NEAR EAST UNIVERSITY
GRADUATE SCHOOL OF SOCIAL SCIENCES
APPLIED PSYCHOLOGY MASTER PROGRAM

MASTER THESIS

FAMILY RELATIONS AND PARENTING STYLES OF DRUG USING YOUNG ADULTS

ÜLKÜ GÜREŞEN
20031347

SUPERVISOR
ASSOC. PROF. DR. EBRU TANSEL ÇAKICI

NICOSIA
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Family Relations and Parenting Styles of Drug Using Young Adults

Prepared by: Ülkü Güreşen

We certify that the thesis is satisfactory for the award of the Degree of Master of Science in Applied Psychology

Examining Committee in Charge

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ÖZET

Madde Kullanan Genç Yetişkinlerde Aile İlişkileri ve Ebeveynlik Biçimleri

Hazırlayan: **Ülkü Güreşen**

Mart, 2010

Genç yetişkinlik uyuşturucu kullanma riskinin en yüksek olduğu gelişim dönemidir. Çünkü bu evrede birey içinde bulunduğu ailevi, sosyal ve duygusal bağlamdan ayrılarak bir birey olarak bağımsızlığını kazanmaya çalışır. Bu çalışmanın temel amacı gençlerin aile ilişkileri ve ebeveynlerinin onlara yaklaşımının genç yetişkinlik döneminde uyuştucu kullanma davranışıyla olan ilişki ortaya çıkarmak ve incelemektir.

İstanbul Alkol ve Madde Bağımlılığı Tedavi Merkezi'nde madde kullanımı nedeniyle tedavi gören 34 kişi hasta grubunu, Yakın Doğu Üniversitesi'nin Psikoloji Bölümü'nden 73 öğrenci 1. sınıf öğrencisi sağlıklı kontrol grubunu oluşturmaktadır. Her iki grup için de yaş aralığı 18-25 olarak belirlenmiştir.. Hastaların sosyodemografik durumunu ve madde kullanım düzeyini incelemek için sosyodemografik form ve madde kullanım sıklığı ölçeği ile aile ilişkilerini değerlendirmek için'Aile İlişkileri Değerlendirme Ölçeği' (AYDA), 'Analık-Babalık Stilleri Ölçeği' (ABSÖ) ve 'Babalık Ölçeği' (BÖ) kullanılmıştır. Türk aile yapısı içindeki ve çocukluk, ergenlik dönemlerindeki önemini vurgulamak üzere BÖ kullanılarak deneklerin babalarıyla olan ilişkileri ayrıca vurgulanmıştır. Elde edilen veriler SPSS programı kullanılarak sıklık, ki-kare, Student t-test yöntemleriyle değerlendirilmiştir.

Hasta grubu tüm ölçeklerden konrollere göre düşük puan almıştır. Hastalar AYDA ölçeğinden aldıkları puanlarda ailelerini"iletişim", "birlik", "yönetim" "yetkinlik ve "duygusal bağlam" boyutlarındaailelerini sağlıklı kontollerden daha olumsuz algıladıklarını beyan etmişlerdir. Ana-babalık stilleri ölçeğinden alınan puanlar hasta grubunun ebeveynlerinin denetimci boyutta olduğunu gösterirken sağlıklı kontrol grubu ebeveynlerini ilgi gösteren boyutta değerlendirmiştir. BÖ'ye göre, hasta grubu "ulaşılabilir baba", "babalık sorumluluğu","Hem erkek hem kadın rolü" , "iyi tedarik

edici rol", " iyi cinsiyet rolü", " ahlak konusunda baba rolü", "olumlu duygusal yanıt verme", "olumlu angajman"alt ölçeklerinden sağlıklı kontrol grubuna göre daha yüksek skor elde etmişlerdir. Ancak "olumsuz ilişki" boyutunda sağlıklı kontroller hasta grubundan daha düşük skor elde etmişlerdir.

Hasta grubunun ailelerinde sağlıklı kontrollerden daha az birlik anlayışı olduğu ve bu ailelerin sınırlarının aşırı esnek ya da katı olduğu belirlenmiştir. Hasta grubunun ebeveynlerinin kontrollere göre daha baskıcı, otoriter bir ebeveynlik tutumu takındığı görülürken, aynı zamanda çocukluk ve ergenlik döneminde babalarıyla kontrollere göre daha olumsuz bir ilişkiye sahip olmuşlardır. Kısacası hasta grubunun aile ilişkileri genel itibariyle sağlıklı kontrol grubuna göre daha olumsuzdur

Bu çalışmadan elde edilen veriler olumsuz aile ilişkilerinin genç yetişklikte madde kullanma rsikini arttırdığını vurgulamaktadır. Bu bağlamda genç yetişkinlerin ve ailelerinin bu dönemin özellikleri hakkında bilgilendirilmesi ve tedavi yöntemlerinin aile ilişkileri üzerinde durması genç yerişkinlikte madde kullanım riskini önleyici olacaktır.

Anahtar Kelimeler: Aile ilişkileri, Ana-babalık Biçimleri, Uyuşturucu Kullanımı/Madde Kullanımı, Genç Yetişkinlik

ABSTRACT

Family Relations and Parenting Styles of Drug Using Young Adults

Prepared by **Ülkü Güreşen**

March, 2010

Young adulthood is the most risky developmental phase of life for drug use. It involves a separation-individuation process which the individual tries to earn his or her independency from the emotional social and family context that he or she lives in. In this present research, the main aim is to identify the relationship between family relations and parenting styles with drug use behaviour in young adulthood.

34 patients receiving treatment for drug abuse or addiction were taken into the sample as patient group and 73 freshman Psychology students as control group. Age rank was between 18-25 years for both groups. We used two questionnaire forms asking questions about sociodemographic features and the frequency of substance use. 'Family Structure Assessment Device' (FSAD), 'Parenting Styles Scale' (PSS) and 'Fatherhood Scale' (FS) were applied to provide information about family relations and parenting styles.

Patient group obtained low scores from all scales. They perceived the "communication", "cohesion", "management", "perfection" and "emotional context" dimensions of their families worse than healthy controls according to FSAD scores. According to PSS 'controlling parenting styles' were more prevalent among patient groups than controls whereas 'benevolent parenting styles' were common among controls. Also according to FS, "the accessible father", "responsible paternal engagement", "the androgynous role", "the good provider role", "the gender role model", "the moral father role", "positive paternal emotional responsiveness" and "positive engagement" were found significantly higher among healthy controls. However "negative paternal engagement" was higher among controls than the healthy control.

It was determined that families of patient group are less cohesive than controls and they have either too flexible or too rigid boundaries. Parents of patient group have

more authoritarian attitudes and they reported having negative relations with their father in childhood and adolescence. To summarize patient group had worse family relations when compared with controls.

Findings of this study emphasize the effect of negative family relations on drug use as a risk in young adulthood. Both young adults and parents may be acknowledged about the role of family relations in young adulthood period and treatment process may emphasize on family interaction to reduce the risk of drug use in young adulthood.

Keywords: Family Relations, Parenting Styles, Drug Use/Substance Use, Young Adulthood

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ABBREVIATIONS

(AMATEM): Alcohol and Substance Addiction Treatment Facility

(TRNC) : Turkish Republic of Northern Cyprus

(FSAD): Family Structure Assessment Device

(PSS): Parenting Style Scale

(FS): Fatherhood Scale

1. INTRODUCTION

1. 1. Definition and History of Adolescence and Youth Period

Adolescence has not always been recognized as a distinct age of human life, in part because prehistoric and ancient civilizations did not think that individuals developed through a number of stages. The classical Greek and Roman civilizations which existed from about 500 B.C. to about 400 A.D. did recognize a stage of life that came to be called adolescence. In Latin language "adolescere" verb means "to grow up". Also the term of puberty derived from the Latin word pubertas which means 'the age of manhood'. But this ancient classification was only valid for a noble class of society. Jean Jacques Rousseau (1712 – 1778) planted the seed of modern concept of adolescence. He defined the adolescence period as a second birth in which the child is born into the world of independent life with his or her own values and virtues. At the beginning of 19th century social conditions in the Europe and America begin to change as a consequence of the industrial revolution. As a consequence of increasing labour need, child labours employed at factory settings. Adolescent period was considered as a different stage after these legislations. G. Stanley Hall (1844 – 1924) is the first scientist who studied the adolescence period. American psychologist G. Stanley Hall (1904) published a two volume study which is known as Adolescence 1904. He examined adolescence period systematically as a stage of human development by the view point of Darwin's evolution theory (Conger, 1979; Stefoff, 1990;).

Adolescence is a period of transition, one when the biological, psychological, and social characteristics typical of children change in an integrated manner to become the biological, psychological, and social characteristics typical of adults (Lerner & Spainer, 1980). Youth is a developmental phase of life including a longer duration that involves the adolescence and social maturity (Kulaksızoğlu, 2005). The age rank of youth is wider than adolescence and adolescence is only a part of this great process. UNESCO defines the young person as an individual who attends to education and who doesn't work to earn his life and who does not live in his own

house. According to UNESCO, ages between 15-25 is accepted as youth period (Kulaksızoğlu, 2005).

Actually there are various definitions about adolescence period. In rural areas males are generally considered as an adolescent until they complete their necessary military task and for girls the end of adolescence period is generally considered as marriage. Unlike rural, in urban adolescence period may extend until post-doctoral study if individual remains single and lives with parents.

In fact, with the exception of infancy, adolescence is the major transitional period in the life span (Brooks-Gunn, Petersen & Eichorn, 1985; Lerner & Foch, 1987).Adolescence period is generally experienced as a stressful and stormy period as a result of transition and changes. Actually storm and stress description is based on a German phrase which is called as Sturm an Drang (Lerner, 2002). Storm and stress period is a trend in German literature. Stanley Hall described the adolescence period as a period with "conflicts" from the point of storm and stress view (Polvan, 2000) .

1.2. Characteristics of Adolescence and Young Adulthood Period

1.2.1. Physical Changes

Bodily changes are another important aspect of adolescence period as well as emotional and cognitive changes. Puberty, the period when the sexual organs mature, begins at about age 11 or 12 for girls and 13 or 14 for boys (Feldman, 2002).James M. Tanner (1962) has classified the physical changes of the adolescence period (Steffof, 1990). He divided the pubertal physical changes into 5 stages through the observation of the obvious changes on the body. These stages range from prepubescent to adult. Physical changes vary according to gender. Finally both of boys and girls achieve sexual or reproductive, maturity and they arrive at their full adult size. The changes that occur during puberty are initiated by an organ called the hypothalamus, which lies near the middle of the brain. Thyroid hormone is responsible for maturity and pituitary gland is responsible for height enlargement.

During the adolescence period, primary sexual characteristics of the women are ability to become pregnant and bear children. Secondary female sexual characteristics are increase in body hair (most often under arms and on the legs and pubic region), developed breasts and hips. These characteristics are dominated by the oestrogen and progesterone hormones. Primary sexual characteristic of males is ability to fertilize a woman's egg; the organs involved the penis and the testes. Secondary sexual characteristics of the boys are increase in testes size, penis growth and appearance of pubic hair. Both of sexual characteristics of boys are dominated by testosterone hormone. During the adolescence period boy identifies the male identity and girl identifies the female identity. Sexual behaviour is significantly related with identity development.

While young adults do not grow significantly taller in their 20s, they typically grow stronger and fuller as their bodies reach adult size. In terms of overall health, as well as peak physical condition, early adulthood is the prime of life (Berger, 1994).

1.2.2. Cognitive and Moral Changes

Cognitive and moral development is another important aspect of adolescence. According to Piaget's cognitive model, adolescence period is the formal operational period. Beginning by the 12 years old, child becomes able to think abstractly as an adult. The most important aspect of the formal operational period is the emergence of abstract thinking. By this way adolescent becomes able to maintain cause-effect relationship to solve problems (Kandır, 2007). Adolescent egocentrism occurs as a result of abstract thinking. However unlike to childhood period, adolescent maintains empathy with others in egocentric form. He thinks that other people concern with such kind of thoughts which are related with adolescence just like himself and he generally considers himself as a focus of concern of others. Unreal existence of these imaginary audiences may be sourced by either adolescence egocentrism or by the need of being an interested one. Adolescent evaluates himself in an emotional dimension. This is called as self worth. For example a young student considers himself either successful or unsuccessful. This evaluation determines self esteem which is known as the emotional aspect of self. It involves the level of evaluation of himself (Kulaksızoğlu, 2005).

Moral reasoning also becomes more complex during adolescence. Kohlberg proposes that the development of moral reasoning occurs through six stages increasing complexity, from the elemental "might makes right" to the recognition of universal ethical principles. Entry into the post conventional stages of moral reasoning require a certain amount of life experience and responsibility, according to Kohlberg, so few adolescents progress beyond stage 4 of conventional level. In stage 4, right behaviour means being a dutiful citizen and obeying the laws set down by these power (Berger, 1994).

Adult thinking seems different from adolescent thinking in many ways. While adolescents often try to distil universal truths from their personal experiences and tend to think about resolving the world's problems in terms of rational absolutes, adult thinking is more personal, practical, and integrative. Piaget regarded development of formal operational thought as the pinnacle of cognitive development and envisioned no new cognitive stages in adulthood. Other researchers have questioned this conclusion that the cognitive challenges of adulthood described by K. Warner Schaie and others result in a new, post formal, stage of cognitive development that builds on accomplishments of formal operational thought. In general, post-formal thought is less abstract, and less absolute, than formal thought, and therefore it can better adapt to life's inconsistencies. Beginning in the late teens or early 20s, a shift occurs as young people move away from indiscriminate acquisition of knowledge and enter the achieving stage, in which they use knowledge to establish themselves in the world. According to Schaie, the thinking of young adult is much more goal-directed, "displaying" more efficient and effective cognitive function with respect to tasks which have "role-related achievement potential" (Berger, 1994).

The challenges and dilemmas of adult responsibilities, in tandem with emerging relativistic and dialectical features about adult thought, can lead to new and different qualities of moral reasoning. Gilligan believes that in matters of moral reasoning, males tend to be more concerned with the question of rights and justice, whereas females are more concerned with personal relationships, tending to put human needs above justice principles. According to Gilligan, however, as all people experience of life expands, especially as they become committed to, and responsible for, the needs

of others, they begin to realize moral reasoning based chiefly on justice principles or on individual human needs is inadequate to resolve real-life moral dilemmas. Consequently they begin to construct principles that are relative and changeable, seeking a synthesis of ethical principles with life experience (Berger, 1994).

1.2.3. Psychological and Psychosocial Changes

Sigmund Freud describes the adolescence period in the terms of psychodynamic theory. Freud believed that human mental life is governed by the energy, which termed as libido. Libido is located at different parts of body at different developmental stages. At the same time libido is the source of pleasure. Placement of the libido within the body determines what stimulation is appropriate and what stimulation is inappropriate for the developing individual (Lerner, 2002). Freud considered the adolescence as a period which disturbs and interrupts into a peaceful development process. Because the impulsivity sourced by the emergence of libido wears down the ego and corrupts the delicate balance between id and ego. Re-emergence of the sexual urges by the gaining the ability of reproduction at adolescence which repressed during the latency period bring out an anxiety as a result of impairment of balance between id and ego (Polvan, 2000).

Whereas Sigmund Freud focused on infancy, her daughter Anna Freud (1895-1983) preferred to emphasize on puberty. She tried to extend and modify the psychoanalytic theory as applied to adolescence (Dacey & Travers, 1990). Anna Freud discovered adolescent's resistance in psychoanalytic therapy. She compared the resistance of adolescent with the resistance of such kind of patients who experienced difficulties during mourning reactions or dissatisfying love relationships. She found so many similarities between these patients and adolescents. The common point of these two groups is the experience emotional object loss. An adolescent has to leave important attachment figures of his or her childhood beginning from the childish love objects and he has to reject all pleasures and concerns faster than as he did in previous developmental stages. This farewell process brings a melancholy with it. Because of this adolescence is known as a melancholic stage (Jacobson, 2004).

Klein emphasizes the role of earlier phases of childhood during the formation of psychic life and she assumes that adolescence period is the re-emergence of childish oedipal conflict. Peter Blos defines the adolescence period as the second individuation period by the view point of Mahler. He claims that adolescent should keep himself away from the internalized primary object representation to form new object relations. According to Blos, the oedipal conflict is dissolved completely only in adolescence period. In oedipal period child has to repress the sexual and hostile urges in order to form an emotional attachment with parent. Sexual maturation during the adolescence period involves the re-emergence of both oedipal and pre-oedipal instinctual orientations for temporary. Re-emergence of instincts animates the childish competition. However the adolescent has to completely leave the sexual and hostile desires that he feels towards the parent. Because the adolescent has to leave the emotional bond between himself and parents to form the further object relations with his peers by adapting himself according to the norms of adulthood society. This necessity is what makes the adolescence different than childhood. Freud (1905) considered separation from the authority of the parents as the most important and painful psychic success of the young one (Jacobson, 2004; Parman, 2008).

As mentioned before, adolescence is a period which destroys the balance between id and superego. This destruction brings out a reconstruction process of psychic structure. Painful and unconscious strive of adolescents to repress unconscious urges often produces an intense anxiety. Id becomes more important than superego. After this change superego is rearranged and reconsolidated. Therefore, the unconscious defences of ego tend to reduce the anxiety. Typical ones of these mechanisms are repression, denial and compensation. Anna Freud described asceticism and intellectualization as two additional defence mechanisms for adolescence. Asceticism, in which, as a defence against the sexual, "sinful" drives of youth, the teenager frequently becomes extremely religious and devoted to God. With intellectualization the adolescent defends against emotionality of all kinds by becoming extremely intellectual and logical about life (Dacey & Travers, 1990).

Erik Erikson proposes psychosocial development theory. Whereas Freud focused primarily on the contributions of the id to development, Erikson focused on the role of ego. Erikson believed the expectations of society determine the developmental

course of human (Lerner, 2007). There are various expectancies of society at different developmental stages from the individual. According to this theory there are 8 non-sexual developmental stages. In stage 5, puberty and adolescence, the crisis is between developing a sense of identity versus role confusion or identity diffusion. Erikson considered this process as strive to integrate the social status, occupational status and gender identity. Erikson defines this strive as identity crisis. But he makes a distinction between identity crisis and identity confusion. Identity crisis is a both conscious and unconscious struggle by adolescents to achieve an identity. Adolescence period is significantly related with young adulthood. Some individuals may not able to cope with this challenge. If an individual fails to integrate his identity then he may improve negative identity. Negative identity is the formation of an identity which is inappropriate for both his and parents expectations. Individuals which internalized a negative identity may exhibit deviant behaviours, serious sexual suspects and may experience feeling of worthlessness (Polvan, 2000).

In stage 6, young adulthood, there is a crisis between developing toward a sense of intimacy versus isolation. This stage involves the initiation into adulthood. Spanning the period of early adulthood (from post adolescence to early thirties), the focus is on developing close relationships with others. Young adults attempt to merge their identity with that of others in intimate relationships rather than face the world alone. Difficulties during this stage result in feelings of loneliness and a fear of relationships with others, but successful resolution of the crises of this stage results in the possibility of forming relationships that are intimate on a physical, intellectual, and emotional level. In this period young adolescent or young adult evaluates himself according to the values of a specific group. Some researchers have suggested parallels to the initiation process in the crimes juveniles are often required to commit in order to become a member of a gang, and in the sequence of experiences that so often lead to drug addiction (Dacey & Travers, 1990; Feldman, 2002).

1.3. Family

1.3.1. Family Structure and Family Functions

The family is a social group characterized by common residence, economic co-operation and reproduction. It includes adults of both sexes, at least two of whom, maintain a socially approved sexual relationship, and one or more children, own or adopted of the sexually cohabiting adults. The structure of family differs from society to society. The smallest family unit is known as the nuclear family, and consists of a husband and wife and their immature offspring. Units larger than the nuclear family are usually known as extended families. Such families can be seen as extensions of the basic nuclear unit, either vertical extensions – for example, the addition of members of the same generation as the spouses parents – and/or horizontal extensions – for example, the addition of members of the same generation as the spouses such as the husband's brother or an additional wife (Haralambos et. al., 1995).

Family system has important functions for both individual and society. These functions are defined as following:

- One function of the family to meet the individual member's need *for love and emotional security*. The family involves a set of "loving obligations" to share both material and emotional resources among its members.

- The need of *protect the young and disabled* is served by the family as well. During infancy and early childhood, humans are dependent on their parents for food, clothing, shelter, and basic care. Even in adulthood family sees its members when special help is needed.

- The family fulfils the need to *"place" people in the social order*. The structure of a society is an intricate web of social roles and statuses. People must somehow be placed within these statuses and motivated to play the appropriate roles.

- The family also fulfils the societal need to *regulate sexual behaviour*. This function is both social and individual. All societies place limits on the sexual

behaviour of their members, including limits regarding who can have sexual relations with whom. Family system fulfils the sexual need of couples and avoids the corruption by restricting forbidden extra-marital relationships.

- Another societal need that family fulfils the need *to produce new generations*.

- The family fulfils the need to *socialize* children. Children must be taught the elements of culture need for the component participation in social life. The family is the primary arena in which this cultural learning takes place (Calhoun et. al., 1994).

1. 3.2. Characteristics of Healthy Families

The structural model was developed by Salvador Minuchin and his colleagues from their research on normal families and their clinical work with "multiproblem" families. This model is based on three major assumptions about the nature of behaviour. First, all individuals operate within a social context that, among other things, defines the parameters of their individual behaviours. This means that system establish rules, goals, and priorities that shape and constrain behaviour. The second assumption is that this social context has a definable structure. Structure, according to Minuchin (1974), refers to the invisible set of functional demands that organizes the way family members interact with one another over time. The term structure here is used to label the strategies families develop for regulating how, when, and with whom family members relate. The third assumption is that some are structures better than others. Those systems build on solid structures are more adaptable to the changing demands of family life. Those systems built on faulty structures are less adaptable in response to the ordinary and extraordinary demands of family life (Anderson & Sabateli, 2003).

Family organization is determined by examining three interdependent characteristics: (1) the manner in which family subsystems are organized; (2) the hierarchical relationships between family subsystems; and (3) the clarity of the boundaries within these subsystems. The family differentiates and carries out its functions through subsystems formed by generation, sex, interest, or function (Walsh, 1993). The

primary subsystems comprising the family - the paternal, marital, and sibling subsystem must perform the tasks they must execute. The parental or executive system must perform the tasks necessary to nurture, guide, socialize, and control children. To do this, parents or other care takers must be able to support and accommodate one another to provide the necessary balance between nurturance and firmness. Parents also must be able to negotiate and accommodate to changes in their children as they grow and mature (Anderson & Sabateli, 2003).

According to the structural model, subsystems must be hierarchically organized in order for the family to function effectively. Hierarchy refers to the idea that well-organized systems have clear distinctions between levels of the system. In families there must be clear lines of authority between the generations, with parents in charge of children. This is not to say that children are not listened to, acknowledged, affirmed, or conferred with. Parents, by virtue of their age, experience, and parental responsibilities, must be in charge of decisions that affect the family and its members. This power and authority hierarchy is flawed when power and control rests with children, or when parents rely on their children for nurture, support, and care (Anderson & Sabateli, 2003).

Boundaries define who is in system and its subsystems and regulate how family members are to interact with one another. The effectiveness of family's structural foundation is tied to the clarity of the boundaries that exists with the system. In well-structured families everyone knows his or her position and or role in relationship to one another. Clear parent/child boundaries, for example, allow information to flow freely from children to parents as well as from parents to children. Clear boundaries also help to establish a tolerance for individuality that allows both children and parents to feel respected and valued. When boundaries between subsystems are well defined, subsystem functions can be carried out without interference, and family functioning is enhanced (Anderson&Sabateli, 2003).

In healthy families individual differentiation and group cohesion are guaranteed by the dynamic equilibrium established between the mechanisms of diversification and those of stabilization. The family may be seen as a system in constant transformation evolving by virtue of its capacity to weaken its own stability and then retrieve it through a reorganization of its structure with new bases. The flexibility and/or

rigidity of a system are both characteristics intrinsic to its structure; rather, they seem linked to the dynamism and variability possible within a defined time and space. Every change in family system is either intra systemic (the birth of a child, children leaving home, menopause, death of a family member, divorce, etc.) or inter systemic (job transfer, family move, change in working conditions, deep crisis of values, etc.). Change requires a process of adaptation which may be seen as a modification in the rules of association in order to insure family cohesion while allowing space for the psychological growth of the individual family members (Andolfi, 1983).

Minuchin (1974) emphasizes the emotional "boundaries" between family members. Boundaries that are too rigid create inadequate contact between family members, and boundaries that are too diffuse create oppressive familiarity between family members. Boundaries that are not clear are either too rigid, resulting in disengagement between family members, or too diffused, resulting in enmeshment or over involvement between family members. Coalition is another impairment that is common among the dysfunctional families. It refers to one member of the family siding of with a second member against the third. Cross general coalition occurs, for instance, when a parent persuades a child to side with him or her against the other parent, or when a wife or husband sides with their own parent against their spouse. Functional systems are those that are flexible and able to change their subsystems, hierarchies, and boundaries when necessary. Dysfunctional systems are those that are rigid and unable to make such changes when they required. Rigid families are closed to any experimentation and new learning. The necessity for change becomes transmuted into adopting of a known solution, applied in the present and "programmed" for the future. A solution which had served in one phase is rigidly applied in others. Thus, a dissociative symptom, anorexia, or depressive behaviour may be programmed to face the threat of momentary instability, such as the emancipation of a child, as well as in interpretation for the distancing of other children, or the death of a parent with consequent functional void produced by such an event (Andolfi, 1983; Anderson & Sabateli, 2003).

The structural family therapist assesses the structure of the family member's interactions and replaces maladaptive relationships with more effective ones. Family

therapy both improves both relationships between family members and the behaviour of individual family members (Andolfi, 1983;Sdorrow 1990).

1.3.3. Parenting Styles

Parenting styles are another important aspect of family relations. They differ according to various culture and families in the same cultural context as well. Family structure determines the attitudes and behaviours of parents and the status of the child in family setting. Interaction of the child with parents, especially with mother, forms the basis of physical, emotional, social and mental development and the personality of the child. Interaction of the child with parents determines the attitude of authority and its effect on adolescent's perception.

Parenting styles can be classified according the common and dominant points of different styles. There are three parenting styles.

- *Permissive* parents set new rules and rarely punish misbehaviour. Permissiveness is undesirable, because children will be less likely to adopt positive standards of behaviour.

- At the other extreme, *authoritarian* parents set strict rules and rely on punishment. Physical punishment is common among authoritarian parents. Studies have found that physical punishment is not an effective means of disciplining children. One of the dangers of a reliance on physical discipline is that it will mushroom into child abuse. Abused children have poorer self esteem and are more socially withdrawn. They also tend to be more aggressive and less empathetic toward children in distress. This may partially explain the cycle in which abused children become the child abusers themselves as adults.

- The most effective approach to discipline is the *authoritative* approach. Authoritative parents tend to be warm and loving, yet they still insist that their children behave appropriately. They encourage independence within well - defined limits, show a willingness to explain the reasons for their rules, and permit their children to express verbal disagreement with them. By

maintaining a delicate balance between freedom and control, authoritative parents help their children to internalize standard behaviour. Children who have authoritative parents are more likely to become socially competent, independent, and responsible(Sdorrow, 1990).

1.3.4. Family Relations During The Adolescence and Young Adulthood Period

Parents provide a stimulus source around which the adolescents organize cognitive and perceptual components of their ego identity. High-identity adolescents appear to be characterized by a family milieu involving less parental restrictiveness and better child-parent communication than do low-identity adolescents. Every human individual must leave the family origin, in which his biological business is that of the child, maturing physically into the adult animal and psychologically into a human being, and learning his humanity in the biosocial terms that are given him (Gomberg, 1961).

Individual changes in adolescence, such as emerging sexual maturity, that promotes this alteration in orientation from family to, for example, peers. Thus, the idea here is that adolescents should have as their primary social "objects" peers, not parents. However unless the child defines him or herself as different than his or her parents, the child can never be in a position to make an independent contribution to the society's maintenance and perpetuation Generation gap is an important issue that worsen the conflict between the parents and children. Socialization difference between two generations, strive of adolescent's need to be accepted as an adult, comparison of the parents between the circumstances of their own and their child's developmental phases are the causes of the conflict between generations. Studies about reports that generation gap is common among the parents who attempt to achieve a dominancy over children without having any idea about the characteristics of adolescence and parents who have opinion difference with the peer group of adolescent. Same studies also report that young ones who have generation conflicts with parents suffers about the conservatism of parents, considering as a child by parents, lack of empathy and tolerance and lack of permission for expressing themselves. To summarize cases parents should form common values, a well balanced regular relationship with adolescent and they should improve the dialog

between themselves and their children to cope with generation gap (Yavuzer, 2005; Belsky et. al., 1984).

During adolescence and early adulthood, the family must respond to the increased pull toward individuation as the young adult's essential movement is away from the family toward the wider social environment. However breaking long-held family ties is not easy, either emotionally or behaviourally. This situation represents an approach-avoidance conflict which can create considerable stress for the adolescent and his family. The one receiving most attention in clinical work are the families who are profoundly and continuously disturbed by the changes in their adolescent members as they prepare to depart from the family group. Most of parents resists against the change in the family that brought adolescence to keep their achieved dominancy over the family. Adolescent rejects the opinions of parents and other adults while forming new object relations with peers. Because peer relations based on a mutually democratic interaction rather than hierarchical parental authority (Anderson & Sabatelli 2003 ;Hauser et. al., 1991; Yavuzer, 2005).

Individuation is a developmental process which a person comes to see the self as separate and distinct within relational (familial, social, cultural) context. Individuation process is characterized by progressive shifts in the individual's ability to take personal responsibility throughout adolescence and into adulthood. The ability is reflected in each individual's functional, financial and psychological autonomy. The well individuated adult, under conditions of conflict or demands for conformity, chooses to respond to feelings of guilt, loyalty, obligation, or anger by behaving in ways that promote intimacy while allowing for personal authority fulfilment. When family's strategies inhibit individuation, or overly control the young's identity, the young adult will generally seek to solve this developmental bind in one of three ways. Some individuals simply fuse with the family, allowing the family to control their identities. In this instance, the young adult sacrifices individuality and the freedom to move developmentally beyond the family's domain of influence. Others rebel, separating from the family and reactively choosing an identity that clearly distinguishes self from the family. In yet other instances, the anxiety engendered by this developmental bind may lead the youth to attempt solutions that are compromises between leaving and staying at home. Such solutions

can have a serious impact not only on the young person's present functioning but also on the mastery of subsequent life-cycle transitions and tasks (Anderson & Sabatelli, 2003).

1.4. Definition and Brief History of Psychoactive Drugs:

The term of psychoactive drug refers substances which alter the conscious, mood, perception and thoughts. This term includes wide variety of prescribed and non prescribed medicines, natural or synthetic substances (Hancı, 1997).

Drug use history is old as history of the whole humankind. It is known that in prehistoric period, people used various plants as a medicine to avoid the pain. Also primitive societies used drugs at the religious rituals, for treatment of various diseases and against the evil spirits and conventional events like transition to adulthood from childhood.

Alcohol was discovered in prehistoric ages by primitive people. They realized that fruits left in a warm place of the cave were becoming a different substance by the time. Then they attempted to reduce their thirsty or hunger by using these fruits. Primitive civilizations loaded a religious meaning on alcohol. They accepted the alcohol as a drink which provides motivation to achieve a spiritual power. Beer yeast was an important nutrition in the ancient Egypt and Sumerian civilizations. They obtained different alcohol drinks by processing yeast. However distillation technique was found in the 15th century. This technique was applied at Europe. Alcohol rate of beer and wine was average 14%. Distillation technique enabled to produce new alcohol drinks that contain about 50% percent of alcohol. Alcohol was very frequent in the Europe at the 19th century.

Cannabis use was frequent in the India about 3000 years ago. Indian people accepted the cannabis plant as a holy plant that gifted to mankind by the gods. Because they believed that cannabis plant enables transition to a spiritual world. About 4000 A.D. in the Middle East, opium and cannabis have been used by Sumerian people in the field of medication. Opium was an important drug that used for treatment of various diseased during the ancient Greek and Roman Empire periods. Alexander the Great

was using opium with wine. But his drug using reason was to feel motivated to fight. His soldiers also used opium to motivate themselves to fight. The famous ancient Greek poet Homeros assumed that a person who drinks opium with wine does not cry even he witnessed the death of his whole family. Roman Emperor Marcus Aurelius was addicted to opium. He used opium to avoid the feeling of tiredness. At the Far East, Chinese people began to use opium over the 10th century. But cannabis was already known at ancient China about the year of 2700 A.D. Chinese Emperor Shen Nung defined the cannabis as a substance that provides pleasure, comfort and calmness. At the same time China is the first country which made legal sanctions about the opium use. In the year of 1729, Chinese government banned commerce and consumption of the opium and cannabis. But this legal arrangement could not prevent opium usage at China. China was an important market for England by means of opium exportation. The Empire of England was selling the opium which they planted at the Bengal. In the year of 1840 a war occurred between the England and China because of the opium commerce. This war is known as the first opium war in history. A second war occurred in the year of 1842.Then two countries signed the Nanking Treaty. Then Hong-Kong annexed by the England as a circumstance of the deal. Hundreds of Chinese people executed because of the opium use during the years of 1930s (Ögel , 1997; Babaoğlu, 1997).

Opium was not common in the Islamic culture. With the rise of Arabic Empires, Muslims started to control the poppy fields. In Islamic orient culture, opium was used as a analgesic drug. Famous Muslim scientist Ibni Sina investigated the effects of opium. Also opium use was contrary to the belief system. Cannabis was well known drug in the eastern Islamic culture as well as opium. Cannabis use was common among the İsmaili sect of Islam religion. Famous Turkish itinerant Evliya Çelebi (1611 -1682) gives information about the cannabis use in Istanbul at the 17th century .He mentions the cannabis producing stores in Istanbul. Alcohol and cannabis use takes an important place in Ottoman literature. Poets Fuzuli, Nafi, Hayali were the most famous cannabis user who are known as the most important figures of Ottoman literature. Also some of Ottoman sultans used opium, cannabis and alcohol. Murat II, Selim II and Murat IV used opium with wine. Murat IV banned the opium, tobacco and alcohol use. However he died because of alcoholic cirrhosis despite his young age. In the same period, church was very effective at the

management of the government in Europe. Religious authorities of Europe decided to reject the healer effect of opium. Then the inquisition courts began to judge the opium users as supporter of demon forces. Opium and cannabis use appeared after the renaissance period in Europe (Babaoğlu, 1997).

Psychoactive drugs were common in new world as well as the old one. Psilocybin Mexicana mushroom was common among the North America natives. When Aztec King Montezuma was crowned in the year of 1502, Aztec natives celebrated it by making a collective ecstasy ceremony of psychedelic mushrooms. Native civilizations of America, before Christophe Coulomb, were familiar to different kinds of drugs. For example coca leaf use common among Inca civilization for both religious and non-religious purposes. Amazon natives were drinking a psychedelic drink which is called as caapi or yaje. Amazon natives believed that this drink enables them to see the future (Babaoğlu, 1997).

Alcohol addiction was prevalent in the USA since the British Colonization period. But marijuana and opium use was not frequent in the USA until the 19th century. Historians believes that opium usage is probably begins with immigration of Chinese railway workers to the America. At the same time USA is the first country that contributed to establishment an international organization in the world (Çakıcı, 2000). USA government arranged a meeting at Shanghais in the year of 1909. The World War 1st was an important turning point at the struggle with the drug use. Prevalence of drug addiction began to increase among soldiers after the war. Soldiers who have injured or experienced traumatic experiences attempted to use drugs. The States of USA was already indented to prevent the usage of opioids and cocaine between the years of 1897 and 1912. In the year of 1915 USA government prepared a legal arrangement to prevent the substance suggestions of the doctors as a part of medical treatment (Ögel, 1997). In the year of 1874, English chemist C.R. Wright obtained a new kind of opiate drug by boiling the morphine with acetyl anhydrite. Dr. Felix Hoffman investigated the same chemical compound and he gave its final form to drug. In the year of 1898, this new drug threw on the market by Bayer in Germany under the name of "heroisch" which means "bravery" in the German language. Then this name changed into the heroine. In the year of 1925, commerce of heroin accepted a criminal act in Germany. But heroine was consumed in the

different parts of the world as a prescribed drug. USA government forbid the heroine in 1931.Heroine was also known in Turkey as a licit drug. The first heroine factory of Turkey was built in Istanbul in the year of 1927 by a Japan firm. Four factories followed the first factory. But council of minister forbidden this drug and they decided to close the factories. In the year of 1931, Turkish government signed the Genève contract. In the year of 1933 Turkish Government forbade drug production totally (Babaoğlu, 1997).

Opium and Cannabis addiction was frequent among so many poets, artists and authors in the history. Shakespeare gave place to opium about 200 different parts of his works. Many European poets and authors was using cannabis about the end of the 19th century and the first years of 20th century. Baudelaire, Gautier, Daumier, de Nerval, Balzac, Dlacroix, Monner were the most known ones of these artists.

In the 20th century, a new generation occurred about 20 years later from World War II. In the 1960s and early 1970s, American youths sought to establish their identities by imitating the very rituals of the preindustrial tribes. Known as "hippies" and "flower children," they attempted to return to simpler life. The youth movements in 1968 are based on two books (Eros and Civilization, 1964 - Human Single Dimension ,1968) of Herbert Marcuse. According to Marcuse "Rebel one is the free person". However the economic comfort brought by modernism avoided the rebellion by changing people into senseless individuals who lost their freedom. Marcuse mentioned that revolution would be brought by the people who reject or cannot succeed to become a part of modern society, such as immigrants, unemployed people, young students. The young people who internalized these ideas decided to join drug use subculture. Many of them returned to the wilderness, living on farms and communes away from the large cities in which they were brought up. Many totally rejected the cultural values of their parents. The most famous symbol of their counterculture was the Woodstock musical marathon in 1969. With this loud, throbbing music, nudity and widespread use of drugs, the event was similar to many primitive tribal rites. Yet these self-designed initiation rites also seem be unsuccessful as passages to maturity. Most of communes and other organizations of the youth movement of the 1960s have since failed (Dacey & Travers, 1999; Köknel, 1997).

Drug use was more common among the African-American ghettos about the years of 1960s in United States. But drug use, especially heroine, spread among the Caucasian Americans during the Vietnam War. Death incidents due to overdose of heroine increased day by day. Especially indefiniteness about the Vietnam War led the American youth in despair. President Nixon decided to fight against the drug traffic. However he could inhibit only a limited part of drug traffic. Drug use is still an important problem in USA today. United nations declared contracts against drug commerce and use in 1948, 1953, 1961, 1971 and finally 1988. (Babaoğlu 1997).

1.5. Terms About Drug Use

The word "drug" refers to wide variety of substances including both prescribed and non prescribed medicines. In this research the term of "drug" or "substance" will refer cannabis, inhalants, heroin, cocaine, crack, inhalants, ecstasy, benzodiazepines, flunitrazepams, pills with alcohol, non prescribed medicines, illegal pills, LSD and syrups with codeine. In this study "drug use" term will refer to denote use that may range from experimental to persistent or dependent use that includes addiction and abuse.

1.5.1. DSM-IV Criteria

Psychoactive drugs are the drugs which have the capacity to alter mood, perception, cognition and behaviour. These drugs – whether extracted from plants (for example cocaine and heroin) or made in a laboratory (for example, amphetamines or LSD), whether legal (such as alcohol) or illicit (such as cannabis) – all act by altering the body's biological functions. Psychoactive drugs can produce two major groups of harms. The first is toxicity (intoxication), usually an immediate effect of the drug when the blood-level concentration rises rapidly. The second is dependence, a more delayed effect that is linked to most the long-term harms associated with use of these drugs (Hamilton, 1998). Drug use behaviour is considered as a disorder and classified as substance abuse and substance dependency in DSM-IV-TR as following:

DSM-IV Criteria for Substance Abuse:

Substance abuse is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress as manifested by one (or more) of the following, occurring within a 12-month period:

1. Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home (such as repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; or neglect of children or household).

2. Recurrent substance use in situations in which it is physically hazardous (such as driving an automobile or operating a machine when impaired by substance use)

3. Recurrent substance-related legal problems (such as arrests for substance related disorderly conduct)

4. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (for example, arguments with spouse about consequences of intoxication and physical fights).

Note: The symptoms for abuse have never met the criteria for dependence for this class of substance. According to the DSM-IV, a person can be abusing a substance or dependent on a substance but not both at the same time (APA,1994).

DSM-IV Criteria for Substance Dependence:

Substance dependence is defined as a maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring any time in the same 12-month period:

1. Tolerance, as defined by either of the following: (a) A need for markedly increased amounts of the substance to achieve intoxication or the desired effect or (b) Markedly diminished effect with continued use of the same amount of the substance.

2. Withdrawal, as manifested by either of the following: (a) The characteristic withdrawal syndrome for the substance or (b) The same (or closely related) substance is taken to

relieve or avoid withdrawal symptoms.

3. The substance is often taken in larger amounts or over a longer period than intended.

4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.

5. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

6. Important social, occupational, or recreational activities are given up or reduced because of substance use.

7. The substance use is continued despite knowledge of having a persistent physical or psychological problem that is likely to have been caused or exacerbated by the substance (for example, current cocaine use despite recognition of cocaine-induced depression or continued drinking despite recognition that an ulcer was made worse by alcohol consumption) (APA,1994).

1.5.2. Substance Addiction

Substance addiction is insistence of the individual for drug use, although he or she experiences obvious problems with behavioural and physiological symptoms that is related with substance (Çakıcı, 2000).

1.5.3. Substance Abuse

It is defined as any drug use that impairs one's physical, cognitive, or social well-being (Berger, 1994).

1.5.4. Physical Dependence

It is the physiological need for substance. Bodily symptoms occur when the substance intake is inhibited. Because this kind of addiction destroys the physiological adaptation of the person (Ögel , 1997).

1.5.5. Psychological Dependence

Substance addiction serves to satisfy one's needs according to his or her own emotional or personality structure (Ögel , 1997) .

1.5.6. Intoxication

Occurrence of inappropriate behaviours or psychological changes appears after substance intake (Ögel 1997).

1.5.7. Tolerance

Adjustment of the mind (brain) to drugs, so more or a different drug is needed to produce the same effect (Moffit, 1998).

1.5.8. Withdrawal

Physical or psychological symptoms that occur in long-term addiction after the amount of substance intake is decreased or substance use is totally quitted. Addicted person needs to take substance to avoid these negative effects (Ögel, 2002).

1.5.9. Crosswise Tolerance

Tolerance that develops towards a substance that is classified in the same pharmacological class after the tolerance development to a specific substance (Ögel , 1997).

1.5.10. Quitting

It is the disuse of any drug by the individual. If duration of disuse is less than one year, this is called as early quitting (Ögel , 1997) .

1.5.11. Abstinence

It is life time disuse of the drug. It must be the main target of addiction treatment (Ögel , 1997).

1.6. Types of Drugs

1.6.1. Alcohol

Ethanol is the most common form of alcohol that is found in various alcohol drinks. This chemical compound has a sedative effect when it is taken at limited amounts. As the amount of alcohol taken increases, it makes an anaesthetic effect on the brain (Çakıcı, 2000). Alcohol effects the part of the brain which is responsible for thinking process. It also influences the part of brain which maintains muscular balance of the body. As the alcohol intensity in the blood increases judgment ability, muscular balance becomes corrupted.

There is no legal inhibition for alcohol consumption. Alcohol can provided easily from the markets, restaurants etc. Because of this alcohol is a prevalent drink. 10% of the alcohol taken into the body is absorbed by the stomach and the rest of taken amount is absorbed by small intestine. Alcohol reaches the higher amount on the blood level about one hour after from drinking. 90% of alcohol absorbed is oxidized in liver. And 10% percent of alcohol is excluded from the body by kidneys and lungs without any change in its content. Alcohol affects the brain. But this affect is indirect. Alcohol has a biochemical effect on the neuron membrane (Çakıcı, 2000).

There are so many wrong beliefs about the alcohol. For example many people believe that alcohol provides to feel sleepy. Actually alcohol contributes during falling to sleep. But Alcohol decreases the quality of sleep.(Ögel, 2002)

Alcohol abuse leads to alcoholism. A person who continues to take alcohol although he or she experiences negative consequences is called as alcoholic. Alcohol has both physical and psychological damages upon health. Long-term and intense alcohol use may lead to coma or death. Individuals who use frequently intense amounts of alcohol are experience withdrawal symptoms. Tremors, agitation, anxiety and panic attacks, paranoia and delusions, hallucinations (usually visual), nausea and vomiting, increased body temperature, elevated blood pressure and heart rate, convulsions and seizures are most common forms of alcohol withdrawal symptoms. Long-term alcohol use effects the cardiovascular, respiratory, immune, gastrointestinal and respiratory system. Fatty liver, hepatitis, cirrhosis, throat and mouth cancer and

tuberculosis are the most important diseases which appear as a result of long-term alcohol use. Negative psychological effects of alcohol include impairment judgment and verbal ability, apathy and inability to concentrate). Alcohol also affects the psychosocial life of the individual. Alcohol abusers become introverted and they experience problems with family interaction and social-occupational functioning. Especially alcohol increases the risk of antisocial and criminal behaviours (Taner, 2005).

1.6.2. Cannabis

Cannabis is a substance that obtained by a plant which is known as Cannabis Sativa or Cannabis Indica. It is an illicit drug. Only the Government of Netherlands allows limited amount of cannabis consumption. This drug is known as "hashish" in English. In fact hashish is obtained from the flower of Cannabis Sativa plant. Marijuana is another type of cannabioid drug that obtained by the leaves of Cannabis Sativa plant. Both hashish and marijuana are mostly smoked either by rolling up into a reefer using tobacco papers or in a cone. It is common to mix it with tobacco to make it burn more easily. Hashish is more effective than marijuana. Main active chemical material of cannabis is THC (delta-9-tetrahydrocannbinol). There are certain THC receptors in the various parts of the brain. They are generally found in basal ganglia, hippocampus and cerebellum. Limited amount of receptors are found in cerebral cortex. Effect of cannabis appears about 30 minutes later. Someone who uses cannabis for the first time may not experience the effect of cannabis. On the other hand other people who use cannabis frequently feel himself in an elevated mood or relaxed. Redness in the eyes, mild tachycardia, increase of appetite, feeling of thirsty in the mouth are the physical symptoms which occur after the cannabis intake. Perception biases are another effect of cannabis. Person feels himself sensitive to external stimuli and explores new details, perceives the colours more bright and obvious than they really exist, perceives the time as it passes slower, moreover and may lose time and place orientation. Impairment in human reflexes is another symptom that occurs after cannabis intake. For example person cannot succeed in the tasks that require attention such like driving. Cannabis is accumulated in the fat tissues. These tissues are generally found in brain and reproduction organs. 50% of active chemical material may found in the body even though one week later

intake. Long term cannabis use causes the adverse effects like problems in respiration system (especially lungs cancer), memory problems, and learning disabilities, deficits in motor skills and cannabis psychosis that in some cases resulted in violence, homicide or suicide. It also has negative effects on both men and women's reproduction system. For example a decrease about 25-30% is discovered short time after cannabis intake in the secretion of male hormone which is called testosterone (Ögel, 1997; Ögel, 2002; Çakıcı,2005 ; Moffit, 1998) .

Cannabis does not cause physiological addiction. But psychological addiction of cannabis is prevalent among the cannabis users. Cannabis addicts experience withdrawal symptoms like feeling irritable, discomfort and they may experience problems such sleep problems, loss of appetite and nausea when they quit cannabis usage. Cannabis is known as a "transition substance". It means that cannabis use generally forms first step of drug addiction. 3/2 of hospitalized heroin addicts in the AMATEM reported the cannabis as the beginning substance (Ögel, 1997). So the cannabis, which is considered as a harmless drug among the young people, may lead to addiction of other drugs.

1.6.3. Ecstasy

It is a kind of amphetamine which is named as methylenedioxymetamphetamine (MDMA).It has similar effects with both amphetamine and hallucinogen drugs. Ecstasy enables the release of dopamine and nor epinephrine as other hallucinogen drugs. But ecstasy use causes release of serotonin as well as release dopamine and nor epinephrine. Because of this it is classified as distinctly than hallucinogen drugs. Ecstasy pills are consumed by the oral way. The pills have generally such kind of symbols like bird, hearth pictures. Ecstasy becomes effective 20-60 minutes after the consumption (Ögel, 1997). The effect of ecstasy vanishes about 4-6 hours later. Feeling of vigour, elevated energy, increased sexual arousal, increased feeling of self-trust and perceptual changes are typical effects of ecstasy. Because of these typical effects, ecstasy is consumed prevalently in such places like disco and dance club. Prevalence of ecstasy is higher among the young population. By the development of tolerance, ecstasy consumers attempt to increase the dose of drug. This kind of use of ecstasy is very dangerous because the person who needs to

increase the dosage may forget the amount of consumed pills. Finally attempt to increase the dosage may bring out fatal results.

Ecstasy seriously damages both physical and psychological health. Psychological damages include confusion, depression, sleep problems, drug craving and severe anxiety. Especially depression is common among the ecstasy users. Decreased levels serotonin due to long term ecstasy use is the main reason for the depression onset. Long-term ecstasy users may experience physical problems such like increased heart rate and blood pressure, muscle tension, involuntary clench of teeth, nausea, blurred vision, faintness and chills or sweating (Taner, 2005).

1.6.4. Opiates

Opium is the name of the sap which obtained by scratching the flowers of "Palaver Somniferum" plant. There are 20 "opium alkaloids" in this sap including morphine too. Also there are "semi-synthetic" and "synthetic" alkaloids other than the natural alkaloids. Opioid is the general name of the drugs that obtained by opium .In fact opioids are different than opiates. Opiates include the substances that obtained from opium. But opioids only include the synthetic narcotics which are not obtained by opium. But DSM-IV prefers the "opioid" term to define opiates. Natural opiates are classified into two groups: Morphine, Codeine, Tebaine and Papaverine, Noskapine, Nar seine. Second group of opiates have no psychological effects. Methadone, meperidine, pentazocine and propyksifene are completely synthetic opiates. They are obtained in laboratory by chemical processes. Morphine is a very powerful pain killer medicine. It is generally used by cancer patients who experience hard pains. Codeine is generally found in sleeping pills.(Ögel,2007; Çakıcı, 2000).

Heroin is the most dangerous type of the opiates. It is two times more effective than morphine. Heroin is obtained by processing of morphine chemically. Heroin usually appears as a brown or white powder. Heroin addicts usually take it by nasal way or they take into a cigarette by smoking. μ receptors in the brain are the main receptors that affected by heroine. Corex is the name of the cigarette which contains heroine. Long-term users generally use it by injection. With dependence, all interest is absorbed in taking the drug and its effects. Lifestyles change, personal hygiene and appearance are neglected. Infectious diseases like AIDS, hepatitis are common

among injection users because they generally use the same injector mutually. They mix the heroin with lactose and lemon juice before they inject it into the vein. Withdrawal from dependency is very difficult. The duration of the desired of the drug is short and the increase in tolerance is so rapid that users soon need many injections to get those effects and avoid the unpleasant withdrawal symptoms which commence rapidly. Withdrawal symptoms of heroine include symptoms like drug craving, restlessness, muscular and bone pain, insomnia, diarrhoea and vomiting, cold flashes with goose bumps (cold turkey), kicking movements (kicking the habit), and other symptoms. After an injection of heroin, the user reports feeling of increased euphoria that is accompanied by a warm flush on the skin and dryness in the mouth. Wakeful and drowsy state which is known as "on the nod" occurs after the euphoric mood state. Chronic users may have collapsed veins, heart problems, abscesses, cellulites and liver disease. Sudden withdrawal of heavily dependent, especially among the people who have poor health status, usually bring out fatal results. (Moffit, 1998; Taner, 2005).

1.6.5. Cocaine

Cocaine is obtained by the Coca plant which is grown in South America. As mentioned previously it was used as medicine by Native Americans and it is still used as local anaesthetic for surgery. Cocaine appears in the form of a white powder. This powder form is generally taken by nasal way. It is also used by oral or intra venous ways. Crack cocaine is consumed by smoking with tobacco. It inhibits the reabsorbing process of dopamine which is a chemical message associated with pleasure and movement (Çakıcı, 2000). Despite it is not related with physiological addiction, it is considered as a very dangerous drug. Psychological addiction may occur even after the first time of use. Relapse of cocaine is very intense. So it is very hard to quit using cocaine for a long term cocaine addict. Withdrawal, can include deep anxiety, depression, insomnia, nausea, exhaustion, agitation or suicide .(Ögel, 1997; Moffit, 1998).

Physical effects of cocaine use include constricted blood vessels, dilated pupils, and increased temperature, hearth rate and blood pressure. Cocaine's immediate euphoric effects are hyper stimulation, reduced fatigue and mental clarity (Taner, 2005). Long term consumption of cocaine may cause serious impairments for both physical and

mental health. Nasal congestion, impairment in respiration system, twitching, headaches which are similar with migraine aches, arrhythmia and epilepsy are known as the certain physical damages of cocaine. Cocaine use may lead to paranoid delusions and hallucinations. Cocaine withdrawal may also lead to suicide. A kind of depression which is called as "crash" occurs one hour after cocaine intake. Symptoms of crash depression are anxiety, unhappiness, irritability, increased need for sleep, nightmares and weakness. These symptoms last about 18 hours. This period may last longer than 18 hours if there is a history of intense consumption. Symptoms achieve to the peak level between 2-4 days and then continue for up to ten weeks. There are many deaths and suicides. In some there are brain seizures, loss of consciousness, memory lapses or paranoia (Ögel, 1997; Moffit, 1998).

1.6.6. Inhalants

Inhalant substances are chemical substances which are used in the field of industry and medicine. Chemicals like spray paints, thinner, glues, butane gas, gasoline, nail polish and ether are the most common types of inhalant drugs (Ögel, 1997).They are generally inhaled into the lungs by nasal or oral respiration. Most common effects of inhalants are feeling of enjoyment and calmness. They have similar effects with anaesthetics. They make body functions slower. Inhalant users also tend to exhibit aggressive behaviours. Sudden death incidents are common among the inhalant users due to suffocation or the negative effects of inhalants on the hearth and brain. This syndrome is known as "sudden sniffing death". Chronic inhalants addiction may lead to sever and long-term health problems for the brain, the liver and the kidneys.

Most of inhalant substances are legal substances. They can be provided easily from hardware dealer stores. In general inhalant addiction is not specific for an age group or socioeconomic class. However the prevalence of inhalant consumption is very common among the young children and adolescents, especially among the homeless ones.

1.6.7. Amphetamines

Amphetamine drugs are used in medical. It is generally used during the treatment of attention deficit and hyperactivity disorder (Especially among children), depression

and narcolepsy disorders. Some diet pills contain certain amount of amphetamine as well. Captagon, Ritalin, Dexedrine are some examples for the amphetamine drugs. Amphetamines are known as stimulant drugs. Because of his stimulant effect, amphetamine use is common among the people who want to increase the performance and attention on a specific concern. For example students, long way drivers may use amphetamines to concentrate on their task (Ögel, 1997).

Amphetamine addiction causes physical and psychological impairments. Irritability, discomfort, weakness, depressed mood, inactivity, nightmares, hypersomnia, headache, sweating, stomach and muscle cramps are the withdrawal symptoms of amphetamine. Tolerance develops rapidly. Doses many times greater are soon needed, thus increasing the risks of serious harmful side effects. These symptoms reach at peak level in 2-4 days and they may last over one week. Psychological damages of long-term amphetamine use include emotional instability, distortion of perception, sudden acts of unpredictable violence, aggression, and paranoia and amphetamine psychosis. Amphetamine psychosis has symptoms similar to those of paranoid schizophrenia, resulting in extreme violence. Physical damages of long-term amphetamine use includes myocardial infract, cerebral vessel diseases, sever hypertension and ischemic colitis. Overdose amphetamine intake may lead to tremor, epilepsy, coma and death.(Ögel, 1997; Moffit, 1998)

1.6.8. Hallucinogens

Hallucinogen drugs are the drugs that lead to experience hallucinations. They are named as "psychedelic" or "psychometric" drugs in medical literature. But today these drugs are not used for medical conditions. These drugs often share, with the two former groups, actions that include a degree of depression or stimulation. However, one of their specific function is to distort perception which leads to misinterpretation of external events. They can produce auditory, tactile or visual hallucinations. LSD (Lysergic acid diethylamide) is the most common kind of hallucinogens. It was common especially among the hippie generation about the years of 1960s. LSD is obtained by the processing of psiylogbin mushroom. LSD liquid that extracted from mushroom is consumed by absorption of this liquid into a paper. User puts this paper on his tongue and then the chemical content becomes effective in the body. Its effect reaches at peak level 2-4 hours later. Effect of drug

reduces about 8-12 hours later. LSD increases serotonin release rate. Psychological dependency of LSD may develop if it is used regularly during 3-4 days. LSD causes physical tremor, hypertension, increased body temperature, sweating and unclear vision. Actually effects of hallucinogen drugs are related with the person's mood during consumption. These effects vary from imagining beautiful things to nightmares. Long-term hallucinogen drug use may lead to psychotic disorders. Hallucinogens include risk factors for individuals who are more prone to experience psychosis. Overdose at hallucinogen use may result with death as a consequence of hypertension and increased body temperature (Ögel, 1997; Hamilton et. al., 1998).

1.6.9. Sedative- Hypnotic Drugs

Although they have different chemical forms, the common aspect of these drugs is making collapse in cerebral functions. Most people who use prescribed medications use them responsibly. However some people use them without any medical prescription. This kind of use generally leads to drug abuse or addiction. Some of these drugs can be provided from the pharmacy stores by the declaration of either red or green prescription. Diazem, nervium, tranxilene, ativan, rivotril, akineton, rohypnol and lomotile are the most common abused drugs. These drugs provide a sedation feeling for the consumer. They can be used as a single drug or additional to another illicit drug. For example heroin addicts often consume the rohypnol together with heroine. These drugs cause both psychological and physical dependence. Overdose may lead to death by pressuring the respiration system (Çakıcı, 2000; Ögel, 1997).

1.7. Risk and Protective Factors for Drug Abuse

Drug use behaviour cannot be considered as a result of single reason. There are certain factors that increase the risk of drug use behaviour and protect the young individual from drug use as well. In this section risk factors and protective factors for young people are determined and identified according to the former and recent studies.

1.7.1. Individual Factors

Freud defined the masturbation as the major habit, in other words "primary dependency" and he assumes that alcohol, morphine or tobacco addiction is substitute of masturbation. According to Freud infantile masturbation is both attractive and anxiety provoking behaviour and it is always banned by parents. Children internalize this banned behaviour. According to the Freud addiction serves to self-punishment because of repressed desire. Freud assumes that resistance of superego, in other words, desire of being punished and patient's feeling of rejection of recovery, is the most difficult resistance to overcome. Addicted person punishes him/her self by consuming alcohol or drug. Freud also emphasizes on narcissism. Because abused substance becomes a love object by the time and individual perceives the substance as a part of him or herself (Abay & Ateş 2001).

Psychodynamic theories do not define a specific personality structure for addiction. But addicted people are defined as dependent, shy, prone to loneliness, unable to tolerate distress, anxious, fearful and sensitive and whom represses sexual urges according to psychodynamic theory. Psychologist Beyhan Coşkun applied Minnesota Multiple Personality Inventory (MMPI) on hospitalized Patients at AMATEM as a part of her dissertation thesis study. She found that addicted people have such characteristics like impulsivity, aggression, hostility, impaired defence skills, negative identity and unstable mood state (Ögel, 1997).

A reason for adolescent drug use is escape from the tension and the pressures of life, or boredom. Ironically, this is also a major reason why adults use substances like alcohol and barbiturates (Conger, 1979). A number of life stresses - competing an education, finding a mate, establishing a career - cluster during 20s. Many people abuse alcohol and other drugs in an effort to escape these stresses, if only for one moment (Berger et. al., 1994). Otto Rank believed that drug use behaviour is an escape from external world to a secure place like uterus. To summarize, Otto Rank assumes that drug use behaviour is a reaction against the birth trauma (Ögel, 1997). Van Laar et. al. (2006) found that in follow up study cannabis use increase the risk of major depression and bipolar depression. Boys & Marsden (2002) found that cannabis and alcohol use among young ones serve to relieve negative mood. In another study of Boys et. al.(1998) important correlation occurred between the

alcohol-cannabis use and mood state. Anxiety level is an important individual factor that increases the risk. Derelioğlu (1998) investigated drug use among university students and he found that both state and trait anxiety level of drug user youngsters significantly higher than non-users (Kulaksızoğlu 2005).

DSM-IV Axis 2 diagnosis is also important risk factor for drug abuse. There is no specific personality disorder defined as the basis of dependence. But there are differences about impulsivity and new experience seeking motives between addicts and non-addicts (Çakmak&Saatçioğlu, 2005). Risk taking behaviour is a result of individual's preference about the risky life style (Ögel, 1997). Personality traits and personality disorder symptoms are not consequences of drug abuse, but individual risk factors that increase the likelihood of drug abuse. Symptomatic model of psychiatry considers the personality pathology as the basic reason of addiction. Symptomatic model defines addiction is a personality disorder that characterized by symptoms like adaptation dysfunction, emotional immaturity and neurotic characteristics. Antisocial personality disorder is the most correlated personality disorder with drug use in the literature. Impulsivity, low distress tolerance and involving criminal acts are the characteristics of antisocial personality disorder. Drug abuse is an unaccepted behaviour for both social ethic values and legal setting. So we can say that the correlation between drug use and antisocial personality construct is not an unexpected incident.

Bolognini et. al. (2006) found higher prevalence of life time and problematic substance use among the violent and antisocial adolescent group than control group. They also found that violent adolescents begin drug abuse earlier. Daughters et. al. (2008) found that drug addicts with antisocial diagnosis perform low success in distress provoking performance tasks. Prevalence of borderline personality disorder among the drug users follows the antisocial personality disorder prevalence. Feeling of emptiness, emotional imbalance, and poor distress tolerance are the characteristics of borderline personality. Borderline people generally use the drug to avoid negative affection. There are important research studies that support the relationship between drug addiction and paranoid, avoidant, narcissistic personality disorders as well. But the most important two disorders correlated with drug addiction are antisocial and borderline personality disorders. Addiction treatment without regard of personality

disorders can cause the stability of this risk factor and it is rarely effective as a result of its negative influences on the supporters or providers of treatment components (Çakmak&Saatçioğlu, 2005).

1.7.2. Family-Parental Factors

Impairment in family functioning is another aspect of this risk factor. Family functioning, parenting style, domestic interaction and consistency directly affect the psychosocial adjustment of the adolescent. As mentioned previous section, in a healthy family structure roles of family members are well determined and flexible according to the situation. Factors like poverty, other socioeconomic factors like education level, marital conflicts and role confusion in the family cause family dysfunction (Ögel, 1997). Cattapan and Grimwade (2008) have found that parents who relinquish substance use as able to restore family routines and domestic organization, and then they noticed positive changes about children of these families.

Bandura rejects to consider the adolescence as a melancholic period. In his studies he reports that children grown in regular, consistent and compassionate families spend the adolescence period comfortably. He doesn't accept the problematic behaviours of young one as a consequence of normal development process. Bandura emphasizes the lack of family concern as a reason for juvenile delinquency (Kulaksızoğlu, 2005).For the child of democratic, authoritative, loving parents, who allow their children gradually increasing, age-appropriate opportunities to 'test their wings' , the risk of serious drug involvement is generally lower than that for the child whose parents have not been loving, and who are neglectful, overly permissive or- in contrast – authoritarian and hostile (Conger, 1979).

In regards to young adulthood, family is another important risk factor. Many young adults are in transition between families, becoming increasingly independent of their family of origin but not yet established in a family of their own. Abuse of drugs and alcohol among youth can be thought of as a compromise, but dysfunctional, solution to the needs of young people to separate sufficiently from individuation-inhibiting families. The use of substances allows youths to maintain some control over their individuality and identity. Being a single, as most young adults are, correlates with drug and alcohol abuse (Berger et. al., 1997; Anderson & Sabatelli, 2003).

Domestic violence, child abuse and neglect, family members with sexual deviation or psychiatric problems are important risk factors for drug abuse (Ögel&Erol). Lack of intimacy, trust and concern in the family system is a serious risk factor for drug abuse in adolescence. If the family is not able to fulfil love and intimacy need of child, then individual may attempt to satisfy this need by using drugs (Kulaksızoğlu, 2005). Pérez (2000) found that physical abuse and sexual victimization, as well as co-occurrence of both, were significantly associated with frequency of various kinds of illicit drug use. In another study Wilents et. al. (2000) found that 59% of children of opiates dependent parents and children of 41% alcohol-dependent parents had at least one major psychopathological condition. They have also found that children of opiates and alcohol dependent parents have more difficulties in academic, social and family functioning.

Parental loss due to death or divorce is another family risk factor for drug use. High incidence of parental deprivation is reported for families of substance abusers both sexes, many of whom have experienced separation from or of a parent (most commonly father) before age sixteen (Anderson & Sabatelli, 2003). Hope et. al. (1997) found that parental separation in childhood as a predictor of alcohol consumption in early adulthood. Barker and Adams found that only 1/3 of substance addicts are grown by real parents and more than 1/4 of subjects live with single parent and 12% of subjects live with step parent (Kasatura, 1998). Maier and Lachman (2000) reported parental divorce as a serious predictor of drug use.

1.7.3. Social-Cultural Risk Factors

Social context is another risk factor for drug use. As mentioned, peer relations become more important at adolescence than family relations. So we can say that social context is very important risk factor for drug use. Behavioural theorists consider addiction as a learned misbehaviour. Bandura's social learning theory emphasizes the role of modelling. Bandura assumes that the adolescents grown in healthy family environment can socialize successfully and their family reinforce appropriate attitudes of them that fit to social norms (Kulaksızoğlu, 2005).

As mentioned earlier drug use is considered as a rebellion against the social values and antisocial individuals are more prone to drug abuse. Poverty, living in a social

context which has low socioeconomic status and high crime rate, being a member of racial or cultural minority, communication and language problems during receiving social service and health services are such social factors that increase the risk of drug use (Ögel&Erol). For example it is easy to provide substance in ghettos of Istanbul (Dolapdere, Hacıhüsrev etc.) and substance use is also accepted. As a result, substance abuse is common in these areas (Ögel, 1997). Because drug users tend to hide their behaviour as a result of the rejection of the society and legal sanctions (Ögel, 2002) .

Köknel (1998) claims that individual decides to participate in alcohol and drug subculture as the result of such factors like characteristics of youth period, addiction prone personality structure, negative family environment that excludes the young one, the effect of social context. McCandless assumes that adolescents feel themselves under a social pressure because of consensus about certain impulses like sexuality in society and the publicly accepted behaviour patterns. He emphasizes the anxiety provoked by the conflict between emerging impulses and social norms (Kulaksızoğlu, 2005). If young one fails to avoid the fear and anxiety which is specific to youth period and fails to find the appropriate context to satisfy his or her own needs may attempt find his or her own identity in different subcultures. Addiction behaviour occurs by the effect of organization of subculture which enables interaction between the individual and other members of the group. Subgroup members are opposed to the values of dominant culture. So they don't consider drug use as a misbehaviour. New member of drug subculture becomes estranged from the non drug users by time.

Peer groups of drug users are generally includes drug using friends. Ögel (2001) reported that friends with drug use history forms the majority of drug user youngsters peer group. Boys et. al. (1999) found the peer drug use as a predictor of drug use in the future. Windle (2000) found peer substance use as a predictor of alcohol problems and illicit drug use. She also found that sibling and peer substance and alcohol use strongly predicts the adolescent substance use.

1.7.4. Biological and genetic risk factors

Limbic system is responsible for basic emotions and behaviours and it forms the base of pleasure perception. The drugs that cause addiction become effective by stimulating "reinforcement pathway" in limbic system. Normal dopamine secretion may change as a result of addiction and withdrawal symptoms occur after quitting of drug use. Alcohol or psychoactive substance use continues in order to reduce withdrawal symptoms. Kennet Blum is the first person who proposed the occurrence behavioural disorders as a result of chemical imbalance in cerebral reinforcement processes. He called this incident as "reinforcement deficit syndrome". The concept of "reinforcement deficit syndrome" explains that how the simple genetic anomalies cause problematic aberrant behaviours and various psychiatric disorders. Studies report that genetic anomaly related with alcohol addiction is also common among such people who manifest substance addiction, compulsive or impulsive disorders. This list can be extended with disorders like substance abuse, smoking, compulsive overeating, obesity, attention deficit and hyperactivity disorder, Tourette's disorder and pathological gambling (Abay & Ateş 2001).

Addiction is related with genetic structure of the person. However the effect of genetic potential is not effective alone. Environment moderates genetic potential in psychological characteristics. We know that alcoholism is at least partly genetic, although the specific genes involved, the nature of their interaction, and precise power have yet to be determined. If a person with a strong genetic affinity to alcoholism spends a lifetime in an environment where alcohol is unavailable, the alcoholic genotype will never become manifest in the phenotype. Alcoholism may be genetically "present" at birth but it is rarely expressed before adolescence (Berger et. al., 1994).

The role of heredity in drug abuse has been most clearly demonstrated in connection with alcohol, the most often abused. Studies about alcohol dependency reported the importance of heredity by when they compare the consumption of twins and adopted children. However there is not enough evidence to support the relationship between heredity and other substances. Other aspects of alcoholism are related to heritable personality traits, among them a powerful attraction to excitement, low tolerance for frustration, and a vulnerability to depression. These same traits make a person

susceptible to almost any mood-altering drug, especially cocaine, which is one reason that many drug abusers become multi drug users before they realize they are vulnerable to psychoactive drugs in general, not just to one specific substance (Berger et. al., 1994; Ögel,1997).

Genetic influences about drug use are only evident about opiate users. Studies reported the existence of a genetically determined hypoactive opiate system is present in opiate addicts. As a result of this hypo activity secretion level of opiate antagonist will be either too much or too less. It is also known that abnormal functioning of dopamine or noradrenalin neurotransmitter systems is another genetic risk factor (Ögel, 1997).

Drug abuse is common among the parents of addicted young ones. However heredity is not able to explain the drug use behaviour as single factor. Because parenting style, social learning is also effective as mentioned before. Genetic and biological factors are important risk factors. However progressions in the either neurobiology or genetics do not present enough evidence yet to explain the addiction with heredity or biological factors (Ögel, 1997).

1.8.Studies About Adolescence and Young Adult Drug Use

This Section includes methodological information regarding studies about the predictors of substance use and studies that target family relations of drug using individuals both abroad and in Turkey and Turkish Republic of Northern Cyprus (TRNC).

1.8.1. Studies Conducted in Other Countries

Many studies conducted in different countries about the prevalence of drug use among young ones. However limited amount of those studies directly focused on family risk factor as a predictor. This section includes a review about the studies that are either directly or indirectly concerned with family relations of drug using adolescents and young adults.

Feelhan et. al. (1995) examined the DSM-III disorders in adolescence (age 15) and DSM-III-R disorder in early adulthood (age 18 years).Parental separation, poor social competence in childhood significantly predicted disorder at age 15. Assessment of disorders was restricted with more common disorders, especially manic depression and psychoses were excluded. They investigated disorders that include such features like impairment in life functioning, police contact, or help seeking. Likelihood of experiencing transition problems significantly correlated if the participant had a disorder at age 15. As mentioned previously disturbance of mental health may serve as an individual risk factor for drug use. Findings of this study indicate the protective characteristics of pre-adolescence family relations for further mental problems which is considered as risk factors for substance use in young adulthood.

Hayatbakhsh et. al. (2006) examined parents' marital status as a predictor DSM-IV cannabis use disorders in young adulthood. The study was conducted as a prospective birth study in Queensland, Australia. It is a 21 years follow up study of 4815 mothers and their children who participated at 14 years after the child's birth. Sample included cohort of 2303 young adults who completed the life-time version of the Composite International Diagnostic Interview - computerized version (CIDI-Auto) at the 21-year follow-up. The findings suggested that parental marital status and quality of the relationship between a child's parents are significant predictors of his or her developing cannabis abuse or dependence. Children reared in non-intact families or families affected by marital disagreement manifest a higher rate of cannabis use disorders in early adulthood. Whereas the adolescents who grew up in step-father families and children who experience maternal marital conflict found more likely to have cannabis use disorders in early adulthood, no significant increase found in subsequent risk of cannabis use disorders for children whose mother were single at 14 years. All these findings suggest that parent's marital status and quality are significant protective factors for cannabis use disorders in young adulthood.

Pidcock et. al (2001) investigated familial and behavioural differences between Hispanic and Anglo-American first year college students. Sample consisted of 78 unmarried students and the mean age was 18. There were 23 Anglo-American females, 16 Anglo males and 28 Hispanic females, 8 Hispanic males and 3 "others".

With regards of family relations Hispanic students appeared to at greater risk for problem behaviour in the area of family. Prevalence of alcohol and substance addiction was more prevalent among the Hispanic parents. Less mentoring of Hispanic students by adults indicates that they may not have access to an important protective factor that may affect problem behaviours. Also the rate of dropping school was higher among the Hispanic students. However Anglo-American students reported more problematic behaviour than Hispanics in the area of alcohol or drug abuse. This situation commented as the ability of Hispanic students to demonstrate resilience despite lack of mentoring and greater parental addiction.

Kuo et. al (2007) conducted a study about the risk factors associated non-injection drug users (NIDU) and recent onset of injection drug users (IDU) with a Muslim sample from Pakistan. The mean age found as 36 for 72 recent-onset IDUs and 20 for 241 long time users NIDUs. The most prevalent drug was heroine. This finding suggests that NIDUs are young adults and early in their career. In this study familial and social influences significantly associated with initiation of injection, which is consistent with previous literature.

Calafat et. al. (2008) conducted a study about risk and protective factors for drug misuse among young Europeans. They interviewed with 1777 young people in recreational nightlife environments in 10 European cities. The mean age was found as 20.3 and 48.5% of participants were females and 51.5% were males. 943 (53%) reported drug use and 834 (47%) did not reported any drug use history. Cannabis was the most prevalent drug (93%) among the drugs consumed, ecstasy (44%) and cocaine (35%) followed it. The main risk factor was found as nightlife related activities of youth subculture. Familial drug use and permissive attitudes of parents for drug use were also found as serious risk factors.

Beitchman et. al. (2005) investigated the role of social support on psychiatric and substance use disorders during the late adolescence. 224 participants interviewed at age 5 and age 19. Drug abusers reported less perceived family support. Early risk factors such like maternal depression, poor parent marital adjustment, and economic pressure have been previously identified at first interview as influencing parents' ability to provide emotional support to their children. This follow up study indicates that family dysfunctions occurred in early childhood may be effective in further

developmental phases. They also found that adolescents who have low family supports are more prone to engage in a deviant behaviour with peer group. This study also examined the effectiveness of co-morbid disorder as a risk factor on substance disorder. However youths who were substance abusers alone did not differ greatly from non-disordered youths in terms of family functioning and support.

Kliewer et. al. (2006) Examined family cohesion and parental monitoring as protective factor for drug use. They investigated 9840 adolescents (50.5% female, Mean age=15.29 range=12-21) living in Panama and Costa Rica. They found violence exposure, witnessing serious violence, family drug use as serious risk factors which predict drug use and problems with alcohol and drug. Violence exposure or witnessing a serious violence less associated with family cohesion and parental monitoring. So it can be said that family cohesion and parental monitoring are protective factors for drug use. Especially family cohesion found stronger among older participants. This finding suggests that young adults are more successful at explaining themselves and communication.

Liddle et. al. (2008) compared the effectiveness of the cognitive behaviour therapy (CBT) and multidimensional family therapy (MDFT) on adolescent drug users in USA. The sample size was 224, the mean age was 15 and 81% was male. 72% of participants were African-Americans from low income single parent homes. All of them were drug users and 75% met DSM-IV criteria for cannabis dependence and 13% met criteria for abuse. Both interventions produced significant decreases in cannabis consumption and slightly significant reductions in alcohol use. MDFT is found to be effective on decreasing substance use problem severity, other drug use and minimal use of all substances and these effects continued to 12 months following treatments. These findings indicate the role of family relations in sustaining the gains of treatment.

Wagner et. al. (2008) examined the relationship between family structure and adolescent drug use. Sample consisted of 255 high school students. 83% were Latino, 58% female and most of them were from low socioeconomic status households. Previous studies reports that drug consumption is more common among the single parent families. However in this sample, divorce rate was found very low, but drug use was prevalent in this sample. Wagner et. al. commented this situation with

characteristics of Latino families. It is known that Latino families has a lower socioeconomic status and risk factors such like violence and parental drug use found prevalent among these families. So it can be said that divorce may be a protective factor for drug use in some cultures. Prevalence of drug use was found higher among those reported that living with individuals from out of family and presence of older sibling or cousin in family was correlated with drug use risk. This can be explained by modelling.

Dolan et. al. (2008) investigated the role of executive dysfunction as a risk factor for substance abuse. They applied a series of performance tasks to measure the quality of executive function. As expected drug users performance of the substance users was less successful than healthy control group. They also assessed family substance use history of participants. They found that substance users with substance dependent family history were less successful than those who did not report family drug use history. These findings indicates that family dysfunction may cause significant cognitive deficits which are known as a risk factor for substance use.

Rey et. al. (2007) investigated the violence-related cases in State Prosecutor's Office of in two cities of Mexico. They applied face to face questionnaires to individuals who have experienced legal problems because of violent-related cases. The age group between 18-24 displayed highest number of legal complaints and arrests. Risk factors for appearing at a State Prosecutor's Office were found as violent family environment and alcohol and illicit drugs.

1.8.2.Studies Conducted in Turkey and TRNC

Ögel et. al. (1997) conducted a survey study about the prevalence and predictors of drug use in 10 different region of Turkey and also in TRNC. The sample consisted 186 subjects between 15 and 55 years old.149 of them were males and 37 of them were females. 72 of them was drug users and 14 of them was a family member of drug using someone. They found the widest age range for cannabis. According to results, illegal pills are generally used by the subjects younger than 25 years old. Beginning age for illegal pills and cannabis is found about 16-17 years for all

regions. Beginning age for inhalants use was found as 10 years old and inhalants use age range was found between 12-18. Heroine use was found prevalent for 25-35 age range and beginning age was found generally over than 20. According to these findings we can say that drug use was found frequent among young people in Turkey.

According to the same study, general opinion about family relations of the drug using subjects are negative. Most of them have poor relationships with their families. Most of them visit their home rarely and they avoid their responsibilities. They accuse their family as they have lack of tolerance. Families generally refuse to communicate with drug using subjects. They generally interact by applying pressure and most of them have no idea how to approach a drug using individual. In general most of the families are not able to realize the underlying reasons of drug abuse and they prefer to focus on drug using behaviour of individual rather than underlying reasons. Some part of families are aware of drug use of their children. However most of them prefer to hide this truth in order to avoid the feeling of shame that may occur in case other people learn it anyway. Cannabis users reports better family relations than others. In general cannabis users are homeless individuals who have no family support. Illegal pill users are generally defined as the individuals who have poor relationships with their family. In general families attempt to support their children when they learn drug use behaviour of them, but they withdraw their support by the time. All of these findings lack of cohesion and communication in family of drug users.

Ögel et. al. conducted two survey studies in 1998 which are called as "Characteristics of drug users: A multi-centred study in Turkey" and "Prevalence and Characteristics of Cigarette, Alcohol and Substance Use Among Young Ones - SAMAY 98" about the general characteristics of drug using young ones.

In the study which is called as "Characteristics of drug users: A multi-centred study in Turkey"369 drug users was taken into the sample. 89.7% of them was male. The mean age was found 30 and the age range was between14-66. Prevalence of preference drug was found as 72 (19.5%) inhalants, 139 (37.7%) cannabis, 107 (29%) heroin and 51 (13.8) illegal pills. In first study In general 51.8% reported good or very good family relations before drug use and 34.5% reported good or very good

family relations after drug use. 55.8% of cannabis users, 55.4% of heroin users , %49.3 of inhalants users defined their family relations as either good or very good before substance use. After the substance use 46.4% of cannabis and 35.7% heroine of users reported either good or very good family relations and 45.3% of illegal pill users, 44.3% of inhalants users reported either bad or worse family relations. So it can be said that drug use worsen the family relations. However it is not limited with heroine, cannabis and pill users. Family relations of all users found worse after drug use when compared before than drug use for all drug types.

SAMAY - 98 reports that parents of students who have drug use experience at least once have lower education level when compared with the students who never tried any type of drugs. This finding is valid for both parents. When they compared the level of any problem share with either father or mother of students who have drug use experience at least once and the students who never tried any drug , they found a statistically meaningful relationship. According to this finding the 32.9% of students who have drug use experience do not share any problems with their parents and 26.2% of those who never tried any drug do not share their problems with their parents. While17.5 % of students who have drug use experience at least once reported that they shared all of their problems with families and 49.6% reports they shared a few problems with their these rates are found as 21.9% and 51% for those who have never tried any drug. They found statistically meaningful relationship when they compared the agreement level of parents and children. According to this finding 53.4% of the students who have never tried any kind of substance considers their own opinion either similar or very similar with their families, while 35.3% of them considers their opinions either different or very different. These rates are found as 46.8% and 44.3% among the students who have drug use experience at least once. When they compared the consistency of the family's and child's opinion about spending free times %33.1 of students who have never tried any substance reported that they have either similar or very similar opinions and 60.1% reported that they have either different or very different opinions. These rates are found as 27.6% and 65.9% for the students who have drug use experience at least once. 46.1% of students who have never tried any substance and 42.9% of students who have drug use experience at least once reports their opinions about their mode of dressing either similar or very similar with their family's opinion. 49.8% of students who have never

tried any substance and 52.6% of students who have drug use experience at least once reported different or very different opinions about the same issue. %47.8 of students who have never tried any substance reported that they have either similar or very similar opinions and 46.1% reported that they have either different or very different opinions with their families about spending their pocket money. These rates are found as 38.9% and 55.1% for the students who have drug use experience at least once. Statistically meaningful difference was found when parent's agreement compared. 77.4%of students who have never tried any substance reported that their parents generally agree with each other whereas 9.1% of them reported their parents rarely or never agree with each other. These results were found as 67% and 15.9% students who have drug use experience.

Ögel et. al. (1998) found that physical abuse (65.3%) and verbal abuse (57.7%)in childhood were most common among inhalant users. Sexual abuse victimization was most common among heroin users (7.5%). Physical and sexual abuse victimization did not differ according to different substances used except the inhalants users formed the majority for physical abuse and heroin users formed the majority for sexual victimization. Only 2.4% of cannabis users reported a sexual abuse experience in childhood. Prevalence of physical abuse during childhood among inhalants users indicates that inhalants users have worse family relations and physical abuse causes bad family relations and inhalants addiction.

According to the SAMAY - 98 findings , 9.5% of students who have drug use experience at least once and 7.5% of students who have never tried any drug reported father loss. Mother loss was found 6.6% for students who have never tried any drug and 4.4% for those who have drug use experience at least once. Loss of both parents was found 4.5% for students who have drug use experience at least once and 2.8% for those who have never tried any substance. 9.9% of students who have drug use experience at least once and 4% of students who have never tried any drug reports either parental divorce or parental separation. 4.4% of students who have drug use experience at least once and 1% of students who have never tried any drug reported that their parents live together but not married officially. All comparisons between groups found statically meaningful for either parental loss or divorce. This finding indicates the significance of family structure.

Ögel et. al. found that alcohol and heroin or cannabis use in the family is a serious risk factor for drug use. Especially heroin and cannabis use predicts the risk of same substances. 36.1% of Cannabis users reported cannabis users and 30.9 of heroin users reported substance use in the family.26.2% of heroin users reported heroin and 14.4% of cannabis users reported cannabis as the most prevalent substances consumed by their families.

According to findings obtained by SAMAY - 98, there is a significant difference between students who have drug use experience at least once and students who have never tried any drug. 63.7% of students who have never tried any drug reports rarely or very rarely alcohol consumption in family and 12.2% of them reports intense or very intense alcohol consumption in their family. 53.9% of students who have tried any drug at least once reports rarely or very rarely alcohol consumption in family and 21.5% of them reports intense or very intense alcohol consumption in their family.

Gümüş et. al. (2002) examined the psychosocial and economic difficulties that families of alcohol and heroin addicts. They found that families of heroin addicts experiences more psychosocial and economic difficulties than the families of alcohol addicts. They suggested that better psychosocial and economic conditions in family may contribute the recovery process.

Ögel et. al. (2005) examined the residence place and gender of hospitalized adolescent inhalants users. They found that most of males are separated from their families and homeless. They also found that the beginning age was younger for the homeless ones. So it can be said that lack of family control and concern is a serious risk factor which increase the risk of inhalants use at adolescence.

Ebrinç et. al. (2002) investigated opinions of a 1945 young adult men towards psychoactive substance use. They were separated into three subgroups as non-users, substance users and the ones who tired. All subgroups over than 50% had inadequate knowledge about substances. As a conclusion it was determined that individuals who try or use substances have a risky self-trust towards substance and have cognitive difficulties in perception of the importance of psychoactive substance use.

Yaşan & Gürgen (2004), conducted a study about the properties of adolescent inhalant abuse in South-East of Anatolia. They investigated 37 adolescents and the mean age found as 13.8 and beginning age found as 10.8. 83.5% participants left school, 35.1% had legal problem for various reasons. They found that most of participants exposed to domestic violence and most of their families experience socioeconomic problems such like immigration from rural to urban and poverty. They considered domestic violence as a risk factor for inhalants use and as a factor that disturbs family relations. This finding is consistent with previous studies.

Akın (2000) conducted a study about general the health education needed by the high school students concerning the detrimental effects of substance. 43.3% of students reported the changing family structure as a reason for drug use and 41.8% of them attempts to acquire information about drug use by their family. These results indicates that family relations are very important to control and prevent the drug use behaviour.

Ögel et. al. (2000) examined the prevalence of tobacco, alcohol substance use prevalence among 10th grade students in a sample from Istanbul. They found cannabis and inhalants as the most prevalent substance. They found the approval of family about substance use behaviour as a serious risk factor for substance use. Howevęr they couldn't find any significant difference between socioeconomic level of families and prevalence of substance use. Ögel et. al. (2003) conducted another study about the cannabis use prevalence among primary and secondary school children. They found the cannabis use prevalence as 1.2% for primary school students and 4% for secondary school students. They found the social context and substance and alcohol use in the family as the most serious risk factors. They also found that higher socioeconomic status of family increases the risk of cannabis use. Ögel et. al (2003) found the same risk factor for ecstasy use among secondary school students. According to this 2.5% of students reported ecstasy use at least once during life time. More than half students who tried ecstasy reported alcohol use in family. Significant amount of them reported that they obtained ecstasy via family members.

Evren (2001) conducted a study about the characteristics of inhalants users in a sample from 9 province of Turkey and TRNC. They found the mean age as 19. In regards to family risk factor, 65.3% participants had physical, 56.9% had verbal

childhood history of abuse. 1/4 of participants reported bad family relations before the substance use and 43% of them reported bad family relations after the beginning of substance use. Also 44.5% reported a family history of heavy alcohol use, 20.8% reported a family history of drug use. All these findings indicate that these results are consistent with previous studies and family relations is important risk factor for inhalants use.

2. METHOD

2.1. Significance of the Study

Young adults are more likely to use alcohol and illicit drugs than are people of any other age. Many young drug abusers do themselves or others serious harm. Sometimes drug itself proves lethal. Even if drug abuse in young adulthood does not lead to addiction or serious injury, it nonetheless can take a serious toll on development. The ability to master the developmental tasks of young adulthood - getting an education, finding a suitable carrier, establishing lifelong friendships and love relationships- impaired by the irrationality, social misjudgement, and eventual isolation that heavy drug use entails (Berger. et. al., 1994).

Young adulthood is a phase which young adults break away from dependence on their parents. Adolescence and young adulthood phases provide an opportunity to test the flexibility and rigidity of the family structure. Changes during the individuation process of young person may bring out important conflicts among the family members. As mentioned earlier, high incidence of parental deprivation is reported for families of substance abusers both sexes, many of whom have experienced separation from or of a parent - most commonly father - before age sixteen. These conflicts may lead to drug abuse at adolescence and young adulthood (Berger. et. al., 1994; Anderson & Sabatelli, 2003).

Although a most family structure have transformed into the nuclear family model from extended family model, in general opinion the father is still known as the primary householder in Turkish families. Situation of mother is generally accepted as a secondary authority figure. When father has an authoritative characteristic, the role of mother is known as benevolent. Mother generally obeys the rules of the father. The obedience of mother is also internalized by the children (Mangır & Aral, 1990).

Difficulties in family relations in young adulthood which is known as the most risky period for drug use will be examined and assessed in this study. We decided to investigate the family structure and relationship with both parents by emphasizing on paternal relations of the young ones which takes a big part in traditional Turkish

families. This study will provide new evidences and information for further studies and treatment programs.

2.2. Aim and Hypothesis of the Study

The aim of this study is to examine the relationship between family relations and drug use risk in young adulthood. The hypothesis of this study is defined as following:

- Drug using young adults have poor and negative family relations when compared with healthy control group.
- Family functioning may be related with frequency of substance use .
- Negative family relationship and dysfunctional parenting styles are serious predictors of drug use in young adulthood.

2.4. Research Model

This is a cross-sectional study. A healthy control group and a patient group are compared according to the data obtained via the self administered survey form.

2.5. Population and Sample

Patient group included the patients receiving treatment at the Alcohol and Substance Addiction Treatment Facility (AMATEM) located in İstanbul and which functions as a department of Bakırköy Prof. Dr. Mazhar Osman Mental Hospital. Patients between 18-25 years old were taken into the study and the patients with severe withdrawal symptoms and psychotic symptoms were excluded from the sample. Exclusion criteria were determined by health professionals of AMATEM.

Healthy control group is selected among the freshmen students from the department of psychology at Near East University.

2.6. Socio Demographic Characteristics of Sample

The sample size of this study was 116. However the students who report to have tried some substance a few times are included into the control group but the students who reported severe substance use history other than cigarette and alcohol and the patients who did not complete surveys sufficiently are excluded from sample. After the exclusion process 107 participants remained as the final total sample size.

Patient group consists of 34 (31.8%) participants. Gender distribution of patient group is 26 (76.5%) males and 8 (23.5%) females. 20 (58.8%) were born in Istanbul, 13 (39.3%) were born in different Anatolian provinces, 1 (2.9%) was born in Bulgaria. Distribution father's birth place of the patients found as 6 (18.2%) in Istanbul, 25 (75.7%) in different Anatolian provinces and 2 (6.1%) in Bulgaria. Distribution father's birth place of the patients found as 5 (14.7%) in Istanbul, 27 (79.5%) in different Anatolian provinces, 1 (2.9%) in F.Y.R.O.M. and 1 (2.9%) in Bulgaria. 26 (76.5%). Distribution of marital status of patient group found as 32 (94.1%) single and 2 (5.9%) married. Education level distribution of participants found as 7 (20.6%) primary school, 11 (32.4%) secondary school, 14 (41.2%) high school and 2 (5.9%) university. Education level distribution of patients found as 7 (20.6%) primary school, 11 (32.4%) secondary school, 14 (41.2%) high school and 2 (5.9%) university. Mother's education level distribution of participants found as 3(8.8%) illiterate, 19 (55.9%) primary school, 5 (14.7%) secondary school, 6(17.6%) high school and 1 (2.9%) university. Father's education level distribution of participants found as 16 (55.2%) primary school, 8 (42.1%) secondary school, 8 (23.5%) high school and 2 (8.7%) university. 33 (94.3%) reported that their mother was alive and 2 (5.7%) reported their mother was dead and 30 (85.7%) reported that their father was alive and 5 (14.3%) reported their father was dead. With regards to marital status of parents 28 (93.9%) reported that their parents were married, 1 (3.3%) reported his or her parents are separated but officially still married, 1 (3.3%) reported his or her parents are divorced.

Healthy control group consists of 73 (68.2%) participants. Gender distribution of healthy control group is 24 (32.9%) males and 49 (67.1%) females. 1 (1.4%) were born in Istanbul, 62 (89.7%) were born in different Anatolian provinces, 1 (1.4%) in Izmir, 2 (1.9%) in Ankara and 1 (1.4%) in England, 4 (5.6%) were born in TRNC. Distribution father's birth place of the patients found as 6 (18.2%) in Istanbul, 25 (75.7%) in different Anatolian provinces and 2 (6.1%) in Bulgaria. Distribution father's birth place of the patients found as 3 (4.2%) in Istanbul, 63 (91%) in different Anatolian provinces, and 5 (4.8%) in TRNC. Distribution of marital status of patient group found as 71 (97.3%) single and 2 (2.7%) married. All participants from healthy control group school. Mother's education level distribution of participants found as 22 (31.9%) primary school, 9 (13%) secondary school, 24 (34.8%) high school and 14 (20.3%) university. Father's education level distribution of participants found as 13 (18.3%) primary school, 11 (15.5%) secondary school, 26 (36.6%) high school and 21 (29.6%) university. 70 (97.2%) reported that their mother was alive and 2 (2.8%) reported their mother was dead and 68 (95.8%) reported that their father was alive and 3 (4.2%) reported their father was dead. With regards to marital status of parents 63 (95.5%) reported that their parents were married, 1 (1.5%) reported his or her parents are separated but officially still married, 2 (3%) reported his or her parents are divorced.

2.7. Instruments

2.7.1. Socio Demographic From

Participants were asked to fill a socio demographic questionnaire form prepared by researchers which included age, gender, birth place, parent's birth place, residence place where the participants have spent most of their lives, marital status, marital status of parents, vital status of parents, if parents are divorced or separated which of them the participant lives with and since how long the participant has been living with either parent, education level, parent's education level, income level per month, mood status of the participant.

2.7.2. Substance Use Frequency Questionnaire

The European School Survey Project on Alcohol and Other Drugs(ESPAD) (Hibell B. et. al., 1995) questionnaire is taken as a model during the formation of Substance Use Frequency Questionnaire. Since the ESPAD questionnaire was developed for high school students, the present questionnaire was developed by the researcher using the ESPAD questionnaire as a model. The developed questionnaire is named "Substance Use Frequency Questionnaire".

Substance Use Frequency Questionnaire is a self-administered questionnaire. It consists of three sections and 29 questions. Section 1 consists of risk factor items such as prevalence of cigarette and alcohol use. Section 2 consists of core items of drug use namely, categories of drugs, onset of drug, alcohol and cigarette use, source the drug was attained, reasons to start drug use, personal opinion about drug use, frequency of peer drug use. Prevalence of each substance was analyzed on three dimensions; lifetime prevalence of use, last 12 months prevalence of use, and last 30 days prevalence of use. Section 3 consists of risk factor items about the cigarette, alcohol and drug use prevalence of family members.

2.7.3. Family Structure Assessment Device (FSAD)

Family structure assessment device is 36 itemed self administered scale which was formed to assess the *structural/systematic variables* of transform model. It was formed by Gülerce (1996). The main purpose of this scale is the evaluation of the psychological structure and functioning of the family. The scale was developed as three different forms. One is them administered to children and the other forms are administered to parents. In this study only the child questionnaire is used for the evaluation of family from the view of child. Self administered questionnaire is scored ranging from completely same with ours (1), to completely different than ours (10).However the scores converted into a five point scale ranging from 1 to 5 for every item during the evaluation process of survey. The maximum score of this scale is 180 if every item is fulfilled completely. But the real total score is obtained by the sum of total subscale scores. Each subscale scores are related with the communication, unity, management, perfection, emotional context domains. These are the brief definitions of these five domains are as follows.

Communication: It is related with clarity and consistency of communication methods of the family system.

Cohesion: It is related with both intimacy and cooperation within family system and also with interpersonal and external limitations of the family.

Management: It is related with structural organization, flexibility, behavioural control, discipline, rules, norms, and roles in the system.

Perfection: It is related with problem solving ability, health, competency and realization of desired goals in the family.

Emotional Context: Supportive and constructive emotional atmosphere in family system which predicts the general harmony of the family system.

Subscale scores are obtained by calculating the mean of related items. In other words prorating process is made by the subscales instead of whole items. If only one of these related items for each subscale is non-answered or not able to score then the subscale score is calculated by the exclusion of absent item. In such cases minimum raw score can be found as 31 and the maximum raw score can be found 36.

In regards with the reliability of survey , Gülerce (1996) found internal consistency Cronbach's alpha coefficient as 0.70 for each item of the scale and this homogeneity rate was considered as sufficient for this survey. Test re-test reliability correlation coefficient rate was found as 0.79. and coefficient rate is found as 0.83 for the whole scale when it was evaluated by the split-halves method.

2.7.4. Parenting Styles Scale (PSS)

The PSS was improved by Sümer and Güngör (1999). The PSS assesses parenting styles of mother and father on two different backgrounds: The conceptual groundwork (acceptance/concern and strict supervision control) and the categorical groundwork (4 parenting styles obtained by putting crosswise of these two conceptual classifications).Finally, 4 parenting styles were highlighted: Explanatory/authorized, permitting/negligent, permitting/spoiling and authoritative.

PSS consists of 22 items.11 of these items are related about the parenting styles of the mother and 11 of items are related with the parenting styles of the father. Each item is scored with 4-point likert scale ranging from not at all true (1), not true (2), true (3) and very true (4) is used. Three item are scored inversely.

In regards with reliability of the PSS, (Sümer and Güngör, 1999) reported an alpha coefficient of 0.86 (acceptance and concern) and 0.88 (strict supervision/control) for mothers and 0.88 (acceptance/concern) and 0.87 (strict supervision/control) for fathers.

Sümer and Güngör (1999b) took the Maccoby and Martin' s(1983) method and Lamborn's et. al.'s method as a model which suggested two factors and they determined 11 items which has the highest item-total correlations for both dimensions (acceptance/concern and strict supervision/control).

2.7.5. Fatherhood Scale (FS)

The FS was improved by Gary L. Dick (2001) and translated to Turkish by Selen Üstüner (2009). The scale is intended assist following:

- Help social workers assess the type of paternal involvement individuals had with their fathers during childhood and adolescence .
- Assist social workers in treatment planning, possibly helping individuals to sort out their unresolved issues with their fathers, clarifying the strengths of the relationship, as well as deprivation
- As men examine their relationships with their fathers, social workers can help them construct the kind of role they want to have with their own child.
- Provide an instrument for further research into understanding levels of paternal involvement.

The FS measures four domains: (a) actual events that occurred with the father; (b) participant's perception of their fathers; (c) how they felt about their fathers; (d) the emotional responsiveness of father. Each item is ranked on a 5 point scale ranging

from never (1), rarely (2), sometimes (3), often (4), always(5). The FS consists of 63 items which assess the perceptions about the emotional responsiveness of the father based on the subjective experience. Higher scores indicate positive paternal involvement and 11 negative items are inversely scored.

The 13 factors are identified as follows: The Positive Emotional Engagement, Emotional Abuse, Physically Abusive, Breadwinner, Wife Abuser, Responsible, Moral, Accessible and Verbal, Gender Role Model, School Involvement, Emotionally Expressive, Androgynous, and the Hateful Father.

Examining the component matrix, a decision was made to combine factors of Physically Abusive, Emotional Abusive, and Wife Abuser into the subscale called Negative Paternal Engagement. The factor representing Emotionally Expressive was combined with Androgynous. Factor 13 only had one item (Hateful Father) and therefore was eliminated from the scale. Eventually, nine subscales were developed: Positive Engagement, Positive Emotional Responsiveness, Negative Engagement, Moral Father Role, Good Provider Role, Gender Role Model, Androgynous Role, Accessible Father, and the Responsible Father.

As with the reliability of the FS, the inter item correlations within each subscale ranged from 0.08 to 0.96, seven subscales had inter item correlations above 0.85, indicating that the items within the subscales were highly related. As with the convergent validity, the results showed that there were significant correlations between all the subscales and the FS. The Cronbach's alpha coefficient of FS was 0.98.

In regards with the reliability of Turkish form of FS, internal consistency of the scale was found to be significant. The Cronbach's alpha coefficient was found 0.94. As with the validity, the Cronbach's alpha level of the criterion validity was calculated as 0.882 when compared with PSS. So it can be said that Turkish adaptation of FS is valid and reliable.

2.8. Data Collection and Evaluation

The data collection process was conducted in December 2009 - January 2010 for patient group and in January 2010 for healthy control group. Permission needed for data collection was obtained from Health Ministry Province Health Office of Istanbul and administration of Near East University. Appropriate time for investigation is determined according to the circumstances.

The applications on patient group were administered in AMATEM inpatient and outpatient services. Participants completed surveys in a room that assigned by directors of AMATEM to avoid distractibility. Participants were informed both verbal and written about the aim of study. Patient who gave consent to participate in this study were included into sample. They were informed about the instruction at the beginning and during application of surveys. They completed surveys in a single session were taken to into one by one.

The applications on healthy control group were administered with assistance of two academicians in University in determined day and hour. Students were informed about the aim of the study both verbal and written. Students who gave consent to participate in this study were included into the sample . Surveys applied in a single session in two different classroom.

All participants were also informed about the privacy guarantee of results. They were not asked to write their name or any other information about their identity and they were also informed about that results would be evaluated collectively, not individually. This acknowledgement was given provide the reflection of real situation about their private lives.

Data collected was coded and evaluated by using SPSS 12.00 statistics programme in order to determine the statistical differences between the variables of two groups. At first distribution of general frequency and percentage of certain variables which describe general characteristics of sample was determined and evaluated according to the aim of study.

Chi-square method was used for comparing qualitative variables between groups. Quantitative differences between groups were determined by Student's- test.

Findings obtained by statistical evaluation are transferred into tables. The significance level of relationship was referred as 0.05 level.

3. RESULTS

3.1. Comparison of Sociodemographic Variables Between Groups

Table 1. Comparison of gender distribution between patient and control groups

Subgroups	Gender		Total
	Male n (%)	Female n (%)	n (%)
Patient	27 (76.5)	8 (23.5)	34 (100)
Control	24 (32.9)	49 (67.1)	73 (100)
Total	50 (46.7)	57 (53.3)	107 (100)

When we compare the groups according to gender with chi-square, we found statistically significant difference (p=0.000). Females forms the majority of healthy controls whereas males form majority of patient group.

Table 2. Comparison of mean age between patient and control groups

	Patient (n)	**Control** (n)	**t** (p)
Mean Age	21.41 ± 2.06 (n=34)	20.43 ± 1.37 (n=73)	2.891 (0.016)

When we compare the mean ages of both groups with Student's t-test, the patient group was found to have significantly higher mean age than the controls (p=0.016).

Table 3. Comparison of education level between patient and control groups

Subgroups	**Education Level**				
	Primary school n (%)	Middle School n (%)	High School n (%)	University n (%)	Total n (%)
Patient	7 (20.6)	11 (32.4)	14 (41.2)	2 (5.9)	34 (100)
Control	0 (0)	0 (0)	73 (100)	0 (0)	73 (100)

When we compare the education level between the patient and control group with chi-square, we find statistically significant difference (p=0.000). The education level of the healthy controls is higher than patients.

Table 4. Comparison of mother's education level between patient and control groups

Subgroups	Mother's Education Level					Total
	Illiterate	Primary School	Middle School	High School	University	
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Patient	3 (8.8)	19 (55.9)	5 (14.7)	6 (17.6)	1 (2.9)	34 (100)
Control	0 (0)	22 (31.9)	9 (13)	24 (34.8)	14 (20.3)	69 (100)

When we compare the mother's education level between the patient and control group with chi-square, we find statistically significant difference (p=0.002). The education level of mothers of the patient group is significantly lower than the patient group.

Table 5. Comparison of father's education level between patient and control groups

Subgroups	Father's Education Level					Total
	Illiterate	Primary School	Middle School	High School	University	
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Patient	0 (0)	16 (45.1)	8 (23.5)	8 (23.5)	2 (5.9)	34 (100)
Control	0 (0)	13 (18.3)	11 (15.5)	26 (36.6)	21 (29.6)	71 (100)

When we compare the father's education level between the patient and control group with chi-square, we find statistically significant difference ($p=0.002$). The education level of fathers of the patient group participant is significantly lower than the patient group.

Table 6. Comparison of marital status of patient and control groups

Subgroups	Marital Status		Total
	Single n (%)	Married n (%)	n (%)
Patient	32 (94.1)	2 (5.9)	34 (100)
Control	71 (97.3)	2 (2.7)	73 (100)

There is no statistically meaningful difference when we compare the marital status of the patient and the control group with chi-square (p= 0.425). Single individuals form the majority in both groups.

Table 7. Comparison of parent's marital status of patients and control groups

Subgroups	Marital Status of Parents			Total
	Married n (%)	Married but separated n (%)	Divorced n (%)	n (%)
Patient	28 (93.3)	1 (3.3)	1 (3.3)	30 (100)
Control	63 (95.5)	1 (1.5)	2 (3.0)	67 (100)

There is no statistically meaningful difference when we compare the parental marital status of the patient and the control group with chi-square (p= 0.842). Married parents form the majority in both groups.

Table 8. Comparison of residence place where the participants spent most of their lives

Subgroups	Residence					Total
	Metropolis n (%)	City n (%)	District n (%)	Small Town n (%)	Rural n (%)	n (%)
Patient	26 (76.5)	8 (23.5)	0 (0)	0 (0)	0 (0)	34 (100)
Control	17 (23.6)	25 (34.7)	21 (29.2)	3 (4.2)	6 (8.3)	72 (100)

We found statistically significant difference between groups when we compare the residence where the participants spent most of their lives with chi-square ($p=0.000$). Most of the patients spent majority of their life in metropolis.

Table 9. Comparison of income level of patient and control groups

Subgroups	Income Level per Month (TL)					Total
	500 and lower	501-1000	1001-2000	2001-4000	4000 and more	
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Patient	5 (14.7)	9 (26.5)	14 (41.2)	4 (11.8)	2 (5.9)	34 (100)
Control	9 (13.4)	11 (16.4)	17 (25.4)	21 (31.3)	9 (13.4)	57 (100)

There is no statistically significant difference when we compare the income level of the patient and the control groups with chi-square ($p=0.104$).

3.2. Comparison of Family Relations Between Groups

Table 10. Comparison of the means of FS subscale scores between the patients and the control group

Name of Subscales	Patients (n)	Controls (n)	t p
Positive Engagement	10.78 ± 5.26 (n=28)	16.15 ± 4.99 (n=65)	-4.653 0.000**
Positive Paternal Emotional Responsiveness	34.45 ± 12.87 (n=24)	48.80 ± 13.31 (n=51)	-4.415 0.000**
Negative Paternal Engagement	40.38 ± 6.98 (n= 26)	44.41 ± 5.49 (n=62)	-2.893 0.012*
The Moral Father Role	12.92 ± 4.94 (n=26)	17.01 ± 4.94 (n=64)	-3.568 0.001*
The Gender Role Model	13± 5.71 (n=28)	16.40 ± 5.05 (n=64)	-2.857 0.009*
The Good Provider Role	13.51 ± 3.28 (n=29)	16.96 ± 7.39 (n=64)	-2.404 0.018*
The Androgynous Role	12.93 ± 4.42 (n=29)	17.52 ± 4.48 (n=72)	-4.676 0.000**
Responsible Paternal Engagement	15.85 ± 7.34 (n=28)	23.65 ± 7.50 (n=67)	-4.647 0.000**
The Accessible Father	9.80 ± 3.99 (n=30)	13.60 ± 3.79 (n=70)	-4.518 0.000**
FS-total	152.19 ± 38.33 (n=21)	192.14 ± 38.11 (n=34)	-3.769 0.000**

* p≤0.05 , **p<0.001

When we compare the means of FS subscale scores between the patients and the control group with Student's t-test, we find statistically significant difference for all subscales (p=0.018-0.000). The control group has significantly higher scores for all subscales and the total score.

Table 11. Comparison of the means of PSS subscale scores between the patients and the control group

Name of Subscales	Patients (n)	Controls (n)	t p
Benevolent mother figure	3.58 ± 0.58 (n=25)	4.12 ± 0.77 (n=36)	-2.909 0.003*
Benevolent father figure	2.87 ± 0.80 (n=20)	3.84 ± 0.84 (n=33)	-4.157 0.000**
Controlling mother figure	3.26 ± 0.61 (n=22)	2.80 ± 0.81 (n=42)	2.271 0.027*
Controlling father figure	3.35 ± 0.86 (n=21)	2.87 ± 0.90 (n=34)	1.967 0.054

* p≤0.05 , **p<0.001

When we compare the means of PSS subscale scores between the patient and the control groups with Student's t-test, we find statistically significant difference for all subscales, except controlling father subscale (p=0.027-0.000). The patient group has significantly lower scores for benevolent mother and father figure and significantly higher scores for controlling mother.

Table 12. Comparison of the means of FSAD subscale and total scores between the patient and the control groups

Name of Subscales	Patients (n)	Controls (n)	t p
Communication	24.84± 7.77 (n=32)	31.65 ± 7.16 (n=72)	-4.356 0.000**
Cohesion	24.67 ± 6.50 (n=31)	27.09 ± 5.20 (n=71)	-1.998 0.048*
Management	25.73 ± 5.99 (n=30)	28.49 ± 5.42 (n=69)	-2.252 0.027*
Perfection	17.42 ± 6.26 (n=33)	20.19 ± 5.30 (n=30)	-2.341 0.021*
Emotional Context	14.84 ± 4 (n=33)	16.45 ± 4.04 (n=72)	-1.899 0.060
FSAD-total	109.66 ± 23.52 (n=24)	125.69 ± 21.03 (n=53)	-2.985 0.004*

* p≤0.05 , **p<0.001

When we compare the means of family structure evaluation survey subscale scores between the patients and the control group with Student's t-test, we find statistically significant difference for all subscales, except emotional context subscale (p=0.048-0.000). Control group has significantly higher scores for all subscales and total score of FSAD.

3.3. Frequency of Drug Use

Frequency of drug use is considered according to the data reported by participants in the questionnaire. 40 or more times drug use frequency during life-time reported by participants are considered as severe use. Cannabis reported by 25 (75.8%) patient group participants as the most frequent substance. 14 patients (46.7%) reported severe ecstasy use during life-time. 14(42.4%) reported severe heroine use, 9 (8.4%) reported heroine use by injection, 2 (8.3%) reported injection once, 1 (4.2%) reported

the frequency as sometimes and 6 (25%) reported heroine use by injection regularly. Life time severe use frequency distribution among the patient group for other drugs is 9 (26.5%) inhalants, 9 (30%) illegal pills, 4 (12.5%) cocaine, 1(3.3%) non-prescribed sedatives,4 (19%) some kind of pills with alcohol.

Substances used as primary drugs are determined according to the intensity of consumption during the last 12 months and last 30 days. Patients who did not reported the consumption frequency during last 12 months and last 30 days are considered according to life time prevalence. The patients who reported severe use of three or more types of drugs during last 12 months are considered as multiple substance users. 10 (29.4%) patients reported the cannabis, 12 (35.3%) reported heroine as the primary substance as the only and primary substance for themselves. 4 (11.8%) patients reported severe inhalants use with cannabis and 2 (5.9%) reported severe cannabis use with severe pill or ecstasy use. 6 (17.6%) patients reported severe use of three or more substances during last 12 months considered as multiple substance users.

Table 13. Comparison of the life time frequency of drug use experience between the patient and control group

Drugs	Patient n (%)	Control n (%)	p
Cannabis	32 (100)	3 (4.7)	0.000**
Inhalants	21 (63.6)	0 (0)	0.000**
Cocaine	16 (51.6)	0 (0)	0.000**
Non-prescribed Sedatives	9 (31)	7 (10.9)	0.017*
Heroin	19 (57.6)	1 (1.6)	0.000**
Pills	22 (75.9)	1 (1.6)	0.000**
Ecstasy	24 (82.8)	0 (0)	0.000**
Amphetamine	2 (12.5)	0 (0)	0.007*
LSD	3 (17.6)	0 (0)	0.001*
Pills with Alcohol	11 (55)	0 (0)	0.000**
Steroids	1 (6.3)	0 (0)	0.060
Syrup with Codeine	3 (16.7)	1 (1.8)	0.019*

* $p \leq 0.05$, ** $p < 0.001$

When we compare the frequency of drug use attempt between the patient and control group with chi-square we found that patient group has significantly higher frequency of drug use than the control group (p=0.019-p=0.000).

Table 14. Life-time frequency of drug use among patient group

Drugs	Frequency							Total n (%)
	0 n (%)	1-2 n (%)	3-5 n %)	6-9 n (%)	10-19 n (%)	20-39 n (%)	40 and more n (%)	
Cannabis	0 (0)	0 (0)	0 (0)	1 (3.1)	1 (3.1)	5 (15.6)	25 (78.1)	32 (100)
Inhalants	13 (36.4)	3 (9.1)	2 (6.1)	1 (3)	3 (9.1)	3 (9.1)	9 (27.3)	33 (100)
Cocaine	15 (48.4)	5 (16.1)	2 (6.5)	3 (9.7)	2 (6.5)	0 (0)	4 (12.9)	31 (100)
Non-prescribed Sedatives	20 (69)	2 (6.9)	3 (10.3)	1 (3.4)	1 (3.4)	1 (3.4)	1 (3.4)	29 (100)
Heroine	14 (42.4)	2 (6.1)	0 (0)	2 (6.1)	1 (3)	0 (0)	14 (42.4)	33 (100)
Pills	7 (24.1)	2 (6.9)	5 (17.2)	4 (13.8)	0 (0)	2 (6.9)	9 (31)	29 (100)

As seen on the table, with regards to life time consumption, cannabis is the most prevalent drug among the patients. Heroine, inhalants and non-prescribed sedatives follow the cannabis. Other drugs are not prevalent as much.

Table 15. Frequency of drug use among patient group during the last 12 months

	Frequency							
Drugs	0 n (%)	1-2 n (%)	3-5 n (%)	6-9 n (%)	10-19 n (%)	20-39 n (%)	40 and more n (%)	Total n (%)
Cannabis	1 (3.8)	3 (11.5)	0 (0)	3 (11.5)	4 (15.4)	4 (15.4)	11 (42.3)	26 (100)
Inhalants	15 (55.6)	4 (14.8)	2 (7.4)	1 (3.7)	1 (3.7)	1 (3.7)	3 (11.1)	27 (100)
Cocaine	16 (57.1)	4 (14.3)	4 (14.3)	2 (7.1)	0 (0)	1 (3.6)	1 (3.6)	28 (100)
Non-prescribed Sedatives	20 (76.9)	3 (11.5)	0 (0)	2 (7.7)	1 (3.8)	0 (0)	0 (0)	26 (100)
Heroine	13 (48.1)	0 (0)	0 (0)	0 (0)	1 (3.7)	0 (0)	13 (48.1)	27 (100)
Pills	12 (42.3)	3 (11.5)	5 (19.2)	0 (0)	3 (11.5)	1 (3.8)	3 (11.5)	26 (100)

Cannabis is still most frequent during last 12 months when compared with others. As expected frequency of heroin use follows it.

Table 16. Frequency of drug use among patient group during last 30 days

	Frequency							
Drugs	0 n (%)	1-2 n (%)	3-5 n (%)	6-9 n (%)	10-19 n (%)	20-39 n (%)	40 and more n (%)	Total n (%)
Cannabis	10 (41.7)	5 (20.8)	2 (8.3)	0 (0)	3 (12.5)	1 (4.2)	3 (12.5)	24 (100)
Inhalants	20 (76.9)	2 (7.7)	0 (0)	0 (0)	1 (3.8)	2 (7.7)	1 (3.8)	26 (100)
Cocaine	22 (88)	1 (4)	0 (0)	0 (0)	0 (0)	1 (4)	1 (4)	25 (100)
Non-prescribed Sedatives	22 (88)	2 (8)	1 (4)	0 (0)	0 (0)	0 (0)	0 (0)	25 (100)
Heroine	14 (58.3)	0 (0)	1 (4.2)	0 (0)	0 (0)	4 (16.7)	5 (20.8)	24 (100)
Pills	20 (80)	1 (4)	3 (12)	0 (0)	1 (4)	0 (0)	0 (0)	25 (100)

Cannabis and heroine is still frequent than other drugs with regards to last 30 days consumption.

Table 17. Life-time frequency of other drugs among the patient group

	Frequency							
Drugs	0 n (%)	1-2 n (%)	3-5 n (%)	6-9 n (%)	10-19 n (%)	20-39 n (%)	40 and more n (%)	Total n (%)
Ecstasy	5 (17.2)	3 (10.3)	3 (10.3)	1 (3.4)	1 (3.4)	2 (6.9)	14 (48.3)	29 (100)
Amphetamine	14 (87.5)	0 (0)	2 (12.5)	0 (0)	0 (0)	0 (0)	0 (0)	16 (100)
LSD	14 (82.4)	2 (11.8)	1 (5.9)	0 (0)	0 (0)	0 (0)	0 (0)	17 (100)
Pills with Alcohol	9 (45)	3 (15)	2 (10)	2 (10)	0 (0)	0 (0)	4 (20)	20 (100)
Steroids	15 (93.8)	0 (0)	0 (0)	0 (0)	1 (6.3)	0 (0)	0 (0)	16 (100)
Syrup with Codeine	15 (83.3)	0 (0)	1 (5.6)	0 (0)	1 (5.6)	0 (0)	1 (5.6)	18 (100)

These drugs are not common as much as other drugs which mentioned before. But among these drugs ecstasy consumption has a significant prevalence when compared with others. Also there is considerable frequency of pills with alcohol consumption.

Table 18. Comparison of the peer substance use frequency between the patient and control group

Drugs	None of Them		A Few One		Some of Them		Most of Them		All of Them		p
	Patient n (%)	Control n (%)	Patient n (%)	Control n (%)	Patient n (%)	Control n (%)	Patient n (%)	Control n (%)	Patient n (%)	Control n (%)	
Alcohol	0 (0)	5 (7)	0 (0)	7 (9.9)	4 (13.8)	16 (22.5)	17 (58.6)	38 (53.5)	8 (27.6)	5 (7)	0.014*
Being Drunk Once in A Week	3 (10.7)	24 (34.3)	5 (17.9)	22 (31.4)	6 (21.4)	15 (21.4)	10 (35.7)	8 (11.4)	4 (14.3)	1 (1.4)	0.001*
Cannabis	1 (3.4)	52 (77.6)	3 (10.3)	12 (17.9)	5 (17.2)	2 (3)	10 (34.5)	1 (1.5)	10 (34.5)	0 (0)	0.000**
Inhalants	6 (25)	60 (90.9)	9 (37.5)	4 (6.1)	2 (8.3)	1 (1.5)	5 (20.8)	1 (1.5)	2 (8.3)	0 (0)	0.000**
Cocaine	5 (21.7)	58 (87.9)	8 (34.8)	5 (7.6)	4 (17.4)	3 (4.5)	4 (17.4)	0 (0)	2 (8.7)	0 (0)	0.000**
Non-Prescribed Sedatives	7 (35)	50 (78.1)	6 (30)	9 (14.1)	4 (20)	4 (20)	3 (15)	1 (1.6)	0 (0)	0 (0)	0.002*
Heroine	5 (19.2)	61 (92.4)	7 (26.9)	5 (7.6)	2 (7.7)	0 (0)	5 (19.2)	0 (0)	7 (26.5)	0 (0)	0.000**
Ecstasy	1 (3.4)	52 (77.6)	3 (10.3)	12 (17.9)	5 (17.2)	2 (3)	10 (34.5)	1 (1.5)	10 (34.5)	0 (0)	0.000**
Amphetamine	13 (68.4)	59 (88.1)	4 (21.1)	7 (10.4)	1 (5.3)	0 (0)	1 (5.3)	1 (1.5)	0 (0)	0 (0)	0.0093
LSD	11 (57.9)	58 (87.9)	5 (26.3)	6 (9.1)	0 (0)	1 (1.5)	1 (5.3)	1 (1.5)	2 (10.5)	0 (0)	0.011*
Steroids	15 (83.3)	62 (93.9)	1 (5.6)	4 (6.1)	1 (5.6)	0 (0)	1 (5.6)	0 (0)	0 (0)	0 (0)	0.057

* $p \leq 0.05$, **$p < 0.001$

When we compare the frequency of peer alcohol and drug use between the patient and control group with chi-square except for the amphetamine and steroids, we found significant statistical difference between the groups for all drugs (p=0.014-p=0.000).

Table 19. Comparison of the peer insistence frequency for alcohol and drug use between groups

	Frequency								
	Never		**Rarely**		**Some much**		**Too Much**		
Drugs	Patient n (%)	Control n (%)	Patient n (%)	Control n (%)	Patient n (%)	Control n (%)	Patient n (%)	Control n (%)	**p**
Alcohol	5 (17.9)	40 (56.3)	11 (39.3)	21 (29.6)	7 (25)	5 (7)	5 (17.9)	5 (7)	0.002*
Cannabis	6 (20)	64 (92.8)	10 (33.3)	2 (2.9)	7 (23.3)	1 (1.4)	7 (23.3)	2 (2.9)	0.000**
Other Drugs	14 (46.7)	66 (95.7)	6 (20)	1 (1.4)	4 (13.3)	1 (1.4)	6 (20)	1 (1.4)	0.000**

* $p \leq 0.05$, **$p < 0.001$

When we compare the frequency of peer insistence for alcohol and drug use between the patient and control group with chi-square we found that peer insistence for alcohol and drug use is significantly more common in patient group (p=0.002-p=0.000).

Table 20. Frequency of the reasons to start using drugs among patient group

Reasons	Prevalence n (%)
For fun	20 (60.6)
To sleep	4 (12.1)
Curiosity	16 (48.5)
Anger	10 (30.3)
Boredom	13 (39.4)
To relax	16 (40.5)
To get away from problems	16 (48.5)
Peer use	6 (18.2)
To feel better	8 (24.2)
To test	8 (24.2)

The most common reason to start drug use is found as "For fun"."Curiosity", "To relax" and "To get away from problems" are the other common reasons to start drug use..

Table 21. Comparing the opinions of the patient and control group about drugs

Opinion	Level of Agree With										p
	Totally Disagree		Disagree		No Idea		Agree		Totally Agree		
	Patient n (%)	Control n (%)	Patient n (%)	Control n (%)	Patient n (%)	Control n (%)	Patient n (%)	Control n (%)	Patient n (%)	Control n (%)	
Provide relaxation	7 (25.9)	45 (77.6)	0 (0)	5 (8.6)	6 (22.2)	5 (45.5)	10 (37)	5 (5.2)	4 (14.8)	0 (0)	0.000**
Damage the health	1 (3.6)	11 (16.7)	1 (3.6)	4 (6.1)	1 (3.6)	1 (1.5)	7 (25)	12 (18.2)	18 (64.3)	38 (57.6)	0.425
Keep away from problems	6 (25)	41 (69.5)	2 (8.3)	7 (11.9)	3 (12.5)	6 (10.2)	9 (37.5)	5 (8.5)	4 (16.7)	0 (0)	0.000**
Give fun	6 (24)	36 (60)	3 (12)	9 (15)	3 (12)	6 (10)	9 (36)	7 (11.7)	4 (16)	2 (3.3)	0.006*
Cause loss of control	0 (0)	10 (15.9)	2 (8.7)	1 (1.6)	1 (4.3)	4 (6.3)	5 (21.7)	11 (17.5)	15 (65.2)	37 (58.7)	0.165
Provide to meet one's him or herself	12 (52.2)	45 (75)	2 (8.7)	7 (11.7)	5 (21.7)	5 (8.3)	2 (8.7)	3 (5)	2 (8.7)	0 (0)	0.050*
Provide Bravery	4 (16)	29 (49.2)	1 (4)	5 (8.5)	1 (4)	10 (16.9)	12 (40)	9 (15.3)	7 (28)	6 (10.2)	0.001**

* p≤0.05 , **p<0.001

When we compare the opinions of patient and control group about the narcotic drugs, we found statistically significant difference between groups. Most of the patients believe that narcotic drugs provide relaxation, keep the individual away from problems and give fun (p=0.050-0.000).

Table 22. Initiation age into drug use for patient group

Drug	Age							
	Never n (%)	11 or below n (%)	12 n (%)	13 n (%)	14 n (%)	15 n (%)	16 n (%)	Total n (%)
Cannabis	0 (0)	1 (3.7)	0 (0)	5 (18.5)	6 (18.5)	6 (22.2)	15 (55.6)	27 (100)
Inhalants	8 (38.1)	0 (0)	0 (0)	2 (9.5)	1 (4.8)	2 (9.5)	8 (38.1)	21 (100)
Cocaine	11 (73.3)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	4 (26.7)	15 (100)
Non-prescribed Sedatives	7 (41.2)	0 (0)	1 (5.9)	0 (0)	1 (5.9)	1 (5.9)	7 (41.2)	17 (100)
Heroine	10 (58.8)	0 (0)	0 (0)	0 (0)	2 (11.8)	2 (11.8)	3 (17.6)	17 (100)
Steroids	12 (85.7)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	2 (14.3)	14 (100)
Ecstasy	4 (18.2)	0 (0)	1 (4.5)	0 (0)	2 (9.1)	4 (18.2)	11 (50)	22 (100)
Amphetamine	14 (87.5)	0 (0)	0 (0)	0 (0)	1 (6.3)	0 (0)	1 (6.3)	16 (100)
LSD	14 (82.4)	0 (0)	0 (0)	0 (0)	0 (0)	0 (0)	3 (17.6)	17 (100)
Syrup with Codeine	0 (0)	0 (0)	12 (80)	0 (0)	14 (6.7)	0 (0)	2 (13.3)	15 (100)

As seen on the table the cannabis is the most frequent substance that consumed in adolescence and even in childhood. Ecstasy and inhalants consumption follow the cannabis.

4. DISCUSSION

This section involves discussion about the significance and implications about the results that obtained by this study. Most of findings are consistent with previous studies.

Low scale scores of patient group indicates that they have worse family relations than controls. With regards to family system they reported less functional family structure than controls. Most of the patients obtained low scores from FSAD total and subscales than controls (Table 11). Low scores of FSAD communication subscale indicate the lack of clear and functional communication among family members. Other lower subscale scores of FSAD subscales indicates lack of cohesion and emotional support in families of patient group. Also factors like role confusion, inability to solve problems and inadequacy of family members are prevalent among patient group families. As mentioned previously Minuchin's (1974) structural model emphasizes on boundaries between family members. In this research findings indicates that there are either too rigid or too flexible boundaries between family members. On the other hand findings indicate that patient group families may follow rigid methods for problem solving and may have lack of flexibility for youth period problems may increase the distress in family system. Rhodes et. al. (2003) investigated the research studies about drug use conducted in European samples. They identified that drug use is common among dissolved or conflicted families. They also reported that "open", "trusting" and "caring" relationships with parents are found as protective factors in many studies. These studies approve the validity of current findings.

Previous studies identified broken homes, in other words parental divorce or deprivation, as another serious risk factor for drug use problems in young adulthood and adolescence. Rhodes et. al (2003) reports that in final follow up study in Europe 13% (67) of families had experienced divorce or separation, with divorce a significant predictor of both initiation into drug use and transitions towards problematic use among male youth. Hayatbakhsh et. al. (2006) found parent's marital circumstances as a predictor of DSM-IV cannabis use disorder among young adults. Unlike previous studies, parental divorce or separation was not identified as a risk factor for either bad family relations or drug use in current study. There was no

statistically meaningful difference between the parent's marital status of patients and controls in current study (Table. 6). Also prevalence of parental divorce and separation found very low for both groups.

With regards to PSS subscale scores whereas the mean score of patient group was lower than controls in benevolent parent figure, controls obtained lower scores in controlling parent figure (Table. 10). This finding indicates that patient group parents tend to have an authoritarian parenting style by applying a harsh discipline to control their children while they are showing inadequate emotional intimacy. Rhodes et. al. (2003) reported many studies identify that over protective and unsupportive, as well as poorly defined and combative, parental relationships can be associated with drug use, including problem use. Amey & Albrecht (1998) examined the effect of parental mentoring on drug use. The assessed the quality of mentoring by calculating the amount of time that parent spent with child. They found parental mentoring and quality of attention that showed to children by parent as a protective factor for drug use. Findings of current study support the indications of previous studies. However it is not clear yet if over controlling parenting style causes drug use or if it is occurs as a consequence of drug use behaviour.

Another important aspect of this study is the quality of father-child relationship. Actually FS is a scale which evaluates the father-child relationship only in childhood and adolescence. Brook et. al. (2007) found a significant relationship between maladaptive paternal child rearing practices and adolescent vulnerable personality attributes including aggression and antisocial personality which are mentioned as individual risk factors in previous section. Patient group obtained significantly low scores from both FS scale and its subscales (Table. 9). This finding approves the finding of previous study which was conducted by Brook et. al. (2007). Except control group obtained a greater mean score from negative paternal engagement subscale. Increase in this subscale may be interpreted as control group has negative relations with their father. However patient group obtained lower scores from all subscales and including positive paternal engagement. High scores on androgynous role subscale indicated the flexibility of the roles in family system which emphasized as one of main characteristic of healthy family structure by Munichin. This subscale includes items like "My father helped my mom clean the house" or "My dad cooks

meals" which indicate flexibility level of father role. This finding indicates that control group families respond to a change with healthy strategies. Low scores of FS subscales like positive engagement, positive paternal emotional responsiveness and good provider role indicate the lack of paternal emotional concern in the family. Consistent with FSAD emotional context subscale, FS scores indicates that lack of emotional concern of father is a serious risk factor for drug abuse in young adulthood and adolescence. Moral father subscale score was also lower among patients than controls. This finding indicates that fathers of the patients are less successful to be a role model for their child who teaches ethical values. When we consider the importance of the father's role model as authority in traditional Turkish family structure, we can clearly see the risk of drug use which is known as an antisocial act.

Males formed a big majority of patient group (Table. 1). This finding, consistent with previous studies, indicates that gender is a risk factor for drug use in young adulthood. Ögel et. al. (2003) found that ecstasy consumption is 4 times more common among adolescent males. In another study Ögel et. al. (2003) found the risk of cannabis use is four times more common among the males. Ebrinç et. al.(2002)reported that young men who have ever tried try or use substances have a risky self-trust towards substance use and have cognitive difficulties in perception of the importance of psychoactive drug use. Yüncü et. al. (2006) investigated the socio demographic characteristics of children and adolescents who applied a dependency centre for treatment. They found that 88.5% of cases were males and 11.5% were females. They also found that most of the participants are encouraged to treatment by their families. All these studies are consistent with the results of this study. If we think that patient group has poor family relations when compared with controls, we can say that males tend to have poor family relations as well.

Taylor et al. (2000) proposed that males generally reacts the stressful events with fight-or-flight response, whereas females react with tend-and-be friend response. The male fight-or-flight response is inherently different from the female tend-and-befriend response. The male stress response most likely evolved as a protective measure to ensure the survival of the male. If the male was likely to overcome the threat he would fight whereas if the threat was unlikely to be overcome the male would flee. In stressful situations, women tend to their offspring to protect them and

also find relief in the presence of other women. Tend-and-befriend stress response that makes a woman better able to handle stress (McCarhty, 2005). Lack of mutual interaction between young boys and family may be related with characteristics related with gender. As mentioned, adolescence and young adulthood is a stressful period for both families parents and children. Wrong strategies during this stressful period may lead serious consequences like addiction or delinquency. Gender may be protective to avoid such kind of risks. As mentioned, patient group tend to have poor relationships withtheir fathers. However it is not possible to explain it according to fight-or-flight response of males. The research conducted by Taylor et al. (2000) was neither to make biological excuses for a male's lack of involvement in parenting nor to conclude that males do not care equally for their offspring. The tend-and-befriend response is not about parenting styles but about responses to stress (http://www.personalityresearch.org/papers/mccarthy.html).

In this study peer drug use among the patient group was found significantly higher than controls (Table. 17). If social context or family fails to provide the needs of young one to reduce anxiety and fear which are specific to youth period, then individual may tend to find his or her identity in different subcultures. Also vulnerability of individual to peer pressure is another risk factor. Patient group reported higher peer insistence for alcohol and drug use than controls (Table. 18). However we don't have enough evidence to prove vulnerability of patient group. The individual who joins in a group internalizes the norms of alcohol and drugs subculture either consciously or unconsciously by the means of such kind of feelings like tolerance, trust, cooperation and share which are known as main functions of a group. By the time alcohol or drug use becomes the main purpose of the life. Family relations become worsen as a consequence of this situation (Köknel, 2001). Erdem et. al. (2006) investigated the peer characteristics of high school students and they found that an adolescent who have either antisocial or drug user friend is six times more prone for drug use. Having antisocial or drug using peers was more frequent among males than females. However they found that females have more serious risk to have antisocial friends. They also found that parent-child conflict about peer group choice is another risk factor for drug use. If we consider that control group had poor family relations than controls, it can be said that dysfunctional family is a serious risk factor for involvement in drug subculture. Rabiner et. al. (2005) examined the

relationship between peer relations in late adolescence and likelihood of exhibiting aggressive behaviours in young adulthood in a follow up study. They found peer rejection in late adolescent as a predictor of aggressive offense in young adulthood, especially among males. This finding indicates that healthy peer relations in late adolescent are important as family relations to reduce the risk of antisocial acts in young adulthood.

There was a statistically significant difference between groups with regards to residence (Table 7). A big majority of the participants (77.1%) reported that they spent majority of their life-time in metropolis. None of them reported rural areas such like small towns or districts as a residence place. Yüncü et. al. found that a big majority of adolescents (81.7%) who applied to a treatment centre for drug addiction treatment lives in urban. Yaşan & Gürgen (2004) found that more than half of inhalant user adolescents from South-East of Turkey, reported that their family immigrated to rural from urban and that they want to live in metropolis in future. They identified that immigration of family from rural to urban is a serious risk factor for drug use in the youth, because immigration significantly damages the family bonds. In current study most of the patient group reported their birth place as Istanbul. However majority of their parents were born in different parts of Turkey. This situation indicates the relationship between immigration and family relations.

Ebrinç et. al.(2002), examined opinions of a group of male about psychoactive drugs. They separated them into three groups: participants who have ever tried any drug at least once (5.8%), participants who have used drugs (9.4%) and participants who have never tried any drug (84.8%). Most of participants, both who used ever and never any kind of substance, reported that psychoactive drugs damages health. However they found significant difference among the groups in response to opinion that assumes people who have problems use drugs. Most of the participants who have never used or tried any drug did not agree to this opinion. This finding is consistent with the finding of current study. In our sample patient group reported that they agree the opinion that assumes drugs keep the individual away from problems (Table. 20). This finding approves that drug using young ones are more vulnerable to stress and they attempt to solve this problem by using drugs. Worse family relations reported by patient group confirm this idea. In addition there were statistically

significant differences between all groups. Boys et. al. (1999) investigated perceived functions of substance and alcohol use among young people. They found most common perceived function as altering or elevating mood state and improve social relations. Limited amount of participants reported negative effects of substances on health as a perceived function. Most common reasons for drug use in current sample reported as for fun, to keep the problems away and relax (Table 19). This finding indicates that most of youngsters use drugs to have fun, or relax as and they lack negative effects of drugs on health. Peer use and insist has already mentioned before as a function of drugs that attempts to improve social relations.

Ögel et. al. (2003) found that ecstasy use correlates with high economic status of families and Yaşan & Gürgen (2004) found that families of most of inhalant users have low socioeconomic level. Gümüş et. al. also reported that families of alcohol and heroin dependent individuals have low economic income level and especially families of heroin dependents experience serious socioeconomic difficulties. Previous studies conducted in abroad emphasize the risk of poverty and racial minority. Daughters et. al (2008) found low distress tolerance and higher prevalence of drug use among African Americans. However in current study, no significant difference found between the income level of patient and control group(Table. 8).

Saatçioğlu et. al. (2003) investigated the sociodemographic characteristics of all cases received who alcohol or drug addiction treatment between the years of 1998-2002 in AMATEM. They found most frequent education level as primary school. Bachelors of high school and university were less than primary school bachelors. They also reported that the finding that obtained by them was consistent with previous studies. In our study all controls have already selected among freshman college students. Education level of patients was significantly lower than controls (Table. 3). Also same difference was valid for between parental education level between groups (Table. 4 - Table. 5).To summarize it can be said that consistent with previous studies, low education status of individual and family was found as a predictor of drug use risk and negative family relations.

Ögel et al. (2002) found the initiation age into cannabis and pills consumption in Turkey as generally about 16-17.They youngest age beginning age was 10 which refers inhalants use. In current sample youngest age of beginning to use any

substance was found less than 11 for cannabis. For all substances, 16 was found as the most frequent beginning age. Bolognini et al. (2007) examined initiation age into substance use among controls, violent and non-violent antisocial adolescents. They found that early substance use initiation age is more frequent among violent adolescents than controls and antisocial adolescents. Rhodes et. al. (2003) reported initiation at the alcohol and drug use in early age, increases the likelihood of drug experimentation and problematic use. Consistent with previous studies, cannabis was found as most frequent substance which has the youngest beginning age.

This study has certain limitations. Findings of current study are limited with the data obtained from the sample group receiving treatment at AMATEM in December 2009-January 2010 and with the sample group freshmen students from psychology department of Near East University in January 2010. So it is impossible to generalize the findings for the whole young adult population. Sample group determined randomly, except the age and drug use variables determined as inclusion criteria. As a result significant difference occurred between patient and healthy control groups regards to gender distribution.

This study used a self-administered questionnaire. Questions about family relations, alcohol and drug use frequency, might provoked anxiety related to privacy of information given. This might affect accuracy of results as well. In this study only family relations examined as a risk factor that predicts drug use in young adulthood. Another factor might contribute to drug use behaviour. However it is not possible to identify them with the findings of current study.

5. CONCLUSION

This study has shown that drug using young adults have negative family relations and most of their parents apply more dysfunctional parenting styles when compared with controls. As we hypothesized family functioning significantly correlated with frequency of substance use. However this sample is not large as much to provide a correlation with any specific type of substance and severity of negative family relations.

All these findings indicate that negative family relations and dysfunctional parenting styles are predictors of drug use in young adulthood. Families of drug users have less flexible or rigid boundaries. As a result, these families are not cohesive and they fail to provide emotional support for their children during such a stressful transition period like adolescence or young adults. Parents of drug using young adults tend to apply harsh discipline to train them without concerning the problems of their children. As regards with father-child relationship, in general, father's of drug using young adults failed to maintain a positive relationship with their children and provide emotional support during childhood and adolescence period. Their father also failed to fulfil their responsibilities as householder.

There were other variables that correlated with drug use other than family relations as well. However it is possible to maintain a link between these variables and family relation, because, as mentioned, drug users tend to have negative relationships with their family. For example gender, education level, peer drug use, residence correlated with drug use. Males formed a big majority of patient group and living in big cities or metropolis, poor education level found as important characteristics of patient group. These findings indicate that young adult males experience more family problems and they often response it with drug use. Impairment in family functioning due to immigration from rural to urban identified as a reason for residence factor.

This study provides a reference for drug use prevention strategies among young adults. Drug abuse or drug addiction in young adulthood should not be evaluated as a problem that only related with individual factors or personality patterns. Family therapy may be applied in addition to classical rehabilitation methods. Further therapy methods should emphasize on family structure and domestic relations.

Family therapist should well define and then reorganize the interaction problems among family members and maladaptive relationships. Families should be acknowledged about the characteristics of adolescence and young adulthood period. New family education programs should be improved to acknowledge families, especially the illiterate ones who immigrated to urban from rural, about the importance of family relations as a predictor of drug use and other delinquent acts in young adulthood. Parents should maintain a close relationship which provides an emotional support and they should adapt themselves into changes which are specific to individuation process of young adult. Parents should respect to values and opinions of youngsters even they don't agree with their children. Otherwise youngsters may tend to seek the emotional support and concern that they need during the formation process of their identity by internalizing the cultural values of drug subculture.

Young adults may be encouraged to improve more functional strategies to cope with distress instead of escape or despair. They should share their problems with their parents. Especially males who form a big majority of drug using young adults may be a victim of their stress coping strategies. They should be encouraged to improve intimacy with parents. Seminars may be arranged to acknowledge the young people about these issues may in such places like high school, university and addiction treatment facilities.

Father-child relationship was also emphasized in this study. Androgynous role of father may be another important factor that contributes to flexibility of the family system. As mentioned, father is known as the primary householder in traditional Turkish family system. Fathers should also be acknowledged about the importance of their role model and they should be encouraged to act an androgynous role model rather than a sexist and conservative one. Also re-emergence of oedipal conflicts at adolescence may contribute to increase distress during transition process from adolescence to adulthood. Hostile attitude of father may affect father-child relationship negatively which increases the risk of drug use in young adulthood. So father must maintain an emotional intimacy with his child during adolescence and he has to fulfil his responsibilities which are necessary for maintenance of healthy family structure.

Further studies may investigate the difficulties which are specific to young adulthood period. Factors that contribute to impairments in young adulthood which has a survival importance for the rest of human life should be further investigated. Family relations of young adults may be investigated and examined in more inclusive way to avoid such risks like antisocial acts, delinquency and drug use.

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Appendix 1

K.K.T.C
Yakın Doğu Üniverstesi
Uygulamalı ve Sosyal Bilimler Enstitüsü
Klinik Psikoloji Yüksek Lisans Programı

Elinizde bulunan bu form Klinik Psikoloji Yüksek Lisans programı dahilinde gençler arasında alkol ve uyuşturucu madde kullanımını konu edinen bir çalışmayla ilgilidir.Anket tamamen bilimsel amaçlarla düzenlenmiştir.Yanıtlarınızı içten ve doğru olarak vermeniz bu anket sonuçlarının psikoloji bilimi ve toplum için yararlı bilgi olarak kullanılmasını sağlayacaktır.Size ait bilgiler kesinlikle gizli tutulacaktır.Bu yüzden anket formuna isim yazmanız gerekmemektedir.Yanıtlarını bilmediğiniz veya yanıt vermek istemediğiniz soruları lütfen boş bırakınız.Bu bir sınav değildir.Dolayısıyla süre limiti, doğru ve yanlış yanıtlar yoktur.Vereceğiniz yanıtları birer oy gibi düşünebilirsiniz.

Katılımınız için içtenlikle teşekkür ederiz.

Psk. Ülkü GÜREŞEN

KİŞİSEL BİLGİ FORMU

Bölüm 1 - Sosyodemografik Veriler:

1. Cinsiyetiniz? a) Erkek b) Kız
2. Doğum Yılınız? .....

3. Doğum Yeriniz? .....

4. Annenizin doğum yeri .....

5. Babanızın doğum yeri .....

6. Yaşamınızın büyük çoğunluğu aşağıdaki yerleşim birimlerinden hangisinde geçti?
   a)Metropol b)İl merkezi c)İlçe d)Kasaba e)Köy

7. Medeni durumunuz?
   a)Bekar b)Nişanlı c)Evli

8. Eğitim durumunuz?
   a)ilkokul b)ortaokul c)lise d)üniversite

9. Annenizin eğitim durumu?
   a)ilkokul b)ortaokul c)lise d)üniversite

10. Babanızın eğitim durumu?
    a)ilkokul b)ortaokul c)lise d)üniversite

12. Anneniz yaşıyor mu?
    a) Evet b)Hayır

13. Babanız yaşıyor mu?
    a)Evet b)Hayır

14. Anneniz ve babanız yaşıyor ise;
    a) Evli, birlikte yaşıyor
    b) Evli, ama ayrı yaşıyor
    c) Boşanmış, ayrı yaşıyor
    d) Boşanmış, ama birlikte yaşıyor

15. Ebeveynleriniz ayrı ise hangi ebeveyninizle birlikte yaşıyorsunuz?
    a) Anne b)Baba c)Diğer .....

16. Ebeveynleriniz ayrı ise şu an yanında yaşadığınız ebeveyninizle kaç yıldır birlikte yaşıyorsunuz? .....

17. Aylık geliriniz?
    a)500 TL altında b)501-1000 TL c)1000-2000 TL d)2000-4000 TL e)4000 TL üzeri

18. Kendinizi bugünlerde nasıl hissediyorsunuz?
    a)Çok mutlu b)Mutlu c)Mutlu değil

Appendix 3

Bölüm – 2: Aşağıdaki sorular alkol ve sigara kullanımıyla ilgilidir

1. Hayatınız boyunca kaç kez sigara içtiniz?
   a) 0 b) 1-2 c) 3-5 d) 6-9 e) 10-19 f) 20-39 g) 40 veya daha fazla

2. Son 12 ay boyunca kaç kez sigara içtiniz?
   a) 0 b) 1-2 c) 3-5 d) 6-9 e) 10-19 f) 20-39 g) 40 veya daha fazla

3. Son 30 günde ne sıklıkta sigara içtiniz?
   a) Hiç içmedim
   b) Haftada bir sigaradan az
   c) Günde bir sigaradan az
   d) Günde 1-5 sigara
   e) Günde 6-10 sigara
   f) Günde 11-20 sigara

4. Eğer sigara kullanıyorsanız, hiç sigarayı bırakmakta zorlandınız mı?
   a)çok zorlandım b)zorlandım c)zorlanmadım d)hiç zorlanmadım

5. Hayatınız boyunca kaç kez alkollü bir içecek içtiniz?
   a) 0 b) 1-2 c) 3-5 d) 6-9 e) 10-19 f) 20-39 g) 40 veya daha fazla

6. Son 12 ay içinde kaç kez alkollü bir içecek içtiniz?
   a) 0 b) 1-2 c) 3-5 d) 6-9 e) 10-19 f) 20-39 g) 40 veya daha fazla

7. Son 30 gün içinde kaç kez alkollü bir içecek içtiniz?
   a) 0 b) 1-2 c) 3-5 d) 6-9 e) 10-19 f) 20-30

8. Hayatınız boyunca kaç kez içki içtiğiniz için sarhoş oldunuz?
   a) 0 b) 1-2 c) 3-5 d) 6-9 e) 10-19 f) 20-39 g) 40 veya daha fazla

9. Son 12 ay içinde kaç kez içki içtiğiniz için sarhoş oldunuz?
   a) 0 b) 1-2 c) 3-5 d) 6-9 e) 10-19 f) 20-39 g) 40 veya daha fazla

10. Son 30 gün içinde kaç kez içi içtiğiniz için sarhoş oldunuz?
    a) 0 b) 1-2 c) 3-5 d) 6-9 e) 10-19 f) 20-30

Bölüm – 3:Aşağıdaki sorular son günlerde hakkında çok konuşulan bir konu olan uyuşturucu maddeler ile ilgilidir.Yanıtlarınızın tamamen gizli tutulacağını unutmayın.Soruların hepsini yanıtlayacağınızı umuyoruz.Ancak eğer sorular içinde dürüst olarak yanıt veremeyecekleriniz olursa, lütfen boş bırakınız.

1. Şimdiye dek kaç kez esrar kullandınız? (Eğer olduysa)

	0	1-2	3-5	6-9	10-19	20-39	40 veya daha fazla
Hayatınız Boyunca	A	B	C	D	E	F	G
Son 12 ay içinde	A	B	C	D	E	F	G
Son 30 gün içinde	A	B	C	D	E	F	G

2. Şimdiye dek kaç kez uçucu bir madde koklayarak (uhu,tiner,bali vs) kendinizi farklı hissetmeye çalıştınız? (Eğer olduysa)

	0	1-2	3-5	6-9	10-19	20-39	40 veya daha fazla
Hayatınız Boyunca	A	B	C	D	E	F	G
Son 12 ay içinde	A	B	C	D	E	F	G
Son 30 gün içinde	A	B	C	D	E	F	G

3.Şimdiye dek kaç kez kokain kullandınız? (Eğer olduysa)

	0	1-2	3-5	6-9	10-19	20-39	40 veya daha fazla
Hayatınız Boyunca	A	B	C	D	E	F	G
Son 12 ay içinde	A	B	C	D	E	F	G
Son 30 gün içinde	A	B	C	D	E	F	G

4. Doktorların insanların sinirlerini yatıştırma ve onları rahatlatmak için yazdığı bazı ilaçlar vardır (Diazem, Nervium, Tranksilen vb).Şimdiye dek kaç kez böyle bir sakinleştirici ilacı doktorunuzunun önerisi dışında kullandınız? (Eğer olduysa)

	0	1-2	3-5	6-9	10-19	20-39	40 veya daha fazla
Hayatınız Boyunca	A	B	C	D	E	F	G
Son 12 ay içinde	A	B	C	D	E	F	G
Son 30 gün içinde	A	B	C	D	E	F	G

5. Şimdiye dek kaç kez eroin kullandınız? (Eğer olduysa)

	0	1-2	3-5	6-9	10-19	20-39	40 veya daha fazla
Hayatınız Boyunca	A	B	C	D	E	F	G
Son 12 ay içinde	A	B	C	D	E	F	G
Son 30 gün içinde	A	B	C	D	E	F	G

6. Şimdiye dek kaç kez hap (rohypnol-roş, nembutal-sarı bomba, akineton) kullandınız? (Eğer olduysa)

	0	1-2	3-5	6-9	10-19	20-39	40 veya daha fazla
Hayatınız Boyunca	A	B	C	D	E	F	G
Son 12 ay içinde	A	B	C	D	E	F	G
Son 30 gün içinde	A	B	C	D	E	F	G

7. Eroini enjeksiyon yolu ile hiç kullandınız mı?
a)Hayır b)Evet, bir kez c) Evet, ara sıra d)Evet, düzenli olarak

8. Hayatınız boyunca kaç kez aşağıdaki maddelerden herhangi birisini kullandınız mı? (Eğer olduysa)

	0	1-2	3-5	6-9	10-19	20-39	40 veya daha fazla
a)Ecstacy	A	B	C	D	E	F	G
b)Amfetamin	A	B	C	D	E	F	G
c)LSD	A	B	C	D	E	F	G
d)Relaktin	A	B	C	D	E	F	G
e)Alkole beraber bazı haplar	A	B	C	D	E	F	G
f)Anabolizan steroidler	A	B	C	D	E	F	G
g)Kodeinli Şuruplar	A	B	C	D	E	F	G

9. Son 30 gün içinde kaç kez aşağıdaki maddelerden herhangi birisini kullandınız mı?

	0	1-2	3-5	6-9	10-19	20-39	40 veya daha fazla
a)Ecstacy	A	B	C	D	E	F	G
b)Amfetamin	A	B	C	D	E	F	G
c)LSD	A	B	C	D	E	F	G
d)Relaktin	A	B	C	D	E	F	G
e)Alkole beraber bazı haplar	A	B	C	D	E	F	G
f)Anabolizan steroidler	A	B	C	D	E	F	G
g)Kodeinli Şuruplar	A	B	C	D	E	F	G

10. Aşağıdakileri ilk olarak kaç yaşında iken yaptınız?

	Hiç	11 yaş ve öncesi	12	13	14	15	16
a)Bira içmek (en az bir bardak)	A	B	C	D	E	F	G
b)Şarap içme (en az bir bardak)	A	B	C	D	E	F	G
c)Rakı, cin vs içmek (en az bir bardak)	A	B	C	D	E	F	G
d)İçki içerek sarhoş olmak	A	B	C	D	E	F	G
e)İlk sigarayı içmek	A	B	C	D	E	F	G
f)Hergün sigara içmek	A	B	C	D	E	F	G
g)Esrar denemek	A	B	C	D	E	F	G
h)Sakinleştirici hap denemek	A	B	C	D	E	F	G
i)Amfetamin denemek	A	B	C	D	E	F	G
j)LSD denemek	A	B	C	D	E	F	G
k)Akineton denemek	A	B	C	D	E	F	G
l.) Kokain denemek	A	B	C	D	E	F	G
m)Relaktin denemek	A	B	C	D	E	F	G
n)Eroin denemek	A	B	C	D	E	F	G
o)Uçucu denemek	A	B	C	D	E	F	G
p)Ecstasy denemek	A	B	C	D	E	F	G
r)Anabolizan steroid denemek	A	B	C	D	E	F	G
t)Kodeinli şurup	A	B	C	D	E	F	G

11. Eğer bugüne kadar kullandıysanız ilk olarak hangi maddeyi denediniz?

a) Aşağıdaki maddelerden hiçbirini denemedim
b) Sakinleştirici veya yatıştırıcı maddeler (doktorun reçete etmesi dışında)
c) Esrar
d) LSD
e) Crack
f) Kokain
g) Ecstasy

h) Eroin
i) Ne olduğunu bilmiyorum
j) Diğer (ne olduğunu belirtiniz.....)

12. Sizce arkadaşlarından kaç tanesi aşağıdakileri yapıyor?

	Hiçbiri	Çok azı	Bazıları	Çoğunluğu	Hepsi
a) Sigara içmek	A	B	C	D	E
b) Alkollü içecek içmek	A	B	C	D	E
c) Haftada en az bir kez sarhoş olmak	A	B	C	D	E
d) Esrar içmek	A	B	C	D	E
e) LSD kullanmak	A	B	C	D	E
f) Amfetamin kullanmak	A	B	C	D	E
g) Sakinleştirici veya yatıştırıcı kullanmak (Doktorun reçete etmesi dışında)	A	B	C	D	E
h) Kokain veya crack kullanmak	A	B	C	D	E
i) Ecstasy kullanmak	A	B	C	D	E
j) Eroin kullanmak	A	B	C	D	E
k) Uçucu (tiner, bali, uhu vs) kullanmak	A	B	C	D	E
l) Anabolizan steroid kullanmak	A	B	C	D	E
m) Kodeinli şurup içmek	A	B	C	D	E

13. Aşağıdakileri yapmanız için arkadaşlarınız tarafından ne kadar ısrar edildiğini hissediyormusunuz?

	Hiç	Çok az	Biraz	Çok fazla
a)Sigara içmek	A	B	C	D
b)Alkol içmek	A	B	C	D
c)Esrar kullanmak	A	B	C	D
d)Diğer uyuşturucu maddeler	A	B	C	D

14. Eğer sigara ve alkol dışında kalan diğer uyuşturucu maddeleri (esrar, eroin, ecstasy vb) bir kez dahi kullandıysanız, ilk olarak hangi nedenlerden dolayı kullandınız? (Birden fazla yanıtı işaretleyebilirsiniz)

a) Eğlenmek
b) Uyuabilmek
c) Merak
d) Sinirlendiğim için
e) Sıkıntıdan
f) Rahatlamak
g) Sorunlarımdan uzaklaşmak
h) Arkadaşlarım içtiği için
i) Kendimi iyi hissetmek
j) Diğer
k) Denemek için

15.Uyuşturucu maddeler ile aşağıdaki görüşlere ne kadar katıldığınızı belirleyiniz.

	Hiç Katılmıyorum	Katılmıyorum	Bilmiyorum	Katılıyorum	Tamamen Katılıyorum
a) İnsanı rahatlatır	A	B	C	D	E
b) Sağlığa zararlıdır	A	B	C	D	E
c) İnsanı sorunlarından uzaklaştırır	A	B	C	D	E
d) Eğlencelidir	A	B	C	D	E
e) Kontrolün kaybolmasına yol açar	A	B	C	D	E
f) İnsanın kendini tanımasına yardımcı olur	A	B	C	D	E
g) Cesaret verir	A	B	C	D	E

Bölüm - 4 :Aşağıdaki sorular ailenizde sigara, alkol ve madde kullanımıyla ilgilidir.

1. Ailenizde sigara içen var mı?
   a)Evet b)Hayır

2. Ailenizde eğer alkol kullanan kişi var ise alkol içme sıklığı nedir?
   a)Çok seyrek b)Seyrek c)Bazen d)Sık sık e)Çok sık

3. Aileniz içinde esrar kullanan kişi var mı?
   a)Evet b)Hayır

4. Aileniz içinde eroin, kokain gibi maddeleri kullanan kişi var mı?
   a)Evet b)Hayır

Appendix 3

AYDA Çocuk Formu

Lütfen aşağıdaki bütün soruları ve kendi anladığınız biçimde yanıtlayınız.Her bir ifadenin sizin gerçeğinizi yansıtma derecesini, sağ taraftaki aynı numaralı ve on bölümlü çizgiler üzerindeki en uygun aralığı işaretleyerek belirtiniz.

	Bizimkiyle Tamamen Aynı	Bizimkinin Tam Tersi
1. Ailemizde her türlü konu ve fikir açıkça konuşulur.	1. !___!___!___!___!___!___!___!___!___!___!	
2. Evimizde birisi bir şey söylediği zaman diğerleri aynı şeyi anlarlar.	2. !___!___!___!___!___!___!___!___!___!___!	
3. Bizim evde olaylar karşısındaki düşünce ve duygular konuşmaktan çok davranışlarla ifade edilir.	3. !___!___!___!___!___!___!___!___!___!___!	
4. Bizim evde sözlerle söylenenler, davranışlarla anlatılanları tutmaz.	4. !___!___!___!___!___!___!___!___!___!___!	
5. Evdekilerle çatışmaktansa susmayı ve başkalarıyla konuşmayı yeğlerim.	5. !___!___!___!___!___!___!___!___!___!___!	
6. Bizim evde kesinlikle konuşulmayacak konular bence çok fazladır.	6. !___!___!___!___!___!___!___!___!___!___!	
7. Beni korkutan, başaramayacağımı sandığım ve üzüldüğüm şeyleri anne ve babama rahatlıkla söylerim.	7. !___!___!___!___!___!___!___!___!___!___!	
8. Beni sevindiren ve aklımdan geçen komik şeyleri anne ve babama rahatlıkla söylerim.	8. !___!___!___!___!___!___!___!___!___!___!	
9. Aile üyeleri arasındaki iletişimi son derece doyurucu buluyorum.	9. !___!___!___!___!___!___!___!___!___!___!	
10. Birimizin işte, okul veya arkadaşından öğrendiği bir şey, bizim evde genellikle ilgi görür, tartışılır ve beğenilirse uygulanır.	10. !___!___!___!___!___!___!___!___!___!___!	
11. Ailem başkalarından gelen eleştiri ya da önerilere tamamen kapalıdır.	11. !___!___!___!___!___!___!___!___!___!___!	
12. Evimizde TV, radyo, gazete, dergi, kitap, konferans, sinema, tiyatro gibi yollarla yeni şeyler öğrenmeye ve dünyada olup bitenlere çok ilgi duyulur.	12. !___!___!___!___!___!___!___!___!___!___!	

13. Bizim evde iş, okul ve ev işleri dışında da en çok uğraş (hobiler, özel ilgiler, vb.) boşluk vardır. 13. !___!___!___!___!___!___!___!___!___!___!___
14. Doğrusu ailemden daha çok bağlı olduğum bir insan (arkadaş, sevgili, öğretmen, terapist, kendi ailem, akraba vb.) var. 14. !___!___!___!___!___!___!___!___!___!___!___
15. Ailem benim pek çok arkadaşımla tanışır. 15. !___!___!___!___!___!___!___!___!___!___!___
16. Ailemizdeki dayanışma ve birlik duygusu çok güçlüdür. 16. !___!___!___!___!___!___!___!___!___!___!___
17. Annem ve babam evde kendi başıma geçirmek istediğim zamana (çalışırken, oyun oynarken, tv seyrederken vb.) karşı çok anlayışlıdır; beni rahat bırakırlar. 17. !___!___!___!___!___!___!___!___!___!___!___
18. Birbirimizle çok iyi geçiniriz. 18. !___!___!___!___!___!___!___!___!___!___!___
19. Bizim aileyi ilgilendiren kararlarda evdeki herkesin fikri alınır veya çıkarı gözetilir. 19. !___!___!___!___!___!___!___!___!___!___!___
20. Bizde aileyle ilgili sorumlulukların dağılımı hakça olur. 20. !___!___!___!___!___!___!___!___!___!___!___
21. Bizim evde birisi diğerlerinden daha önemlidir, yani daha çok sevilir, kayrılır veya dediğini yaptırır. 21. !___!___!___!___!___!___!___!___!___!___!___
22. Ailemizde iş bölümü, herkese düşen görevler ve diğer kurallar açık seçik belirgindir. 22. !___!___!___!___!___!___!___!___!___!___!___
23. Bizim evde karşılaşılan aksamalar ve çıkan çatışmalar mutlaka çözülmelidir. 23. !___!___!___!___!___!___!___!___!___!___!___
24. Bizim aileyi ilgilendiren kararlarda, ev içinden söz sahibi olanlar, dışarıdan karışanlar her zaman çoktur. 24. !___!___!___!___!___!___!___!___!___!___!___
25. Evimizdeki görevini aksatan veya kurallara uymayan(lar) şiddetle kınanır. 25. !___!___!___!___!___!___!___!___!___!___!___
26. Evde yapmam gereken şeyler için her zaman yeterli zamanım vardır. 26. !___!___!___!___!___!___!___!___!___!___!___
27. Genel olarak bizim sağlıklı, huzurlu ve iyi bir aile olduğumuzu düşünürüm. 27. !___!___!___!___!___!___!___!___!___!___!___
28. Ailem büyük bir sağlık ya da bir para sorunu dışında bir problemle karşılaştığında bunu kendi başına halledebilir. 28. !___!___!___!___!___!___!___!___!___!___!___
29. Ailem geçmişte karşıaştığı zor durumların üstesinden geldi. 29. !___!___!___!___!___!___!___!___!___!___!___

30. Gerektiğinde ailem çevresinden yeterince destek alabilir. 30. !___!___!___!___!___!___!___!___!___!___!___
31. Ailemden son derece gurur ve haz duyuyorum. 31. !___!___!___!___!___!___!___!___!___!___!___
32. Bizim ailede herkesin birbirini değiştirmeye çalıştığı çok belirgindir. 32. !___!___!___!___!___!___!___!___!___!___!___
33. Bizim evde kimsenin eleştiriye tahammülü yoktur. 33. !___!___!___!___!___!___!___!___!___!___!___
34. Bizim ailede her çeşit duygunun (üzüntü, mutluluk, coşku, kızgınlık, korku vb.) hissettiğimiz gibi yaşanması olağandır. 34. !___!___!___!___!___!___!___!___!___!___!___
35. Bence ailemizde değişmesi mümkün olmayan tavırlar çoktur. 35. !___!___!___!___!___!___!___!___!___!___!___
36. Birbirimize yeterince sevgi ve şefkat gösteririz. 36. !___!___!___!___!___!___!___!___!___!___!___

Appendix 4

Anababalık Stilleri Ölçeği (ABSÖ)

Aşağıda, anneniz ve babanızla olan ilişkileriniz hakkında cümleler verilmiştir.Sizden istenen, **çocukluğunuzu ve genel olarak anne ve babanızla ilişkinizi düşünerek** her bir cümlenin **sizin için** ne derece doğru olduğunu ilgili yeri işaretleyerek belirtmenizdir.Bunu anne ve babanız için ayrı ayrı yapmanızı istemekteyiz.Hiç bir maddenin doğru veya yanlış cevabı yoktur.Önemli olan her cümle ile ilgili olarak kendi durumunuzu doğru bir şekilde yansıtmanızdır.Anne ve/veya babanızı kaybetmişseniz yetişmenizde en çok katkısı olan kişiyi göz önüne alınız.

	ANNEM					BABAM				
	Hiç doğru değil (1)	Doğru değil (2)	Kısmen doğru (3)	Doğru (4)	Çok doğru (5)	Hiç doğru değil (1)	Doğru değil (2)	Kısmen doğru (3)	Doğru (4)	Çok doğru (5)
1.Benimle sık sık rahatlatıcı bir şekilde konuşurdu										
2.Her davranışımı sıkı sıkıya kontrol etmek isterdi										
3.Nasıl davranacağım ya da ne yapacağım konusunda bana hep yararlı fikirler vermiştir										
4.Onun istediği hayatı yaşamam konusunda hep ısrarlı olmuştur										
5.Sorunlarım olduğunda onları daha açık bir şekilde görmemde yardımcı olmuştur										
6.Arkadaşlarımla ilişkilerime çok karışırdı										
7.Sorunlarımı çözmemde destek olurdu										
8.Onunkinden farklı bir görüşe sahip olmama genellikle tahammül edememiştir.										
9.Sevgi ve yakınlığa her zaman güvenmişimdir										
10.Kurallarına aykırı davrandığımda beni kolaylıkla affetmezdi										
11.Hiçbir zaman fazla yakın bir ilişkimiz olmadı										
12.Ne zaman, ne yapmam gerektiği konusunda talimat verirdi										
13.Bir problemim olduğunda anlamaktansa, kendime saklamayı tercih ederdim.										

	ANNEM					BABAM				
	Hiç doğru değil (1)	Doğru değil (2)	Kısmen doğru (3)	Doğru (4)	Çok doğru (5)	Hiç doğru değil (1)	Doğru değil (2)	Kısmen doğru (3)	Doğru (4)	Çok doğru (5)
14.Geç saatlere kadar oturmama izin vermezdi.										
15.Onunla birbirimize çok bağlıydık										
16.Arkadaşlarımla gece geç saate kadar çıkmama izin vermezdi										
17.Onun düşüncelerine ters gelen bir şey yaptığımda suçlamazdı										
18.Boş zamanlarımı nasıl değerlendireceğime karışırdı										
19.Bir sorunum olduğunda hemen bunu anlardı										
20.Hangi saatte hangi arkadaşımla buluşacağımı bilmek isterdi										
21.Hiç bir zaman benim ne hissettiğimle veya ne düşündüğümle gerçekten ilgilenmedi										
22.Arkadaşlarımla dışarı çıkmama nadiren izin verirdi.										

Appendix 5

Babalık Ölçeği

Yönerge: Çocukluk ve ergenlik döneminde babanızla ilişkiniz hakkında düşününüz.Onun hakkında düşünerek, her sorunun önündeki çizgiye 1 ve 5 arasında bir sayı vererek her soruyu cevaplayınız.Babanız veya büyürken babanız olarak nitelediğiniz kişiyle ilişkinize ait algılarınızı en iyi yansıtan sayıyı aşağıdaki seçenekler arasından seçiniz.

	Hiçbir Zaman (1)	Nadiren (2)	Bazen (3)	Sık Sık (4)	Daima (5)
1- Babam ev ödevlerinde bana yardım ederdi					
2- Babam benimle kişisel problemlerim hakkında konuşurdu					
3- Babam beni etkinliklere götürürdü					
4- Babam bana beni sevdiğini söylerdi					
5- Babam bana iyi bir oğlan / kız olduğumu söylerdi					
6- Babam değer veren bir insandır					
7- Babam okul konferanslarına katılırdı					
8- Çocukluğumda babama kendimi yakın hissederdim					
9- Ergenlik döneminde babam ve ben birlikte bir şeyler yapardık					
10- Babam benimle vakit geçirmekten hoşlanırdı					
11- Babam popoma vururdu					
12- Ergenlik döneminde babama yakın hissederdim					
13- Baban anneme vururdu					
14- Babamın beni önemsediğini biliyorum					
15- Babam çocukken benden utanırdı					
16- Babam birisi sataştığında bana kavga etmeyi öğretti					
17- Babam giysi ve oyuncak gibi ihtiyacım olan şeyleri sağlardı					
18- Babam çocukken bana kitap okurdu					
19- Babam maddi olarak bize iyi imkan sağlardı					
20- Babam duygularımı inciten şeyler söylerdi					
21- Babam hissettiklerimi söylemem için beni cesaretlendirirdi					
22- Babam okulda yaptıklarımla ilgilenirdi					

	Hiçbir Zaman (1)	Nadiren (2)	Bazen (3)	Sık Sık (4)	Daima (5)
23- Babam bana sarılırdı					
24- Babam iyi bir adamdır					
25- Başım derde girdiğinde babam beni fiziksel olarak cezalandırırdı					
26- Babam bana doğruyu yanlıştan ayırmayı öğretti					
27- Babamın annemi dövdüğünü gördüm					
28- Babamı ağlarken gördüm					
29- Babam ailenin ekmeğini kazanan kişiydi					
30- Babam problemlerimi çözmede bana yardım etti					
31- Babamla her şey hakkında konuşabilirdim					
32- Babam benimle kilise/cami vd. gitti					
33- Babamla spor yaptığımızı hatırlarım					
34- Babam anneme evi temizlemede yardım etti					
35- Babam kendimi kötü hissettiğimde beni rahatlattı					
36- Ben büyürken babamın daima işi vardı					
37- Babam bana kendimi özel hissettirdi					
38- Sinirlendiğim zaman babamla olanlar hakkında konuşurdum					
39- Babam ve ben birlikte iyi zaman geçirdim					
40- Babam bana karşı sevgi doluydu					
41- Babam tarafından istismara uğradım					
42- Babam benimle cinsellik hakkında konuştu					
43- Babam yemekte şükrederdi					
44- Çocukken eğer yanlış bir şey yaparsam babam bana bağırırdı					
45- Babama karşı sıcak duygularım vardır					
46- Babam dünyada olan bitenle ilgili benimle konuşurdu					
47- Babam bana adam olmanın nasıl bir şey olduğunu öğretti					
48- Babam benim oynadığım spor faaliyetlerine geldi					
49- Babam ve ben birlikte iyi zaman geçirdik					
50- Babam bana önemli değerler aşıladı					
51- Babam beni doktora götürdü					

	Hiçbir Zaman (1)	**Nadiren** (2)	**Bazen** (3)	**Sık Sık** (4)	**Daima** (5)
52- Babam kibar adamdır					
53- Babam beni anlardı					
54- Babam onu sevdiğimi söylerdi					
55- İhtiyacım olduğu zamanlar babam etrafımdaydı					
56- Babam beni överdi					
57- Babam kaba bir adamdır					
58- Babam öfkelenir ve benden hoşlanmadığını söylerdi					
59- Babam katıldığım okul etkinliklerine gelirdi					
60- Babam benimle Allah hakkında konuşurdu					
61- Babam incindiğim zaman bana ilgi gösterirdi					
62- Babamın kardeşlerimden birine vurduğunu gördüm					
63- Babam yemek yapardı					