Family functioning of out-of-treatment cocaine base paste and cocaine hydrochloride users

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Abstract

Knowledge of family structure and behavioral dynamics of out-of-treatment drug users under poverty becomes relevant, because of the role that the family plays in drug use and rehabilitation.
Hypotheses: 1. The perception of drug users about their family functioning reveals a dysfunctional organization and communication–connection problems with their families; and 2. the family system of cocaine base paste (CBP) users presents greater dysfunctionality than cocaine hydrochloride (CH) users.
Method: Cross-sectional descriptive design of primary users of CH ($n=236$) and primary users of CBP ($n=231$) during the last month, out-of-substance abuse treatment during the last 6 months.
Instruments: Risk Behavior Questionnaire and How-Is-Your-Family Questionnaire.
Results: The total sample presented 72.9% of families with risk functioning; CBP users registered a more deteriorated family structure and communication–connection than CH users.
Conclusions: CBP and CH users, who are hidden from health treatment services, do indeed present a high degree of family dysfunction; and the CBP group, compared to the CH group, presented various indicators of greater risk in their family dysfunction.

Keywords: Cocaine; Addictions; Family functioning; Out-of-treatment users

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1. Introduction

The family and its relational dynamics is the primary and most basic context for the biopsychosocial development of individuals. Theoretical models and family studies have shown that a functional family, capable of lending support to its members, is characterized by the presence of an adequate hierarchical organization, clear roles and limits between subsystems, as well as adequate alignments (alliances and coalitions) concerning the functions that the family must accomplish (Haley, 1967; Minuchin & Fischman, 1984; Aponte & Van Deusen, 1989). From the standpoint of interactions, it has been demonstrated that a high degree of family cohesion and emotional connection, coupled with flexibility for change according to developmental stages and vital events, as well as a good communication between family members, favors the development of individual members and constitutes an important social support in the face of any adversity (Olson et al., 1983). On the contrary, scarce emotional cohesion–connection, deficient communication and rigidness in facing change, are dimensions of family dysfunction (Minuchin & Fischman, 1984; Falicov, 1991; Olson, 1991; Patterson & Garwick 1994; Valdés, Rodríguez, & Serrano, 1999; Hidalgo, 1999). A review of Olson's (2002) Circumplex Model of Family Systems, with its dimensions of cohesion, flexibility, and family communication, shows that systems that are unbalanced in these dimensions are more dysfunctional and are in worse condition to face situations of family stress. Olson (2002) has developed questionnaires in order to measure these dimensions (Faces II, III, and IV), together with numerous studies of reliability and validity, which are widely used in research.

Family functioning can be considered a protective or risk factor with respect to the health problems of its members, particularly concerning chronic illnesses and mental disorders (Florenzano, 1995; Hidalgo & Carrasco, 1999; Hidalgo & Scharager, 2001). Currently, there is a consensus that the family plays an important role both in the prevention as well as in the treatment of substance use disorders (Florenzano, 1998; Amaro & Cortés, 2003; Szapocznik & Williams, 2000; Szapocznik, 2003; Garmendia, 2006; Olson, 2002). Family-based treatment seems to be successful for adolescent substance users, especially within the Spanish-speaking population (Szapocznik, 2003; Santisteban et al., 2003).

Chile, like other countries, has been affected by the increasing use of cocaine hydrochloride (CH) and cocaine base paste (CBP) (Jeri, 1984; Montoya & Chilcoat, 1996). The main form of administration of CH in Chile is nasal; in the case of CBP it is pulmonary (CONACE, 2000, 2002, 2004, 2006). This last substance is an intermediate product extracted during the elaboration of hydrochloride cocaine, and is made up of cocaine sulphate plus various hydrocarbons (ElSohly, Brenneisen, & Jones, 1991). The most recent study of the Chilean general population – aged between 12 and 64 years – showed a prevalence for CH use of 1.2% and of CBP of 0.6% for the last year (CONACE, 2006). The median age of initial use is 21 years for CH and 19 years for CBP (CONACE, 2004). The frequency of dependency among users of the last year is 30% for CH and 50% for CBP (CONACE, 2006). The highest frequency of use and dependency towards illegal drugs is observed in men, between the ages of 19 and 25, coming from low socioeconomic level (CONACE, 2002, 2004, 2006).

A small percentage of these users spontaneously demand treatment in rehabilitation services (Vaillant, 1998; CONACE, 2002), and a significant proportion presents socially stigmatized behaviors associated with drug abuse (drug traffic, delinquency, prostitution, etc.). The illegal nature of the substance used, as well as the potential social sanction of their behaviors, determines the difficulty in detecting these users, turning it into a "hidden" or "hard-to-reach " population (Wiebel, 1990; Atkinson & Flint, 2001). These out-of-treatment users, detected through methods for the study of hidden populations (Santis et al., 2002, 2006; Santis, Hidalgo et al., 2004; Santis, Hayden et al., 2004) seem to differ greatly of the characterization

of users studied in the general population (National Commission for the Control of Narcotics: CONACE, 1994, 1996, 1998, 2000, 2002, 2004). Urban users from low socioeconomic levels and out-of-treatment, present an earlier age of initial use (median age of 16 and 17 years for CBP and CH respectively) and a higher percent of dependency (97% for CBP and 92% for CH). They present a high frequency of school desertion, unemployment and risk behavior, characteristics which confer them a high degree of social marginalization (Santis, Hidalgo et al., 2004; Santis et al., 2007).

Different authors have established an important link between substance abuse and the characteristics of the family of origin. According to Stanton and Todd (1988), drug addiction can be conceived as part of a cyclical process that involves three or more individuals, generally an adolescent and his/her parents (or their substitutes). Drug abuse is considered a "paradoxical resolution" to developmental dilemmas faced by the adolescent and his/her family, especially in relation to the maternal figure. Through drugs, the addict can be both distant and close, be aggressive and powerful, without taking responsibility for his/her actions and even so, still maintain faithful to his/her mother (Cirillo, 1999). In the literature, we find three hypotheses with respect to the families of substance users (Florenzano, 1998): 1. Developmental blockage, referred to infantile and symbiotic child-rearing practices that restrain the process of individuation–separation; 2. Organization of the system around drugs, where substance abuse becomes an organizing and structure-giving principle of family life, through daily routines, family rituals and short-term solutions; and 3. Co-dependency: an interpersonal relationship is generated, where the co-dependent allows himself or herself to be influenced by the user's behavior, attempting to control this behavior, feeling anxious and guilty, assuming responsibilities of the user, and at the same time, victimizing himself or herself. To this is added the knowledge that poor families tend to present a higher degree of family disintegration and lack of organization (Minuchin & Fischman, 1984; Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967), an element which facilitates drug abuse. No additional prior work concerning the functioning of poor families with out-of-treatment drug using members has been reported in the literature. Therefore, knowing the family structure and dynamics of these users is highly relevant, since the family is a social system that can predispose and maintain the consuming behavior, as well as suffer the consequences of substance abuse.

The hypotheses contrasted in this report are: 1. That families of CBP and CH users hidden from health-care services, constitute highly dysfunctional family systems, both in their structure as well as in their interactions; and 2. That CBP users have families with a more dysfunctional family dynamic than CH users.

2. Method

2.1. Research design

This report presents data from the initial assessment within a prospective panel study of CBP and CH users. The methodology designed to study hidden populations, known as Privileged Access Interviewing (PAI) (Griffiths, Gossop, Powis, & Strang, 1993), was used. PAI consists of an information-gathering network through the selection of interviewers who have access to the study subjects. These interviewers were selected through a rigorous procedure, trained in the administration of the instruments and supervised by the research team. 28 paid community agents participated in this study. This research project was approved by the Ethical Committee of the Faculty of Medicine of Pontificia Universidad Católica de Chile.

Table 1
Socio-demographic variables according to sample group: Group 1: cocaine base paste users ($n=231$); and Group 2: hydrochloride cocaine users ($n=236$)

	Group 1		Group 2	
	N	%	*N*	%
Distribution by gender [a]				
Male	153	66.2	154	65.3
Female	78	33.8	82	34.7
Distribution by age [a]				
18 years or younger	75	32.5	76	32.2
19 to 25 years	79	34.2	77	32.6
26 years or older	77	33.3	83	35.2
Marital status				
Single	188	81.4	178	75.4
Married	7	3.0	16	6.8
Separated/divorced	10	4.3	15	6.4
Living with couple	26	11.3	27	11.4
Lives with				
Family of origin	161	69.7	164	69.5
Nuclear family	20	8.7	29	12.3
Only with spouse/couple	9	3.9	8	3.4
Other	24	10.4	26	11.0
Alone	7	3.0	9	3.8
Homeless	10	4.3 *	0	0 *
Educational level				
Without formal education	5	2.2 *	0	0 *
Elementary school complete/incomplete	116	50.2 *	48	20.3 *
High school complete/incomplete	106	45.9 *	138	58.5 *
Technical or University	4	1.7 *	50	21.2 *
School desertion	172	74.5 ***	92	39.0 ***
Occupational situation				
Unemployed	107	46.3 *	64	27.1 *
Informal employment	75	32.5 *	45	19.1 *
Formal employment	26	11.3 *	84	35.6 *
Student	23	10.0 *	43	18.2 *

[a] Sample stratification variables.
* Chi-Square (standardized residuals), $P<.05$.
*** Chi-Square, $P<.001$.

2.2. Participants

A stratified sample by gender (two thirds male and one third female) and age distribution (below 19, between 19 and 25, and older than 25; one third of the sample, respectively) was used. The sample was aimed at territorial zones of high abuse through a geographical map which was based on official information and information from local organizations concerning drug abuse and traffic.

Due to the absence of national data with respect to the coexistence of CH and CBP use, the research team decided to use the criterion of primary or chosen substance use for sample allocation. In this

manner, a sufficient sample size of each group was guaranteed. The inclusion criteria for the study were: Group 1, primary CBP use during the last 30 days; and Group 2: primary CH use during the last 30 days. Participants in both groups had not received drug abuse treatment during the last 6 months. Those who reported primary use of both substances during the last month were excluded from the study.

The minimum sample size considered critical for the study, and determined by the variable frequency of substance abuse during the last month, was 404 cases, with a power of 80% and a level of significance of 5%. A total sample of 467 subjects were recruited: 231 primary CBP users, and 236 primary CH users. Table 1 describes the sample characteristics of both groups.

Both groups present a similar pattern of last-month substance use, with the exception of the drugs that determine the sample groups (see Table 2).

2.3. Setting

Four of the municipalities with the highest level of CBP and CH use in the Metropolitan Region of Chile were selected, mostly inhabited by people from a low socioeconomic level: the communes of Pedro Aguirre Cerda (106,459 inhabitants), Huechuraba (46,581 inhabitants), La Pintana (168,019 inhabitants) and San Joaquín (72,589 inhabitants) (CONACE, 2000).

Table 2
Substance use pattern in the last month, according to the sample group: Group 1: cocaine base paste users ($n=231$); and Group 2: hydrochloride cocaine users ($n=236$)

Substance used in the last month	Group 1		Group 2	
	N	%	*N*	%
Cocaine base paste [a]	231	100.0	50	21.2
Dependency [b]	224	97.0 ***	39	78.0 ***
Cocaine hydrochloride [a]	75	32.5	236	100.0
Dependency [b]	64	85.3	217	91.9
Marihuana	172	74.5	173	73.3
Dependency [b]	145	84.3	150	86.7
Amphetamine	12	5.2 *	26	11.0 *
Dependency [b]	9	75.0	14	53.8
Solvents	8	3.5	4	1.7
Dependency [b]	6	75.0	1	25.0
Tranquilizers	26	11.3	22	9.3
Dependency [b]	19	73.1	12	54.5
Alcohol	184	79.7 **	213	90.3 **
Dependency [b]	116	63.0	124	58.2
Polysubstance use	202	87.4	195	82.6
Polydependency [b]	197	86.8	189	84.0

[a] Sample inclusion variables.
[b] According to ICD-10 criteria (WHO, 2007), administered to users of the last month.
* Chi-Square, $P<.05$.
** Chi-Square, $P<.005$.
*** Chi-Square, $P<.001$.

2.4. Measurements

2.4.1. Risk Behavior Questionnaire (RBQ)

This instrument was constructed based on the "Maudsley Addiction Profile" questionnaire (Marsden et al., 1998), and on the questionnaire designed by the Swiss Study of Hidden Populations (Kuebler & Hauuser, 1997). It was adapted for the Spanish language, and compiled 193 items concerning socio-demographic data, pattern of substance use (including the assessment of substance dependency according to ICD-10 criterion (WHO, 2007), based on the questionnaire designed for national studies of CONACE, 2002); risk behaviors, legal status; contacts with and perception of health-care services; and Goldberg's General Health Questionnaire GHQ-12 (Araya, Wynn, & Lewis, 1992). The internal consistency of the sections of the instrument considered in this study showed Cronbach Alpha values of 0.631 for pattern of use and of 0.866 for the criterion of dependency.

2.4.2. How-Is-Your-Family Questionnaire, brief version (Valdés et al., 1999)

Constructed in Chile based on the How-Is-Your-Family Questionnaire, designed and validated by a group of researchers commissioned by The Pan American Health Organization Program of Adolescent Integral Health, which is based on Olson's FACES III instrument and on the Family Time and Routine Index of McCubbin (OPS, 1996; Rodríguez et al., 1996). This abbreviated screening questionnaire of family functioning that has two versions: one for adolescent children (TU) from 10 years onwards, with 22 items that measure two factors of family functioning: F1 = communication–connection with the father and family hierarchy, and F2 = communication–connection with the mother, nuclear family and family hierarchy, from the child's perception of the family system. The parents' version (SU) has 16 items that measure two factors of family functioning: F1 = communication–connection with spouse/partner and family hierarchy, and F2 = connection with the mother and nuclear family (Cronbach's Alpha of 0.884 for TU and 0.965 for SU versions).

Even though the instrument was designed for self-administration in groups, in this study it was administered by the community agent, and the criterion used in order to define which version was administered, was self-perception of the main role performed by each subject in the family at the moment of administration. 81% of the participants identified him or herself as having a predominantly son/daughter role in their family, independent of their age. 19% of the users identified him or herself with a predominantly paternal role. Each factor gives a score indicative of the degree of communication–connection with members of the family, and of who exercise authority (the higher the score, the better communication and power of parents). Additionally, as a function of the score, each factor can be categorized into High Family Risk, Family Risk and No Family Risk for presenting psychosocial risk behavior during adolescence such as suicidal attempts, drug use and abuse, aggressive behavior, undesired pregnancy (Valdés et al., 1999). In order to define a classification of global family functioning for each subject, according to his/her score and corresponding category obtained in each of the factors, the family risk categories used in this study were conformed as is specified in Table 3.

2.5. Procedure

Each subject was contacted by the privileged access interviewers within the risk zone of each municipality. Only 20% of the subjects contacted refused to participate. These persons answered a brief questionnaire of basic socio-demographic information and pattern of substance use during the last month. 83.6% who refused to participate did fit the inclusion criteria.

Table 3
Classification of Family Risk according to scores on factor 1 and factor 2 of the How-Is-Your-Family Questionnaire

Scores How-Is-Your-Family Questionnaire	F1 SU=0 to 2 or F1 TU=0 to 3	F1 SU=3 to 5 or F1 TU=4 to 6	F1 SU=6 to 12 or F1 TU=7 to 14
F2 SU=0 to 7 or F2 TU=0 to 13	1. High family risk	3. High family risk	6 Risk
F2 SU=8 or F2 TU=14 to 18	2. High family risk	5. Risk	8. No risk
F2 SU=9 to 12 or F2 TU=19 to 24	4. Risk	7. No risk	9. No risk

F1 SU= Communication–connection with the spouse/partner and family hierarchy (0 to12 points).
F2 SU= Communication–connection with the mother and nuclear family (0 to12 points).
F1 TU= Communication–connection with the father and hierarchy (0 to14 points).
F2 TU= Communication–connection with the mother, nuclear family and hierarchy (0 to 24 points).

Prior to the administration of the RBQ, informed consent was obtained from each subject. The administration of the RBQ was performed anonymously, in different places (in the street, at the interviewer's and user's house, in parks, etc.), lasting about an hour and a half. The administration of the RBQ was recorded in audiotapes. Each interview was verified by the researchers, in order to check the fidelity of the registered data. A response rate of 80% was obtained; only 20 questionnaires were eliminated due to inconsistency between the written registry and the taped interview. The interviewers received approximately US$ 12 for each questionnaire correctly administered; recruited subjects did not receive payment for their participation.

In 10% of the total subjects, part of the interview was administered by a Gold Standard interviewer, with the objective of establishing the reliability of the data. According to the classification of Landis and Koch (1977), a substantial or quasi-perfect agreement was found for the categorical items, with Cohen's Kappa coefficient of 45.9%; a 30% additional presented moderate agreement. The continuous variables presented in 70.2% of the cases a statistically significant correlation using Spearman's coefficient.

2.6. Statistical analysis

Descriptive analyses were performed, and parametric (Student's *t*, anova, Scheffé) and non-parametric (Chi^2 and standardized residuals analysis) were used. A maximum error of 5% was considered significant.

From the total sample (467 cases), 17 cases were excluded from the analysis of the How-Is-Your-Family Brief Questionnaire due to errors of administration of this instrument (omission of one or more items; or "does not apply" due to death or disappearance of the father or mother; these cases were excluded from the analysis of the corresponding factor and the global classification of family risk).

The allocation of the sample according to primary use of CBP or CH revealed a group where the use of both substances coexisted during the last month (even though only one of the substances was reported as primary) (see Table 2). The same variables were analyzed excluding these subjects with simultaneous use, therefore considering only CBP users not using CH during the last month ($N=156$), and CH users not using CBP during the last month ($N=186$), in order to evaluate the possible effect of superimposing substance use between both groups. The statistical analyses did not show any different effect than those found among primary substance users of CBP and CH, and therefore the initial criteria for sample inclusion were maintained.

3. Results

3.1. Family functioning in out-of-treatment users

Analysis of family functioning according to the average score of factors 1 and 2 showed that, among the users who responded the TU version (81% son/daughter role), a deficient connection–communication with their mother as well as with their nuclear and extended family, and with scarce family rituals. Likewise, the relationship with the father is weak and lacks a clear organization of the family hierarchy. Subjects who answered the SU version (19% parent role) consider that the relationship with their spouse/partner and the hierarchical organization of the family tends to be adequate or with some deficits, whereas the relationship between mother and children, along with family routines, are considered weak with respect to emotional connection, communication, and routines (see Table 4).

CBP users, compared to CH users, presented a significantly lower score in factors 1 and 2, indicating a worse communication–connection with the father, mother, and nuclear family, as well as few figures of authority.

The percentage of subjects who answered the SU version revealed a difference between groups on factor 2, indicating a worse communication with the mother, the extended family and the management of authority in CBP users. Although the same tendency was observed for factor 1 (connection with spouse/partner), the difference did not reach statistical significance (see Table 4).

3.2. Family risk and substance use

When subjects are classified according to the criterion defined as Family Risk, the total sample showed a distribution of 27% of users belonging to non-risk families and, therefore, with the presence of some family interaction that might exercise a protecting role concerning adolescents' risk behavior. On the other hand, 73% of users perceive their family functioning as having scarce communication and affective connection, few family rituals and a weak hierarchical structure associated with a high probability of risk

Table 4
Score of the factors of the How-Is-Your-Family Questionnaire in cocaine base paste (Group 1; $n=218$) and cocaine hydrochloride users (Group 2; $n=232$)

	Group 1		Group 2	
	N	Mean (SD)	*N*	Mean (SD)
SU Version				
Factor 1 [a]	38	5.4 (3.7)	49	6.2 (3.8)
Factor 2 [b]	38	6.5 (3.4) *	49	7.9 (3.4) *
TU Version				
Factor 1 [c]	180	4.3 (3.3) **	183	5.4 (3.4) **
Factor 2 [d]	180	10.8 (6.4) **	183	12.7 (6) **

[a] Communication–connection with the spouse/partner and family hierarchy.
[b] Communication–connection with the mother and nuclear family.
[c] Communication–connection with the father and hierarchy.
[d] Communication–connection with the mother, nuclear family and hierarchy.
* *t*-test, $P<.05$.
** *t*-test, $P<.005$.

Table 5
Distribution of family risk according to age distribution of the global sample of cocaine base paste and cocaine hydrochloride users ($n=450$)

	Younger than 19 years of age		19 to 25 years of age		Older than 25 years of age		Total	
	N	%	*N*	%	*N*	%	*N*	%
High risk	84	57.2	74	49.3	86.0	55.8	244	54.2
Risk	30	20.4	27	18	27.0	17.5	84	18.7
No risk	33	22.4	49	32.7	41.0	26.6	122	27.1
Total	147	100.0	150	100.0	153	100.0	450	100.0

behavior of children. According to age distribution, users younger than 19 years of age most frequently perceive their family as dysfunctional, but with no statistically significant differences between them and the other two age groups (see Table 5).

The analysis of the classification of family risk of the two sample groups shows that primary CBP users have families of higher risk than CH users. The association is found between CBP users and high family risk, and between CH users and low family risk. The analysis of type of use and family functioning according to age distribution shows that the difference is due to the higher risk among CBP users between 19 and 25 years old and older than 25, than the corresponding CH users. No significant differences were observed between CBP and CH users younger than 19 years of age.

With respect to gender, both in men and women, CBP use was associated with higher family risk than CH use (see Table 6).

3.3. Family functioning, pattern of use and drug dependency

With respect to the pattern of use, the CBP group of users with high family risk present a significantly higher mean of days of substance use during the last month, than those classified as having no family risk (22 days, SD=8.9 versus 18 days, SD=9.7; Scheffé Test: $F=3.54$, DF=2, $p=0.031$). This association was not observed in the CH group of users.

No association was found between the presence of drug dependency and the level of family risk concerning family functioning, in any of the groups.

4. Discussion

As to the first hypothesis, the data show that almost three quarters of this population of illicit drug users perceive an impoverished family context with respect to the level of communication–connection with their parents and close relatives, as well as with respect to family organization, particularly family rituals and management of power and authority. This percentage of families with family dysfunction in the dimensions studied, is greater than the percentage observed in another Chilean study of families with adolescent offspring with a sample of 635 school teenagers under 19 years. In that study of general population, only 14.5% of the children informed being part of high-risk families, whereas 75.3% of families presented a no-risk family functioning, with the children perceiving an adequate connection–communication with the nuclear family and an adequate family organization (Valdés et al., 1999). On the

Table 6
Distribution of Global Family Risk and Family Risk according to age distribution and gender distribution, in cocaine base paste users (Group 1; $n=218$) and cocaine hydrochloride users (Group 2; $n=232$)

	Group 1		Group 2	
	N	%	*N*	%
Global **				
High risk	135	61.6	109	46.8
Risk	38	17.4	45	19.3
No risk	46	21.0	79	33.9
Distribution by age				
Younger than 19 years				
High risk	41	56.9	43	56.6
Risk	14	19.4	16	21.1
No risk	17	23.6	17	22.4
19 to 25 years ***				
High risk	47	62.7	27	36.0
Risk	15	20.0	11	14.7
No risk	13	17.3	37	49.3
Older than 25 years *				
High risk	47	65.3	39	47.6
Risk	9	12.5	18	22.0
No risk	16	22.2	25	30.5
Distribution by gender				
Male ***				
High risk	88	60.3	67	44.4
Risk	32	21.9	27	17.9
No risk	26	17.8	57	37.7
Female **				
High risk	47	64.4	42	51.2
Risk	6	8.2	18	22.0
No risk	20	27.4	22	26.8

* Chi-Square, $P<.05$.
** Chi-Square, $P<.005$.
*** Chi-Square, $P<.001$.

other hand, an important proportion of CH and CBP users reported having a family that can still maintain a role of protection, since the family is perceived as having a good communication and family cohesion, which generates a possible niche for treatment interventions with family interventions.

The Chilean out-of-treatment users in the four municipalities studied perceive highly dysfunctional families, both considering the categorization of family risk as well as in the quantitative analyses performed separately for each factor of the How-Is-Your-Family Brief Questionnaire. CBP users are associated with a worse hierarchical organization, with inadequate limits and a bad communication with the father, the mother, and the extended family members, as compared to CH users.

Overall, substance users present scores in each factor that indicate a level of communication–connection with their respective mother, father, and extended family members, as well as an overall family organization within the range of families-at-risk, according to the classification proposed by Valdés et al. (1999). The only exception is the group of CH users who identify themselves with the role of parents, who in average perceive their relationship with their spouse/partner within levels that indicate a connection–

communication associated with a certain degree of functionality. The corresponding CBP users, on the other hand, present a moderate risk in this factor. Therefore, it seems that those users who identify themselves with a predominantly paternal role perceive their spouse/partner relationship with a certain degree of communication and closeness, which constitutes a more protective factor, especially for CH users. This could be interpreted along the lines of co-dependency, in the sense that drug users who assume the role of parents and maintain a couple relationship, might present a collusion with his/her couple.

Our data support the results reported by other authors concerning the link between drug use and the characteristics of the family of origin. Being a male (Hyman, 2001), belonging to a family with an inefficient direction and discipline, with low emotional connection, a high level of conflict, and deficient social networks that interfere with effective parental roles (Cunningham & Randall, 2003), is related to drug use. Likewise, families incapable of flexibly supporting their children's attempts towards differentiation and giving them a secure base to allow them to obtain autonomy as well as an adequate connection with their family of origin (Cirillo, 1999); parents with low educational expectations for their children (high school desertion), and mothers with weak guidelines of control and inconsistency in their patterns of discipline, with infantile child-rearing practices (Florenzano, 1995, 1998), are variables related to drug use. On the other hand, the results of this sample of out-of-treatment users from low socioeconomic levels confirm what has been described about poor families: a significant degree of disintegration and lack of family organization (Minuchin & Fischman, 1984; Minuchin et al., 1967; Hidalgo, 1999).

The issue concerning limits in families with drug-addicted members seems to be crucial. The literature has described a dysfunctional intergenerational coalition between one of the parents and the substance user, against the other parent. When the addicted person is male, an over-involvement on behalf of the mother tends to occur, through overindulgent, permissive and overprotective attitudes that tend to consider the addicted son as "her favorite" and "the sweetest and easiest child to bring up" when young. The father tends to appear detached, weak or absent, or on the other hand, authoritarian and violent but inconsistent and dominated by the mother. If the addict is female, a relationship of competence between daughter and mother is frequently seen, as well as a close and indulgent father with respect to his daughter (Stanton & Todd, 1988). More evidence with respect to some of these hypotheses will be reported in the future, through a one-year follow-up study of this group of out-of-treatment cocaine base paste and cocaine hydrochloride users.

Among the adolescents who answered the TU version, a certain number of absent parents were found, and the bad relationship with the mother was strongly present in both types of users, which was worse for CBP users. This supports the hypothesis of a present but highly conflictive relationship with the mother, and of a deficient hierarchical structure.

Our data support the hypothesis of a developmental block among substance users: 81% of the users identified themselves as sons/daughters, even though the category of minors (below 18 years of age) was stratified only in one third of the total sample, while another third was aged between 19 and 25. The remaining third were subjects over 26 years, which places them in a stage of their developmental cycle in which they should have already reached autonomy. CBP users between 19 and 25 years present a great vulnerability from the point of view of use and family functioning. In Chile, only since the middle of 2007, treatment for drug users, 15 years and older, is a priority in health care. This opens a new scenario for the design and development of family interventions with this objective group.

We note that the instrument How-Is-Your-Family is a brief questionnaire, and that although it presents very good indexes of internal consistency and considers elements essential to the structure and dynamics of the family, it does not allow the specification of other factors involving the family functioning.

Additionally, it does not give a global score of family risk for each subject. This last limitation forced us to create a conceptual categorization, based on the at-risk categories of the two factors that the instrument measures. This left at the level of moderate risk, subjects with a great variety of family characteristics. Another shortcoming of this instrument is that both versions (parents and children) had to be included due to the age composition of the sample and to the family-life cycle of the subjects. The decision as to which version was to be used was taken based on each subject's perception of his/her main role at the moment of assessment. This introduced an important modification to the normal administration procedure of the questionnaire. Likewise, the SU version is meant for parents with adolescent children, and in this sample there were participants with younger children. In this sense, the results associated with the SU version may be more biased than those of the TU version, due to sample size and subject profile.

Acknowledgements

The present article corresponds to part of the data obtained in the project: Prospective descriptive study of the hidden population of cocaine base paste and hydrochloride cocaine users, non-consultant of drug and alcohol rehabilitation services, of four communes of high use in the Metropolitan Region of Chile. Project No. 1030431, financed by the National Fund for Science and Technology (Fondo Nacional de Ciencia y Tecnología (FONDECYT, 2003–2006), Santiago de Chile.

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