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Family with a drug problem: intergenerational transmission of the dysfunction

Rodzina z problemem narkotykowym: międzypokoleniowa transmisja dysfunkcji

Abstract
Introduction. This article discusses several family conditions conducive to drug use.
Aim. The research aims to determine the impact of the family environment, especially a dysfunctional one, on drug use among people growing up in such a family. It was assumed that, according to the concept of the family as a system, if at least one of its elements is dysfunctional, the consequences of this state affects the other members of the family, who do not acquire proper patterns of functioning in the family and society.
Material and methods. 154 standardized interviews with drug users were conducted. The research tool used to collect data was interview questionnaires; in addition, seven interviews were recorded on audio-tracks. Each interview consisted of 39 questions, several of

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which related directly, or indirectly, to their family situation. The study was qualitative, but some of the responses can be represented by quantitative data, which was used to provide numerical values for the indications obtained.
Results. The analysis of the empirical material collected during interviews with drug users shows the links that have been identified between reaching for these measures and growing up in a family struggling with the drug use of one or more of its members. Permanent disorders in relations between members of a dysfunctional family affect the development of a whole spectrum of personality problems, including addiction.

***Keywords*:** psychoactive drug, youth, drug initiation, family negligence, harm reduction

Abstrakt
Wprowadzenie. W niniejszym artykule omówiono rodzinne uwarunkowania determinujące używanie narkotyków.
Cel. Celem badań było określenie wpływu środowiska rodzinnego, zwłaszcza dysfunkcyjnego, na używanie narkotyków przez osoby wychowujące się w takiej rodzinie. Założono, że zgodnie z koncepcją rodziny jako systemu, jeśli przynajmniej jeden z jej elementów jest dysfunkcyjny, konsekwencje tego stanu dotykają pozostałych członków rodziny, którzy nie nabywają prawidłowych wzorców funkcjonowania w rodzinie i społeczeństwie.
Materiał i metody. Przeprowadzono 154 standaryzowane wywiady z osobami używającymi narkotyków. Narzędziem badawczym służącym do zbierania danych były kwestionariusze wywiadu. Dodatkowo siedem wywiadów zostało nagranych na pliki audio. Każdy wywiad składał się z 39 pytań, z których część dotyczyła bezpośrednio lub pośrednio ich sytuacji rodzinnej. Badanie miało charakter jakościowy, jednak część odpowiedzi można przedstawić w postaci danych ilościowych. Posłużyły one do przedstawienia wartości liczbowych uzyskanych wskazań.
Wyniki. Analiza materiału empirycznego zebranego w trakcie wywiadów z osobami używającymi narkotyków przedstawia związki pomiędzy sięganiem po te środki a dorastaniem w rodzinie zmagającej się z problemem używania narkotyków przez jednego lub kilku jej członków. Trwałe zaburzenia w relacjach między członkami rodziny dysfunkcyjnej wpływają na rozwój całego spektrum problemów osobowościowych, w tym uzależnienia.

***Słowa kluczowe*:** narkotyki, młodzież, inicjacja narkotykowa, zaniedbania rodzinne, redukcja szkód.

Introduction

Drug use is an issue explored by researchers in many scientific disciplines, who focus their attention both on describing this dynamic phenomenon, trying to estimate its scale, and identifying factors conducive to its development. In the last decade, social studies authors have signalled an increase in the indication of drug use and the intensification of social and health problems related to drug use (European Monitoring Centre for Drugs and Drug Addiction [EMCDDA], 2019; United Nations Office on Drugs and Crime [UNODC], 2019). The data collected indicates a worrying increase in the number of drug users, which is now 30 % higher globally than in 2009. The re-

sults also indicate that adverse consequences associated with drug use are much more common and more severe than previously assumed (UNODC, 2019). Identifying the reasons for the increased interest in such activities requires regular surveys of this phenomenon in order to undertake adequate preventive actions.

Researchers highlight the multidimensionality of drug initiation conditions observed in the social environment, cultural influences, and in the peer and family environments of those who admit to using drugs (Jiloha, 2009; Motyka, 2018a; Spooner, Hetherington, 2005). Literature also includes a division that takes into account individual or social predictors of such behaviour. Individual characteristics that are conducive to risky activities include poor self-control, curiosity, searching for exciting sensations, a lack of skills in dealing with stress, and a lack of knowledge about the consequences of drug use. In terms of social conditions: weak ties with the environment, a lack of role models, poverty, inappropriate family relationships, low emotional support, peer influence, and low availability of satisfactory life choices (Chan, Lo, Tam, Le, 2019).

The family environment seems to play a key role between making right, or dysfunctional, choices for life, as its impact affects both the signalled individual characteristics and the social dimension of the individual's relationship with their environment. The family is the primary source of norms, principles, values, and attitudes instilled in a child during the socialization process (Baferani, 2015). Whereas the behaviour of those persons from whom these patterns are acquired is consistent with the principles implemented, and at the same time, free of pressure and excessive control, the process of their assimilation becomes clear, and these values shape the identity of the individual, thus contributing to the creation of strong internal control (Hardy, Padilla-Walkera, Carlo, 2008). Acceptance of universally accepted moral values and principles is an essential element of mutual trust, which determines proper relationships between family members and a sense of security (Putnam, 2000; Sztompka, 2016).

However, this process is not always correct. Relationships between family members, depending on their quality, have been identified as both favourable and protective factors for drug initiation. The greater the closeness between parents and child, the greater the absence of family dysfunction, and the increased proper control over the child, the decreased likelihood of abnormal activities, including drug initiation. In contrast, a lack of closeness, too little or excessive control, conflicts and inappropriate behaviour of family members are conditions that may favour such behaviour (Brook, Brook, Gordon, Whiteman, Cohen, 1990; Brook, Duan, Brook, 2007; Hawkins, Catalano, Arthur, 2002). In such circumstances, drug use may be treated by an adolescent family member as a strategy for the ultimate satisfaction of psychological needs when relationships with important people disappear (Chan et al., 2019).

Family conditions related to drug addiction

In the literature on the subject, one can find numerous initiatives to establish the family conditions related to drug addiction. The authors emphasize, among other factors, the significant role of genetic factors responsible for the susceptibility to addiction of children from parents who abuse alcohol and use drugs (Uhl et al., 2008). According to Bogdan Szukalski (2011), the use of the most addictive drugs – cocaine and opiates – may be the most inherited, and the use of the hallucinogens with low addictive effects may be the least inherited. It has also been found that the risk of drug use in the children of parents who use drugs is eight times higher than that of non-users (Merikangas et al., 1998). The research carried out among adopted children separated from biological parents at birth has observed the occurrence of relationships between the origin of at least one addicted parent and alcohol dependence, alcohol abuse, drug use, and mental disorders observed in their children. Therefore, the predisposition to using drugs may also occur when a child grows up outside the dysfunctional environment of a biological family (Szukalski, 2011).

System theories focus their attention on the interaction of elements of the system as the family is considered to be. According to Fred Streit and Hilory Olivier (1972), the use of psychoactive agents is the result of different interpretations – by adults and children – of the relations taking place in a given community. The difference in perception may concern i.a., parents' attitudes towards their children, the demonstration of emotional support, love, and the relationships between parents and other siblings. The fact that a child considers the actions of the parents to be unfavourable for themselves may encourage the occurrence of behavioural disorders, such as directing attention towards the use of psychoactive agents (Jędrzejko, Neroj, Wojcieszek, Kowalewska, 2009; Streit, Olivier, 1972).

According to Judith S. Brook, weak bonds between family members are a crucial factor in drug initiation. The author attributes great importance to parental control during adolescence and the support of a child experiencing difficulties related to growing up. Family conditions conducive to maintaining the homeostasis of proper relationships within the family include parents' acceptance of universally respected values and principles, showing emotional support, an upbringing based on love, exercising intrusive control over the child, and at the same time, the emotional maturity of mothers. On the other hand, weak emotional bonds between children and parents, a child's abnormal personality, susceptibility to influence, low self-esteem, predisposition to depression, aggressive and rebellious behaviour, and especially deviant behaviour, and the attitudes of parents were considered risk factors (Brook et al., 1990; Brook et al., 2007).

Shanta Dube and her team of researchers have found that adverse childhood experiences (ACEs) associated with growing up in a dysfunctional family (addiction,

violence, neglect, crime, mental illness, conflicts between parents) are important predictors of drug initiation. The more difficult the childhood experience, the greater the probability of reaching for drugs in early adolescence (Dube et al., 2003).

A study by Denise Kandel and her colleagues found that abnormal parental attitudes – excessive dominance, overcontrol, rejection – increase the risk of dependence on psychoactive agents. Modelling of children's behaviour by adults was also considered to be important in the undertaking of abnormal behaviour. The three-stage model of social interaction presented by the researchers indicates that parental consumption of spirits can encourage the alcohol initiation of children (Stage I); that these behaviours can increase peer influence and generate marijuana experimentation (Stage II); and that, as a result of overcontrol, lack of consistent disciplinary requirements. or parental drug use can lead to the use of much stronger and more dangerous drugs (Stage III). According to researchers, the influence of parents on the child is only weaker at the second stage of drug use. However, it is their attitudes and behaviours that have been identified as crucial in the development of risky behaviours among children (Jędrzejko et al., 2009; Kandel, Kessler, Margulies, 1978).

Interesting data are also quoted by Duncan Stanton (1997), indicating an abnormal cyclic pattern of interactions observed in families where intoxicated individuals live. A child who is a drug user integrates the other family members to take joint action to improve their situation and reduce the problems associated with the use of the drugs. When the quality of life of an addicted person improves, the loved ones, losing their common goal, move away from each other. Then again, some conflicts and divisions can encourage the individual to resort to these measures, creating a specific addiction cycle of the family system. In this case, drug use serves as a temporary family cohesion objective; it is a response to the behaviour of other family members, not always in line with the expectations of the user (Stanton, 1997).

John Bowlby (2007), in a concept called the attachment theory, focuses on the child's relationship with carers, which, according to the researcher, plays a key role in the psychological development of a juvenile family member. The great sense of the closeness of the parents fosters the development of the child's ability to anticipate their behaviour and react to various types of activity, and the repetitiveness of these interactions provides the child with important information about interpersonal relationships. Deficits in these contacts in early childhood result in abnormalities in later life: avoidance of direct contact with other people, no need to establish such relationships, permanent fear of losing a loved one. These disorders were considered to be a consequence of a lack of attention paid to the child in the early stages of development or as a result of the child experiencing insufficient closeness on the part of the parents or guardians (Bowlby, 2007). Then, according to researchers, individuals with dysfunctional attachment patterns develop a sensitivity to the psy-

choactive substance as a substitute for human closeness. Psychoactive substances are then a way to fill the emptiness created by the lack of a stabilizing relationship (Wyrzykowska, 2012).

The lower quality and reduced frequency of adolescents' relationships with their parents are the reasons identified in studies for adolescents' interest in drugs (Motyka, 2018b). Data from measurements carried out among students attending schools in the Podkarpackie region of Poland showed relationships between the regularity of contact with parents and attitudes towards psychoactive drugs: the reduction of daily conversations with the child resulted in both an increase in liberal attitudes towards drugs and higher preference for these drugs. The results, therefore, suggest that the continued interest of parents in their child's affairs is conducive not only to control the child's behaviour but also the attitudes the child has towards drugs. A sense of constant interest and control may, therefore, encourage a child to not engage in risky activities, such as establishing close relationships with peers who use drugs, attending meetings where there is a likelihood that proposals to take the drug may be made and, if faced with such an offer, assertive refusal to take the drug (Motyka, 2018b).

According to Zbigniew Michalczyk (2018), theories of family systems describe the pathology of the family as a specific social system in which the whole family, the whole system, and not an individual, is the carrier of the disorder. Intrapsychic processes are the result of family relationships. This theory considers the family to be a homeostatic system that is capable of responding plastically to any change (Michalczyk, 2018). Relationships between family members who are unable to meet the needs of the child, inappropriate behaviour of family members, and excessive, or insufficient requirements are established risk factors for turning towards drugs to isolate oneself from uncomfortable circumstances, or to give the person taking them a substitute for a closeness they have never experienced. The taking of drugs by one child, parents, siblings, as well as other members of the family system also affects the rest of its members.

Research purpose

The data presented in the text comes from interviews carried out from 2014 to 2019 of persons who confirmed their drug use and who were assisted by institutions located in Podkarpackie Voivodeship in Poland. The initiative aimed to establish the conditions for the initiation of drug use by respondents. In addition to questions related to drug use, the exploratory nature of the interviews focused on obtaining information on three probed areas: family life, peer influences, and the role of mass culture products in their decision to use drugs. Due to the extensive empirical material collected, which

requires much more space than the content of a single article, this paper presents a description of family conditions related to drug addiction collected from participants. During the interviews, information was collected about the structure of the family in which the respondents grew up. The occurrence of dysfunctions in the family and the current family situation of the respondents were also established, and the quality of the relationships between them and other family members was discussed. They also surveyed the resources they had: education, financial background, life plans, goals, and achieving them. In connection with the initiative, research problems have been formulated, which set the directions of research:

– Were the respondents brought up in full families?
– Were there drug addicts or drug users in the families?
– Has the use of drugs by a family member affected the initiation of drugs?
– How drug use has affected their family situation:
– Did they start their own family?
– What are their current relationships with members of the original family?
– What is their relationship with their spouses and children?
– How do they cope with adulthood?

Material and methods

In the research, a deliberate and convenient nonprobability sampling was used. It was assumed that information would be collected from those who voluntarily seek a consultation or therapy in institutions where one of the co-authors of this work was employed as an addiction therapist. The research was planned to be carried out in two facilities, i.e., the Addiction Therapy Ward at the Regional Psychiatric Hospital of Podkarpackie Voivodship in Żurawica and the Municipal Centre for the Prevention of Addictions in Przemyśl. The research was planned and carried out in accordance with the *Sociology's Code of Ethics* binding in Poland. Applications for permission to conduct the research were sent to the heads of both institutions, ensuring the full anonymity of participants. After approval, a standardized interview was conducted with each person who confirmed their drug use. All interviews were conducted and recorded with the consent of the respondents. From May 2014 to August 2019, data from 154 people were collected.

The research tools used to collect data were interview questionnaires, and seven conversations were recorded using recording devices. Each interview consisted of 39 questions, several of which directly or indirectly concerned the family situation. The research on drug use focused on determining the motives and circumstances of drug initiation, the means they used, and their perception of addiction. Some of the

questions, as indicated earlier, referred to the influence of popular culture products (literature, music, film) on their risky choices. When collecting data, data concerning gender, age and place of residence were also collected. The preparation of such a set of questions has allowed for obtaining data on issues common to all, and above all, it has increased their sense of security when disclosing sensitive data. Depending on the openness of the respondents, additional questions were also asked in order to obtain more complete information.

The research was qualitative; however, some of the answers could be presented using quantitative data, which was used to give numerical values of the indications obtained. This article mainly presents data on the research issues indicated in the title. Other research results will be presented in other studies.

Research results

One hundred and forty men and fourteen women attended the interviews. Most of the respondents were between 20 and 35 years old – 115 people; fifteen respondents were under 20, twenty-four respondents over 35. The average age of respondents is 28, with the youngest being 13 and the oldest 49. Most of them indicated the city/town as a place of residence (120 people), thirty-four indicated that they lived in the countryside.

The average age of drug initiation was found to be 16 years, with the lowest indicated age of first drug use being 10 years and the highest being 39 years. The vast majority of survey participants stated that they had taken drugs before the age of 18 (129 people); almost half (73 people) reported such experiences before the age of 15. Only one respondent indicated a late initiation age (39 years). The most frequently indicated reasons for the first contact with drugs are curiosity (83 indications) and persuasion from peers (44). For most people, the initiation drug was marijuana, indicated by 132 people. The others were: amphetamines (5 people), OTC drugs (5), new psychoactive substances – NPS (6), inhalation substances (4) and opiates (2). Twenty-one interviewees remained with the initiation drug (marijuana) while the rest confirmed their experience with many drugs. Apart from marijuana derivatives (153 people), the drugs indicated are amphetamines (111), NPS (77), ecstasy (43), cocaine (39), hallucinogenic mushroom (27), LSD (27), opiates (22), OTC drugs (20). Twenty-five people also reported that they use other substances, including inhalation and sleeping pills. The analysis of the obtained answers confirmed that half of the respondents alternate between at least 5-6 different drugs. Most of them have been diagnosed with multi-drug addiction syndrome.

The structure of the respondent family

From the data collected, it was found that 75 people were raised in single-parent families due to divorce, death of one parent, or lone parenthood. For many of the respondents, it was difficult to talk about this period and only a few of them found themselves able to give slightly more complete information. The statements presented below illustrate the circumstances in which the respondents grew up:

> I don't know my father. It was often hard at our home, the food was always ok, but I wore clothes from a second-hand shop (respondent 2).

> Dad died when I was 11. Mom pulled herself together quickly after his death. She had to because there were five of us to feed. We took care of ourselves, that is, we looked after ourselves, my brothers and I (respondent 40).

> We lived with our mother only, but it was as if she didn't live there. She has always been treated for depression. She only takes some drugs and sleeps. That's the way it is all the time; the house is a total dump, there was never anything in the fridge, maybe only at Christmas when we got some donations from family support services (respondent 65).

> We've lived separately with our mother since I was eight years old, I mean me, my brother and sister. The old man drank and beat our mother and us. Our uncle, our mother's brother, took us. She didn't want to, but he said that if we don't go, he'll kill the old man because he won't let him kill us (respondent 71).

Several of them presented drastic circumstances related to the loss of a parent:

> Dad hung himself, I don't know why, nobody knows what happened (respondent 64).

> I was 5 years old when she drank herself to death (mother). Dad worked all the time to make sure there was money for my brother and me, and I guess that's what killed him. He had a heart attack and died when I was 16 (respondent 153).

Twenty-seven respondents were found to have lost full parental care after the divorce of their parents, twenty-five because of the death of one or both of them, twelve experienced abandonment in childhood by addicted or mentally ill parents (mainly respondents living in an orphanage), and nine indicated that they did not know their fathers (raised only by their mother). In two cases, parental care was found to be incomplete due to the fathers' long-term imprisonment.

The survey also included statements suggesting that despite growing up in a full family, respondents experienced attention deficit on the part of their parents:

> Dad had an accident when I was 11. My mother took care of him all the time and I watched over the younger siblings. I looked after them for seven years. When my father recovered, I already had my own life. I was already after the first detox and they didn't know anything anyway (respondent 104).

A statement suggesting low interest from parents was also expressed by other respondents:

> I grew up with a full family, but Dad raised us. Mom has been going to Italy to work for thirty years. She comes for Christmas and Easter (respondent 53).

> The family is full, but the mother is abroad at work (respondent 96).

The addiction problem in the family

Other important data was obtained by researching the problem of addiction in the family environment of interview participants. Two-thirds of the respondents (98 people) confirmed that there were, or are, people addicted to alcohol or drugs in their families. The statements collected indicated growing up in such an environment:

> Mother often drank, she said she had to calm down because she was getting more and more nervous (respondent 2).

> Both parents were addicted – they were drinking, and my brother was drinking and doing drugs, but he got a big sentence and was locked up, and I lived only with my parents (respondent 5).

> There's always been a brawl and doing drugs at home. Both old folks used to do meth, take some drugs and sometimes smoke weed (respondent 7).

> My mother is an alcoholic, and my sister has been smoking weed for years (respondent 15).

> My older brother smoked weed and there were often parties at home (respondent 36).

> My brother has been smoking weed since I can remember (respondent 61).

> My parents are addicted. Dad is addicted to drugs, mum is addicted to alcohol (respondent 102).

> Mom was boozing at night. She was always unconscious in the morning, but I know she was drinking because my brother told me. I was five years old when she drank herself to death (respondent 153).

> My father did drugs. He overdosed on drugs when I was little, I was seven. It's a good thing he overdosed because he was taking something that made him the devil. Now I think it was meth. I was always afraid of him when he was at home and when he was leaving home (respondent 154).

The addiction of one parent was indicated by a total of 68 respondents, sixteen respondents indicated the addiction of both of them, and fourteen admitted that their siblings were users of psychoactive agents in the family. Also, 14 people reported that addiction occurred, or was present, among the extended family (grandparents, uncles), 12 people reported that there were several addicts (parents and siblings) in the family.

Impact of drug use by a family member on drug initiation of respondents

In the study group, twenty-six respondents confirmed drug use among their family members; one person admitted that both parents were using drugs, nine respondents indicated a father who was using drugs, and sixteen respondents indicated that their siblings used drugs. Analysing the impact of drug use by the family members on the participants of the interviews, further relevant data was established. Eight people admitted that the drug initiation took place in the presence of a family member, and even in a few cases, it took place on the initiative of the family member:

> I was ten years old at that time. I was at home with my father, and my mother was gone for a few days, and I didn't know what had happened and I was worried about her. I was always worried at that time. My father used to sell meth, now I know it, and all the time someone used to come to us and go into the bathroom with my father. They could sit there for a few hours even, and they only left when they were short of ciggs. My mother also did drugs, but her grandmother used to take her to rehab, or she used to run away by herself. The old man was fucked up about neatness, and when he got high, he kept doing something, but he was doing some bullshit, and the house was a total dump. I told him then to clean up because my mother would come back, and he threw some drugs at me and said «eat some and clean up yourself». And I took it, I wanted to eat with a wet finger, but he started laughing, poured some into my juice and let me drink it (respondent 7).

Other respondents reported similar circumstances of drug initiation:

> There was a party at home that my brother was doing. It was a few weeks after mom died. There were some of his mates, smoking weed and drinking. There was nobody but us, and I was sitting with them all the time. My brother is seven years older than me. He gave me some weed (respondent 17).

> When I confessed to my brother that I smoked weed at school before, he gave it to me and we were smoking together (respondent 61).

Other respondents indicated the clear influence of drug use among family members on their decision to try the drug:

> I was smoking the first weed with my friends, but I took the white (amphetamines) from my father – he always had so much of it that he didn't even know I was taking it. When he had a 5-6 day trip after doing the white, he took something and slept for a long time. Then I could do anything (respondent 86).

> The old man did amphetamines. I wanted to nick a little bit from him one day, but he saw me, and he beat me up. But there was glue at home, and nobody was watching it, and I wanted to see what it was about (respondent 102).

> I saw my brother having fun and I wanted it to (respondent 61).

> I knew my brother was on drugs and I envied him for that. I was afraid of shooting up as he did, but I knew that I would surely smoke the weed (respondent 153).

> One of the subjects admitted that he even used blackmail for this purpose: "I got amphetamine from my brother. I said if he would not let me try it, I would tell my parents he does drugs. I knew for a long time that he did drugs" (respondent 47).

Impact of drug use by respondents on their family situation: did they start their own family?

Two-thirds of the participants did not start their own families (102 people). When asked about their plans in this respect, only twenty-nine admitted that they would like to start a family. The others in this group either did not signal the need or did not believe it was possible. Sixteen people confirmed that they were married, four – in cohabitation, while thirty-two admitted that they were separated from their partners. The reason given for the break-up was usually drug use and especially the lifestyle associated with this type of behaviour: "I was in a relationship for seven years, but it broke up because of drinking and doing drugs (respondent 58)".

In this group, only nine people admitted that they would like to improve relations with their loved ones.

The acute consequences of the drug use, which affected the family situation, were also indicated by two respondents:

> I don't have my own family. I was pregnant, but I was carrying a dead foetus and I didn't know about it. When they cleaned me out, they said I wouldn't have any more children. I don't think about having a relationship (respondent 125).

> During the first pregnancy, I didn't know I was pregnant. I was on drugs all the time, I had pains and bleeding. When they took me to the hospital, they said I had been pregnant. During the second pregnancy, I didn't do drugs. Even when my son was born, I didn't do drugs. But I couldn't breast-feed, so I was taking some coke from time to time. Now I'm alone and I don't know what's happening to him (respondent 154).

Impact of drug use on the family situation, by respondents: current relationships with members of the original family

In the course of the interviews, many participants confirmed that their contacts with their parents or parent are superficial, although most of them (88 people) admitted that they still live together. Some pointed out the great care and constant interest of the parents in improving their lives, and the family home was a stronghold where they could always find shelter and help, especially after drug and alcoholic pregnancies.

> I could leave home when I wanted and for as many days as I wanted. I didn't say anything. I just disappeared and I was gone for a few months. I was untraceable because there were no mobiles at the time. Sometimes I called them and informed them that I was alive, that's all. But when something happened to me, I always knew that I had a place to go back and where I could get over it (respondent 104).

Some, despite the deficits in their relationship with their parents, confirmed the presence of emotional bonds:

> We live in two rooms, my mother drinks in one and I do drugs in the other. If I go on a bender, I don't live in the house, because I think I'd kill her for that drinking. Besides, I have nothing in the house, just a room and a bed. I think I love my mother because when she drinks, I'm afraid she'll die. My mother sucks, but I think I love her anyway (respondent 2).

However, many of the statements, especially those depicting relationships with an addicted parent or sibling, suggested a break in emotional connection with loved ones:

> I meet my mother sometimes, but I won't go back to her. In summer I can manage, in winter there is a shelter and hospitals with two months' rehab (respondent 65).

> While we were moving out, the old man was ignoring us. We don't talk to each other. I know where he lives, but we have nothing in common (respondent 71).

> I have no contact with my brother. I think he's in some junkie centre now or somewhere else. Maybe in jail, because he was a drug dealer (respondent 153).

I know he's either been doing drugs and treating himself in different centres, in turn (like his father). I don't know where he lives (respondent 86).

The aversion to family members who do drugs has been noticeable even in relation to the deceased:

My grandmother told me that my father died somewhere in Poland. I don't want to know where (respondent 14).

My brother drank and did drugs, but he committed suicide. Silly him, because now there is so much new stuff to try (respondent 36).

I don't go to his grave (respondent 47).

Impact of drug use on the family situation, by respondents: current relationships with their spouses and children

On the basis of the conducted interviews, it can be assumed that some of the research participants have transferred the patterns of behaviour observed in the original family to their current relationships:

I have a son, but we don't live together. I only see my partner when I visit my son (respondent 14).

I don't live with my husband. He beat my daughter and me and I ran away from him to my parents. My parental rights are limited, but my parents became a foster family because my husband didn't want to take care of her (respondent 24).

I have a cohabitee and two daughters. We are not together but we don't keep in touch (respondent 59).

I have a child, but we don't live together. I have never seen my daughter (respondent 53).

I have a daughter, I don't live with her (respondent 102).

I don't know what's happening to my child. A partner took our son away when he was 3. He said I would die anyway, and he would not let the child see it (respondent 154).

My son is 12 years old. He has autism. I have no contact with his mother or with him (respondent 73).

When I found out that I couldn't have kids, I did some extremely silly things. I never thought of becoming a mother, but the news killed me. My lad kicked me out.

> I won't come back to my family house. I live in a shelter, well, I think I will live in a shelter once I finish my therapy, I hope they will accept me (respondent 125).

> We have a child, but we don't live together. My parents didn't agree to the wedding because my boyfriend does drugs and he sells amphetamines. When my father goes to work, he sometimes comes to me, but it is always a holy stink, and we get in each other's way (respondent 139).

Coping with adulthood

Deficits in the family environment (negligence) can also be observed when analysing the education of the respondents and their professional situation. Thirty-one respondents finished their education at the primary school stage, and one of them did not even manage to reach this level. Twenty-seven respondents graduated from junior high school and did not start further education, forty-nine respondents – vocational schools (none of them took up a job in their profession), 40 respondents – secondary education, and 6 respondents – higher education. Only sixteen respondents confirmed that they had a paid job, the rest were unable to provide a source of income.

The data presented may result from deficits of social capital inherited to a large extent from the family environment or acquired from the environment under favourable conditions. A lonely individual left alone is socially helpless. If, on the other hand, an individual enters into frequent and positive relations with family members, relatives, or acquaintances, there is an accumulation of social capital, making it possible to satisfy social needs. The individual's participation in a group, and especially in the family community, increases their social potential to strengthen social bonds and improve living conditions. Strong group ties, including family ties, bring measurable benefits to the individual and allows them to discover the advantages of positive relationships with other people (Putnam, 2000). The data obtained in the course of the research indicates that, in the case of the interview participants, the circumstances allowing the acquisition of this capital – both family and community – were, at least, inconvenient.

Discussion

A characteristic feature of the respondents is the young age of drug initiation, indicating that almost half of the respondents started taking drugs before the age of fifteen and the vast majority (84%) before they reached the age of majority. The most

frequently indicated reasons for the first contact with drugs are curiosity (83 indications) and peer pressure. An equally important factor conditioning the initiation was the upbringing of the respondents in the family where the transmission of addiction took place. According to the respondents' statements, half of them take several drugs alternately.

The disturbed structure of their families undoubtedly influenced the development of conditions conducive to drug use by the respondents. Half of the respondents were brought up in lone-parent families and dysfunctional families. Some of them lost full parental rights. The death of one parent, the breakup of a marriage, and the father's imprisonment contributed to the formation of a lone-parent family. Sometimes the respondents lost both parents as a result of their premature death or abandonment due to addiction or mental illness. In dysfunctional families, which are mentioned by the respondents, the inappropriate style of the upbringing of a child, weakening or breaking the emotional bond with parents, negative attitudes and behaviours of parents, domestic violence, alcoholism, and crime dominated. Thus, there was no proper parental influence on the child, which disintegrated the bond between the child and their parents and led to the creation of emotional anaesthesia.

Drastic violations of social norms by family members and the rejection of universal moral values and principles were directly related to the conditions presented above. In the family, the rules of conduct were not clearly defined, but an occasional and inconsistent upbringing without a clear educational attitude towards the child prevailed. Parents or other family members have regularly violated social norms and moral principles, affecting the child's system of values and norms that are shaped by the process of socialization. The lack of socially accepted values and moral norms generated the formation and development of pathological behaviour.

A factor that was strongly influential on the drug problem of the respondents was the alcohol and/or drug addiction of one or both of their parents. Two-thirds of the respondents confirmed such an addiction among their parents. Alcoholism and drug addiction disrupting the intra-family system created a dysfunctional system in which the addiction of the family member(s) became an integral part of this system. In a family with alcohol and/or drug problems, children felt insecure because they had no adult support. This phenomenon was accompanied by stress, anxiety, and a sense of threat. The child, not trusting their loved ones, closed in on themselves, adopted an attitude of withdrawal and did not take the risk of opening up to other people. A serious problem for young people became loneliness, lack of plans for the future, as well as being unprepared for life in society. The young people did not receive positive education models or axiological systems in the socialization process. They also had no plans for the future, which deprived them of hope for a better life and generated depressive behaviour. Alcohol and/or drug addiction among family members generated aggres-

sion and various forms of domestic violence. Children from families with alcohol and/or drug problems often, and at an early age, started to take drugs to compensate for loneliness, insecurity, powerlessness, and humiliation, and to "free themselves" from stress, anxiety, and frequent emotional tensions.

Drug addiction affected the adult personal life of the respondents. Two-thirds of them did not start their own family. Others were separated from their partners or were in cohabitation relationships. It can be presumed that the educational patterns of the original family, and especially conflict-forming tendencies, have become the cause of the maladjustment to family life or have led to its disorganization. Problems with starting a family or with its permanence were caused by the fact that more than half of the respondents (57%) still lived with their parents or one parent, with whom relations were superficial.

Research conducted by Judith S. Brook among teenagers confirmed that deviant attitudes and the behaviour of parents, and a lack of emotional bonds are the main causes of risky behaviour among children (Brook et al., 1990). The results of these investigations have been described as family interaction theories and have been used by many researchers to observe and design further measurements to determine the family causes of drug use. Numerous studies have confirmed that patterns acquired in the family may be conducive to the use of psychoactive agents, early drug initiation, and the choice of the drug (Jędrzejko et al., 2009). According to Kathleen R Merikangas et al. (1998), the history of drug use in the family is one of the strongest risk factors for children to develop drug dependence. The review of research on family conditions of drug addiction presented by Małgorzata Przybysz-Zaremba (2017) is also a valuable compendium of current family conditions of risky behaviour among young people. The author indicates both pathological and non-pathological risk factors. The former includes alcohol and domestic drug abuse, aggression, and violence. The indicated non-pathological predictors of risky behaviours of adolescents include poverty, social exclusion of the family, and economic migration of parents which may favour deficits in the relationship between parents and children.

Based on the research results, it can be assumed that an important cause of falling into drug addiction is the erosion of moral values and norms, which takes place in dysfunctional families. Acceptance of moral values and norms proves to be the dominant factor in uniting the family community and building mutual trust. It is also a fundamental source of social capital (Fukuyama, 2003). In turn, the disintegration of the system of values and moral norms in the family makes it impossible to build family ties based on mutual trust. In some dysfunctional families, mutual trust develops into a form of loyalty enforced by punishment, which, over time, turns into mistrust, weakening the emotional basis of cooperation. Lack of trust induces discouragement, the feeling of rejection by others and significantly reduces participation in important

activities (Sztompka, 2007). Distrust makes the family members alienate themselves and become pessimistic, characterized by suspicion and caution against possible problems. Thus, if there is mistrust in relations between family members, with all the negative consequences resulting from it, the frequency of mutual interactions decreases, and individuals, maintaining distance and scepticism towards each other, are not interested in maintaining mutual relations (Sztompka, 2007).

Summary

The results obtained in the presented studies confirm that the factors favouring drug use identified in the family environment are a lack of parental care, lack of emotional support, growing up in a single-parent family (death, divorce, long absence of a parent from home), growing up in a dysfunctional family (violence, poverty, addictions), a lack of interest of parents in the child's extracurricular activities, lack of arrangements for behaviour in the family home and outside it, a lack of clear rules relating to the use of psychoactive agents, reduction or a complete lack of conversations between parents and child, and the use of psychoactive agents by a family member.

Growing up in a family with a drug problem significantly reduces the socialization process of children who are not properly prepared for independent adult life. Abnormal patterns of behaviour observed by children in the original family are reproduced by them in relations with other people, making it impossible to establish lasting and strong social bonds. Moreover, they constitute a serious obstacle to the development of a system of values and norms necessary to generate social capital. Inherited dysfunctions clearly disrupt the process of functioning in society. Research suggests that in families with drug problems, there is a generational transmission of dysfunctions, including drug addiction tendencies.

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