together.					
27. In our family, members ask for what they need, quite openly.					
28. Having hobbies is encouraged in our family.					
29. Quite often members of our family stay out without informing at home.					

30. Only when we do something well we get praise and attention from others in our family.					
31. Family members do not get along with each other.					
32. Complaining about something that we don't like is not accepted in our family.					
33. Finding faults with each other is quite common in our family.					
34. It is difficult to do something on your own in our family, without someone feeling rejected or left out.					
35. Watching T.V is our only form of entertainment.					
36. There is plenty of time and attention for everyone in our family.					
37. Everyone comes together to sort out any new situation that may arise in our family.					
38. At home we feel free to anything we want to.					
39. Shouting in anger is not common in our family.					
40. Everyone is expected to accept all decisions made in the family, whether they like it or not.					
41. Our family members are just confined to wither work or school.					
42. We are careful not to hurt anyone in the family by making thoughtless remarks.					
43. Whenever something needs to be done in the houses, everyone joins in, happily.					
44. When any member is feeling upset, he/she talks to someone in the family.					
45. The members of our family constantly keep bickering over small matters.					
46. Whenever a marriage takes place in our family the person concerned is asked his/her views.					

47. We go out often to visit friends or relations.					
48. In our family if anyone is upset, there is always someone to comfort them.					
49. There is no sense of closeness in our family.					
50. Family members often keep their feelings to themselves.					
51. Whenever anyone in our family is angry with another member, he makes sure to sort out things with him.					
52. The decision to take on or continue a particular job is taken by the family members concerned in consultation with other family members.					
53. Joking and laughing is not encouraged in our family.					
54. When things get tough there is always someone in the family whom we can turn to.					
55. When someone is sick in our family everyone participates in looking after the person.					
56. Expressing an opinion about matters at home is strongly encouraged in our family.					
57. Whenever a family member does something well, the other members feel upset about it.					
58. All major decisions in our family are taken by the elders in our family, without asking anyone else's opinion.					
59. There is a lot of affection amongst our family members.					
60. When a family vacation is planned we all give our suggestions.					
61. Our family believes in not letting differences continue unsorted out.					
62. If any member gets into trouble he/she gets help and sympathy from other family members.					
63. When in trouble, all of us stand up for our family member.					

64. Quite often members of our family fail to arrive at a mutually acceptable solution.					
65. When anyone makes a mistake, the other members ridicule him.					
66. In our family we enjoy sitting together and talking to each other.					
67. Showing anger by banging doors is rarely seen in our family.					
68. Members of our family are very critical of each other.					
69. All of us participate together in family functions/ programmes.					

Appendix V

Coping inventory of stressful situation (English)

Instructions: the following are ways people react to various difficult, stressful, or upsetting situations. Please circle a number from 1 to 5 for each item. Indicate how much you engage in these types of activities when you encounter a difficult, stressful or upsetting situation.

Not At All (1) Very Much (5)

1	2	3	4	5	1. Schedule my time better.
1	2	3	4	5	2. Focus on the problem and see how I can solve it.
1	2	3	4	5	3. Think about the good times I've had.
1	2	3	4	5	4. Try to be with other people.
1	2	3	4	5	5. Blame myself for putting things off.
1	2	3	4	5	6. Do what I think is best.
1	2	3	4	5	7. Become preoccupied with aches and pains.
1	2	3	4	5	8. Blame myself for having gotten into this situation
1	2	3	4	5	9. Window shop
1	2	3	4	5	10. Outline my priorities
1	2	3	4	5	11. Try to go to sleep
1	2	3	4	5	12. Treat myself to a favorite food or snack.
1	2	3	4	5	13. Feel anxious about not being able to cope.
1	2	3	4	5	14. Become very tense
1	2	3	4	5	15. Think about how I solved similar problems
1	2	3	4	5	16. Tell myself that it is really not happening to me.
1	2	3	4	5	17. Blame myself for being too emotional about the situation.
1	2	3	4	5	18. Go out for a snack or meal.
1	2	3	4	5	19. Become very upset
1	2	3	4	5	20. By myself sometime.
1	2	3	4	5	21. Determine a course of action and follow it
1	2	3	4	5	22. Blame myself for not knowing what to do

1	2	3	4	5	23. Go to a party
1	2	3	4	5	24. Work to understand the situation.
1	2	3	4	5	25. "Freeze" and not know what to do.
1	2	3	4	5	26. Take corrective action immediately.
1	2	3	4	5	27. Think about the event and learn from my mistakes.
1	2	3	4	5	28. Wish that I could change what had happened or how I felt.
1	2	3	4	5	29. Visit a friend.
1	2	3	4	5	30. Worry about what I am going to do.
1	2	3	4	5	31. Spend time with a special person.
1	2	3	4	5	32. Go for a walk.
1	2	3	4	5	33. Tell myself that it will never happen again.
1	2	3	4	5	34. Focus on my general inadequacies.
1	2	3	4	5	35. Talk to someone whose advice I value.
1	2	3	4	5	36. Analyze my problem before reacting.
1	2	3	4	5	37. Phone a friend.
1	2	3	4	5	38. Get angry.
1	2	3	4	5	39. Adjust my priorities.
1	2	3	4	5	40. See a movie
1	2	3	4	5	41. Get control of the situation.
1	2	3	4	5	42. Make an extra effort to get things done.
1	2	3	4	5	43. Come up with several different situations to the problem.
1	2	3	4	5	44. Take some time off and get away from the situation.
1	2	3	4	5	45. Take it out on other people.
1	2	3	4	5	46. Use the situation to prove that I can do it.
1	2	3	4	5	47. Try to be organized so I can be on top of the situation.
1	2	3	4	5	48. Watch TV.

Appendix VI

World Health Organization Alcohol, Smoking and Substance Involvement Screening Test (WHO-ASSIST, Version 3.0):

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills.

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

Question 1

In your life, which of the following substances have you <u>ever used</u> ? (<i>NON--MEDICAL USE ONLY</i>)	No	Yes
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3

g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

If "No" to all items, stop interview. If "Yes" to any of these items, ask Question 2 for each substance ever used.

Question 2

In the past three months, how often have you used the substances you mentioned (FIRST DRUG, SECOND DRUG, ETC)?	never	Once or	Monthly	Weekly	almost daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6. If any substance in Question 2 were used in the previous three months, continue with questions 3, 4 & 5 for each substance used.

Question 3

During the past three months how often have you had a strong desire or urge to use (FIRST DRUG, SECOND DRUG, ETC) ?	never	Once or	Monthly	Weekly	almost daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

Question 4

During the past three months, how often has your use of (FIRST DRUG, SECOND DRUG, ETC) led to health, social, legal or financial problem?	never	Once or	Monthly	Weekly	almost daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7

g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the past three months, how often have you failed to do what was normally expected of you because of your use of (FIRST DRUG, SECOND DRUG, ETC)?	never	Once or	Monthly	Weekly	almost daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	5	6	7	8
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

Question 6

Has a friend or relative or anyone else ever expressed concern about your use of (FIRST DRUG, SECOND DRUG, ETC)?	No, never	Yes, In the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other - specify:	0	6	3

Question 7

Have you ever tried and failed to control, cut down or stop using (FIRST DRUG, SECOND DRUG, ETC)?	No never	Yes In The Past 3 months	Yes, but not In The Past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other - specify:	0	6	3

Question 8

	No, never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you ever used any drug by injection? (NON-MEDICAL USE ONLY)	0	2	1