Gender-specific profile of substance abusing women in therapeutic communities in Europe

Joke De Wilde

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Joke De Wilde

Promotor Prof. dr. E. Broekaert

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Begeleidingscommissie:

Prof. dr. E. Broekaert (promotor) – Universiteit Gent, Vakgroep Orthopedagogiek

Prof. dr. P. Verhaeghe – Universiteit Gent, Vakgroep Psychoanalyse en Raadgevingspsychologie

Dr. G. De Cuypere – Universitair Ziekenhuis Gent, Centrum voor Seksuologie en Genderproblematiek

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Dedicated to my family

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Happiness is something you need to share, and that is why it is time to look back on the last four years, now that the work is finished. Although it has been a time of stress and hard work, there have been many fantastic times and now and then I have been really proud of being able to realize this "project". Four years ago, I graduated with a masters thesis on the opinion of youngsters concerning euthanasia. Most probably due to the fact that this subject received quite some interest from the media, I also came into the view of the Department of Orthopedagogics. Prof. Dr. Eric Broekaert consequently asked me whether I was interested in a PhD on the differences between men and women who are using drugs and are in treatment in therapeutic communities in Europe. Although initially this subject stood far from my own field of interest, it appeared to be the best thing that could happen to me at that moment. Step by step, I learned about the world of drugs and realized more and more how privileged I had been growing up in a protected and warm nest. However, concerned about the fate of substance abusing women and the injustice they have experienced through times and are still experiencing today, I wanted to focus this study on their situation, in order to make sure they can receive the help they need.

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proud of me now, but I am also very proud to have a father like you. Thanks for shaping my views!
Jilke, Sanne, Bram, Natacha and Lien, now I'm sure, if you really want something you can make it happen. You can count on my support for your future plans.

Dear Bart, we have known each other for a long time and during the last couple of years it has become clear that we each have our own ambitions. In spite of these stressful and difficult times to run a company, you have always been there for me, unconditionally. I am more convinced than ever that together we are ready for the future!

Joke,
September 16, 2005

PREFACE

American research in therapeutic communities (TCs) illustrated that there are important differences between substance abusing men and women in the development of their addiction (Carroll & McGinley, 1998), in the severity of their substance-related problems (Arfken, Klein, di Menza, & Schuster, 2001; Jainchill, Hawke, & Yagelka, 2000) and in their treatment careers (De Leon & Jainchill, 1982). Because of these gender-specific characteristics, men and women have other treatment needs (Ashley, Marsden, & Brady, 2003; Pelissier & Jones, 2005). However, substance abuse treatment doesn't always seem to meet these specific needs of women (Arfken, Borisova, Klein, di Menza, & Schuster, 2002; Grella, 1996; Nelson-Zlupko, Dore, Kauffman, & Kaltenbach, 1996).
In Europe, this gender-focused research tradition is less prevalent, and until today TC research studying gender differences is scarce (Broekaert, Raes, Kaplan, & Coletti, 1999). The major aim of this dissertation was therefore to fill this gap by focusing in a systematic way on differences between men and women entering TC treatment and developing a gender-specific profile of women, in order to learn more about these women's special treatment needs and to formulate some suggestions for a more gender-sensitive treatment approach.

In *chapter 1*, an answer is formulated to the question why substance abusing women escaped the attention of clinicians and researchers for such a long time. The TC, widely used as a treatment modality for substance abusing men, and later on for special target groups – including women – is described. Thirdly, the importance of studying gender differences is discussed. In a fourth part, the European BIOMED II "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups" (IPTRP) project, which provided the data for this study, is described. Finally, the aims and general methodology of this dissertation are detailed.
A first descriptive study, *chapter 2*, presents an overview of the gender differences in the TC clients and it also lists the treatment characteristics of the different European TCs, which participated in the BIOMED II project. It is discussed whether the TC programme differentiates between men and women and whether the "community as method" approach is gender-sensitive.
In *chapter 3*, a psychiatric profile for women in TC treatment is developed since a first screening of the BIOMED II data revealed some important differences between men and women in their psychiatric status when entering a TC treatment.
In *chapter 4*, gender differences in TC client profiles in other than the psychiatric life area are explored, using the same screening instrument as in the previous

chapter. Since the client characteristics may vary by country and the age of the clients, possibly confounding effects of both variables were controlled for.
Chapter 5 exists of an in-depth exploration of the psychiatric status of men and women, by means of a diagnostic instrument.
Chapter 6 is a qualitative study, in which the views of women on residential substance abuse treatment are explored. Women are asked about their previous treatment experiences and possible barriers they feel to enter and remain in residential treatment.
Chapter 7 reports on the development of the Video Addiction Challenge Tool for women, which is a flexible tool for the treatment of substance abusing women.
Chapter 8 summarizes the main findings of the previous chapters and discusses their implications for the treatment of substance abusing women. The limitations of the executed studies and possible directions for future research are presented.

This dissertation is comprised of several papers, which have been submitted for publication, are under editorial review or are currently published. To make each of these papers self-containing, the texts of the chapters may overlap.

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1

General introduction

Abstract. In this first chapter, the substance abusing women as a hidden population will be discussed. Women have been overlooked by clinicians and researchers for a long time, therefore, research, treatment and service provision has been designed from a purely male point of view.
This also holds for the therapeutic community (TC), a treatment modality widely used for substance abusing men, and later on for special target groups, including women. The third part of this chapter discusses the importance of studying differences between men and women in order to improve the gender-based quality of treatment programmes. The European BIOMED II "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups" (IPTRP) project, which provided data of men and women in TC treatment, is described. This chapter ends with a description of the aims and general methodology of this dissertation.

1.1 SUBSTANCE ABUSING WOMEN: HIDDEN POPULATION? [1]

For a long time, substance abuse has been seen as a male problem (Goldberg, 1995). Theorisations and research on addiction were restricted to the outline of male paths of evolution, without paying the least attention to the specific factors of the female population (Ezard, 1998).
Women's drug addiction was considered as an extension of men's drug addiction till the end of the 1980s. Possible reasons for this negligent attitude could be found in the fact that women were outnumbered by men and therefore their substance abuse problems were less noticed (Ettorre, 1994). However, it was probably also less interesting to invest in women's drug addiction from an economical point of view (Ezard, 1998; Marsh, Colten, & Tucker, 1982).
It was not until two decades ago that clinicians and researchers gradually became interested in the drug-specific characteristics of women. This increased awareness was related to the negative consequences of the woman's substance abuse on the different aspects that define the functions of the woman (procreative, maternal, social, etc.) (Finkelstein, 1994). Later on, influenced by the feminist movement, there was attention for differences between substance abusing men and women and for the position of women within the "traditional" substance abuse treatment system (Abbott, 1994; Butler, 1990; Wald, Harvey, & Hibbard, 1995). Whereas previous research findings on men had been inappropriately generalized to women, it now became clear that the addiction affects women in another way than men, due to biological and societal differences (Brady & Randall, 1999; Ettorre, 1994). Therefore, women may have other treatment needs, which are not met within the traditional care (Reed, 1987).

Men are the greatest consumers of substance abuse treatment, which was therefore developed from a purely male point of view. Women are still a minority among the substance abuse treatment population with a gender ratio of approximately 4 to 1, although this may differ between different substance abuse treatment modalities (Vanderplasschen, Colpaert, Lievens, & Broekaert, 2003). The question remains, however, whether this gender distribution has to be seen within the lower prevalence of drug abuse among women or a lack of equal opportunity and subtle discrimination by inadequate drug service provision.

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[1] This subchapter is mainly based on: De Wilde, J., & Vandeplasschen, W. (2003) Man-vrouwverschillen bij personen in behandeling voor drugproblemen. In W. Vanderplasschen, K. Colpaert, K. Lievens & E. Broekaert, *De Oost-Vlaamse drughulpverlening in cijfers: kenmerken, zorggebruik en uitstroom van personen in behandeling* (Orthopedagogische Reeks Gent 15). Gent: Universiteit Gent, Vakgroep Orthopedagogiek.

Women seek more help in low-threshold mental health care services (Fiorentine, Anglin, Gil-Rivas, & Taylor, 1997; Kauffman, Silver, & Poulin, 1997), also for their substance abuse problems (Grella & Joshi, 1999). This may implicate that women feel less stigmatised or role-discordant in these settings (Arfken, Borisova, Klein, di Menza, & Schuster, 2002; Green, Polen, Dickinson, Lynch, & Bennett, 2002). However, several American studies have illustrated that substance abusing women may profit from a long-term residential treatment programme targeting their special needs (De Leon & Jainchill, 1991; Grella, Joshi, & Hser, 2000; Messina, Wish, & Nemes, 2000). In Europe, there is a need for more studies to look specifically into the situation of women as users of illicit drugs in order to learn more about their specific needs (Council of Europe, 1998).

It is generally accepted that men are involved in alcohol and illicit drug use in greater numbers than women. Women, on the contrary, use more psychotropic medication (Matthys, 2000). The literature contains only a few attempts at a theoretical understanding of these gender differences, but they are usually seen as reflecting the norms and values prevailing in modern society and culture (Hakkarainen, 2003). Attitudes, behavioural norms and sanctions regarding illicit drug use – as well as excessive drinking and intoxication – are judged as more deviant when it concerns women (Hakkarainen, 2003; Kauffman et al., 1997; Malloch, 1999; van Oosten, Kok, & van Bavel, 2000). Drug use is seen as "not womanly" (Ettorre, 1994). Women are also supposed to be more responsive to social expectations and gendered role models; men's role is less well defined, more flexible, and seems much less demanding (Laudet, Magura, Furst, & Kumar, 1999). Therefore, women's drug use is more "hidden". They use substances which are more socially acceptable and of which the use is not immediately labelled as "abuse" (Demarest et al., 2002; Simoni-Wastila, 2000).
However, the last few years, the gender gap, i.e. the differential in drug use prevalence between males and females, seems to be narrowing, especially in the younger age groups. It seems plausible that education is a crucial factor in explaining this narrowing gender gap (Korf & Benschop, 2002). Since women have more access to education, they are more likely to occupy social positions in which male and female roles are less polarised (Hakkarainen, 2003). This gender convergence seems to be especially true for alcohol and cannabis use (Bloomfield, Gmel, Neve, & Mustonen, 2001; Korf & Benschop, 2002). This evolution makes "gender" a hot item, which will be the topic of future research studies[2]. As a

[2] The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) will address the topic of "gender" in its 2006 *Annual report*. For our contribution to this report for Belgium see chapter 9 (annexe) of this dissertation.

consequence of the *International Women's Day* of this year (March 8, 2005) Professor S. Ahlström states: "Young women in Europe may be increasingly vulnerable to using drugs and to consuming harmful levels of alcohol, therefore we need to develop gender-sensitive prevention and treatment approaches that will engage young women and alter their behaviour (EMCDDA, 2005)."

1.2 THE THERAPEUTIC COMMUNITY AS A TREATMENT MODALITY FOR SUBSTANCE ABUSERS IN EUROPE

In the 1970s, Europe was confronted with a growing amount of young adults who abused illicit drugs (mainly heroin). As the traditional mental health care could no longer deal with these emerging drug problems, there was a need for new treatment modalities (Vanderplasschen, De Bourdeaudhuij, & Van Oost, 2002). The therapeutic community (TC) model, which originates from the American hierarchic drug-free concept TC, was introduced in Europe (Broekaert & Slater, 2001). The TC views the substance abuse as a multidimensional disorder of the "whole" person and therefore promotes changes in lifestyle and identity. This is expected to be reached through the interplay of two mechanisms: the "community as a method" approach and the encounter groups (De Leon, 2000). The first one, the community, which consists of the residents in treatment and the staff, is both teacher and healer. Most TC activities are collective and are designed to strengthen the sense of community. Residents move through explicit phases that are sequenced to provide incremental degrees of learning, both psychological and social (De Leon, 1997). The latter, the encounter or confrontation groups in general, aim to change negative patterns of behaviour, thinking and feeling. Each encounter more specifically tries to heighten the individual's awareness of specific attitudes or behaviour patterns that should be modified. All this takes place in a drug-free self-help environment, where a hierarchic structure prevails (De Leon, 2000).

In those early years, it was commonly believed that the TC was highly selective in its provision of treatment (Reichmann, Kaplan, & Jansson, 2001). The daily structure of the TC, the chain of commands, and the harsh confrontation groups were experienced as extremely male-oriented, and therefore not appropriate for women or residents with psychiatric problems or learning disabilities (Kooyman, 1992).

Over the years, the European TC underwent some important changes resulting in the model it is nowadays. One moderating influence might come from the so-called democratic TC, which has its origin in psychiatry and was mainly pioneered by Maxwell Jones in the United Kingdom (Rawlings & Yates, 2001). More participation by professionals and other treatment modalities, such as psychoanalysis, social learning, and milieu-therapy, led to a more "humanistic" approach instead of the rather behaviourally oriented programme of the traditional TC (Broekaert, Vandevelde, Schuyten, Erauw, & Bracke, 2004; Vandevelde & Broekaert, 2003). The TC was also influenced by the rapidly changing society in the 1980s. New popular drugs and the spreading of AIDS merged with an enormous increase of substance abuse, often associated with health problems and criminal behaviour. Harm reduction approaches were promoted as an alternative to specialised treatment and the TC was forced to reconsider its position. The TC reacted by expanding its methods to other kinds of drugs and a fairly broad range of new target groups. The TC became more open to the outside world and research gradually took a more central place (Broekaert, Vandevelde, Soyez, Yates, & Slater, in press; Soyez & Broekaert, 2005). Although these important evolutions, the basic elements and treatment goals of the TC remained unchanged (Broekaert, Kooyman, & Ottenberg, 1998).

As a result of the increased awareness of women, several TCs adopted a "women-centred" approach, which means that women get special attention and privileges within the mixed treatment programmes (Martens, 1999). Due to the initiative of female staff, women's groups and women-only activities were organised. Existing TC models were somewhat modified to accommodate mothers with their small child(ren) (Bracke, 1997; Hedrich, 2000).
It was only from the mid 1980s, early 1990s, that the first women-only residential programmes were established in Europe, because substance abuse treatment was still dominated by men in both number and style. These centres were sometimes run by women, who had left "traditional" mixed agencies because of their reluctance to introduce women-sensitive or women-specific services (Hedrich, 2000). It is not always clear if all these programmes are valid TC models. Literature shows that "residential treatment" is a generic and vague term covering a range of programmes that are extremely diverse. TC programmes, although serving diverse populations for varied durations of stay, all have similar designs, subscribe to shared assumptions, concepts, and beliefs, and engage in similar practices (De Leon, 2000, p. 11).

Anyhow, the study "Problem drug use by women: focus on community-based interventions" carried out by the Pompidou group[3] in 2000 (Hedrich, 2000), illustrated that the availability of women's services in Europe is scarce[4], and women-only programmes, whether TCs or not, are still the exception rather than the rule (James, 1995).

1.3 THE IMPORTANCE OF STUDYING GENDER DIFFERENCES IN CLIENT PROFILES

Being male or female is an important fundamental variable, which should be included in basic research designs (Mertens & Weisner, 2000; Stocco et al., 2002; Wizemann & Pardue, 2001). However, differences between men and women should be understood within a gender-inclusive framework, since feminists have argued for decades that drug use and drug abuse are gendered (Van Den Bergh, 1991): differences that were found could be due to biological sex differences, but even more to differences in gender[5] or to an interaction of both (McCallum, 1998). Synonymous use of the words *sex* and *gender* is common in the scientific literature and the popular press, which may often be confusing (Wizemann & Pardue, 2001). Most articles on substance abuse research indexed in *Web of Science* (Institute of Scientific Information – ISI) clearly prefer the use of the word *gender*, when reporting about differences between men and women.

It was not until the 1980s that many researchers began to consider women specifically. The "new" research identified female-specific characteristics which may be responsible for the obstacles women face when they seek help and for the higher dropout rates for women in (TC) treatment (Copeland & Hall, 1992; Hughes et al., 1995). From then on, several researchers became aware of the importance of studying differences between men and women in their problem severity at treatment intake, in order to improve the gender-based quality of treatment programmes (Arfken, Klein, di Menza, & Schuster, 2001; Brady & Randall, 1999; Broom, 1995; Pelissier & Jones, 2005). The assessment of client

[3] European cooperation group to combat drug abuse and illicit trafficking in drugs
[4] For Belgium, only a few programmes specifically targeting women could be mentioned. There are no women-only services available.
[5] "Gender" refers to "the socially constructed roles, behaviours, activities, and attitudes that a given society considers appropriate for men and women", "sex" refers to "the biological and physiological characteristics that define men and women" (WHO, 2005).

characteristics and the quality of care cannot be separated (Chan et al., 2004; Van Strien, 1986).

One of the world's most widely used assessment instruments in substance abuse research, but also in clinical milieus, is the *Addiction Severity Index* (ASI) (McLellan et al., 1992). Since its introduction in 1980, it has been used by numerous researchers in studies of treatment intake and outcome and as a clinical assessment tool in thousands of treatment facilities. ASI data have been published on many different samples of substance abusing clients and the instrument proved to be a reliable and valid instrument that has a wide range of clinical and research applications (McLellan, Luborsky, Cacciola, Griffith et al., 1985). However, as an overall conclusion, it is still a challenge for the substance abuse field to translate research findings on gender differences to the treatment community in order to improve treatment outcome for both men and women (Brady & Randall, 1999; Davis et al., 2002; Pelissier & Jones, 2005). An increased understanding of gender issues may have important implications for the planning and provision of cost-effective and efficacious treatment for substance abusers (Hanson, 2002; Hodgins, El-Guebaly, & Addington, 1997).

In Europe, this gender-focused research tradition is less prevalent. Although the TC has been more scrutinised than almost any other treatment model (Ravndal, 2003), studies focusing on gender differences in profiles of TC clients are scarce. Whereas most studies report on the characteristics of the male TC populations, there are a few women-only studies (Malloch, 1999; Ravndal & Vaglum, 1994; Rosenbaum, 1981; Trulsson & Hedin, 2004). However, merely studying women is as meaningless as merely studying men (Anglin & Hser, 1987).
It will be important to study treatment populations that consist of both men and women, in order to learn something about their different client profiles, and through this about their different treatment needs (Hakkarainen, 2003; Stocco, Llopis, De Fazio, Calafat, & Mendes, 2000). A possible reason why European studies have failed to attend to gender differences, is properly summarized by IREFREA[6]: "this scant scientific output is not due to a lack of interest on the part of researchers, but rather to the difficulty in compiling samples of sufficient scale to be able to study the incident and characteristics of drug addiction amongst women with a minimum of representation (Stocco et al., 2002, p. 27)." As a consequence, this lack of knowledge on the specific nature of certain

[6] The European Institute of Research on the Risk Factors in Infancy and Adolescence (IREFREA) is a European research network, funded by the European Commission.

characteristics of addiction in women has led to the spread of a general concept of the drug addict with a single profile, mistakenly accepted as the standard profile, which does not recognise gender differences.

A European BIOMED II research project, entitled "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups" (IPTRP), provided a relatively large sample of men and women in TC treatment, and in this way permitted a first focus on gender differences in a systematic way (Kaplan, Broekaert, Frank, & Reichmann, 1999; Kaplan & Broekaert, 1999). This project was the starting point to perform this dissertational study.

1.4 THE EUROPEAN BIOMED II IPTRP PROJECT[7]

1.4.1 INTRODUCTION

Between 1996 and 1999 the Department of Orthopedagogics acted as a Belgian national coordinator in a European research project that aimed at "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups through Relapse Prevention" (IPTRP) for substance abusers.
The IPTRP project was accepted within the Fourth Framework Programme of the European Commission BIOMED II (Biomedicine and Health Research)[8]. This multi-site research involved treatment centres from nine countries (Norway, Sweden, Belgium, France, Germany, Scotland, Spain, Italy and Greece) spread over Northern, Central and Southern Europe. The major aim of the BIOMED II project was to identify and address the needs of "emerging dependency groups". These groups are the new high-risk, drug-using groups that have emerged in Europe and America in recent years and have placed the TC for an important challenge, because they are characterised by high treatment dropout (Kaplan, Broekaert, & Morival, 2001). In order to improve their (psychiatric) treatment, a large database was set up with their characteristics, since the existing, mainly American, literature on the client profiles of these groups has been extensive, but not conclusive (Kaplan & Broekaert, 1999).

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[7] This subchapter is based on: De Wilde, J. (2004). Results of the BIOMED II "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups" (IPTRP) project. Paper presented at the Scottish-American Congress 2004, University of Stirling, Scotland.
[8] Contract number BMH4-CT96-0688 (DG 12-SSMA)

Considering the importance of the BIOMED II project for this study, we will successively describe the data collection, the used instruments and the general results of the project already published before the study on gender differences was started.

1.4.2 DATA COLLECTION

The "emerging dependency groups" could be found in residential programmes using "community as method" (Eley Morris, Yates, & Wilson, 2003; Kaplan et al., 2001). Therefore, several TCs were selected by national representatives in each country and asked to participate in the project. Techniques involving targeted sampling were used (Watters & Biernacki, 1989). The *Monitoring Area and Phase Systems* (BioMAPS – unit form) (Öberg, Gerdner, Sallmén, Jansson, & Segraeus, n.d.), an instrument developed especially for the BIOMED II project, was used to evaluate the treatment approaches. Thirty treatment centres agreed to participate and met the criteria.
Each client entering a participating TC between May 1, 1997 and October 31, 1998 was asked to give their informed consent for participation in the project. Different screening and diagnostic tools were administered when clients were approximately four weeks into the programme. By then most clients were not in crisis anymore and in a fully detoxified status.

1.4.3 INSTRUMENTS

The *European Addiction Severity Index* (EuropASI) (Kokkevi & Hartgers, 1995) was collected from all clients. This instrument is an one-hour, semi-structured interview, that provides a multidimensional profile of the client by covering six main life areas (medical, employment/support, alcohol and drugs, legal, family history and family/social relationships and psychiatric) most often associated with substance abuse. The symptoms are measured over the person's lifetime and during the 30-day period prior to the interview. Two summarizing scores are provided: 1) the *interviewer's severity rating* (range 0-9), which also incorporates client reported ratings of problem severity and need for additional treatment, and 2) the *composite scores* (range 0-1), which are arithmetically based indicators of current problem severity (McLellan, Luborsky, Cacciola, Griffin et al., 1985; McLellan, Luborsky, Cacciola, Griffith et al., 1985).

The instrument is the European adaptation of the fifth edition of the Addiction Severity Index (McLellan et al., 1992; McLellan, Luborsky, Woody, & O'Brien, 1980) and its validity and reliability have been established in European resident populations (Hendriks, Kaplan, Vanlimbeek, & Geerlings, 1989).

Other instruments were used in subgroups of clients within selected TCs: the *Structured Clinical Interview for Diagnosis* (SCID) (Spitzer, Williams, & Gibbon, 1992), the *Maastricht Social Network Analysis* (MSNA) (Baars & Verschuren-Schoutissen, 1998), the *Video Addiction Challenge Tool* (VACT) (Broekaert & Soyez, 1997), the *Childhood Trauma Questionnaire* (CTQ) (Bernstein & Fink, 1988; Bernstein et al., 1994), and the BioMAPS – client form (Öberg et al., n.d.).
The SCID provides diagnoses on Axis I psychiatric disorders and Axis II personality disorders of the DSM classification system. The MSNA assesses the extensiveness and quality of the client's social network and measures the degree of social integration/isolation. The VACT was developed for educational assessment and individual treatment planning. It employs a videotape depicting an "average" life story of a resident in a TC. The video is shown to a "new" client admitted to the TC programme and stimulates personal discussions with the client on his/her own life, leading to an enhanced conceptualisation by providing new and additional information from this experience. The CTQ assesses five areas of maltreatment (emotional, physical, sexual abuse and emotional, physical neglect) in childhood and adolescence, using a dimensional system. The BioMAPS – client form provides complementary data on intake, discharge and follow-up.

The implementation process of the different screening and diagnostic instruments used in the project, has been described briefly in European Addiction Research (Broekaert et al., 2002), and in greater detail in the Journal of Substance Use (Segraeus et al., 2004).

1.4.4 General results of the BIOMED II project

The results of the IPTRP project are published in several articles. The project started with a literature review of the research on TCs in Europe (Broekaert, Raes, Kaplan, & Coletti, 1999). The review revealed that there is a strong relationship between the psychopathology of European clients admitted to TC treatment and their long-term chance of success in remaining abstinent after treatment. An article of Kaplan et al. (2001) reported on the cross-border scientific networking of the project and its methodological innovations. A

combination of innovative, quantitative and qualitative methodologies was needed to analyse the complex, multi-site data sets of information about populations. The study also described the characteristics of the emerging dependency groups. Besides their psychiatric comorbidity, they are about 30 years old and poly-substance abusers. However, non-drug-specific characteristics are as important as drug-specific characteristics in distinguishing emerging dependency groups. "History" and "social networks" seem to play an important role. These two key concepts were the starting point for different BIOMED studies.

A study of Frank et al. (2001) using the EuropASI and the MSNA data of respectively 723 and 194 clients, wanted to discriminate the treatment needs of TC clients, based on the quality of their social network. Clients of Belgium, France, Germany, Italy, Norway, Spain, Sweden and Scotland were involved. It was found that if there is exposure to addicts in the family, there is bound to be a higher risk of an acute need for professional intervention than when there is no such exposure. For clients with no exposure in the family but with exposure to substance abusers among their friends, there is a lower risk of need for help. However, this effect seems to be influenced by the better psychiatric status of the clients in the latter group. The article did not report on differences between different European countries.

Another BIOMED study by Reichmann, Kaplan and Jansson (2001), also using the EuropASI and the MSNA data, compared the French clients with residents of other European countries on the characteristics of their social network. The same countries of the study of Frank et al. were involved. The most important findings can be summarized as follows: Southern European clients usually live with their parents while northern clients more often live on their own. Fifty percent of the clients spend their free time with drug-using friends; however, this is not related to developing intimate relationships. The European risk networks seem to be characterised by having no real friends and social exclusion. The authors stressed the importance of paying attention to the function of social network relations in risk networks.

Researchers at the Stirling University found that clients with a high level of general childhood abuse were more likely to have grandparents with an alcohol problem than those with an intermediate or low level of maltreatment. This suggests that we must take into account the interaction of genetic and environmental variables in substance dependence in order to improve clinical and social diagnosis (Kaplan et al., 2001). At the same university, a study by Eley Morris, Yates and Wilson (2002) reported on the CTQ data of 60 men and 31 women undergoing treatment in 3 Scottish TCs. Significant gender differences were found for emotional, sexual

and physical abuse. Fifty-six clients met the criteria for a distinct "abuse" profile, which underlines the diversity of problems of this client group. The authors concluded that this should act as a warning against broad stroke treatment plans for the "traumatised in childhood" within this population.

Another study, focusing on "childhood trauma", was an in-depth study of the Norwegian population by Ravndal, Lauritzen, Frank, Jansson and Larsson (2001). The authors emphasised the importance of gender issues in understanding the dynamics of addiction severity in the emerging dependency groups, but did not report on the implications for treatment. One hundred and two substance abusers (27% women) were assessed with the EuropASI and the CTQ. Women had higher scores for all types of trauma, except for physical abuse. There were some correlations between the type of trauma and the different life areas of the EuropASI (composite scores). The strongest correlation was noted between all types of trauma and the psychiatric status during the past 30 days. Emotional abuse was correlated with the clients' medical status during the past 30 days and emotional neglect with the status of the clients' family/social relations. There were no correlations with any substance-related variables or with problems in the family of origin. There was also an association between the level of childhood trauma and the EuropASI lifetime psychiatric symptoms with higher levels of maltreatment for lifetime suicide attempts, lifetime anxiety symptoms, lifetime prescription of medication and lifetime hallucinations. Again, there was no correlation between the substance-related variables or the problems in the family of origin and the level of maltreatment. The study also revealed that the correlation between psychical abuse and high scores on the psychiatric status is more frequent among women than men.

An article of Broekaert et al. (2001) reported on the experience of developing and implementing the Video Addiction Challenge Tool (VACT). The authors addressed the need for innovative qualitative methodologies in order to improve the sensitivity of the diagnosis and effectiveness of the treatment planning. This should result in an individual treatment plan that is more closely allied to client expectations, thus reducing the risk of relapse. Since the "average" resident of the TC is male, the story used by the instrument is about a man.

1.4.5 A NEED FOR FURTHER STUDY: THE BIOMED FOR WOMEN

The BIOMED II project aimed to establish a concerted action targeting the needs of emerging European substance dependence groups. Since the characteristics of the emerging dependency groups were not reported fully and consistently across different studies (Hox, van Gils, & Klugkist, 1999), this was the first challenge for the research project. In order to improve treatment, the characteristics of clients at treatment intake should be determined. The IPTRP studies illustrated that non-drug-specific client characteristics, such as the presence of psychiatric problems, abusive experiences, genetic and/or environmental variables, are as important as drug-specific characteristics in detecting clients' treatment needs.

Although the BIOMED II database contained the data of both men and women admitted to TC treatment, the research project failed to focus on gender-specific characteristics and their implications for the organisation of TC treatment. The study of Ravndal et al. (2001) functioned as an eye-opener since it showed that women in TC treatment are more often traumatised than men, and therefore are at a greater risk of psychopathology and relapse after treatment (Eley Morris et al., 2003). The relapse prevention instrument the VACT (Broekaert et al., 2001) seemed to ignore typical female characteristics and therefore could not contribute to the individual treatment planning for women.

A further promotion of the BIOMED data was needed in order to gain insight in the characteristics of women in treatment, and in this way better address their treatment needs.

1.5 AIMS AND METHODOLOGY OF THIS DISSERTATION

Six different studies were executed, which all had their own contribution to the major aim of this dissertation, i.e. the development of a gender-specific profile[9] of substance abusing women in therapeutic communities in Europe. In the following, the different research goals and used methodologies of the six separate studies will be presented.

[9] In this dissertation, we will consequently use the word *gender*, although the starting point of each study was the biological sex of the clients, because this was the way in which the questionnaires were administered. However, differences between men and women will be understood by giving *gender*-sensitive explanations.

Although the BIOMED II project provided promising data of clients in TC treatment, the analysis of the data was a huge task, due to the complexity of the data collection which had to deal with both coding and language problems. The eclectic and multi-faceted nature of the project, along with the number of instruments to be implemented within an ambitious time frame, forced researchers and treatment staff to begin data collection before the required materials were fully developed and tested (Broekaert et al., 2002). Consequently, different instrument versions were implemented in the different countries, which resulted in several missing variables, when the final database was set up.
Before the different studies of this dissertation were executed, all data were collected at the Department of Orthopedagogics. Most raw data were available at the Maastricht University, the principal coordinator of the project, other data files were gathered by contacting the national representative of the different countries. The available electronic SPSS file of the EuropASI data was compared with the raw data files and checked for any inconsistencies and if necessary, cases were removed from the final database. Other instruments used within this study were brought together and finalised in one database.

Four out of the six instruments of the BIOMED II project were used to achieve the objectives of this dissertation. The screening instrument the EuropASI was the starting point in the first three studies *(chapters 2, 3, and 4)*. In the first study the EuropASI was complemented with the BioMAPS unit form. In the fourth study (*chapter 5)* the diagnostic instrument the SCID-I formed the basis, while the EuropASI was used in the second part of the study. Finally, the VACT was the subject of the sixth study *(chapter 7)*.
In the fifth study *(chapter 6)*, none of the BIOMED II instruments were used, a semi-structured interview was conducted to obtain our study goal.

Since several TC programmes spread over nine different European countries delivered client-data for the BIOMED II project, the first descriptive study *(chapter 2)* of this dissertation aimed to present two overviews: one of the client characteristics of the men and women (EuropASI), and one of the programme characteristics of the participating TCs (BioMAPS – unit form) and this separately for each of the nine countries.
The first overview allowed to determine striking gender differences in client characteristics between the different countries or between parts of Europe.
Since the TC was introduced in Europe in the 1970s, a number of studies have been written about the evolution the TC-model went through (Broekaert, Van der Straten, D'Oosterlinck, & Kooyman, 1999; Broekaert et al., in press; Soyez &

Broekaert, 2005), therefore it was the purpose of the second overview to verify these changes among the participating TCs.
Finally, this study intended to explore if the "community as method" approach of the mixed TCs differentiates between men and women, i.e. if the TC-model is gender-sensitive.

In the second study[10] (*chapter 3*), the six life areas of the EuropASI were screened for gender differences by means of the EuropASI composite scores. These were chosen above the interviewer's severity ratings, since they are based on objective information and have the advantage of being well-defined and continuous (Alterman, Brown, Zaballero, & McKay, 1994). On the basis of this first screening of the database, the last life area of the EuropASI "psychiatric status" was selected for further study, because this area revealed some important differences in client characteristics between men and women, and it also showed clinical significance as several studies revealed a strong relationship between psychopathology and substance abuse, and the long-term chance of success after treatment (Brady & Randall, 1999).
By scrutinizing this "psychiatric" area, a number of problems could be identified as being reported more often by women than men in TC treatment. Since a previous BIOMED II study showed a correlation between the psychiatric status of a client and childhood maltreatment (Ravndal et al., 2001), the "abuse" items were also included. Combining these "female-specific" items, it was possible to construct a psychiatric profile for women in TCs and to formulate suggestions for a more targeted treatment, focused on women's more acute psychiatric needs.

In continuation of the previous study, the third study *(chapter 4)* aimed to focus on gender differences in client profiles in the various other areas of functioning of the EuropASI. Since the previous two studies illustrated that gender differences may vary across countries and by the age of the clients, a statistical model was used to avoid possible confounding effects of both variables. The objective of this study was to detect those client characteristics for which gender differences remain significant, no matter the country of origin, and no matter the age of the client.
This study made it possible to complete our previously developed psychiatric profile for women with more female-specific characteristics, and in this way gain insight in their female-specific treatment needs.

[10] The total sample used for this study is somewhat smaller than the one in the first study, because this study was executed first, and at that time not all programme information needed to include all French cases was available from the French centres.

Since there is a lack of research illustrating the extent of psychiatric problems in European TCs, and a need to get more insight into gender differences concerning comorbidity in the TC population, the aims of the fourth study *(chapter 5)* were threefold. First, we wanted to explore the lifetime prevalence of Axis I mood and anxiety disorders among our clients (SCID-I). These two affective disorders were chosen since they are the most common comorbid psychiatric disorders in the substance abusing population (Hendriks, 1990). The second aim was to focus on related differences between men and women. Thirdly, client characteristics measured by the EuropASI were related to the mood and anxiety disorders measured by the SCID-I. In addition, this study allowed to deepen our previously developed psychiatric profile for women.

Since the previous studies illustrated the under-representation of women in TC treatment, a fifth study *(chapter 6)* was performed with the intention to explore possible barriers women feel to enter and remain in residential treatment. In order to gain insight in the views and opinions of the women themselves, a qualitative approach was chosen.
The women were recruited in a low-threshold substitution programme in the province of East Flanders, since a registration study illustrated that women were more likely to be admitted to such programmes compared to other ambulatory or residential settings (Vanderplasschen et al., 2003).
This study aimed to know why and where substance abusing women seek help, what they like and do not like about residential treatment and what their treatment needs are.

The sixth study *(chapter 7)* reports on the construction of the Video Addiction Challenge Tool (VACT) for women. Since the original VACT, developed during the BIOMED II project, was regarded as female-unfriendly and not gender-sensitive (Broekaert et al., 2002), it was the aim of this study to construct a new instrument that addresses typical female characteristics, in order to contribute to the individual treatment planning of women.
Women in TC treatment were asked to tell their life stories, with special attention for those topics which were an addition to the "male" themes of the "old" VACT. The methodology used relied on the methodology for the development of the old VACT, complemented with the researchers' "own style".
This study also contributed to the development of our gender-specific profile because topics that were not covered by the EuropASI or SCID questionnaire, were revealed.

Finally, in the discussion *(chapter 8)*, the main findings of the different studies and their implications for the treatment of substance abusing women are summarised. We discuss the relevance of the development of a gender-specific profile for women in treatment if we want to provide gender-sensitive treatment and we illustrate where the VACT for women could be applied. In this last chapter, we also warn of a possible pitfall when studying differences between men and women.
The limitations of the previous studies and directions for future research are presented.

In this dissertation, quantitative research instruments were varied by qualitative methodologies, in order to meet the criticism expressed by feminist researchers that most quantitative positivistic methods include a male-as-norm bias and therefore do not reflect the patriarchal society in which data are gathered (Westmarland, 2001). Besides the four quantitative studies on gender differences, two studies were executed in which a qualitative approach was chosen. We let the women talk freely about their treatment experiences and asked them to reflect on their own lives. In addition, the women were able to fully participate in the development of the VACT instrument, and this from the start of the project to the finish. This is the only way to fully understand women's experiences and take into account the societal structures in which we live.

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2

Is the "community as method" approach gender-sensitive? Client and treatment characteristics in European therapeutic communities. Results of the BIOMED II (IPTRP) project [11]

Abstract. The BIOMED II project, "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups through Relapse Prevention", provided a large database of characteristics of men and women in European TCs. One of the aims of the project was to improve the treatment of "emerging dependency groups" through better assessment. Although American TC research has shown that there are important differences between men and women that should be taken into account when organising treatment, the BIOMED project failed to report on gender differences. This article tries to fill this gap by presenting an overview of the gender differences in the TC clients and it also lists the characteristics of the participating European TCs. The two overviews are given for each country separately. Descriptive methods were used. The authors discuss whether the TC programme considers the differences between men and women and whether the "community as method" approach is gender-sensitive .

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2.1 INTRODUCTION

From 1996 to 1999, the research project "Improving Psychiatric Treatment in Residential Programmes for Newly Dependent Groups through Relapse Prevention" (IPTRP) was funded within the framework of the BIOMED II (Biomedicine and Health Research) programme of the European Commission (Kaplan & Broekaert, 1999). Nine countries (Belgium, France, Germany, Scotland, Greece, Italy, Spain, Sweden and Norway) and 30 different therapeutic communities (TCs), spread over Northern, Central and Southern Europe participated in this multi-site trial. The main objective of the project was to identify and address the needs of "emerging dependency groups". One of the underlying aims was to improve their treatment through better assessment in residential programmes using "community as method". Different screening and diagnostic instruments were, therefore, implemented during the duration of the project (Broekaert et al., 2002; Segraeus et al., 2004). Since 2001, the first results have been published in several articles (Broekaert et al., 2001; Frank et al., 2001; Kaplan, Broekaert, & Morival, 2001; Ravndal, Lauritzen, Frank, Jansson, & Larsson, 2001; Reichmann, Kaplan, & Jansson, 2001).

Although the IPTRP project provides a large database of characteristics of men as well as women in TC treatment, it fails to report on gender differences. Also other European studies (listed in the Web of Science) largely ignore a gender perspective, which could be due to the small number of women in the European TCs. Most articles deal with socio-demographic and psychological characteristics of clients as predictors of treatment retention, dropout or outcome (Broekaert, Raes, Kaplan, & Coletti, 1999; Ravndal, 2003) and do not differentiate between men and women. However, in order to improve treatment, we should focus on the characteristics of the men and women starting treatment. Assessment, treatment and evaluation cannot be seen separately and are part of a regulative cycle of action (Van Strien, 1986).

The American TC research has a much longer tradition and teaches us that there are important differences between men and women (Carroll & McGinley, 1998; De Leon & Jainchill, 1991; Jainchill, Hawke, & Yagelka, 2000). Women report more medical, employment, social and psychiatric problems at assessment (Arfken, Klein, di Menza, & Schuster, 2001; Brown, Sanchez, Zweben, & Aly, 1996) and it is suggested that different treatment approaches should be adopted to

meet the specific needs of women in treatment (Ashley, Marsden, & Brady, 2003; Bride, 2001).

The European TC, after the American example, started its development in the seventies. The traditional TC is characterised by such terms as "residential", "drug-free", "self-help movement", "confrontation", "hierarchy" and "community as method" (De Leon, 2000). Since its development, the treatment modality has evolved and professionals have taken a more dominant role. They were historically influenced by Maxwell Jones, the democratic TC, social learning and milieu-therapy (Rawlings & Yates, 2001). This led to a less strict use of behavioural techniques and the avoidance of humiliating learning experiences and signs (Broekaert, Van der Straten, D'Oosterlinck, & Kooyman, 1999). During the mid-eighties, the TC has been challenged by an expansion of drug misuse and the emerging HIV epidemic. Its method was broadened to encompass more specific target groups such as homeless persons, prisoners, immigrants, ethnic minorities, women, and women with children (Bracke, 1997; Broekaert, Raes et al., 1999; Vandevelde & Broekaert, 2003). Both alcohol and drugs were considered. The role of social networks and family members was given more prominence, and harsh encounter groups evolved into meetings in which dialogue became quintessential (Broekaert, Vandevelde, Schuyten, Erauw, & Bracke, 2004). Since the nineties, new management has been gaining ground. The treatment of substance abusers has moved towards a more integrated system approach, in which different treatment settings provide a broad range of services. TCs have become aware that a single treatment modality cannot solve the multiple problems and have therefore introduced diverse modalities of treatment (Vanderplasschen, De Bourdeaudhuij, & Van Oost, 2002). Humanistic, behavioural, systemic, evidence-based and educational approaches have been integrated (Vandevelde, 2003). "Harm-reduction" principles, and the use of methadone in particular, have become increasingly accepted (Broekaert & Vanderplasschen, 2003).

This article presents an overview of the gender differences in the TC clients and describes the characteristics of the participating European TCs. The authors discuss if the TC programme considers the differences between men and women and if the "community as method" approach is gender-sensitive?

2.2 MATERIALS AND METHODS

2.2.1 DATA COLLECTION AND INSTRUMENTS

The TCs were selected by national representatives in each country who used targeted sampling (Watters & Biernacki, 1989) as it was not their aim to reach a representative, random sample. Which TCs were asked to participate depended on the number available in the country, their accessibility, their willingness to participate and their use of "community as method" as the main treatment approach. "It is the use of community as method that distinguishes the TC from other forms of community. Community is both the context and method in the change process" (De Leon, 2000, p. 85).

Each client entering a participating treatment centre between 1 May 1997 and 31 October 1998 was asked for their informed consent to participate in the project. Various instruments were implemented in order to give a general descriptive view of the TC clients: the European Addiction Severity Index (EuropASI) (Kokkevi & Hartgers, 1995), the Structured Clinical Interview for Diagnosis (SCID) (Spitzer, Williams, & Gibbon, 1992), the Maastricht Social Network Analysis (MSNA) (Baars & Verschuren-Schoutissen, 1998), the Monitoring Area and Phase Systems (BioMAPS) (Öberg, Gerdner, Sallmén, Jansson, & Segraeus, n.d.), the Video Addiction Challenge Tool (VACT) (Broekaert & Soyez, 1997) and the Childhood Trauma Questionnaire (CTQ) (Bernstein & Fink, 1988; Bernstein et al., 1994).

The EuropASI (Kokkevi & Hartgers, 1995) was the only instrument that could be successfully employed in all countries. For that reason, only information on this instrument is used to describe the client characteristics in this article. It was conducted about four weeks after clients were admitted to the programme. There are two reasons for this: (1) to eliminate people in crisis from the sample; and (2) to obtain the most homogeneous study sample possible. Several authors have warned that most clients are generally anxious, depressed and confused at the beginning of treatment (Brown, Melchior, Waite-O'Brien, & Huba, 2002; Carroll & McGinley, 1998; De Leon & Jainchill, 1982). In traditional long-term residential TCs, there are three main programme stages: introduction, primary treatment and re-entry (De Leon, 2000, p. 196-204). It was decided to involve clients taking part in the first and second phase of the programme, while clients in the re-entry phase were not selected for our study. According to the EuropASI criteria, these stages are labelled as "detoxification residential" (first phase) and "drug-free residential" (second phase), respectively.

The EuropASI is the European version of the Addiction Severity Index (McLellan et al., 1992; McLellan, Luborsky, Woody, & O'Brien, 1980), adapted from the fifth edition of the American version. Its validity and reliability have been established in European resident populations (Hendriks, Kaplan, Vanlimbeek, & Geerlings, 1989). It is an instrument fulfilling the need for comparability between countries in relation to descriptions of the clients. The EuropASI is a semi-structured, personal interview designed to provide a multidimensional profile of clients by examining the frequency, duration and severity of problem symptoms in six areas of functioning: medical status, employment and support status, drug and alcohol use, legal status, family history and family and social relationships, and psychiatric status. These symptoms are measured over the person's lifetime and, more recently, during the 30 days prior to the interview.

The BioMAPS (Öberg et al., n.d.) was developed on the initiative of the IPTRP project because there was no satisfactory instrument available for the description of the different treatment programmes and the preconditions for delivering treatment. It is a method for trans-theoretical and cross-cultural applicability on both unit and client levels. It was used in evaluating the treatment approaches to make sure that they fit to the criteria of residential programme using "community as method". The BioMAPS consists of a unit and a client form, but for this article, we used only the unit form to describe a number of treatment characteristics. The instrument was filled in by a staff member of the TC. In the first part it provides some basic information such as type of setting, client capacity, treatment orientation, staff characteristics, target group and problem, accepted substances, etc. In the second part it describes the different treatment phases, referring to the five phases of change according to the theory of Prochaska and DiClemente (Prochaska, Diclemente, & Norcross, 1992). The third part of the BioMAP-unit contains information on the six areas in which different treatment interventions are provided during the programme. The areas refer to the six problem domains in the EuropASI.

2.2.2 STUDY SAMPLE AND METHODOLOGY

The study sample consists of 863 clients in 30 different TCs: 660 (76.7%) men, 200 (23.3%) women, three were missing. In the first overview (see Table 2.1), the differences between men and women in several interesting EuropASI items are presented in percentages. Due to the sometimes small amount of data for each country, we used only descriptive methods. The Statistical Programme for Social Sciences (SPSS) was used for all statistical analyses (SPSS Inc., Chicago, IL, USA). The overview is not exhaustive, and we did not consider the influences of other variables (age, country); we present only some of the EuropASI items. The selection was chosen on the basis of Pearson chi-square analyses between the different items of the EuropASI and gender. Only those items for which a significant chi-square test of 0.01 was obtained were restrained in the table.

We do not present items focusing on the most recent 30-day period because all our clients were in treatment. All other items, where possible, were made binary. For example, the items concerning drug and alcohol use were recoded as "never used or less than one year" and "used for at least one year." The "legal" items were recoded as "never" and "one or more times charged/one or more convictions as a result of these charges." For the family history, only data about the alcohol, drugs and mental health problems of the parents were used in the analyses.

In the second overview (see Table 2.2), a description of the basic characteristics of the different participating TCs is given for each country. The characteristics described are selected items of the BioMAPS. In the table, the number of participating centres having a specific characteristic can be found.

Lastly, the authors aimed to ascertain if there are gender differences in the treatment characteristics. Therefore, Pearson chi-square analyses were executed for the mixed treatment centres, between gender and the main orientation (see Table 2.3) and between gender and the main treatment orientation (see Table 2.4). In the two tables are given the percentages and the Pearson residuals of men and women represented respectively in a specific main orientation and main treatment orientation.

2.3 RESULTS

2.3.1 GENDER DIFFERENCES IN THE CLIENT CHARACTERISTICS

Table 2.1 shows the gender differences in the characteristics of the TC clients. They are presented conform to the different life area's of the EuropASI.
In each country more men than women follow a TC treatment programme. The Northern European countries have the highest number of women in TC treatment, particularly Sweden (45.9%). This could be explained by the selection of the different centres, as one of them only takes women. The difference in proportion between men and women is highest for Southern Europe. We do not have a large amount of data for Spain.
The mean age of the respondents is shown in the second row. Men in TC treatment are on average older. TC residents in the Northern European countries are the oldest, particularly in Sweden (mean age for men is 46.3, for women 40.7). The older age of the Swedish population should be viewed in relation to the selected centres (compulsory care centres). The clients are mostly in the last phase of their treatment careers. Substance abusers are youngest in Belgian TCs, which could be because some of the centres allow younger clients.
Female TC clients take, in general, more prescribed medication for their medical problems. In some countries, medication for medical problems is widely prescribed for women. It is not surprising that there is some similarity between prescribed medication and being treated by a physician during the past six months. In most countries, more people rely on female TC residents for their livelihood. It should be noted that in the Southern European TCs, most men hold a valid driver's license (range from 58.6% to 73.7%). More men than women generally hold a valid driver's license.
Differences between male and female TC clients were found for cocaine and cannabis use and for injecting drugs. The use of cocaine was particularly high for the French TCs (82.7% versus 80%) and German (85.1% versus 76.9%). None of the women in the Swedish TC had used cocaine for at least a year. The use of cannabis was very high, except for Sweden (20.5% for the men and 23.7% for the women). In most TCs, more men than women have used cannabis. Well in excess of 50 percent of the TC residents have injected drugs, except for the residents of Swedish TCs and the women in Belgian TCs. In the Swedish sample, the low drug usage could be explained by the fact that one centre does not primarily deal with illicit drugs. The major substance abuse problem of the TC residents was alcohol. For the Belgian TC population, this is probably because of their younger age.

Table 2.1: Gender differences in client characteristics

	Norway		**Sweden**		**Belgium**		**France**		**Germany**		**Scotland**		**Greece**		**Italy**		**Spain**	
	M	*W*	M	*W*	*M*	*W*	*M*	*W*	*M*	*W*	*M*	*W*	*M*	*W*	*M*	*W*	*M*	*W*
	n=70	n=32	n=46	n=39	n=98	n=19	n=52	n=15	n=47	n=13	n=83	n=40	n=158	n=23	n=87	n=12	n=19	n=7
Background characteristics																		
Gender proportion (%)	68.6	31.4	54.1	45.9	83.8	16.2	77.6	22.4	78.3	21.7	67.5	32.5	87.3	12.7	87.9	12.1	73.1	26.9
Age (mean in years)	32.5	29.2	46.3	40.7	24.4	22.6	29.5	27.5	28	31.5	28.1	24.9	30.2	26.7	28.5	26	31.2	25.1
Medical situation (%)																		
Taking prescribed medication	18.6	34.4	32.6	40.5	23.5	42.1	19.6	66.7	6.4	15.4	21.7	30	12.7	17.4	10.3	8.3	15.8	71.4
Treated by physician	24.3	65.6	51.1	43.2	53.6	68.4	38	66.7	36.2	30.8	38.6	42.5	21.2	36.4	28.7	25	36.8	57.1
Employment/support situation (%)																		
One or more people rely on person	4.3	9.4	8.7	30.8	9.3	10.5	9.8	13.3	2.2	15.4	12	27.5	8.9	9.1	8	0	26.3	28.6
Holding valid driver's license	23.2	34.4	21.7	25.6	36.7	26.3	51	46.7	48.9	15.4	22.9	10	65.8	13	58.6	41.7	73.7	42.9
Substance abuse history (%)																		
Usage of cocaine	17.1	21.9	2.2	0	62.5	63.2	82.7	80	85.1	76.9	39.8	34.2	35.3	39.1	59.8	33.3	55.6	71.4
Usage of cannabis	98.6	93.8	20.5	23.7	84.5	78.9	96.2	93.3	93.6	92.3	95.2	89.5	96.2	91.3	93.1	75	83.3	100
Ever injected	97.1	87.5	26.1	43.6	66.3	47.4	84.6	86.7	83	76.9	92.8	86.8	93.5	87	92	91.7	57.9	71.4

	Norway		Sweden		Belgium		France		Germany		Scotland		Greece		Italy		Spain	
Legal situation (%)																		
Charged for possession and dealing drugs	82.9	67.7	15.2	35.9	73.7	52.6	51	53.3	72.3	84.6	65.1	42.5	63.3	26.1	44.7	33.3	26.3	14.3
Charged for crimes of violence	34.3	21.9	17.4	17.9	49	22.2	29.4	33.3	19.1	7.7	66.3	32.5	20.9	4.3	30.6	16.7	21.1	14.3
One or more convictions	92.2	78.1	47.8	47.4	71	50	74.5	50	83	84.6	79.5	73.7	54.4	30.4	55.4	33.3	31.6	0
Charged for prostitution	NA	NA	0	0	2.1	11.1	0	6.7	0	15.4	0	33.3	0.6	4.3	21.7	0	0	0
Charged for major driving violations	62.3	31.3	37	15.4	41.7	16.7	17.6	0	40.4	15.4	34.9	7.5	41.4	4.3	41.7	25	15.8	14.3
Family/social relationships																		
Family history (%)																		
Alcohol problems mother	14.5	16.1	8.7	15.4	12.5	22.2	NA	NA	19.6	15.4	14.3	27.5	0.7	5.3	4.6	8.3	16.7	0
Drug problems mother	8.6	31.3	2.2	10.3	10.4	11.1	NA	NA	6.7	15.4	3.8	7.5	0.7	10.5	3.4	8.3	0	0
Psychiatric problems mother	27.5	53.1	13.6	38.5	16.8	5.6	NA	NA	23.9	15.4	11.7	17.5	10.6	10.5	18.6	27.3	33.3	28.6
Experienced serious problems with mother	47.1	75	37	68.4	62.2	57.9	71.7	86.7	60.9	84.6	59.3	76.9	54.1	72.7	61.6	66.7	52.6	85.7

	Norway		Sweden		Belgium		France		Germany		Scotland		Greece		Italy		Spain	
Living situation (%)																		
Living with partner with/without children	21.4	31.3	30.4	53.8	14.3	15.8	25	33.3	23.4	38.5	33.7	51.3	14.1	34.8	15.1	41.7	31.6	14.3
Living alone with children	0	6.3	2.2	10.3	0	0	0	13.3	0	7.7	0	2.6	1.3	0	0	0	0	14.3
Living together with parents	15.7	6.3	0	0	24.5	36.8	23.1	20	25.5	7.7	18.1	10.3	42.3	30.4	53.5	33.3	52.6	42.9
Living alone	41.4	21.9	63	33.3	18.4	21.1	26.9	20	31.9	23.1	19.3	2.6	12.8	13	8.1	0	0	0
Living with person with alcohol/drug use	17.1	25.8	2.2	25.6	24.7	50	11.5	26.7	15.2	15.4	28.2	73	19.1	56.5	30.2	58.3	21.1	14.3
Satisfied with free time	30	12.5	26.7	39.5	19.4	26.3	38.5	57.1	32.6	38.5	26.5	43.6	22.4	47.8	30.2	50	15.8	42.9
Serious problems with sexual partner/spouse	40	70	69.4	59.5	52.3	70.6	75	55.6	68	72.7	56.3	89.5	53.5	69.6	64.3	41.7	52.9	71.4
Emotionally abused	49.3	75	39.1	76.9	63.9	78.9	43.1	66.7	41.3	76.9	62.2	97.4	73.2	91.3	63.5	50	52.6	57.1
Physically abused	26.1	59.4	23.9	56.4	38.1	68.4	23.5	53.3	28.3	53.8	35.4	76.3	19.9	69.6	38.4	58.3	10.5	57.1
Sexually abused	11.6	40.6	2.2	35.9	17.7	42.1	7.8	53.3	2.2	23.1	6.1	55.3	2.5	39.1	2.4	25	15.8	42.9

	Norway		Sweden		Belgium		France		Germany		Scotland		Greece		Italy		Spain	
Psychiatric situation (%)																		
One or more times treated as outpatient	20	46.9	11.8	29	17.6	28.6	41.2	81.8	6.5	50	17.6	22.6	9.3	22.2	16.2	36.4	16.7	0
Experienced serious depression	55.7	71.9	71.7	66.7	60.2	63.2	80.8	93.3	34	61.5	59.8	80	41.1	69.6	50	41.7	52.6	85.7
Been prescribed medication	40	40.6	47.8	69.2	45.9	57.9	59.6	86.7	12.8	38.5	27.7	64.9	10.1	13.6	25.9	41.7	42.1	57.1
Experienced serious thoughts of suicide	64.3	78.1	41.3	48.7	55.1	68.4	61.5	93.3	53.2	46.2	42.2	76.3	39.7	63.6	34.1	58.3	26.3	42.9
Attempted suicide	35.7	62.5	26.1	36.8	43.9	63.2	43.1	73.3	25.5	38.5	36.6	62.2	22.2	57.1	25.9	41.7	31.6	71.4

A large proportion of the male residents of the Norwegian TCs injected drugs (97.1%).

A large proportion of TC residents have been charged for possession and for dealing in drugs, the percentages being particularly high for TCs in Norway (82.9% and 67.7%) and Germany (72.3% and 84.6%). In Germany and Sweden, even more women have been charged for this. The percentages are somewhat lower for crimes of violence. A large proportion of people have had one or more convictions (the highest percentage was 92.2% for men and 84.6% for women). The data suggest fewer convictions in the southern part of Europe. In most TCs, more women have been charged with prostitution. There is no information available for Norway, as the question was not asked in the Norwegian ASI. More men than women in TC treatment have been charged with major driving violations.

Gender differences were found only concerning the alcohol, drug and mental health problems of the mother. More women in TC treatment have a mother with an alcohol problem. In Belgian and Scottish TCs, 22.2 percent and 27.5 percent of the women, respectively, reported having a mother with an alcohol problem. More women also have a mother with a drug problem, particularly for the women in Norwegian TCs (31.3%). At first glance there seems to be a large number of men and women in TCs with mothers with mental health problems, particularly for Norwegian TC residents (27.5% and 53.1%, respectively). There is no information for the family history of the French clients. A large proportion of the residents have experienced serious problems with their mothers in their lifetime, particularly in France (71.7% of the men and 86.7% of the women). More women have serious problems, except for Belgian TC residents (62.2% of the men and 57.9% of the women).

More female than male residents in the TCs have lived with a partner, some with and some without children. A higher proportion of the women also live alone with their children. Men in TCs live together with their parents or live alone to a greater degree. A higher proportion of women live together with someone who has a current alcohol problem or someone using drugs. In Belgian, Scottish, Greek and Italian TCs, more than 50 percent of women live together with someone who has an alcohol problem or uses drugs (50%, 73%, 56.5% and 58.3%, respectively). Women in TC treatment are more satisfied with the way in which they spend their free time. Men and women in French TCs are most satisfied (38.5% versus 57.1%). A large proportion of residents have experienced

serious problems with their sexual partner or spouse; in most countries these are women.

It should be noted that women in TCs have been emotionally, physically and sexually abused to a greater degree. The rate of abuse of women is high, particularly for emotional (range from 50% to 97.4%) and physical abuse (range from 53.3% to 76.3%), but sexual abuse (range from 23.1% to 55.3%) cannot be ignored either. There is no trend in relation to abuse of women in the different parts of Europe.

Female TC clients are treated as outpatients for their psychological or emotional problems to a greater degree. The percentage of both men and women who have ever been treated as outpatients is very high for the French TCs (41.2% for men and 81.8% for women).

More women have experienced serious depression in their lives. The percentage is again particularly high for the clients in French TCs (80.8% for men, 93.3% for women), which is not surprising when compared with the high percentage of people treated as outpatients for psychological problems. Women in TCs are taking more prescribed medication for their psychological problems (range from 13.6% to 86.7%). This could probably be explained by their more serious psychiatric condition. The percentages are again particularly high for France (59.6% for men versus 86.7% for women). Female TC residents have experienced more serious thoughts of suicide during their lives (for France as many as 93.3% of the women). In the southern part of Europe, clients have less commonly experienced serious thoughts of suicide. In all countries, women in TCs have also attempted suicide more often.

2.3.2 TREATMENT CHARACTERISTICS OF THE PARTICIPATING CENTRES

Table 2.2 presents the treatment characteristics of the different participating TCs. The first two items in the table deal with the "main orientation" and the "main treatment orientation" of the treatment centres. The main orientation is the etiological and philosophical background of the TC. The main treatment orientation is the managed treatment model in the programme. The different centres were asked to label their orientation and their treatment programme. Different possible answers were given. A scientific orientation could be understood as theory-based, on the basis of the treatment orientation.

Table 2.2: Treatment characteristics of participating centres

BioMAPS Criteria	Norway 5 centres	Sweden 3 centres	Belgium 4 centres	France 5 centres	Germany 1 centre	Scotland 3 centres	Greece 3 centre	Italy 5 centres	Spain 1 centre
Main orientation	3: theory-based 2: self-help movement	2: theory-based 1: self-help movement	2: self-help movement 1: pluralistic 1: none	5: educational	1: theory-based	3: educational	3: self-help movement	3: theory-based 1: self-help movement 1: none	1: theory-based
Main treatment orientation	3: psychoanalytical/ dynamic 1: cognitive/ behavioural 1: relational	2: pragmatic 1: cognitive/ behavioural	2: relational 1: cognitive/ behavioural 1: psychotherapeutic/ systemic	2: psychoanalytical/dynamic 1: psychotherapeutic 1: eclectic 1: relational	1: cognitive/ behavioural	3: relational	2: relational 1: psychoanalytical/ dynamic	3: cognitive/ behavioural 2: relational	1: relational
Target problem	4: alcohol 4: prescription drugs 5: illicit drugs 5: poly-substance 3: psychiatric disorder 3: DD 5: criminality 2: gambling	3: alcohol 3: prescription drugs 2: illicit drugs 3: poly-substance 1: psychiatric disorder 3: DD 1: criminality	4: alcohol 4: prescription drugs 4: illicit drugs 4: poly-substance 2: psychiatric disorder 2: DD 1: criminality 2: gambling	2: alcohol 3: prescription drugs 5: illicit drugs 3: poly-substance 3: psychiatric disorder 3: DD 1: criminality	1: illicit drugs 1: poly - substance 1: psychiatric disorder	2: alcohol 3: illicit drugs 1: poly - substance 1: psychiatric disorder 1: DD 1: criminality	3: alcohol 3: prescription drugs 3: illicit drugs 3: poly-substance	3: alcohol 1: prescription drugs 5: illicit drugs 2: poly-substance 1: psychiatric disorder 2: DD 2: criminality	1: alcohol 1: prescription drugs 1: illicit drugs 1: poly-substance 1: DD

BioMAPS Criteria	Norway 5 centres	Sweden 3 centres	Belgium 4 centres	France 5 centres	Germany 1 centre	Scotland 3 centres	Greece 3 centre	Italy 5 centres	Spain 1 centre
Target group	1: homeless 2: couples 1: families 3: ethnic minorities 5: females 5: males	1: homeless 1: couples 1: females 2: males	2: homeless 4: ethnic minorities 3: females 4: males	3: homeless 2: couples 2: families 1: ethnic minorities 5: females 5: males	1: homeless 1: couples 1: ethnic minorities 1: females 1: males	1: homeless 1: ethnic minorities 2: females 3: males	1: homeless 1: couples 2: families 1: ethnic minorities 3: females 3: males	2: homeless 3: couples 1: families 1: ethnic minorities 4: females 4: males	1: homeless 1: couples 1: families 1: females 1: males
Age	18+	20+	15+	18+	18+	18+	18+	15+	18+
Acceptance of involuntary admissions	4 centres	3 centres	3 centres	2 centres	1 centre	3 centres	1 centre (1 missing)	5 centres	No
Accepted substances at the unit	2: methadone 4: anti-depressants 4: anti-psychotics	2: methadone 3: benzodiaze-pines 3: anti-depressants 3: anti-psychotics	1: alcohol 1: benzodiaze-pines 2: anti-depressants 2: anti-psychotics	5: methadone 1: benzodiaze-pines 5: anti-depressants 5: anti-psychotics	1: anti-depressants 1: anti-psychotics	2: methadone 2: benzodiaze-pines 2: anti-depressants 2: anti-psychotics	2: no 1: missing	1: methadone 2: benzodiaze-pines 3: anti-depressants 2: anti-psychotics	1: methadone 1: benzodiaze-pines 1: anti-depressants 1: anti-psychotics

A pragmatic treatment orientation could be described as based on experience and common knowledge. Most participating TCs described their programme background as theory-based, self-help-oriented or educational. They labelled their treatment model as relational, cognitive/behavioural or psychoanalytical/dynamic.

The item "target problem" gives us an overview of the different problems the centres focus on. Most centres deal with illicit drug use, except for one TC in Sweden, which primarily focuses on alcohol. Most TCs also take alcohol and medication abusers and poly-substance abusers. Half of them take dual diagnosis (DD) clients. They show interest in the assessment and treatment of different psychiatric disorders.

The "target group" of a TC tells us which specific population a treatment centre focuses on. Not all centres are mixed TCs. There is one TC specifically for women in Sweden, while the other two take only men. In Belgium three centres are mixed, while one focuses only on a male population. Two of the three centres are mixed in Scotland, while one takes only men. One centre in Italy has no specific target group.

The "age" item is the age from which clients are accepted in the unit. Most centres accept clients from the age of 18. Two countries, Belgium and Italy, accept younger clients in some of their TCs. Swedish TCs take clients from the age of 20.

The "acceptance of involuntary admissions" item means that a centre takes admissions which were made obligatory by the mental health compulsory civil commitment and/or the social welfare compulsory civil commitment and/or referrals by the criminal justice system. As can be seen in Table 2.2, most centres make involuntary admissions. In Sweden, for example, all centres participating in the project were compulsory care institutions (LVM-institutions). This means that all clients in the centres were obliged to follow treatment under the law on compulsory care within the social welfare system, on the grounds that the clients are a danger to themselves or to others.

The last item in the table gives an overview of the "accepted substances" in the different TCs. Most countries tolerate the use of psychoactive medication in their TCs. Belgium and Germany do not allow the use of methadone in their treatment centres. Two programmes in Greece do not permit any substances.

2.3.3 GENDER DIFFERENCES IN THE TREATMENT CHARACTERISTICS

Twenty-five of the 30 TCs are mixed treatment centres. Tables 2.3 and 2.4 present the gender differences respectively in the main orientation and in the main treatment orientation.

Table 2.3: Gender differences in main orientation

Main orientation		**Gender**	
		Man	*Woman*
Theory-based	(%)	75.9	24.1
	Pearson residual	-0.4	0.8
Self-help movement	(%)	83.5	16.5
	Pearson residual	1.0	-1.9
Pluralistic	(%)	84.2	15.8
	Pearson residual	0.4	-0.7
Educational	(%)	70.7	29.3
	Pearson residual	-1.2	2.4
None	(%)	84.4	15.6
	Pearson residual	0.4	-0.8
Total		78.7	21.3

A significant gender difference (χ^2 = 0.008, df = 4) was found for the main orientation. Studying the Pearson residuals, we noticed that the discrepancy was mainly due to two cells. Fewer women were observed in the self-help movement than one would expect under independence. More women were observed in the educational orientation.

Although the chi-square test (χ^2 = 0.130, df = 4) did not suggest any association between gender and the main treatment orientation, the Pearson residuals indicated that slightly fewer women were observed in the cognitive/behavioural treatment orientation than expected under independence. It could be interesting to bring these findings in relation to the development of the TC in Europe, as mentioned in the introduction.

Table 2.4: Gender differences in main treatment orientation

Main treatment orientation		**Gender**	
		Man	*Woman*
Psychoanalytical/Dynamic	(%)	75.0	25.0
	Pearson residual	-0.5	1.0
Cognitive/Behavioural	(%)	85.4	14.6
	Pearson residual	0.9	-1.7
Relational	(%)	77.6	22.4
	Pearson residual	-0.2	0.5
Psychotherapeutic/Systemic	(%)	81.8	18.2
	Pearson residual	0.5	-0.5
Eclectic	(%)	63.6	36.4
	Pearson Residual	-0.6	1.1
Total		78.7	21.3

2.4 DISCUSSION

This article starts with the finding that the European IPTRP project, providing a large database with characteristics of men and women in TC treatment, fails to report on gender differences. There are almost no European TC studies focusing on differences between men and women starting treatment. American TC research, however, showed us that there are important differences that should be taken into account when organising treatment (Ashley et al., 2003; Bride, 2001). In this study, the authors gave an overview of the gender differences in the TC clients and described certain characteristics of various European TCs. The authors also asked if the TC programme takes the differences between men and women into account. Is the "community as method" gender-sensitive?

2.4.1 WOMEN STILL UNDERREPRESENTED IN TC TREATMENT

Several authors have suggested that the traditional drug treatment was developed by men and for men (Ettorre, 1992; Lubinski, 1991). In the past two decades, however, increasing attention has been given to women, but they are still underrepresented in TC treatment (Eland-Goossensen, van de Goor, Benschop, & Garretsen, 1998; Hinojal Fonseca, Martinez, & Rodriguez-Hevia, 1988;

Kokkevi, Stefanis, Anastasopoulou, & Kostogianni, 1998; Poulopoulos & Tsiboukli, 1999; Ravndal et al., 2001; Ravndal & Vaglum, 1999). This is also the case in our study. As shown in Table 2.2, 25 of the 30 TCs indicate that women are their target group; however, on the basis of Table 2.1 we could see that there are still not many women in treatment. When comparing the different countries, we found more women in the Northern European TCs and Scotland. This is particularly the case for Sweden. This might be explained by the fact that in our Swedish sample there is a TC solely for women. Unfortunately, the TC primarily focuses on women with an alcohol addiction. In some Scandinavian TCs, the policy is also that a certain percentage of their population has to be of the female gender.

The fact that there are more men than women in TC treatment could mean that women experience some barriers in entering treatment. Several authors (Arfken, Borisova, Klein, di Menza, & Schuster, 2002; Callaghan & Cunningham, 2002; Davis et al., 2002; Kauffman, Silver, & Poulin, 1997) have given some explanations, which could be largely distinguished as being of two types. The first one concerns the societal expectations we have of women. Women's drug abuse is "sicker" and conflicts with what is seen as her traditional role as wife, women and carer. This stigma restrains women from seeking help for their drug problems, especially in treatment settings focusing primarily on substance abuse. The second type of explanation is linked to the fact that most treatment centres are inappropriate to women's needs. Because women are a minority, their gender-specific needs are less noticed.

2.4.2 GENDER DIFFERENCES IN CLIENT CHARACTERISTICS

The men in our dataset are on average older than the women, as confirmed by other research (Callaghan & Cunningham, 2002; Grella & Joshi, 1999; Odegard & Bretteville-Jensen, 2002). This is not surprising, considering that most TCs have not foreseen the need for childcare which is an important barrier for women of childbearing age to go into treatment (Ashley et al., 2003). Women could also be concerned about losing custody of their children if they seek help for their drug problem (Kristiansen, 1999). We found that more women live with their children and that more people, probably children, rely on them for their livelihood.

The result that women take more prescribed medication for their physical problems and that they are treated by a physician to a greater degree is consistent with the findings of earlier research (Fiorentine, Anglin, GilRivas, & Taylor, 1997; Simoni-Wastila, 2000) and could probably be explained by the fact that women

have more contact with low threshold services (van Oosten, Kok, & van Basel, 2000).

Our finding that, compared with men, more women are unemployed and fewer have a valid driver's license is also in agreement with other studies (Berglund et al., 1991) and is not surprising, knowing that this is the same in the general population and is linked to the societal roles we attribute to women.

In a study by Poulopoulos and Tsiboukli (1999), more men than women were found to inject drugs, while the opposite was found for cocaine use. Both findings are partly confirmed by our dataset. There was no significant gender difference in medication abuse, contrary to what is found in the general population (van Oosten et al., 2000). We could assume that clients in TC treatment do not have medication as their dominant abuse.

The differences between men and women in their criminal situation were rather small, especially for possession and dealing in drugs. This could mean that the number of women active on the drug scene is rising. The same was found from the Swedish SiS DOK system (2001): 36 percent of the men and 45 percent of the women have at some time been convicted for drug-related crime. More women have been charged with prostitution. This does not hold for Sweden because prostitution is not forbidden there. Buying sexual services is illegal, however, but is seldom if ever reported.

In Europe, Ravndal and Vaglum (1991; 1994) have stressed the importance of parents, partners and peer relationships for positive treatment outcome of women in hierarchic TCs. She noted considerable alcohol and psychological problems amongst the parents of these women. In our study, we also found a large proportion of alcohol, drugs and psychiatric problems amongst the parents of the TC population. More women than men have mothers with alcohol and drug problems. They also seem to have more serious problems with their mothers. More women than men also live together with someone with an alcohol or drug problem. They also have more serious problems with their partners. If support from a partner, parents and peers is important for women and men in treatment, we could say that women are disadvantaged.

A higher percentage of the women than men in our database have been emotionally, physically and sexually abused, in agreement with the literature (Jainchill et al., 2000; Ravndal et al., 2001). However, this is also the case in the general population, and the abuse of men may be underreported, we should endeavour to detect these problems at the beginning of treatment and take them into account when organising treatment.

As confirmed in the literature (De Leon & Jainchill, 1991; Hinojal Fonseca et al., 1988; Jainchill et al., 2000; Ravndal & Vaglum, 1999), in our dataset also a higher

proportion of women than men experience depression, take prescribed medication and have been treated for their psychological and emotional problems. They have suffered from thinking about and attempting suicide to a greater degree than the men have. However, we would probably find the same differences between men and women in the general population. We should ask ourselves how this comes about and how should we deal with it in treatment.

2.4.3 GENDER DIFFERENCES IN TREATMENT CHARACTERISTICS

There are some differences between men and women with respect to the main orientation of the TCs studied. More women than men were observed in the educational orientation, more men than women in the self-help movement. Since the TC encompassed more specific target groups (such as women), it has integrated other treatment modalities (Vandevelde & Broekaert, 2003). It seems that women prefer other treatment approaches than the self-help orientation of the traditional TC.

There was no significant difference between men and women with respect to treatment orientation. There was only a small difference in the cognitive/behavioural treatment orientation, which could mean that this one is less appropriate for women. Despite all the changes the TC has gone through, we cannot deny that not only in research but also in treatment a gender-inclusive framework has been largely ignored.

2.4.4 IS THE "COMMUNITY AS METHOD" APPROACH GENDER-SENSITIVE?

A confrontational technique that is typical for the "community as method" programme may not work for victims of abuse. They might profit by a trusting, safe and women-friendly environment (Davis, 1997; Grella & Joshi, 1999). The question remains whether such an environment could be guaranteed in a male-dominated treatment system.

Some TCs with a certain percentage of female clients organise, on a weekly or monthly basis, women groups or days to give women the opportunity to share their feelings and experiences. Although this is an initiative designed to show approval, we wonder whether it is useful in the existing male-dominated treatment system and whether we, by doing so, are not merely confirming the societal roles. Perhaps a better approach would be to organise a female-dominated treatment system as an equivalent alternative to the existing treatment system. Research on

gender-responsive treatment has shown that treatment settings that address women's needs show promising results (Trulsson, 2003). However, as reported by Bride (2001), gender-sensitive treatment entails more than providing "traditional" treatment in a single-gender environment.

2.4.5 SUGGESTIONS FOR FURTHER RESEARCH

The differences found between men and women could also be related to the kind of questionnaire used. Is the EuropASI gender-sensitive? Some researchers have criticised quantitative positivistic research methods for being too simplistic to examine the complexity of the social reality (Westmarland, 2001). Such methods treat all individuals as being equal and therefore do not reflect the patriarchal sociality in which the data are gathered (Graham, 1983). However, to ascertain whether the "community as method" approach is gender-sensitive, it is important to focus on men and women, but it is even more important to learn how these gender differences affect their lives separately.
The Video Addiction Challenge Tool (VACT) for women is a qualitative phenomenological research instrument, focussing on themes and events, which are important for women during their lives. It was recently developed on the Department of Orthopedagogics, with the help of women in TC treatment (Broekaert & De Wilde, in press). It is our hope that this tool will contribute to solving specific problems and deal with background characteristics of women in TC treatment.
The authors recommend more research focussing on the differences between men and women in treatment, with special attention given to how they cope with their specific characteristics, in order to make it possible to organise a gender-sensitive treatment programme. Quantitative research methods will be useful in producing the background data of men and women, but should be combined with other methods, e.g. qualitative ones.

2.4.6 LIMITATIONS OF THE STUDY

This study is not without limitations. Because the authors preferred to give the data for each country separately, the number of clients is rather small. Only descriptive methods were used, which means that the results should be handled with care. Another limitation concerns the use of the BioMAPS questionnaire. Due to implementation and translation problems of the instrument, the

information on specific treatment interventions is not complete (Segraeus et al., 2004). That is why we could only give the basic treatment characteristics.

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3

Problem severity profiles of substance abusing women in European therapeutic communities: Influence of psychiatric problems [12]

Abstract. This article aims to search for a specific female, psychiatric profile based on a large European sample of substance dependent clients (n = 828) entering therapeutic communities. First, all six areas of functioning of the EuropASI were included, using the composite scores to search for gender differences. Next, the "psychiatric" status section was selected for further study. A binary logistic regression was performed with gender as the dependent variable, and nine individual psychiatric items, country and age as predictors. According to this model a number of problem variables could be identified as being reported more often by women than by men in therapeutic community treatment. Women are more likely to report serious depression, problems in understanding, concentrating or remembering, being prescribed medication, and serious thoughts about suicide; they have also attempted suicide more often than men. Women find treatment for these psychological problems more important than their male counterparts. They also have a more severe history of abuse. Women in therapeutic communities may need specific treatment interventions for their more severe psychiatric needs.

[12] This chapter is based on: De Wilde, J., Soyez, V., Broekaert, E., Rosseel, Y., Kaplan, C., & Larsson, J. (2004). Problem severity profiles of substance abusing women in European therapeutic communities: Influence of psychiatric problems. *Journal of Substance Abuse Treatment, 26*, 243-251.

3.1 INTRODUCTION

Women are gaining more attention as a subgroup in the treatment of substance abuse. More studies report on the nature and severity of psychological and psychiatric problems of women in treatment (De Leon & Jainchill, 1991; Ravndal, 1994). In the European Therapeutic Communities (TCs), a culture of psychiatric assessment and research has been slowly but surely developing (Broekaert, Haack et al., 2002). This changing culture opens possibilities to investigate whether women in mainstream TC treatment suffer from underestimated psychiatric problems that may impair their recovery process. This article tries to provide empirical evidence for this issue by constructing a specific psychiatric profile for women in TCs. The severity of psychiatric problems in women entering drug-free substance abuse treatment is considered and some suggestions for more targeted treatment are proposed.

3.1.1 PSYCHIATRIC STATUS OF FEMALE RESIDENTS IN EUROPEAN THERAPEUTIC COMMUNITIES

- Psychiatric status

The European TC for substance abusers started its development and expansion in the early 1970s as a direct offspring of the American drug-free, hierarchic or concept TC (Broekaert, Vanderplasschen, Temmerman, Ottenberg, & Kaplan, 2000), which, in turn, was based on the Synanon-model (Rawlings & Yates, 2001). Over many years and even today, there is continuous interaction and influence between the American and European TC. This is evidenced not only by the treatment methodologies used in the TC, but also in research. In the past, TC research depended mainly on American researchers, such as G. De Leon, V. Biase, N. Jainchill, H. Barr and S. Holland (Broekaert, Raes, Kaplan, & Coletti, 1999). Jainchill was considered to be the leading scientist in the field of women and their psychiatric problems (Broekaert, Raes et al., 1999). Consequently, the study of European TCs can only take place by including the American research.
At the start of the TC movement in Europe (Broekaert & Slater, 2001), little attention was paid to the psychiatric status or the psychopathology of the residents. Addicts were considered to be "dope fiends," or "character disordered" people who needed to "change their behaviour first and deal with social-psychological issues later" (Janzen, 2001, p. 1). Influenced by the "anti-psychiatric" and "human potential movement", it was believed that a psychiatric

diagnosis was a label that interfered in the process of self-development and self-reliance (Broekaert, Vandevelde, Vanderplasschen, Soyez, & Poppe, 2002). Residents were described as "frozen personalities, disconnected from their deepest-level emotions, damaged through deprivation during infancy and childhood" (Casriel, 1972, p. 3). The psychological and pathological characteristics of residents were already beginning to be studied during the 1970s, primarily to determine personality changes and the success of TC treatment (De Leon & Jainchill, 1985).

Psychiatric assessment was not the first interest in those early years. Until the 1980s it was limited to a differential diagnosis between neurosis, antisocial personality, and character disorder on one hand, and psychosis, mental retardation, and brain damage on the other (Kooyman, 1992). Persons diagnosed as suffering from psychosis were excluded from the TC, as the method was considered to be too direct and too confrontational. Borderline personalities were in the centre of the discussion, since it was difficult to determine whether or not they belonged to the TC.

But the situation changed in the mid-1980s, when the European TC was confronted with a rapidly growing drug epidemic, the spreading of AIDS, new popular drugs, and petty delinquency. Emerging harm reduction approaches, including substitute prescription, forced the TC to reconsider its position (Broekaert & Vanderplasschen, 2003). The TC reacted by enlarging its method to include psychiatric patients and other new target groups such as homeless persons, prisoners, immigrants, ethnic minorities, women, and mothers with small children. The influence of research increased, the importance of social networks and family members became more prominent, and harsh encounter groups evolved into meetings in which dialogue became quintessential (Bracke, 1997a; Broekaert, Van der Straten, D'Oosterlinck, & Kooyman, 1999; Vandevelde & Broekaert, 2003).

Despite some remaining scepticism (Ravndal, 1994), this treatment differentiation and expansion of the method was the impetus for a more pronounced attention to the diagnosis of residents. Greater interest in psychopathology, psychiatric conditions, dual diagnosis, or comorbidity was stimulated by the emerging influence of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III; American Psychiatric Association, 1980) and the Addiction Severity Index (ASI; McLellan, Luborsky, Woody, & O'Brien, 1980), which was adapted to European standards (Hendriks, 1986). The proliferation of new managed care, and the

emphasis on integrated treatment systems based on the coordination and continuity of care, provided a further impetus for the differentiation of pathology, needs and demands of substance abusing clients (Vanderplasschen, De Bourdeaudhuij, & Van Oost, 2002). Under the influence of American researchers it became increasingly clear that the drug problem was not an isolated problem, but a complex constellation of intervening factors (Carroll & McGinley, 1998; De Leon & Jainchill, 1991). The reciprocal influence of medical (Brown, Melchior, Waite-O'Brien, & Huba, 2002), social and psychological problems (Jainchill, Hawke, & Yagelka, 2000), and comorbid psychiatric disorders (Brown et al., 2002; Carroll & McGinley, 1998) became generally accepted and further investigated by European researchers (Broekaert, Haack et al., 2002; Kaplan, Broekaert, & Morival, 2001; Ravndal & Vaglum, 1994). In turn, TC staff members gained awareness of the high rate of psychiatric comorbidity among the substance abusing population seeking treatment and learned that the nature and severity of the problems differ greatly between major subgroups.

- Psychiatric status of women

In the "Old Synanon" days, Chuck Dederich - Synanon's leader - had subtly placed women in an inferior position. His "Father Principle" suggested that character disordered people had "too strong a dose of mother love" and had never been properly "housebroken by father" (Janzen, 2001, p. 94). Early TC studies indicate that special rules were applied concerning the relation between the sexes. The residents were supposed to act as "brothers" and "sisters" in a large family. Engagement in sexual activities was forbidden (Sugerman, 1974, p. 23), primarily because this was seen as a "negative contract." The daily structure of the TC, the chain of command, and the harsh confrontation groups were extremely male-oriented. While those practices have changed over the years, women still experience difficulties today. According to an observation report by Martha Ottenberg[13], based on discussions with women at the Centro Italiano di Solidarietà di Roma, men in TCs often send out a strong underlying message, "Be good, be nice and you will be OK - I will protect you and no one will hurt you" (Ottenberg, 2000, p. 125).
On the other hand, according to M. Ottenberg, women tend to be in competition with each other. They have difficulties exposing themselves to each other with

[13] The maiden name of the late Martha Ottenberg is Martha Moldauer. Her statements should not be confused with those of her husband Dr. Donald J. Ottenberg, the former director of Eagleville Hospital in Pennsylvania and author of several papers on the TC.

regard to their sexual problems, fears, and anxieties, because they are afraid to be judged as unwomanly (Ottenberg, 2000). Occasionally, these issues have caught the attention of (mainly female) researchers or staff members. Several of them agree that women have specific characteristics and treatment needs (Broekaert, Vandevelde et al., 2002, p. 374; De Leon & Jainchill, 1991; Martens, 1999; Ravndal & Vaglum, 1994).

As a result, an increasing number of residential TCs have tried to address the specific needs of women and to expand their programmes to serve substance abusing women in general (De Leon, 1997; Martens, 1999). They have set up special female groups and activities and have established specific programmes for substance abusing mothers and their children (Bracke, 1997b, p. 60). However, despite these efforts, still too few treatment modalities are tailored specifically for female substance abusers (De Leon & Jainchill, 1991); women are still under the supervision of predominantly male staff members, and they are still outnumbered by men. Both in the United States and in Europe, the male-to-female ratio of admission to therapeutic communities is approximately 3:1 (De Leon & Jainchill, 1991).

Suffering from severe psychological, emotional, and psychiatric problems may be one of the most important reasons that substance abusing women enter treatment (Brown et al., 2002; De Leon & Jainchill, 1982, 1991; Jainchill et al., 2000). They show lower levels of self-esteem (Carroll & McGinley, 1998) and have a "triple negative self-image": as a person with a character disorder, as a person with an addiction problem, and as a woman in society (Martens, 1999). They feel guilty because they have failed as mother, partner, and woman (Van Damme, 1998). Furthermore, women accept the conventional view that their drug abuse is "sicker" or more deviant when compared to substance abuse by men. Women manifest significantly more psychiatric problems (Carroll & McGinley, 1998; Jainchill et al., 2000), they contemplate and attempt suicide more often than men (Ravndal, 1994). Women also seem to be diagnosed with additional DSM Axis I and II disorders more often: they tend to produce higher levels of depression and anxiety (De Leon & Jainchill, 1991). They suffer more from a phobia or from post-traumatic stress disorder (PTSD; Van Damme, 1998). With respect to PTSD, several authors (Jainchill et al., 2000; Ravndal, Lauritzen, Frank, Jansson, & Larsson, 2001) have concluded that psychopathology and substance abuse problems are significantly related to physical and sexual abuse: women have significantly higher rates of abuse than men, the difference is especially large for

sexual abuse (Jainchill et al., 2000). They are also often victims of domestic violence in later life (Jainchill et al., 2000).

In Europe the psychiatric status of women is rarely researched and to our knowledge no large European studies on this subject exist. The multi-site research of the BIOMED II IPTRP project provides us with a large quantity of data, of women in treatment as well as men. This article seeks to contribute to this research by searching for a specific psychiatric profile of women TC residents based on a large European sample.

3.2 MATERIALS AND METHODS

3.2.1 THE BIOMED II IPTRP PROJECT

- Data-collection and instruments

The data analysed in this article were collected for a major European research project entitled "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups (IPTRP)." The Statistical Programme for Social Sciences (SPSS) was used for all statistical analyses (SPSS Inc., Chicago, IL, USA). The project, subsidized by the Fourth Framework Programme of the European Commission BIOMED II (Biomedicine and Health Research), was coordinated by Maastricht University in the Netherlands in close collaboration with Ghent University in Belgium. The first results of the IPTRP project have now been published (Broekaert, Haack et al., 2002; Broekaert et al., 2001; Frank et al., 2001; Kaplan et al., 2001; Ravndal et al., 2001; Reichmann, Kaplan, & Jansson, 2001; Segraeus et al., 2004).
The main objective of the project was to identify and address the needs of "emerging dependency groups" in Europe. The project also aimed at setting up an international database with client data from substance abuse treatment centres in several European countries. Universities and or research centres from eight EU Member States (Belgium, France, Germany, Greece, Italy, Spain, Sweden and Scotland), and Norway as a non-EU partner, participated in this multi-site trial, which involved 33 residential treatment centres across Europe. National representatives in each country chose the different treatment centres. It was not their goal to reach a representative, random sample; rather they made use of techniques that involve targeted sample selection (Watters & Biernacki, 1989),

using BioMAPS (described below in section 3.2.2). This means that they selected the TCs on the basis of the number available in the country, their accessibility, their willingness to participate and the use of "community as method" as the main approach in treatment. This approach, which was introduced by G. De Leon, refers to the use of community as the quintessential element of the therapeutic community. "Community is both the context and method in the change process. It is the element of community that distinguishes the TC from all other treatment or rehabilitative approaches to substance abuse and related disorders. It is the use of community as method that distinguishes the TC from other forms of community (De Leon, 2000, p. 85)."
Each client entering a participating treatment centre between 1 May, 1997, and 31 October, 1998, was asked to provide informed consent to participate in the project. The European Addiction Severity Index (EuropASI; Kokkevi & Hartgers, 1995), the Structured Clinical Interview for Diagnosis (SCID; Spitzer, Williams, & Gibbon, 1992), the Maastricht Social Network Analysis (MSNA; Baars & Verschuren-Schoutissen, 1998), the Monitoring Area and Phase Systems (BioMAPS; Öberg, Gerdner, Sallmén, Jansson, & Segraeus, n.d.), the Video Addiction Challenge Tool (VACT; Broekaert & Soyez, 1997), and the Childhood Trauma Questionnaire (CTQ; Bernstein & Fink, 1988; Bernstein et al., 1994) were selected for implementation.

3.2.2. STUDY SAMPLE AND INSTRUMENTS

- Study sample

The EuropASI intake interview was conducted on 96 percent of all clients (Kaplan, & Broekaert, 1999) and was the only instrument that could be successfully implemented in all countries (Broekaert, Haack et al., 2002). For this reason, only information on this instrument was used for further analysis. Most of the clients were administered the EuropASI about 4 weeks after being admitted to the programme. This was to eliminate people in crisis from the sample.
In traditional long-term residential TCs, there are three main programme stages: introduction, primary treatment and re-entry. In order to obtain the most homogeneous study sample possible, it was decided to involve the clients taking part in the first and the second phase of the programme, clients in the re-entry phase were not selected for our study. According to the EuropASI criteria, these programme stages are respectively labelled as "detoxification residential (first phase)" and "drug-free residential (second phase)." Only centres focusing on

drug-free treatment were retained. Programmes labelled as "outpatient programmes," "substitution programmes," and "psychiatric hospitals" were eliminated from this study.
The final database contains data on 828 subjects in 30 different TCs, spread over Belgium, France, Germany, Greece, Italy, Spain, Sweden, Scotland and Norway.

- Instruments

The BioMAPS was an important tool in the selection of the participating treatment centres. Consisting of a unit form and a client form, the instrument was designed specifically for the IPTRP-project and aims to measure treatment setting characteristics as well as complementary data on intake, discharge, and follow-up of each client (Öberg et al., n.d.).
The EuropASI (Kokkevi & Hartgers, 1995) is the European adaptation of the fifth edition of the Addiction Severity Index (McLellan et al., 1992). Its validity and reliability have been established in European resident populations (Hendriks, Kaplan, Vanlimbeek, & Geerlings, 1989; McLellan et al., 1985). The instrument produces a multidimensional profile of clients by examining the frequency, duration, and severity of problem symptoms in six areas of functioning (medical, employment/support, alcohol/drugs, legal, family/social relationships and psychiatric) over the person's lifetime and, more recently, during the 30 days prior to the interview. Completion time is approximately 60 minutes.

3.2.3. PROFILE-DEVELOPMENT

Although the authors are mainly interested in psychological/psychiatric characteristics, they initially included all six areas of functioning of the EuropASI in their analysis. The first concern was to look for those areas of functioning where significant gender differences might be found. For this analysis, the authors used the ASI *composite scores* for the different areas of functioning. Although these give a rather rude measure of the severity of the problems in each area, they have the advantage of being well-defined, continuous, and based on objective information (Alterman, Brown, Zaballero, & McKay, 1994; McLellan et al., 1992). In any case, they seem to reflect the severity of problems in a more objective fashion than the so-called "severity ratings" which are based on an interviewer's subjective perception (Alterman, Brown, Zaballero, & McKay, 1994). However, one drawback of these composite scores is that they include only "past 30 days"

items. Especially for the psychiatric problem area, these items are less relevant, given that several authors have warned that most clients are generally anxious, depressed, and confused during the beginning of treatment (Brown et al., 2002; Carroll & McGinley, 1998; De Leon & Jainchill, 1982). Therefore, for this psychiatric section, the authors constructed a "lifetime" version of the composite score where all "past 30 day" items were replaced by their "lifetime" alternatives (the specific items used are given in Table 3.1).

Following these overall analyses, the authors looked for specific EuropASI variables that significantly ($p < 0.05$) differentiated women from men. By combining these "female-specific" variables, the authors attempted to construct a profile of women in therapeutic communities.

3.3 RESULTS

Data on 828 subjects were included in the final analysis; 637 (77.2%) residents were male, 188 (22.8%) female, three were missing. The mean age was 30 years (SD = 8.4) for men and 29.6 (SD = 8.9) for women, which is not significantly different. One hundred and sixty-one (22.2%) residents had no diploma.
In terms of alcohol and drug use, there were no important differences between men and women for lifetime use of alcohol and or drugs. Most of the clients were poly-drug users: 508 (81.9%) men and 141 (77.5%) women. Five hundred and nineteen (81.9%) men and 134 (72%) women injected drugs at least once.

3.3.1. GENDER DIFFERENCES BASED ON THE COMPOSITE SCORES

For each of the six problem areas in the EuropASI, composite scores were computed following the guidelines of Koeter & Hartgers (1996). For some areas, two composite scores were used to capture the different aspects of a problem area (e.g., for the area of Family/Social Relationships, a different composite score is used for the family and non-family relationships respectively). In addition, for the psychiatric problem area, a new composite score was constructed by replacing the "past 30 days" items by their "lifetime" equivalents. For each problem area, an appropriate linear model is fitted with the corresponding composite score(s) as the dependent variable(s), and the following selection of predictors: Age, Country,

Gender and the interaction between Country and Gender. Both Country and Gender were considered as fixed factors with nine and two levels respectively[14]. Note that, for this paper, the authors are especially interested in significant main effects of the factor Gender, but *not* for (significant) interaction effects between Country and Gender. In the latter case, the possible differences between genders may differ from country to country. Although these patterns may be interesting in their own right, in this paper the authors only seek differences between genders across countries. In the following, they summarize the main results for each problem area. To improve readability, the F-values of non-significant effects will not be reported.

- Medical status

For the medical problem area, significant effects were found for Age and Country, $F(1,756) = 6.8$, $p = 0.009$ and $F(8,756) = 2.7$, $p = 0.005$. Neither the effects of Gender nor the interaction effect between Country and Gender were found significant. The finding that there were no gender differences for the medical problem area may seem surprising, but note that only items used in the composite score are reflected.

- Employment and support status

For this problem area, two composite scores were available (i.e., one for the economic situation, and one for satisfaction in the work situation). The correlation between the two scores is fairly low ($r = 0.042$) and not significant ($p = 0.28$). Therefore, the scores were analysed separately. For both scores, the effect of Gender was significant: $F(1,802) = 6.5$, $p = 0.011$ and $F(1,648) = 4.831$, $p = 0.028$. The trend is clear: women in TC treament reported more employment problems, but are more satisfied with their work situation than men in TC. Apparently, this is true for most countries, since the interaction with Country was not significant.

[14] Note that the authors do not consider the country variable as a random factor. The selection of the countries was not a random, but very much restricted by several criteria.

- Alcohol and drug use

The two problem areas were treated together since the results exhibited a similar pattern. The only significant variable was Country: $F(8,749) = 13.6$, $p < 0.001$ for alcohol use and $F(8,596) = 32.7$, $p < 0.001$ for drugs use. No gender differences were found in either area.

- Legal status

For the legal problem area, several interesting patterns were found. Age had a significant effect on the composite score, $F(1,756) = 7.0$, $p = 0.008$. The younger the residents, the higher their score for legal problems. The main effect of Country was also significant, $F(8,756) = 10.1$, $p < 0.001$. The main effect of gender was not significant, but the interaction between Country and Gender was, $F(8,756) = 2.2$, $p = 0.025$.

- Family and social relationships

Two composite scores are available for this domain (one for family and one for non-family relationships). This time, the correlation between the two scores was fairly high ($r = 0.374$) and significant ($p < 0.001$), so consequently a multivariate test was conducted with the two composite scores as dependent variables. A significant effect was found for Country, $F(16,1382) = 5.3$, $p < 0.001$[15]. The interaction between Country and Gender was also significant, $F(16,1382) = 1.8$, $p = 0.025$.

- Psychiatric status

The main effect of Country was significant, $F(8,733) = 6.4$, $p < 0.001$. The main effect of Gender was also significant, $F(1,733) = 5.9$, $p = 0.015$. The interaction between Country and Gender fell just short of significance, $F(8,733) = 1.9$, $p = 0.05$. Interestingly, when using the lifetime version of the psychiatric composite score as a dependent variable, the main effect of gender remains,

[15] All multivariate F-tests reported in this paper are based on Wilks' lambda.

$F(1,727) = 16.5$, $p < 0.001$, but the interaction between country and gender disappears, $F(8,727) = 1.6$, $p = 0.134$.

In summary, significant main effects of gender were found in four areas: employment, legal status, family status and psychiatric status. In two cases (legal status and family status), the main effect of Gender was accompanied by an interaction effect between Country and Gender. The authors were mainly interested in gender differences that can be observed across all countries in a similar fashion; that is a main effect of Gender, but no interaction between Country and Gender. This pattern was found for two problem areas: the employment and the psychiatric area. The former area is clinically less important, because job training is provided when a person leaves residential treatment, usually during the last phase (re-entry) of the programme. Psychiatric problems should be dealt with after the addiction is handled, i.e. within the second stage of the programme (De Leon, 2003). The authors thus turned their attention to an examination of the psychiatric area, looking at the individual variables that have been used to construct the (lifetime version of the) composite score.

3.3.2. GENDER DIFFERENCES BASED ON THE PSYCHIATRIC ITEMS

To find out which of the psychiatric variables were responsible for the main effect of gender, the authors performed a binary logistic regression with gender as the dependent variable, and with nine individual psychiatric items as the main predictors. They also included the variables country and age in the model. The effective sample size for the analysis (after removing cases with missing values) was 761, 175 were female. The overall fit of the model was significant $\chi^2(18) = 120.6$, $p < 0.001$ (Nagelkere $R^2 = .222$). The individual regression parameters together with the Wald tests for each predictor are summarized in Table 3.1.

Table 3.1: The raw and exponentiated regression coefficients, and the Wald tests for predictors in the logistic regression model with gender as the dependent variable

Psychiatric items	**B**	**Wald**	**df**	**sign.**	**Exp (B)**
3. Experienced serious depression in your life?	0.268	1.290	1	0.256	1.308
4. Experienced serious anxiety or tension in your life?	-0.258	1.152	1	0.283	0.772
5. Experienced trouble understanding, concentrating in life?	0.049	0.052	1	0.820	1.050
6. Experienced hallucinations in your life?	-0.090	0.118	1	0.731	0.914
7. Experienced trouble controlling violent behavior in life?	-0.647	9.059	1	0.003	0.523
8. Been prescribed medication for any psychological problem in your life?	0.694	9.562	1	0.002	2.001
9. Experienced serious thoughts of suicide in your life?	0.031	0.014	1	0.905	1.032
10. Attempted suicide in your life?	0.819	10.820	1	0.001	2.269
Age	-0.080	23.447	1	0.000	0.923
Country	/	48.947	8	0.000	/
13. How important is treatment for psychological problems now?	0.073	1.157	1	0.282	1.076

Clearly, it was necessary to include Age and Country: both had a significant effect within the model. Variables with exponentiated regression coefficients higher than 1.0 are more typical for women than for men in TC. In other words, according to this model, women in TC treatment were more likely to report serious depression, trouble understanding, concentrating or, remembering, being prescribed medication, serious thoughts of suicide, and they also have attempted suicide more often than men. Women also found treatment for these psychological problems more important. When controlling for all other items, only the medical and suicide items were significant. From all psychiatric items, these two items may be considered the best indicators to differentiate between genders.

3.3.3 Additional variables related to Gender Differences

It appears from the literature that psychopathology and substance abuse problems are significantly related to physical and sexual abuse. Therefore, the authors repeated the same logistic regression as in the previous section, but they included an additional three items in the model: sexual abuse, physical abuse, and emotional abuse (during their life, not only in the past 30 days). Adding these three variables improved the fit of the model significantly, $\chi^2(3) = 101.0$, $p < 0.001$. For the other variables in the model, the parameters and p-values were almost identical as in Table 3.1, so they are not repeated here.

The direction of the effects of these variables is not surprising: women TC residents were significantly more likely to report that they have been victims of abuse, especially sexual, than men TC residents. Moreover, when controlling for all other variables, the effect of "sexual abuse" and "physical abuse" was significant, $Wald(1) = 40.4$, $p < 0.001$ and $Wald(1) = 12.5$, $p < 0.001$ respectively. The effect of emotional abuse was almost significant, $Wald(1) = 3.3$, $p = 0.068$.

3.3.4 Psychiatric Profile of Women in Therapeutic Communities

The above analyses identified five problem variables (available in the EuropASI) that are reported significantly more often by women than by men in TC treatment, which are listed below in decreasing order of importance as determined by the magnitude of the exponentiated regression coefficients as reported in Table 3.1.

1. Sexually abused in lifetime
2. Physically abused in lifetime
3. Attempted suicide in lifetime
4. Being prescribed medication for any psychological or emotional problem in lifetime

Five other "lifetime" variables also showed a trend ($p > 0.05$) toward being reported more often by women (Emotionally abused; serious depression; importance of treatment for psychological problems; trouble understanding, concentrating, or remembering; and serious thoughts of suicide).

3.4 DISCUSSION

Results from this European study indicate that there are important differences in the psychiatric status of men and women in TC treatment. These results are consistent with past research (Fridell in Ravndal, 1994). American and European studies indicate that women in mainstream TC treatment have more psychological and emotional problems (Brown et al., 2002). They are more depressed (De Leon & Jainchill, 1991), have more trouble understanding, concentrating and remembering, have been prescribed more medications for their psychological and emotional problems and they have more serious thoughts of suicide and have attempted suicide more often (Ravndal, 1994).

Many women also have histories of emotional, physical, and sexual abuse. These findings suggest that women in TC treatment have special and pronounced needs.
Previous studies have demonstrated that residents receiving treatment specifically tailored to their clinical needs are more likely to complete the programme (McLellan et al., 1997; McLellan, Woody, Luborsky, O'Brien, & Druley, 1983; Winick & Evans, 1997). Ravndal and Vaglum (1994) illustrated that women who are able to finish TC treatment had close contacts with other women, were less involved with men, found warmth and emotional support in their peer groups, and experienced positive identification with strong mothers who were not subordinated to their partners. Women who report more deviance among their friends, who didn't complete high school, and who had been arrested in the 6 months before admission were less likely to complete treatment (Knight, Logan, & Simpson, 2001).

Additional treatment modifications may be needed in order to construct a more female-friendly environment. Bride (2001) found that to improve treatment outcomes for substance abusing women, gender-specific treatment must provide more than traditional treatment in a single-gender environment. A treatment that accepts more medication, includes more dialogue instead of confrontation, employs more individual psychotherapy, and places a stronger accent on the creation of a milieu with less hierarchy may be more appropriate for women in TC settings.
Furthermore, women may need to have the opportunity to share their experiences related to gender abuse in special female groups, through which women can examine their negative experiences of abuse in relationships and discover current changes in their perceptions and attitudes (De Leon, 2000). Women and men appear to deal with trauma in different ways: women tend to internalise the

trauma associated with abusive experience(s), while males externalise it (De Leon & Jainchill, 1981-1982; Jainchill et al., 2000). This suggests that there might be some evidence for a modified approach for women during the initial stages of treatment. However, such a proposition has to be balanced with the traditional TC belief that, during the first stages of treatment, the addiction problem itself should be the centre of treatment and women as well as men should not get involved with inner, often self-defeating thoughts and emotions.
To further resolve these questions it is important to have a better understanding of the specificity of the problems women have when entering a TC, and it is important that diagnosis and assessment receive a more central place.

3.5 CONCLUSIONS

This study has limitations, such as the unequal distribution of residents over the various countries and the lack of specific knowledge of the content of the different centres using "community as method". Nevertheless, it may be concluded that the results generally supported the study's assumptions. Women in TC treatment were characterized by a generally more severe psychiatric profile than their male counterparts. This more severe profile may require specific treatment interventions and services focused on these symptoms. Many options still remain open concerning the requirements of this treatment and further research is clearly indicated. It would be interesting to investigate whether these "European findings" are transferable to the United States and other countries and cultures.

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4

Problem severity profiles of clients in European therapeutic communities: Gender differences in various areas of functioning [17]

Abstract. The BIOMED II "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups" project provided a relatively large sample (n=863) of men (76.7%) and women (23.3%) in therapeutic community treatment in nine European countries. This paper's aim is to search for gender differences in profiles of therapeutic community clients on the basis of the different areas of functioning of the EuropASI. A binary logistic regression model was used to avoid the confounding effects of country and age. Our findings confirm what is found in American literature: compared to men, women have a much worse profile in various areas of functioning when entering treatment. In response, they may require a gender-adapted set of therapeutic interventions at the moment they enter treatment.

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4.1 INTRODUCTION

In a previous European study published in *Journal of Substance Abuse Treatment*, the authors developed a psychiatric profile of women in therapeutic communities (TCs) (De Wilde et al., 2004). To do so, the composite scores for the areas of functioning of the EuropASI were used to search for gender differences, and the "psychiatric status" section was selected for deeper study.
In this paper, we will focus on the gender differences in the various other areas of functioning of the EuropASI. This will fill the gap in European TC research, as there are almost no European TC studies dealing with this issue. Most studies concern socio-demographic and psychological characteristics of TC populations as predictors of treatment retention, dropout, or outcome (Broekaert, Raes, Kaplan, & Coletti, 1999; Ravndal, 2003), and do not differentiate between men and women. However, in order to improve treatment for men and women, we should concentrate on their characteristics when they start treatment. American TC research has a much longer tradition, and some researchers have particularly focused on gender differences in TC client profiles.
This article will search for differences between men and women in different areas of functioning: medical status, employment and support status, drug and alcohol use, legal status, family history and family and social relationships, and psychiatric status (EuropASI-items). Possible treatment implications will be formulated.
In what follows, we will first provide a short overview of both American and European literature concerning profiles of TC clients and, if mentioned, differences between men and women.

4.1.1 TC RESEARCH IN THE U.S.: FOCUS ON GENDER DIFFERENCES

In the U.S., gender has been the subject of increasing concern among clinicians seeking to identify specific treatment needs of women in residential treatment (Doyle, Quinones, Tracy, Young, & Hughes, 1977; Stevens & Arbiter, 1995). This is reflected in the American literature by studies focusing on women only or on differences between men and women in TC client profiles.
A number of studies report on the much worse profile of substance abusing women when they enter TC treatment (Arfken, Klein, di Menza, & Schuster, 2001; Brown, Melchior, Waite-O'Brien, & Huba, 2002), despite their generally younger age (De Leon & Jainchill, 1991). Women in treatment tend to be much more vulnerable than men (Brown et al., 2002). They often come from deviant families in terms of drug/alcohol use, criminality and psychopathology (De Leon

& Jainchill, 1991; Knight, Logan, & Simpson, 2001). They suffer more from psychopathology (Carroll & McGinley, 1998; Jainchill, Hawke, & Yagelka, 2000): they tend to produce higher levels of depression (Brown et al., 2002; De Leon & Jainchill, 1991) and more often develop a combination of antisocial personality disorder plus depression (Messina, Wish, & Nemes, 2000). Women also seem to be diagnosed more with DSM Axis I disorders (Messina et al., 2000). They suffer more from a phobia or post-traumatic stress diagnosis (PTSD) (Jainchill et al., 2000). They yield higher rates on measures of abuse, especially sexual abuse (Jainchill et al., 2000), but also physical abuse (Messina et al., 2000). The relationship between psychopathology and abuse also appears to be much stronger for women than for men (Jainchill et al., 2000).
Women have more employment and social problems prior to their admission: lack of social resources and lower socio-economic status (Oggins, Guydish, & Delucchi, 2001). However, a study of Messina et al. (2000) did not find gender differences in employment history. Women are less involved in criminal activities, except for prostitution (Messina et al., 2000).

4.1.2 TC RESEARCH IN EUROPE: FOCUS ON CLIENT PROFILES

In Europe, the only author giving special attention to women in TC treatment is Ravndal (Ravndal & Vaglum, 1994b). Unfortunately, the author did not compare their profiles with those of the men in treatment. Ravndal found that female TC clients have many family problems: alcohol and psychiatric problems among their parents and feeling more or less rejected by both parents during their childhood.
Ravndal and Vaglum (1991a; 1991b; 1994a; 1998; 1999) researched hierarchic TC clients[18] with co-morbid psychopathology and the consequences for treatment. They did not focus especially on gender, but did find some differences: women have more psychological problems when they start up treatment.
Ravndal and others (2001) also wrote an article about childhood maltreatment among a Norwegian TC population. They found gender differences in physical, sexual and emotional abuse, and physical and emotional neglect. Women have significantly higher scores on all types of trauma except for physical abuse.
Another European TC research focusing on client profiles was a study by Broekaert and others (2001). He developed the Video Addiction Challenge Tool

[18] "Hierarchic TC clients" refers to clients who are treated in a hierarchic drug-free concept-based TC, a treatment modality originating from America. It is a self-help movement, primarily using behavioural modification techniques, where a hierarchic structure prevails (De Leon, 2000).

(VACT), an instrument employing a video depicting the "average life-story" of a client in a Belgian TC. It gives deeper insight into the clients' personal characteristics and treatment requirements. Some of the "average" characteristics of substance abusers in TC treatment include the following: unmarried, no children, relationship problems, unhappy childhood, no schooling beyond primary education, and suicide attempts. Because the greatest majority of TC clients are men (80%), it was concluded that the profile used in the video corresponds better to men than to women in treatment.

Poulopoulos and Tsiboukli (1999) researched socio-demographic differences, patterns of use, and dropout among clients of different Greek TCs. The results show that women are younger when they start using drugs and when they go into treatment for the first time. More women report using sedatives as their primary drug. They are more apt to live together with a drug-addicted partner. They are less likely to finish their elementary school and are more often unemployed. Other items were not analysed separately for men and women.

Hinojal Fonseca, Martinez and Rodriguez-Hevia (1988) investigated the profile of a Spanish population undergoing treatment in a TC. They did not deal with gender differences in particular, but they did find some differences between men and women. Women are generally a bit younger, are more often unemployed, are more likely to come from lower-class families, had more prior incarcerations, had more prior psychiatric treatment, and have attempted suicide to a greater degree. Men began their addiction with cannabis, women with heroin.

A possible explanation of why European TC studies have failed to attend to gender differences could probably be explained by the under-representation of women in TC treatment. To learn something about gender differences in TC client profiles, and through this about their different treatment needs, we should study treatment populations that consist of both men and women.

The BIOMED II "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups" project provided a relatively large sample of men as well as women in TC treatment in nine European countries. To our belief, this is the first large-scale European research project that permits a focus on gender differences in a systematic way. There is a danger, however, that gender differences may vary across countries. Therefore, a binary logistic regression model was used to avoid the confounding effect of country. In addition, we also controlled for age. Our goal is to detect only those client characteristics for which gender differences remain significant, no matter the country of origin, and no matter the age of the client. It is our hope that on the basis of these gender

profiles, we will be able to formulate some suggestions for a more gender-specific treatment.

4.2 MATERIALS AND METHODS

4.2.1 DATA COLLECTION AND STUDY SAMPLE

From 1996 until 1999, the research project "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups" (IPTRP) was funded within the framework of the BIOMED II (Biomedicine and Health Research) programme of the European Commission (Kaplan & Broekaert, 1999). Nine countries (Belgium, France, Germany, Greece, Italy, Spain, Sweden, Scotland and Norway) and 30 different therapeutic communities (TCs) spread over Northern, Central and Southern Europe participated. The whole was coordinated by the Maastricht University in the Netherlands in close collaboration with the Ghent University in Belgium. Results of the IPTRP project have been published in several articles (Broekaert et al., 2002; Broekaert et al., 2001; De Wilde, Broekaert, Segraeus, & Rosseel, in press; De Wilde et al., 2004; Frank et al., 2001; Kaplan, Broekaert, & Morival, 2001; Ravndal et al., 2001; Reichmann, Kaplan, & Jansson, 2001; Segraeus et al., 2004).

One of the aims of the project was to identify the characteristics of the "emerging dependency groups", which could be found in residential programmes using "community as method" (Eley Morris, Yates, & Wilson, 2003; Kaplan et al., 2001). The term "community as method" is introduced by George De Leon and refers to the quintessential element of the TC. "Community is both the context and method in the change process. It is the element of community that distinguishes the TC from all other treatment or rehabilitative approaches to substance abuse or related disorders" (De Leon, 2000, p. 85). The different TCs were selected by national representatives in each country. It was not their aim to reach a representative, random sample; instead, they made use of targeted sampling (Watters & Biernacki, 1989). More information about the treatment characteristics of the participating TCs can be found in De Wilde et al. (De Wilde et al., in press).

Different instruments were implemented during the project: the European Addiction Severity Index (EuropASI) (Kokkevi & Hartgers, 1995), the Structured Clinical Interview for Diagnosis (SCID) (Spitzer, Williams, & Gibbon, 1992), the Maastricht Social Network Analysis (MSNA) (Baars & Verschuren-Schoutissen,

1998), the Monitoring Area and Phase Systems (BioMAPS) (Öberg, Gerdner, Sallmén, Jansson, & Segraeus, n.d.), the Video Addiction Challenge Tool (VACT) (Broekaert & Soyez, 1997), and the Childhood Trauma Questionnaire (CTQ) (Bernstein & Fink, 1988; Bernstein et al., 1994).
Each client entering a participating TC between May 1, 1997, and October 31, 1998, was asked to provide informed consent to participate in the project. The EuropASI was the only instrument that could be successfully implemented in all nine countries, because it was the only questionnaire which was available in all languages of the participating countries (Segraeus et al., 2004). Therefore, only information on the EuropASI is used for the analyses reported in this paper.
The EuropASI (Kokkevi & Hartgers, 1995) is the European version of the Addiction Severity Index, adapted from the fifth edition of the American version (McLellan et al., 1992). Its validity and reliability have been tested in European resident populations (Hendriks, Kaplan, Vanlimbeek, & Geerlings, 1989). The EuropASI is a semi-structured, personal interview designed to provide important information about aspects of a client's life that may contribute to the person's substance abuse syndrome. The interview provides a multidimensional profile of clients by covering different areas of functioning: medical status, employment and support status, drug and alcohol use, legal status, family history and family and social relationships, and psychiatric status. These problems are measured over the person's lifetime and, more recently, during the 30 days prior to the interview.
The interview was conducted about three or four weeks after clients were admitted to the programme. At that moment, most clients were not in crisis anymore and in a fully detoxified status.
The final database contains the EuropASI data of 863 men and women admitted to TC treatment.

4.2.2 METHODOLOGY

- Preparing the data

The EuropASI consists of a huge amount of different items. For this study, we made our own selection of items we wanted to screen for gender differences. We did not use "past 30 days" items, because most of our clients were in treatment for that period.
All dependent items in our study are categorical. We decided to turn all items into binary items. This was done for two reasons. First, many subcategories of these items were of little interest and contained too few observations, if any. Second,

the relationship between gender and the binary dependent item can conveniently be expressed with an odds ratio (OR). To illustrate how we did some recoding, consider these examples: the item "usual employment pattern past three years" with eight possible options (full time, part-time regular hours, part-time irregular hours, unemployed, military service and so on) was simply recoded as "employed" or "unemployed." The items concerning drugs and alcohol use are recoded as "never used or less than one year" and "used for at least one year." The items about previous received treatment are converted into "not received" or "one or more times received." We also made three new items by computing all alcohol and drugs services, all psychiatric services, and all other services. The "legal" items are recoded as "never" and "one or more times charged/one or more convictions as a result of these charges."

In a second step, all items were removed with less than 10 observations for either men or women in our sample. Six items were removed: "previous received treatment in outpatient detoxification for alcohol", "previous received treatment in outpatient substitution for alcohol", "previous received treatment in day care services for alcohol" and "previous received treatment in other treatment services for alcohol", "living alone with children past three years", and "receiving pension for psychiatric disability."

For the family history, only data about the alcohol, drug, and mental health problems of the parents were used in the analyses. For the questions about having personal relationships and experiencing serious problems with people, only the items concerning mother, father, sexual partner/spouse, and children were taken into account.

- Data analysis

Since a previous study of the authors (De Wilde et al., 2004) revealed that some client characteristics may vary by country and age of the clients, we identified those items (n=100) for which the relationship between the target item and gender was dependent on either age or country. All statistical analyses were done with the statistical package R (www.r-project.org). We first screened for the items for which "country" played a confounding role. For each item, a binary logistic regression model was fitted with the following form:

$$Y \sim \text{age} + \text{gender} + \text{country} + \text{gender} \times \text{country}$$

This model was fitted 100 times, each time using one of the 100 binary items as a dependent variable (Y). For each item, we were only interested if the interaction term (gender x country) was significant. A significance level of alpha = 0.05 was used. (We are aware that the large number of tests may dramatically inflate the chance of Type I error; however, in this case, we felt that making a Type I error - rejecting the null hypothesis of no interaction effect while in fact there is none - is rather conservative in our case: if we make many Type I errors, this means that we remove too many items from the analysis.) For some binary items, the resulting 2 (gender) x 2 (Y) x 9 (country) frequency table contained empty cells. This was mostly due to three countries in which some of the ASI questions were not asked. For example, in Norway, no information on the item "prostitution" in the legal area was available. In Italy, no information was available on the item "driving while intoxicated." In France, no information about the family history was recorded. For these items, those countries were excluded from the regression analysis. A significant (gender x country) interaction effect was found for 14 items, which were removed.
Next, we screened for items for which "age" acted as a confounding variable. Again, for each item, a binary logistic regression model was fitted using the following model:

$$Y \sim \text{age} + \text{gender} + \text{country} + \text{gender} \times \text{age}$$

This model was fitted 86 times. A significant (gender x age) interaction effect was found for only four items, which were also removed.
Finally, the remaining 82 items were screened for gender differences. A binary logistic regression model was fitted with the following form:

$$Y \sim \text{age} + \text{gender} + \text{country}$$

No interaction terms were included in the model. This time, we were interested in a significant main effect of "gender." A significance level of alpha = 0.01 was used to select the items.
For each item with a significant effect of gender, we will report the odds ratios, and discuss the nature of their association.

4.3 RESULTS

4.3.1 CHARACTERISTICS OF THE STUDY SAMPLE

The study sample consists of 863 TC clients: 660 (76.7%) men and 200 (23.3%) women, three are missing. The mean age is 30 years (SD = 8.3) for men, 29.4 years (SD = 8.8) for women. Forty-two (28.4%) women have no diploma, compared to 130 (22.2%) men. Ninety-eight (50%) women are unemployed, 266 (40.9%) men.
Five hundred forty-one (82.3%) men have ever injected drugs, compared to 146 (73.7%) women. Two hundred sixty-seven (40.9%) male clients have a major substance problem with heroin, 66 (33.7%) female clients. The same amount of women reported poly-substance abuse as their major problem, compared to 180 (27.6%) men.

4.3.2 INTERACTION EFFECT WITH COUNTRY OR AGE

A significant (gender x country) interaction effect was found for 14 items: "treated for medical problems during past six months", "having valid driver's license", "ever used opiates", "previous received treatment in detoxification residential services for drugs", "previous received treatment in drug-free residential services for drugs", "previous received treatment in psychiatric hospital for drugs", "previous received treatment in other treatment services for drugs", "previous received treatment in all other treatment services", "admission suggested by criminal justice system", "charged for possession and dealing of drugs", "presently awaiting charges", "experienced serious problems with sexual partner/spouse", "emotionally abused", and "experienced hallucinations."
The interaction (gender x age) effect was significant for only four items: "ever used alcohol (over threshold)", "never married", "having personal relationship with mother", and "experienced serious thoughts of suicide."

4.3.3 GENDER DIFFERENCES

A significant main effect of gender was found for 25 items. In other words, for these items (see table 4.1), a strong relationship between the target item and gender was found, and this relationship is relatively homogeneous for each country and not dependent on the age of the client.

Table 4.1: Estimated odds ratios of the 25 items with a significant main effect of gender for each area of functioning.

EuropASI's areas of functioning	Lower CI	OR	Upper CI
Medical status			
Prescribed medication on regular basis	1.73	2.55	3.76
Employment/support status			
One or more people rely on person	1.55	2.53	4.15
Drug/alcohol use			
One or more times overdosed drugs	1.20	1.72	2.49
One or more times treated for drugs in outpatient substitution	1.23	1.97	3.15
Legal status			
Charged for crimes of violence	0.29	0.44	0.67
Charged for other crimes	0.30	0.49	0.80
One or more convictions	0.39	0.57	0.82
Charged for disorderly conduct	0.38	0.56	0.83
Charged for prostitution	2.44	5.22	11.14
Charged for driving while intoxicated	0.18	0.30	0.52
Charged for major driving violations	0.15	0.23	0.36
Family history			
Drug problems mother	1.64	3.06	5.73
Family/social relationships			
Satisfied with marital status	1.90	2.73	3.93
Living together with partner with or without children	1.53	2.21	3.19
Living together with parents	0.28	0.45	0.73
Living alone	0.30	0.49	0.80
Living with someone who uses drugs	2.44	3.65	5.46
Satisfied with free time	1.14	1.63	2.33
Experienced serious problems with mother	1.43	2.08	3.03
Physically abused	3.28	4.72	6.78
Sexually abused	6.55	10.38	16.45
Psychiatric status			
One or more times treated as outpatient	1.86	2.84	4.34
Experienced serious depression	1.23	1.78	3.15
Been prescribed medication	1.62	2.34	3.37
Attempted suicide	1.90	2.70	3.84

First and last column represent the lower and upper bound of the 95% confidence interval for the estimated odds ratios (middle column)

In what follows, we will briefly comment on these items for each area of functioning and discuss the nature of their relationship with gender.

- Medical status

A significant difference between men and women was found for only one item in the "medical" life area. The (estimated)[19] odds that clients in TC treatment report taking prescribed medication for a physical problem is 2.55 times higher for women than for men.

- Employment / support status

Again, in this area, only one item could be found showing a significant gender difference. More people rely on women (the odds are 2.53 times higher) for the majority of their food, shelter, etc., than on men in TC treatment.

- Drug / alcohol use

Gender differences were found for two items. Women in TCs have had more overdoses on drugs than men. In addition, they are treated more often in outpatient substitution programmes for their drug problems.

- Legal status

Different items show a significant gender difference within this life area. However, most of the time the relationship is reversed. Men are more likely than women to be charged for crimes of violence, for disorderly conduct, for driving while intoxicated, for major driving violations, and for other crimes. They have also had more convictions in comparison with women in TC treatment. On the other hand, women have been charged with prostitution to a greater degree.

[19] All reported odds are estimated, and depend on the current model and sample. However, from now on we will omit the word "estimated."

- Family history

The only significant difference between men and women in this area concerns the drug problem of their mothers. Women in TC treatment tend to report more often that they have a mother with a drug problem.

- Family / social relationships

This life area presents the most significant gender differences. Women in TC treatment seem to be more satisfied with their marital situation and with the way they spend their free time than men.
More women live together with their partner with or without children and with someone who uses drugs. Men live significantly more often with their parents, or they live alone to a greater degree.
Women experienced more serious problems with their mothers.
When starting a TC treatment, women report more often that they have been physically and sexually abused.

- Psychiatric status

There are four items of the psychiatric life area with a significant main effect of gender. Women have been treated more frequently as outpatients for their psychological problems. They have experienced more depression, have been prescribed medication more often, and have attempted suicide to a greater degree than men.

4.4 DISCUSSION

The aim of this study was to search for gender differences in profiles of TC clients on the basis of the different areas of functioning of the EuropASI. Although this study started with exploring differences between "men" and "women" – categories used by the EuropASI, corresponding with the "sex" of the persons – we prefer to use the word "gender." Differences that were found are not only related to biological sex differences, but even more to differences in gender, i.e. "the socially constructed roles, behaviours, activities, and attitudes that a given society considers appropriate for men and women"[20], or to an interaction of both (McCallum, 1998). Feminists have argued for decades that drug use and drug abuse are gendered (Ezard, 1998; Van Den Bergh, 1991). In what follows, we will try to understand the differences between men and women by giving "gender"-sensitive explanations. Understanding these differences is of critical importance, as they may or may not be risk factors for poorer treatment outcomes of women (Pelissier & Jones, 2005).

The amount of women in our sample is 1 to 4, which is similar compared to other TC studies. This could mean that women experience some barriers to going into TC treatment. The European BIOMED II project provided a relatively large database with the characteristics of men and women starting treatment, making it possible to search for gender differences. Since some client characteristics may vary by country and age of the clients, it was necessary to control for possible confounding effects of these variables.
We found a significant main effect of gender for 25 EuropASI items. This means that for these items there is a significant difference between men and women in TC treatment, regardless of the country of origin and the age of the client.
This study shows that substance abusing women differ from men in many issues surrounding their abuse; because of this, they may require a gender-adapted set of therapeutic interventions.

When comparing our results with the above-mentioned TC literature, these are more or less confirmed (Brown et al., 2002; Carroll & McGinley, 1998; De Leon & Jainchill, 1991; Jainchill et al., 2000; Knight et al., 2001; Messina et al., 2000). Women in TC treatment have more or, at the least, other substance-related

[20] Definition provided by the World Health Organization (available on: http://www.who.int/gender), "sex" is defined as "the biological and physical characteristics that define men and women (WHO, 2005)."

problems compared to men. Some of the differences found may be explained by the way in which the society looks at men and women (Ezard, 1998). Since women's drug use is seen as more deviant, women may wait longer to seek help for their substance abuse problems, especially in high-threshold substance abuse treatment programmes (Green, Polen, Dickinson, Lynch, & Bennett, 2002). Therefore, women's situation could be more severe when they finally choose to go into TC treatment.

The results of our study are also comparable with the profiles of clients in other alcohol and drug treatment settings. In our study, men and women do not differ significantly in their alcohol and drug use, nor in their major substance problem, which is comparable with the results of a review study on clients in different treatment settings (Pelissier & Jones, 2005). However, since women experience more severe health effects of drug and alcohol use (Brady & Randall, 1999), it is not surprising that the women in our study have more often overdosed on drugs. It is also illustrated that the women had already received more prior treatments in outpatient substitution programmes for their drug problem, which could mean that women feel less barriers to go to such low-threshold programmes. Having more prior treatment histories, however, could implicate more complex treatment needs (Grella & Joshi, 1999), and a higher dropout among the female population. In order to learn more about women's specific treatment needs, it is even more important to understand why women start to use alcohol and/or drugs, in which they differ from why men do (Ensminger, Brown, & Kellam, 1982).

The women in our study have a more severe medical profile. They report taking prescribed medication for physical problems to a larger degree than men. The same difference will be found in the general population and could be explained by the different societal expectations regarding male and female roles and medical behaviour. Women are allowed to express more emotions and exhibit more physical and psychological symptoms than men and also visit doctors more often than men (van Oosten, Kok, & van Bavel, 2000). Therefore, physicians and health clinicians may be more willing to prescribe medication to women (Gutierres, Patton, Raymond, & Rhoads, 1984).
We found that women have more people depending on them for the majority of their living, of whom we could assume that these are their children. Having children makes these women even more vulnerable, which is strengthened by the proliferation of literature focusing on the negative obstetrical, neonatal, and child development outcomes. Such studies do not examine treatment options for these women and do not address their specific needs (Carten, 1996). Because of the

importance of motherhood for many women – since this may be seen as a way to become a "normal" woman, who can take care of somebody – we should empower them in taking up their parental role and not punish them by taking away their children, as this may confirm their feelings of being a bad mother, who does not meet society's ideal (Trulsson, 2003; Young, 1997).

The differences found between men and women in the "psychiatric status" section are confirmed by our previously developed psychiatric profile for women. However, a review study on gender differences in mental health issues illustrated inconsistent findings across different studies (Pelissier & Jones, 2005). Some studies found more serious psychological and psychiatric dysfunction among women in treatment, others reported no differences between men and women. Although some of the studies may be executed within specific populations (e.g. mentally ill chemical abusers), questions could arise about the gender-sensitivity of some instruments. Since women express their psychological problems more easily, some questionnaires may overestimate women's problems (Franken & Hendriks, 2001).

One of the most frequently cited gender differences among substance abusers concerns their abusive histories. The above-mentioned studies illustrate that women show higher rates for sexual abuse, but for physical abuse the findings are less consistent. Our study finds differences between men and women in both abuse items, with the biggest difference of all found for sexual abuse, which means that this should attract attention within substance abuse treatment (Swift, Copeland, & Hall, 1996). Women's drug use may be a way to cope with the emotional pain of their abusive experiences (Van Den Bergh, 1991).

Different studies also confirm our findings for women in the areas of family history and family and social relationships: positive family history for substance abuse (Gregoire & Snively, 2001), being more apt to live together with their (substance abusing) partner (Acharyya & Zhang, 2003; Westermeyer & Boedicker, 2000) and children, and having more troubled relationships with others (Grella, Scott, Foss, Joshi, & Hser, 2003). The fact that they have substance abusing partners could increase the risk for relapses (Grella et al., 2003). It seems that the connection between substance abuse and the family situation is much stronger for women than for men, which is not surprising since girls are raised with the conventional notion that they have to take care of and affiliate with others, where boys are taught to be independent. Women's well being is, therefore, much more related to the quality of their relationships with others (Van Den Bergh, 1991).

The women in our study are less charged for criminal activities, except for prostitution. This could mean that women are less involved in criminal behaviour or that the criminal justice system is less severe to women's criminal activities,

which is mentioned by several authors who illustrate that the society assesses women as kind, emotional and not malicious (Nicolai, 1997). Stein and Cyr (1997) found that women arrested for prostitution are less likely to stay in treatment, which could mean that their needs are less met.

Caroll and McGinley (1998) stress the importance of identifying those substance-related problems in living early on in the treatment process, because this can enable the treatment staff to develop more individualized (gender-sensitive) treatment interventions and increase the retention rate. However, this study also showed that we should be critical in our instrument choice for assessing men and women's characteristics at treatment entry, since some instruments may be gendered (Wilke, 1994).

Gender has been rendered invisible for a long time, and therefore, substance abuse treatment programmes were developed from a purely male-point of view (Ezard, 1998). With an increased attention for women, the traditional TC-model was somewhat modified in order to improve treatment outcomes for women (Stevens, Arbiter, & Glider, 1989). De Leon (1997) found the modified TC to be a model with many powerful features to meet women's specific needs, since their complex needs could be addressed better in long-term residential treatment (De Leon & Jainchill, 1991). However, relatively few substance abuse treatment programmes offer specialized services for women, and effectiveness has not been fully evaluated (Ashley, Marsden, & Brady, 2003). Considering the above, gender-sensitive programmes should provide services addressing child and family care, and medical and mental health issues. But above all, these programmes must give women an opportunity to concentrate on their needs and desires away from their traditional concerns of social approval and the welfare of others (Copeland, Hall, Didcott, & Biggs, 1993). Stevens et al. (1989) argue to include special theme groups for women in the programme, to give awareness training to alter negative perceptions and patterns of derogatory communication that reflect gender stereotypes, and to organize special seminars (assertiveness training, health promotion, and current women's issues). Ashley et al. (2003) reviewed the literature on the effectiveness of drug treatment programmes for women. Six components seem to be important when dealing with substance abusing women: child care, prenatal care, women-only admissions, supplementary services and workshops that address women-focused topics, mental health and comprehensive programming.
All these gender-sensitive programming changes need to be implemented within a supportive environment if they are to succeed (Nelson-Zlupko, Dore, Kauffman,

& Kaltenbach, 1996). Hopefully, they will also help to remove the barriers women face when they choose to go into (long-term) residential treatment.

This study does not provide information on outcome or follow-up data of our studied population. A previous study (De Wilde et al., in press) showed us that the different European TCs do not systematically take women's specific needs into account. However, it would be interesting to carry out a large outcome study and search for gender differences. We could also learn something about the way in which men and women handle their own problems. Another limitation concerns the fact that we only made use of the EuropASI. We could broaden our results with more diagnostic instruments.
Despite its limitations, this study gave insight into the profiles of men and women at treatment admission and revealed that drug (ab)use is a complex issue, in which many biological and sociological variables interact. Determining the differences and understanding the societal context of gendered roles is important in order to provide a more gender-sensitive treatment and improve the treatment retention and outcome of women.

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5

The role of gender differences and other client characteristics in the prevalence of DSM-IV affective disorders among a European therapeutic community population [21]

Abstract. There is a lack of research illustrating the extent of psychiatric problems in European TCs. Furthermore, there is a need to get more insight into gender differences concerning comorbidity in the TC population. Trying to give an answer to previous shortcomings, three specific aims were formulated for the current study. The primary aim is to explore the lifetime prevalence of affective disorders in European TC clients. The second aim is to focus on related gender differences. Finally, client characteristics measured by the EuropASI are related to mood and anxiety disorders measured by the SCID-I. The implications for TC treatment are discussed. Logistic regression analyses are used. Nine out of ten substance abusers treated in a European TC programme have an affective disorder. Gender differences are noted for two anxiety disorders: men have more obsessive compulsive disorders, women more post traumatic stress disorders. Different client characteristics are related to the prevalence of any mood or anxiety disorder. This study revealed that not only gender but also other client characteristics should be taken into account when organising treatment. The TC is an appropriate treatment model, but psychiatric problems should be detected early in the treatment process and become part of an individualized treatment approach.

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5.1 INTRODUCTION

The therapeutic community (TC) modality was initially introduced in the United States as a group therapy answer to the growing population of young substance abusers. In those early years, the focus was almost entirely on the addiction, while there was no interest in psychiatric problems or assessment (Broekaert & Slater, 2001; Janzen, 2001).

The situation changed in the 1980s, when (TC-)clinicians and researchers became aware of the comorbid psychiatric disorders among many clients (De Leon & Jainchill, 1985). Several TC studies reported higher dropout rates in mentally ill chemical abusers (MICAs) (De Leon, 1974; De Leon, Sacks, Staines, & McKendrick, 1999; Hendriks, 1990). Consequently, modified TCs with mental health staffing were introduced in the United States. While traditional TCs are completely drug-free, the modified TCs allow the use of psychiatric medication and offer a more individualized, flexible programme with less confrontation and intensity. Other core features of traditional TCs such as reliance on peer self-help and the principle of "community as method" were retained (De Leon, 2000). Research has shown more favourable treatment outcomes for MICA clients treated in modified TC programmes (Carroll & McGinley, 1998; De Leon, Sacks, Staines, & McKendrick, 2000).

When it comes to psychopathology, women have been reported for being a more vulnerable group compared to men (Brown, Melchior, Waite-O'Brien, & Huba, 2002; Carroll & McGinley, 1998). Generally, women are more likely to be diagnosed with Axis I disorders (Messina, Wish, & Nemes, 2000). Jainchill, Hawke and Yagelka (2000) found that women showed higher rates on all measures of psychiatric disturbance and physical and sexual abuse but not for antisocial personality. However, women who are diagnosed with antisocial personality in turn are at greater risk for developing psychological distress (Grella, Joshi, & Hser, 2003). In reaction to previous findings De Leon (1997) concluded the modified TC to be an appropriate treatment model to meet not only MICA's but also women's special needs.

Although in Europe the drug-free TC was only introduced about a decade later than in the U.S., a comparable attitude towards psychiatric problems was found there. From the 1980s on, in European TCs there was a movement towards more professionalism and a growing interest in research and diagnostics (Broekaert, Raes, Kaplan, & Coletti, 1999). The TC gradually became more open to the

outside world: social network and family members became more important, harsh and confrontational techniques made room for more dialogue (Broekaert, Van der Straten, D'Oosterlinck, & Kooyman, 1999; Broekaert, Kooyman, & Ottenberg, 1998). At the same time, some psychiatric and general hospitals started special wards for substance abusers and (outpatient) mental health care centres specialized in substance abuse treatment. Consequently, substance abusers with severe psychiatric disorders were referred to psychiatric treatment. Nevertheless, persons with borderline personality disorders remained an issue, as it was not clear if they were better off in TC treatment or in psychiatric (medical) treatment. This was specifically the case for women, as they seem to score significantly higher on borderline scales than men (Ravndal & Vaglum, 1995).

European TC studies mainly reported on personality disorders among substance abusers (Ravndal, 2003). These disorders are associated with poor social functioning, higher dropout rates and adverse treatment outcomes (Ravndal & Vaglum, 1991; Seivewright & Daly, 1997). However, Kokkevi, Stefanis, Anastasopoulou and Kostogianni (1998) found Axis II personality disorders to be less important than Axis I psychiatric disorders in predicting attrition from TC treatment. A previous study of De Wilde et al. (2004) using the "psychiatric section" of the European Addiction Severity Index (EuropASI), revealed a much worse psychiatric profile for women compared to men. Unfortunately, in other European TC studies gender-specific relations were largely ignored.

It can be concluded that there is a lack of research illustrating the extent of psychiatric problems in European TCs. Furthermore, there is a need to get more insight into gender differences concerning comorbidity in the TC population. Trying to give an answer to previous shortcomings, three specific aims were formulated for the current study.

The primary aim is to explore the lifetime prevalence of Axis I mood and anxiety disorders in a European TC population. Analyses are limited to these affective disorders because they are the most common comorbid psychiatric Axis I disorders in the substance abusing population (Hendriks, 1990). The second aim is to focus on related differences between men and women. Finally, client characteristics measured by the EuropASI are related to the mood and anxiety disorders measured by the Structured Clinical Interview for Axis I Diagnoses (SCID-I). The authors discuss the implications for treatment in the European TCs.

5.2 MATERIALS AND METHODS

5.2.1 DATA COLLECTION AND STUDY SAMPLE

Data were collected between 1996 and 1999 in the framework of a major European collaborative project entitled "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups" (IPTRP) (Kaplan & Broekaert, 1999). The project was part of the Fourth Framework Programme of the European Commission BIOMED II (Biomedicine and Health Research). Centres from nine countries (Sweden, Norway, Belgium, France, Germany, Scotland, Greece, Italy and Spain) spread over Northern, Central and Southern Europe participated in the study. The project was coordinated by Maastricht University (the Netherlands) in close collaboration with Ghent University (Belgium).

One of the aims of the project was to identify the needs of "emerging dependency groups" in European TCs. Therefore, a large database was set up containing client characteristics of men and women admitted to TC treatment. The TCs included in the study consisted of a convenient sample chosen by national representatives in each country on the basis of availability, accessibility, willingness to participate and the use of "community as method" as main treatment approach. Techniques involving targeted sampling were used (Watters & Biernacki, 1989). Thirty treatment centres were selected for participation (see De Wilde, Broekaert, Segraeus, & Rosseel, in press).

The data collection in the IPTRP project has been described in detail elsewhere (Broekaert et al., 2002; Segraeus et al., 2004). The European Addiction Severity Index (EuropASI) (Kokkevi & Hartgers, 1995) was used for most clients (n=863). Additionally, other instruments were administered in subgroups of clients within selected TCs. The SCID-I (First, Spitzer, Gibbon, & Williams, 1996) was used for 150 clients in 10 TCs spread over five countries (Belgium, France, Germany, Scotland and Spain). The EuropASI and the SCID were both assessed about four weeks after admission. At that moment, most clients were not in crisis anymore and in a fully detoxified status. Several articles have been written about the results of the IPTRP project (Broekaert et al., 2001; De Wilde et al., in press; De Wilde et al., 2004; Frank et al., 2001; Kaplan, Broekaert, & Morival, 2001; Ravndal, Lauritzen, Frank, Jansson, & Larsson, 2001; Reichmann, Kaplan, & Jansson, 2001), but till today the SCID was never used.

This article will report on the SCID and EuropASI data of the subgroup of 150 clients.

5.2.2 INSTRUMENTS

The EuropASI (Kokkevi & Hartgers, 1995) is the European adaptation of the fifth edition of the Addiction Severity Index (McLellan et al., 1992; McLellan, Luborsky, Woody, & Obrien, 1980). It is a semi-structured interview that gives a multidimensional profile of the substance abuser and the severity of the addiction in several areas of functioning (medical, employment, alcohol, drug, legal, family/social and psychiatric), over the person's lifetime and during the 30 days prior to the interview. The EuropASI is administered by a trained interviewer. A severity rating is composed for each life area, indicating on a 9-point scale the severity of the client's problem and his or her present need for additional treatment.

The SCID-I (Spitzer, Williams, Gibbon, & First, 1992) is a semi-structured interview which provides diagnoses on Axis I of the DSM-classification system. It is assessed by a trained psychiatric clinician. The result of the SCID is a record of lifetime and current presence or absence of symptoms and syndromes.

The first SCID version, published in May 1990, was based on the DSM-III-R classification system. The current version of the SCID, produced in February 1996, assesses the DSM-IV. In the BIOMED II project both versions were implemented. The SCID-III-R was available in most languages and used in Belgium, France and Spain. The SCID-IV was only available in English and German at the time of the study and used in Scotland and Germany. The module for Post Traumatic Stress Disorder (PTSD) was not available in the German SCID version.

5.2.3 DATA ANALYSIS

Several items of the EuropASI were recoded to binary variables, as many subcategories of these items were of little interest for our research aims and contained too few observations. Because the study concerns a treatment cohort, the "past 30 days" items were not included in the analyses, as these items could yield a distorted impression of reality. All data were managed and analysed using SPSS for Windows (SPSS Inc. Chicago, USA).

In order to examine which client characteristics are related to the prevalence of any mood or any anxiety disorder (binary indicator), a binary logistic regression model was fitted with the following form:

$Y \sim age + gender + country + X$

This model was fitted 99 times, each time using one of the 99 (recoded) binary items of the EuropASI as independent variable (X). The model was first executed with mood as dependent variable (Y) and then with anxiety.
For each model, we were focusing on a main effect of the EuropASI item.

5.3 RESULTS

5.3.1 GENERAL CHARACTERISTICS OF THE STUDY SAMPLE[22]

The study sample contains 150 TC clients; 47 (31.3%) are women. The number of clients for each country ranges from 20 to 41.
The mean age for men is 28.7 years (SD = 5.9), for women 27.2 years (SD = 6). Thirty-one men and 26 women reported poly-substance abuse as their major problem (respectively 31% and 58%), followed by heroin use (27% for both men and women). The average time spent on taking heroin is 6.4 years (SD = 5) for men and 6.8 years (SD = 4.6) for women. Men and women used more than one substance per day for respectively 7.3 (SD = 5.2) and 8.6 years (SD = 5.8). Thirty-six women (78%) ever injected drugs, compared to 75 (73%) men.
Twenty-six women (57%) and 47 (47%) men are unemployed. Seventy-five (73%) men and 33 (70%) women are never married.
Throughout their lifetime, 11 (24%) women had received inpatient treatment for psychological or emotional problems, even more (14, 36%) had received outpatient treatment. Thirty (29%) men had received inpatient treatment for psychological or emotional problems, 22 (24%) had received outpatient treatment.

5.3.2 THE PREVALENCE OF MOOD AND ANXIETY DISORDERS IN A TC POPULATION

The lifetime prevalence of the different mood and anxiety disorders is summarized in table 5.1. Almost half of the TC population is diagnosed with a lifetime Axis I mood disorder (48.6%). Major depression is the most reported mood disorder (30.7%). The lifetime prevalence of any anxiety disorder is even higher (76.8%). Generalized Anxiety Disorder (GAD) occurs most often (24.1%); panic disorder, social phobia and PTSD have the same incidence (approximately

[22] These characteristics could differ from the characteristics of the whole sample of 863 clients.

one out of five). Other anxiety disorders, like Obsessive Compulsive Disorder (OCD) and simple phobia, occur less frequently (respectively 9.7% and 7%). Nine out of ten substance abusers treated in an European TC programme have a lifetime affective (i.e. mood and anxiety) disorder.

Table 5.1: Gender differences in the prevalence of mood and anxiety disorders (SCID-I)

Disorders	**Lifetime prevalence (%)**		
	Men n=103	Women n=47	Total n=150
Mood disorders			
Bipolar disorder	11.1	19.1	13.7
Dysthymia	12.2	13.6	12.7
Major depression	29.6	33.3	30.7
Any mood disorder	45.5	55.6	48.6
Anxiety disorders			
Panic disorder	18.4	21.7	19.4
Agoraphobia without panic disorder	2	4.3	2.8
Social phobia	20.6	20	20.4
Simple phobia	7.2	6.5	7
Obsessive Compulsive Disorder (OCD)**	13.1	2.2	9.7
Post Traumatic Stress Disorder (PTSD)**	11.8	34.3	19.4
Generalized Anxiety Disorder (GAD)	21.4	29.8	24.1
Any anxiety disorder	76.7	76.9	76.8
Any affective disorder	90.9	89.7	90.5

** $p < 0.05$

5.3.3 GENDER DIFFERENCES IN MOOD AND ANXIETY DISORDERS

There are no significant differences between men and women in the prevalence of mood disorders. Significant gender differences are noted for two anxiety disorders: men have more OCD ($p = 0.041$); women more PTSD ($p = 0.006$). There are no significant gender differences in the lifetime prevalence of any affective disorder.

5.3.4 CLIENT CHARACTERISTICS RELATED TO THE PREVALENCE OF MOOD OR ANXIETY DISORDERS

Table 5.2 reports the estimated odds ratios (and their 95% confidence interval) of the seven EuropASI items for which a significant main effect was found. These items were strongly related to the prevalence of any mood disorder.

Table 5.2: Estimated odds ratios of the seven items of the EuropASI which are significantly related to the prevalence of any mood disorder

EuropASI 's area of functioning	Lower CI	OR	Upper CI
Medical status			
Prescribed medication on regular basis	1.19	3.43	9.88
Alcohol / drug use			
Treated for drugs in a drug-free residential programme	1.12	2.71	6.58
Legal status			
Charged for crimes of violence	1.2	3.07	7.84
Family / social relationships			
Spending free time with family or friends with alcohol or drug problems	0.13	0.31	0.78
Psychiatric status			
Experienced serious depression	1.18	3.02	7.69
Been prescribed medication	1.13	2.66	6.25
Experienced serious thoughts of suicide	1.09	2.65	6.44

First and last column represent the lower and upper bound of the 95% confidence interval for the estimated odds ratios (middle column)

Only one item of the "medical" life area was significant. The (estimated)[23] odds to have a mood disorder is 3.43 times higher for clients who reported being prescribed medication for a medical problem. In the area "alcohol and drug use", there is a significant main effect for the item "being treated for drug problems in a drug-free residential programme". The odds that clients have a mood disorder is 2.71. Clients with a mood disorder reported more often that they have been charged for crimes of violence (the odds is 3.07 times higher). Furthermore, in the area "family and social relationships" one item showed a significant, though negative, main effect. Clients who reported that they spent their free time with

[23] All reported odds are estimated and depend on the current model and sample.

family or friends who also have alcohol or drug problems are less likely to be diagnosed with a mood disorder. In the area "psychiatric status", three items are significant. Clients with a mood disorder reported more often that they were: depressed, prescribed medication for psychological problems and experiencing serious thoughts of suicide during their lifetime.

Table 5.3 presents the (estimated) odds ratios of the two EuropASI items that are strongly related to the prevalence of any anxiety disorder.

Table 5.3: Estimated odds ratios of the two items of the EuropASI which are significantly related to the prevalence of any anxiety disorder

EuropASI's area of functioning	**Lower CI**	**OR**	**Upper CI**
Alchol / drug use			
More than one substance per day	1	4.23	18.05
Family / social relationships			
Sexually abused	1.1	4.1	15.3

First and last column represent the lower and upper bound of the 95% confidence interval for the estimated odds ratios (middle column).

Only one item of the area "alcohol and drug use" showed a significant main effect. However, the 95% confidence interval is very wide, which indicates a less reliable estimate. The odds that clients have an anxiety disorder is 4.23 times higher for poly-substance abusers. Furthermore, in the area "family and social relationships" clients with an anxiety disorder reported more often that they are sexual abused in their life's (the odds is 4.1 times higher).

5.4 DISCUSSION

This study explored the lifetime prevalence of Axis I mood and anxiety disorders among European TC clients and the gender differences in that group. Up to now most European studies have focussed on the Axis II personality disorders (EMCDDA, 2005); furthermore gender differences proved relevant in several American studies (Grella et al., 2003; Messina et al., 2000), but were never a focus of study in European TC populations. Additionally this study examined which characteristics measured by the EuropASI are related to the prevalence of

any mood or anxiety disorder. It was expected that this could be of interest in organising TC treatment (Majer, Jason, Ferrari, & North, 2002).

5.4.1 TC CLIENTS COMPARED TO OTHER POPULATIONS

The present study confirms that the lifetime prevalence of mood and anxiety disorders in a substance abusing population is high (van Limbeek, Wouters, Kaplan, Geerlings, & Alem, 1992). The results of our study were compared with the lifetime prevalence of psychiatric disorders in the general European population and we found higher rates among our study sample (Alonso et al., 2004). The relative frequencies of subtypes of anxiety disorders are also different between groups: while simple phobia is the most common anxiety disorder in the general population, GAD seems to be more common in the group of TC clients.

Of all mood disorders, major depression is most prevalent in both the general population and the TC group. The lifetime prevalence rates for major depression found in our population are comparable to those of Franken and Hendriks (2001), who studied a substance abusing population entering a psychiatric treatment centre. In general, figures for any mood disorder were comparable. Our TC population scored somewhat higher for the lifetime prevalence of any anxiety disorder. However, figures in the study of Franken and Hendriks (2001) may reflect an underestimation because they did not report on PTSD, an anxiety diagnosis that seem to be very prevalent among the substance abusing population (Majer et al., 2002). Both our study and the study of Franken and Hendriks (2001) found that the anxiety disorders were more common than the mood disorders.

5.4.2 GENDER DIFFERENCES IN MOOD AND ANXIETY DISORDERS

Landheim, Bakken and Vaglum (2003) studied gender differences in the prevalence of Axis I disorders in poly-substance abusers and pure alcoholics in an inpatient and outpatient treatment programme. Only current Axis I disorders (last 12-month) were reported. The authors found that female poly-substance abusers were significantly different from all other substance abusers (they suffered more often from major depression, simple phobia and PTSD) and consequently concluded that the pattern of comorbidity is different in men and women. Gender differences in major depression and simple phobia could not be replicated in our study but we did find significant differences for PTSD and OCD.

5.4.3 SCREENING VERSUS DIAGNOSTIC INSTRUMENTS

A previous published study on the same sample (De Wilde et al., 2004), using the EuropASI as a screening instrument for psychopathology, found more serious depression in women compared to men in TC treatment. These results could not be replicated in the present study, in which the SCID was used to diagnose psychopathology. Several explanations for these divergent findings can be raised. First, the clients assessed with the SCID-I (n=150) are only a sub sample from the total IPTRP study sample. Characteristics of the current sample may therefore differ, as e.g. SCID data were available for only five out of the original nine IPTRP countries. International comparative studies showed large country differences between specific diagnostic subcategories (Bijl et al., 2003). Secondly, the difference between the two studies may be caused by the use of different instruments. Screening instruments, such as the EuropASI, seem to inflate the difference in the prevalence of depression between men and women. This could implicate that there are more false-positives for women when scoring with the EuropASI; probably women have a lower threshold for admitting depressive mood. The actual formulation of items is different. The EuropASI asks "Have you had a significant period, in which you have experienced serious depression"? Gender differences may be a result in response styles – which are more critical in screening instruments – and not in actual symptomatology – which is controlled for in diagnostic instruments. It is possible that the EuropASI "psychiatric life area" is a limited indicator for psychiatric comorbidity (Franken & Hendriks, 2001; Hendriks, 1990).
In most European TCs, standardized psychiatric assessment instruments are not part of the intake protocol, because they are very time consuming. Screening instruments such as the EuropASI are used more often, as they fulfil the need to collect many information about problems in different life areas, commonly associated with addiction.

5.4.4 CLIENT CHARACTERISTICS RELATED TO THE PREVALENCE OF MOOD OR ANXIETY DISORDERS

Some EuropASI items from the "psychiatric" section are related to the prevalence of any mood disorder. Substance abusing persons with a mood disorder reported more often serious depression, serious thoughts of suicide and being prescribed medication for psychological or emotional problems during their life. We couldn't find any "psychiatric" item that showed a significant main effect

for the prevalence of any anxiety disorder. One would expect though that the EuropASI "anxiety" item is related to the prevalence of the Axis I anxiety disorder. Clients with an anxiety disorder are more often poly-substance abusers.
Clients with a mood disorder are more likely to have already received treatment in a drug-free residential programme. Several explanations are possible: persons suffering from psychiatric disorders are maybe at greater risk for relapse. Secondly, it is also possible that clients only enter treatment once their psychiatric problems have become more severe.
Substance abusers suffering from anxiety disorders are more likely to be sexual abused in their life. A previous study illustrated that mainly women are victims of sexual abuse (De Wilde et al., 2004). This is probably the reason why more women are diagnosed with PTSD, compared to men (Cottler, Nishith, & Compton, 2001). Persons with a mood disorder have been charged more often for crimes of violence; a finding that is also consistent with other research (Stalenheim & vanKnorring, 1996). Several studies have shown that persons charged and convicted for violence crimes are mainly men (Hser, Huang, Teruya, & Anglin, 2003).
In agreement with previous research findings (EMCDDA, 2005; Watkins et al., 2004), our study revealed that clients with a mood disorder are more likely to have a somatic illness for which they have been prescribed medication.
One client characteristic seems to have an extenuating influence on the occurrence of psychiatric disorders. Clients who reported that they spent their free time with family or friends who also have an alcohol or drug problem are less likely to develop an anxiety disorder. This finding may initially sound a bit surprising, but can probably be explained by the protective nature of social support (even this is "negative" support from an abstinence point of view) in developing psychiatric problems (Cohen & Wills, 1985; House, Landis, & Umberson, 1988).

5.4.5 TC TREATMENT FOR PERSONS SUFFERING FROM AFFECTIVE DISORDERS

Several American studies have illustrated that substance abusers suffering from psychiatric disorders are better off in long-term residential treatment (Moos, Moos, & Andrassy, 1999; Mueser, Drake, & Miles, 1997) as they have more and other treatment needs and are at greater risk for dropout (van Limbeek et al., 1992). Mueser et al (1997) argued that the substance abuse and psychiatric disorder should be treated simultaneous; a recent review study has illustrated that

greater levels of integration of substance abuse and mental health services (integrated treatment) is most effective (Brunette, Mueser, & Drake, 2004). The traditional TC expected the substance abuse disorder to be treated first (De Leon & Jainchill, 1982).
Currently, clients with comorbid psychopathology are admitted to European TCs, although they don't merely focus upon MICA clients. A recent study (De Wilde et al., in press) has showed that these TCs tolerate the use of psychoactive medication and integrate psychotherapeutic, psychoanalytical, relational and other treatment methods. Unfortunately, the same study revealed that most TCs do not differentiate between subgroups of clients. Gender and other client characteristics, which showed clinically relevant in research (Landheim et al., 2003; Marsden, Gossop, Stewart, Rolfe, & Farrell, 2000), are not taken into account in the treatment process. Consequently, these specific characteristics and problems remain a probably cause for dropout. It is therefore important that psychiatric problems should be detected early in the treatment process and become part of an individualized treatment approach.
Only then the European TC will reach its full potential to meet the needs of substance abusers suffering from mood and anxiety disorders.

5.4.6 LIMITATIONS OF THE STUDY

This study has several limitations. First, we were only able to assess 150 TC clients. Secondly, the choice for the SCID as a diagnostic tool was problematic. The SCID was not easily implemented within the BIOMED project. Frequently reported problems were: the time needed for conducting the interview, the complicated layout and structure of the instrument, and the extensive training needs for the interviewers (Segraeus et al., 2004). Therefore, the SCID was only administered in a subgroup of clients in specific countries. These were not representative of the whole study sample.
Furthermore, different SCID versions were implemented in the different countries (for DSM III-R and IV), often in non-standardized translations. This results in several missing cases, especially for PTSD, which was not available in the German SCID version.

5.4.7 SUGGESTIONS FOR FURTHER RESEARCH

Despite its limitations, this study contributes to the discussion on which instruments to use at the beginning of treatment, in order to detect the treatment needs of individual clients. Most screening instruments give a first, global picture of the person. Diagnostic instruments will provide a more in-depth analysis of a relevant domain of problems that affect almost all treated clients. Unfortunately, comprehensive standardized diagnostic instruments are often time consuming and need to be administered by clinical or trained staff with a psychiatric background. For the same reason these instruments are seldom used in general psychiatry. More studies on the ideal set of screening or diagnostic instruments at the beginning of TC treatment are needed.
Finally, it remains unclear how our TC sample relates to other populations in the psychiatric/addiction field. It would be interesting to compare TC clients with substance abusing clients admitted to psychiatric treatment. These studies could shed some light on treatment optimisation.

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6

Views of methadone maintained women on residential substance abuse treatment: a qualitative study [24]

ABSTRACT. Substance abuse treatment does not always seem to meet the treatment needs of women. This may be one of the reasons why women drop out of residential treatment or feel barriers against seeking help for their substance abuse problems. In most studies, the views of the women themselves have been largely ignored. This study aims to know why and where women seek help, what they like and do not like about residential treatment, and what their needs are. Interviews were conducted with women in a low-threshold substitution programme. Most women had an external reason to seek help, in which they were not always supported by their partner. The women's children were an important barrier for entering (residential) treatment. Many women were confronted with negative reactions when they seek help. The women's previous treatment experiences were mainly based on their experiences with therapeutic community treatment. It will be important to reach these women in a non-condemning way. They need a safe, homelike place where they can take their child(ren) and meet other women. The programme should adopt a holistic approach and provide social, instrumental, and cognitive support. The women's feelings of guilt and shame should be addressed

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6.1 INTRODUCTION

During the past two decades, an increased attention to women can be observed in substance abuse treatment and research. Several large-scale American studies have systematically looked for differences between substance abusing men and women in treatment (Acharyya & Zhang, 2003; Grella & Joshi, 1999; National Institute on Drug Abuse, 1989). Women differ from men in their drug initiation and their motivation to seek treatment (Amaro & Hardy-Fanta, 1995; Pelissier, 2004). Moreover, women seem to have many more problems surrounding their abuse. They experience more negative health effects because of their abuse (Lex, 1991) and are more frequently the victims of sexual and physical abuse (Brems, Johnson, Neal, & Freemon, 2004). Women have more psychiatric problems and their substance abuse seems to be more connected to their family situation (Davis & DiNitto, 1996; Robbins, 1989). Despite these gender differences, substance abuse treatment does not always seem to meet the special needs of women (Knight, Logan, & Simpson, 2001; Swift, Copeland, & Hall, 1996; Wilke, 1994). This may be one of the reasons why women drop out of residential treatment within 30 days of admission (Arfken, Borisova, Klein, di Menza, & Schuster, 2002).

In Europe, this gender-focused research tradition is less prevalent, which could be due to the small number of women in substance abuse treatment settings (Hakkarainen, 2003). A European research project, BIOMED II "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups," providing a relatively large sample of men and women in residential therapeutic community (TC) treatment (Broekaert et al., 2002), revealed that women are underrepresented in TC treatment, which means that women not only feel barriers against staying in treatment, but also against seeking treatment for their substance abuse problems (De Wilde, Broekaert, Segraeus, & Rosseel, in press). This seems especially true for women of childbearing age, who are afraid of losing their children when they choose to go into residential care (Kristiansen, 1999).

In the above-mentioned studies, the views of the women themselves have been largely ignored. Nevertheless, the women's own experiences with treatment in general and possible barriers against entering and remaining in residential treatment may help to address their needs more effectively and thereby improve treatment outcomes (Fiorentine, Nakashima, & Anglin, 1999). Therefore, women treated in a low-threshold substitution programme were asked about their

treatment initiation and experiences, whether they were satisfied with the help they received, and why they chose not to go into residential substance abuse treatment. The authors' aim is to know why and where women seek help, what they like and do not like about residential treatment, and what their treatment needs are. The implications of the findings for the treatment of substance abusing women will be discussed.

6.2 METHODS

The province of East Flanders, Belgium, has the most elaborated and differentiated network of services for substance abusers in the country (Vanderplasschen, De Bourdeaudhuij, & Van Oost, 2002). In the 1970s, the first residential initiatives for substance abusers (a psychiatric hospital and two therapeutic communities) were developed in that province (Raes, Lenders, & Geirnaert, 1995). The study sample was recruited from the MSOC (Medical-Social Care Centre) Ghent, since a registration study in the region around Ghent (the province of East Flanders) illustrated that women of childbearing age were more likely to be admitted to such low-threshold substitution programme compared to other ambulatory or residential settings (Vanderplasschen, Colpaert, Lievens, & Broekaert, 2003).

Several quantitative instruments, widely used in substance abuse research, have been criticized because they include a male-as-norm bias and therefore "add" women to male knowledge (Wilke, 1994). Since this study aimed to explore the views and opinions of the women themselves, a qualitative approach was chosen.
Semi-structured, open-ended interviews were conducted with 19 women. The women were recruited by means of a flyer, which was displayed in the waiting room of the centre. They received 5 € to participate. All interviews were carried out by the same female researcher, the first author of this article. She was at the treatment centre for half a day each week. The interviews took place between the end of August and the beginning of December 2004. The interview period was finished after the researcher has been in the centre for several times without having any participant.
Prior to the start of each interview, a written informed consent was obtained along with agreement to audiotape the conversation. After obtaining some general information such as age, living situation (partner/children), schooling, and work situation, several topics were brought up for discussion. The women were

encouraged to talk freely about their own thoughts and concerns, but attempts were also made to address most of the key issues with every woman. The different key issues were: (1) first treatment contact, motivation, and support; (2) treatment experiences, satisfaction, and needs; and (3) access to treatment and reasons for (or against) choosing residential.

The analysis of the interviews was carried out by the first author with five final-year master-level students. In a first step, all interviews were transcribed verbatim. Secondly, all researchers read the interviews and individually selected the different themes that arose from the interview material. After discussion in the research team, one final "tree structure" with main and sub-themes was generated. The tree structure contained the codes which would be used to classify the data according to the different themes.
The qualitative software package *"WinMAX 98"* was used to facilitate the systematic text-based analysis (Kuckartz, 1998). Each of the five students coded three or four interviews using the previously developed tree structure. All coded segments were controlled by the principal researcher; if there was an inconsistency, a discussion was held with the research team until agreement was reached.

6.2.1 STUDY SAMPLE

Nineteen women were interviewed. The average age of these women was 33 years and ranged from 20 to 50. Four of them had no children; the others had at least one child, and one woman had five children. For those women with more than one child, in most cases the children were from different fathers. The children did not always live with their mother due to temporary or permanent loss of custody. Several children were being raised by the woman's parents or by their father, the ex-partner of the woman. Other children had been placed in foster care or special juvenile care. Three children were already of age and lived by themselves. Nearly all of the women had a partner, but only half of them were living together with their partner. Two of the participating women had a lesbian relationship with each other and were living together. One of the women lived on the streets with her boyfriend, and one woman lived together with her parents and child.
One-third of the women had no qualifications at all, one-third had finished general secondary education, and one-third had received vocational training. Only five of the participating women had a job.

The majority of the women came to the programme to get their methadone, but also to talk to somebody from the staff. Less frequently mentioned reasons were: medical check-ups, budget support, getting help with their paper work, and making a phone call. One woman only came to the centre for syringe exchange.

6.3 RESULTS

6.3.1 FIRST CONTACT WITH SUBSTANCE ABUSE TREATMENT AND MOTIVATION TO SEEK HELP

All the women had their first experience in substance abuse treatment between the ages of 18 and 25. Eight of the 19 women got in touch with treatment because they wanted methadone or medication that could help them to quit their abuse. There were several reasons to search for help the first time, such as financial problems or the fear of losing their children or their job.

"At a certain moment they [social workers] said: 'Wouldn't it be better if we took away some of the burden by putting your children in a foster home during the week so that they're only with you for the weekends?' I guess then there was a click. Must've thought I couldn't do this. Got in touch again with the crisis intervention programme. It was losing my kids or going through with this. And in X this programme for mothers and their children had just been started." (Mother, age 37)

One of the women related that her son was her first motivation to go into treatment, but in the second place she did it for herself, to have a future together with her child. The women wanted to function again in a decent way. Two women had already lost custody of one or more children and were trying to get them back by seeking help for their substance abuse problems. Four women said that they went into treatment because this was a way of staying out of prison.

"There was some kind of pressure, because else I had to spend 18 months in prison and I already had my daughter at that time." (Mother, age 37)

One of the women said that her family insisted that she go into treatment. For another participant, the end of her relationship was the motivation to search for help. She did not want to give up her abuse at first, but she wanted somebody to

talk with. Almost all the women agreed that treatment only helps if you want it yourself. However, it is still a process of muddling through.

"They say you have to do it for yourself, but if you're this far gone there's no more 'yourself'. That's the last thing to worry about. It has to bring something. You first need a goal and if you eventually start doing it for yourself, that's even better. You've got to have a reason somehow. But it didn't immediately work out just fine as you know…" (Mother, age 38)

6.3.2 SUPPORT FROM SIGNIFICANT OTHERS

Four women felt supported by their parents. However, this support was not always linked to treatment. Their parents' homes were places to rely on when there was no other way out. One woman felt supported because her parents came to visit her in the programme. Other women received no support at all.

"My parents do not understand it. They know it only from television and they think they are all the same." (Mother, age 36)

One of the women could go to her parents at any time, but her boyfriend is not welcome.

"On Friday I go home to my parents again, not to do any drugs anymore. Two more days here, before I get taken in again [in psychiatry]. Then I can do it [use no drugs], when I'm home… Then I can eat a decent meal. My boyfriend can't come [to my parents' home]. My mother doesn't want it as long as I'm not doing well. And I don't want it either. It would be too easy otherwise, we could go and sit there both of us." (Women, age 20)

Twelve women said that they have a partner who also uses drugs. Five of them felt supported by their present partners because they could talk with them about their abuse. Six women come to the centre together with their partners or even met their partners at the centre. However, there was a time when their partners did not support them going into treatment. One woman said:

"In the beginning, he didn't want me to seek help. He's 37 and he's been using for 20 years. He thought that I'd end our relationship if I got treatment. He didn't like it at all, but now he's also on the right track." (Women, age 25)

6.3.3 TREATMENT EXPERIENCES: SATISFACTION WITH PREVIOUS RECEIVED RESIDENTIAL TREATMENT

Except for one, all of the women had had other experiences with treatment before they came to the substitution programme. Eight women had had long psychiatric treatment careers. Their experiences varied. Two women liked psychiatric treatment because they did not have to do anything and could talk a lot.

"It is easy there, you can take your time. You've got two hours to wake up. You don't have to clean. You can be lazy." (Women, age 20)

Two women had rather bad memories.

"You get a lot of medication to calm you down, so that you could sleep all day." (Mother, age 38 years)

It seems clear that they did not go to psychiatric treatment to quit their abuse, but rather to settle down.

Nine women had been in a TC programme. Sometimes it was for a very short period because they did not feel comfortable in the programme.

"I was in a TC for a week, but I couldn't handle it because I was missing my son too much. The conversations I had there with the residents got me even more depressed than when I was sitting at home with my parents." (Mother, age 36)

It is striking that there were several exaggerated stories going around regarding treatment in a TC.

"I don't see myself playing Mickey Mouse now, after 42 years. I've been called names for 42 years. I don't want to be called names anymore. I now want to give my life a chance. I can't handle it mentally." (Mother, age 42)

Another participant said:
"I've heard stories that if you see somebody stealing a cookie you have to go tell on him. All the things they forbid you then, it's just so… you're more temped to do it just because you can't." (Women, age 25)

Three women said that it was not their own choice to go to such programme and their experiences were mostly negative.One woman said:

"Shouting, yelling, getting criticized: you are such a rude person, so bad… They want to break you down, they want to change you. And then they want to rebuild your personality." (Mother, age 24)

The women expressed dislike for the rough forms of confrontation and the strict hierarchy. Two women also didn't like living in a group. One woman said that she didn't have enough self-confidence to talk freely about her problems.

One woman ended the programme prematurely because of a relationship.

"It is a pity that you cannot call your boyfriend whenever you want. You have to call him secretly." (Mother, age 38)

Two women started a relationship during the programme. For one of the two this represented a reason to organize a women-only programme. Another woman ended her relationship before she started with the programme.

The women who finished the whole programme, were more positive.

"The programme made me feel stronger. I'm more stable and confident and will never fall back as I used to. I've learned to talk there and speak up for myself. Learned to deal with problems instead of running away from them. I've really picked up a lot about the children." (Mother, age 37)

One of the women said that she was glad that she only has to think about herself in the programme and that her other problems [legal, financial] were arranged for her. However, sometimes it was hard to resume life after the TC programme.

"You have to pay your debts, find a home, get a job. You don't immediately have a social network. You have to do it on your own." (Mother, age 38)

One of the TCs also has a programme for mothers and their child(ren), which could be an extra motivation to go into treatment. Because the women could bring their child, the programme is described as *"giving more attention to women"* and *"being more respectful to women*." One woman thought that there were also more

women in that programme because the TC programme is less rude. However, the places were limited and one of the women said that there was no place for her child and so she did not go into treatment because she had already lost custody of one of her children.

6.3.4 ACCESS TO RESIDENTIAL SUBSTANCE ABUSE TREATMENT

The reasons why the women chose not to go into residential care seem to be very diverse.

"I prefer outpatient treatment. It's not that bad anymore as it was earlier when I had to go into residential care. My friend is supporting me, he has already done several treatment programmes. And I also get enough support here [in the substitution programme]." (Mother, age 24)

Other reasons were that they could not use their drugs within residential care or just because:

"There is no point in going [into residential care]." (Mother, age 28)

However, most reasons were related to the women's social network, and in the first place to their children. One of the women stated:

"In fact it is especially giving up the surroundings what stops me the most. It is also that surrounding that lures me to do what I shouldn't, so… I don't know, really… That physical withdrawal doesn't really scare me." (Women, age 25)

Two other women mentioned their partner as being the most important reason for not going into residential treatment.

"I am together with him again, so that is out of the question." (Mother, age 37)

Five women mentioned their children as representing an important barrier to going into residential treatment. Even the fact that there was a TC programme where they could go together with their child was not enough.

"You can bring your kids to some of them. I've been thinking about that as well, but I don't like the thought of my boy having to sit in the middle of all this. If for example you're in a bad mood or have an attack of aggression, and the children have to see it and all. The best thing is if you

can have a baby-sitter. That's also why I went back, because you miss your kid and in moments like those you really need them when you're getting off drugs." (Mother, age 36)

Children are not only a barrier to entering and staying in residential treatment, but also to searching for help in the first place. One of the women said that she was afraid that her child would be taken away if she told her social worker about her "real" problems.

"Mostly you don't say anything, out of fear of the consequences. For example, not to risk having your kid taken away." (Mother, age 25)

The fact that women have to take care of the children or that they are more attached to their children was mentioned as one of the reasons why women are outnumbered by men in residential substance abuse treatment.

"I think that only few women get treatment because they have a kid at home. They can't just say they get out of it for a month." (Mother, age 37)

The juvenile court or services for child and family welfare have been keeping an eye on several mothers.

"When I had my son I was ten years older than with my daughter. I didn't want to lose him. But I also realized that I couldn't keep it up for a long time. Regularly the juvenile police stopped by and the people from child and family welfare were also very cautious of what was going on." (Mother, age 38)

If the women, after all, chose to go into residential care, they preferred to place their children in the care of somebody they knew, such as their parents or (ex-) partner. However, such help was not always available. One participant related:

"My parents were aware of the fact that I was pregnant. My father said that I was sick: 'We are already raising your daughter and you, in your condition: you have no place to live, no income, and you're living with a criminal, and now you're going to bring another child into the world. Who's going to bring that one up? Not us you know. You're not setting one foot into this house with that baby…' My mother didn't come to visit, there was nobody, really nobody." (Mother, age 38)

Three women thought that women are outnumbered by men in substance abuse treatment because the criminal justice system is less severe toward women compared to men regarding the imposition of treatment. Two women were convinced that society is less tolerant of women regarding their treatment admission for substance abuse problems and that this is why women try to keep their head above water without external help. Five women found themselves stronger than their male counterparts and thought they could keep up better.

"Women can manage much longer, and combine everything." (Mother, age 50)

It's also easier for women to supply themselves with drugs. One woman stated:

"Women are more often helped in the scene, if you have a good way of going about it and you know someone. I didn't have to go stealing, really. If I went to this dealer of mine and gave him a sweet look. I didn't actually have to DO anything for it you see, but a bit of sucking up did the trick. Men cannot pull that off so easily. With men it's more like: Got any money? No? Bad luck then." (Women, age 23)

6.3.5 TREATMENT NEEDS

The women need someone who will stand behind them and support them, also when they relapse.

"I give support as much as I can, but if I'm the one who needs support I am on my own. I need to become selfish." (Mother, age 41)

And another woman said:
"I need someone to follow up on me, someone who slaps my behind from time to time." (Mother, age 50)

They need somebody they can trust, somebody to talk to. It seems important to be able to build a trustworthy relationship with the treatment staff, considering that they have been hurt several times.

It does not matter if their social worker is a man or a woman; however, two women preferred a woman because she would better understand their specific situation.

"No problem to talk to a man about my problems. They also received an education. However, sometimes it will be easier to talk to a woman. Certainly about specific situations." (Mother, age 42)

More or less the same could be concluded regarding group therapy. It does not matter that there are men; however, four women wanted more women in their group because they were still outnumbered by men.

"A mixed group is not really a problem, but then not me alone with all men, because I'm kind of sick of that. Prefer at least one girl to join. Then at least you have someone." (Woman, age 20)

The women also wanted some activities to spend their free time or a place where they could meet other women. Six women found themselves in an isolated situation.

Five women thought there was enough attention to them within the treatment system; the same number thought there was not. The latter group said that there should be more attention to mothers and their children. One woman said that she was pregnant and did not get any help.

"When I was pregnant I asked for help in the hospital, to support me during pregnancy. But they couldn't help me there because I'm a drug addict. So I had to go to a TC or whatever, but you know too that they don't accept any pregnant women there, and all places where they did accept pregnant women were full. I've had to stay for three months in hospital, in maternity, because there is a shortage in relief for pregnant women or women with children who are addicted." (Mother, age 28)

But the women need support after their child is born as well, not only emotional but also financial. Three mothers claimed that they needed somebody who could take over from them for a while.

Six women had questions about the effect of their drug abuse on their unborn child. Three women said that they were relieved they did not take methadone instead of heroin, because the withdrawal symptoms would have been much worse for the newborn child. During their pregnancies, one-third of the women quit their abuse. However, after their child was born they started using again. Three women said that they were dealing with feelings of guilt. They hoped that their children would do much better. However, four women said that they were talked

into feelings of guilt by the staff of the hospitals where they gave birth to their child.

"Especially the nurses, the doctors, the way they treated me. It was really bad. Often when I was standing at the incubator and asked when he could come home with me, they said if you hadn't taken that filth during your pregnancy he wouldn't have been here. Sure I know that too, but that's the way it is now. I was treated so mean." (Mother, age 33)

The women were not treated respectfully by the nurses.

"You know, in hospitals, it's unbelievable how tricky they can be. The remarks they can give you, just to hurt you. They wouldn't look after me, my room wasn't cleaned. I really suffered there. Even the gynaecologist sterilized me without me being aware of it! It stays a taboo [being a mother and using drugs], you're living on the edge of society." (Mother, age 37)

6.4 DISCUSSION

Women have been overlooked in substance abuse research and treatment for a long time, not least because they are outnumbered by men. Findings from research on men have been generalized to women, and therefore women's special needs have been ignored in substance abuse treatment (Copeland & Wayne, 1992; Ezard, 1998). A qualitative approach was chosen for this study because the aim was to give the women a voice and let them talk freely about their treatment experiences, in order to explore possible barriers women feel against entering and staying in residential treatment. Analyses of the women's views on treatment revealed some interesting findings on what they expect from treatment.
However, the applied research methodology also has it limitations as only 19 women could be involved in this study. Caution should be taken in generalizing these results since the women's views could differ from the opinions of women in other treatment settings or women who receive no treatment at all. Secondly, the data were analysed by coding the women's open-ended responses. Consequently, the number of women discussing a particular topic could be less than the number of respondents who would have (dis)agreed with that finding. Thirdly, the researcher interviewed the women only once. It may have been better to conduct more interviews with the same women to give them more time to reflect on some issues (Trulsson, 2003).

The women's previous treatment experiences were mainly based on their experiences with TC treatment. This is not surprising, since there are three drug-free TC treatment programmes available in the province of East Flanders, which is much more than in any other Belgian region. Whereas most substance abusers go to a psychiatric hospital for a three-month withdrawal treatment, treatment in a TC lasts for nine months to one year or even longer.

This study showed that most women had an external reason to seek help. However, nearly all of them were convinced that if you really want to quit your abuse you have to want it yourself. This is confirmed by De Leon (2000), who states that one of the greatest challenges of treatment is to change a person's external motivation to an internal one. Not all women had their first treatment contact because they wanted to stop their drug abuse. Sometimes they just wanted to reduce the harm related to their abuse, such as medical, financial, or legal problems. These women still wanted to use some drugs. For them a drug-free programme was/is not an option. It could be that their level of drug dependence is lower compared to those residents for whom the treatment goal is abstinence (McKeganey, 2004).

The women were not always supported in their choice to seek help for their problems. Previous studies showed that this support is an important motivating factor, and this seems to be especially true for women (Ravndal & Vaglum, 1994). Laudet, Magura, Furst and Kumar (1999) found in their study that most men are not enthusiastic about their partners going into (residential) treatment because they are afraid that this will threaten their relationship, which might be mainly based on using drugs together.

Not only the women's partners are a barrier to going into treatment, but also their children. The traditional gender roles that give women primary responsibility for child-rearing place them in an extra vulnerable position because of the built-in contradiction based on the general view that children and drug use do not match (Trulsson, 2003). Therefore, it will be important to reach these women in a non-condemning way, because at that moment they are confronted with the fact that they cannot keep up society's ideal. This study illustrated that many mothers are confronted with negative reactions, which may originate from the fact that authorities just want the best for the child and look at the drug use rather than the relationship between the child and the parent. Substance abusing mothers in average have a positive, normal, or acceptable relationship with their children, and therefore should be given the opportunity to keep their children with them (Trulsson, 2003). Some studies illustrate that children raised by their own mothers show fewer behavioural problems and better development (Tyler, Howard, Espinosa, & Doakes, 1997).

Since pregnancy and motherhood are a turning point for mothers to quit their abuse and accept treatment (Dahlgren, 1992; Grella, 1999), we should organize more treatment alternatives for these women. Residential substance abuse treatment programmes providing childcare are scarce, although several studies have illustrated that these programmes yield higher rates of women and also give better treatment outcomes (Grella, Joshi, & Hser, 2000; Wobie, Eyler, Conlon, Clarke, & Behnke, 1997). Such programmes should provide women with the choice of medicated or non-medicated detoxification.

The findings presented in this paper clearly reveal what the women expect from treatment. They need a safe, homelike place where they can take their child(ren) and meet other women. These other women could play an important role in taking over for a while and taking care of other women's child(ren) within the programme, thus possibly strengthening their own self-esteem. The women do not like confrontational models used by some programmes – a finding that is confirmed by a study of Copeland (1997) – but may profit from an empathic counselling style (Fiorentine et al., 1999). Considering the importance of parents and partners for the women, the programme should adopt a holistic approach and give the women the possibility to stay in touch with them. Women leave their drug abuse with the support of family members and/or children, men with the support of drug-free women (Rosenbaum, 1981). This support is a central theme within the stories of the women, since several women find themselves in an isolated situation. They talk about the importance of emotional and instrumental support, but also cognitive support should be available since many women have questions about their children (Trulsson & Hedin, 2004). This cognitive support could involve parental skills training, in which the women's feelings of guilt, shame, and failure surrounding their maternal role could also be addressed (Copeland & Wayne, 1992). The women's drug abuse should be understood in the societal context of gendered roles, norms, and circumstances (Sibthorpe, Drinkwater, Gardner, & Banner, 1995). Finally, it will be important that the social support also stays available after the women decide to quit the programme (Trulsson, 2003).

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7

The construction of the Video Addiction Challenge Tool for women: a flexible tool for treatment of female substance abusers [25]

Abstract. Treatment refers to meaningful action in context and therefore is best investigated from a qualitative perspective. The core of this position goes back to the sociologist Weber who wanted to provide the social sciences with a proper methodology. He stated that a causal explanation of the proceedings and the effects of an action assumes interpretative understanding. A deducting methodology should at least be complemented by a phenomenological or nowadays (social) constructivist methodology. This move from modernism towards a more postmodernist approach occurred at the Department of Orthopedagogics at Ghent University while the "Video Addiction Challenge Tool" was developed. The VACT is an instrument for (individual) treatment planning in the therapeutic community. The original version of the VACT, which confronted residents with the life story of an "average" male to reach therapeutic openness and dialogue, seemed to be too female-unfriendly. Thus, the new version of the VACT for women was developed. The female residents, facilitators and researchers followed "their own style" and by doing so contributed to a more collective, inter-subjective and interconnected methodology. They adapted the methodology to the requirements of validity and reliability in evidence-based qualitative research and strived for accuracy, replicability and transparency. This paper describes how the new VACT for women was developed and demonstrates how belief and evidence can play their part.

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7.1 INTRODUCTION

The National Treatment Agency for Substance Misuse of the United Kingdom defines treatment as "a range of interventions which are intended to remedy an identified drug-related problem or condition relating to a person's physical, psychological or social (including legal) well-being" (NTA, 2002). In this context, treatment consists of taking adequate action in special situations where taking care of people is involved. Treatment aims at facilitating (mental) health and well-being, and can be considered as a form of methodical approach that involves the whole person and his social network. The reference in the definition to interventions for well-being, implies that meaningful action is needed and this should lead to the logical conclusion that treatment should primordially be researched from a qualitative perspective. Its success should be measured by the reported effects (on well-being) of the intervention. Using a deducting methodology, without taking the meaning of action into account, could lead to an incomplete picture and should at least be complemented by a phenomenological methodology (Black, 1994). However, nowadays the actual tendency in substance abuse research towards evidence-based research relies heavily on the empirical analytical methodology of the natural sciences. It concentrates on clear objectives, obvious research designs, methodological rigor, statistical reporting and analysis, adequate use of data, and conclusions based on data. This tendency leads for example to the ambiguous position of Westermeyer (2004). He correctly sees the missing link between the clinical intervention and the scientific methodology as the main reason for the failures of science in substance abuse treatment and consequently questions the treatment results of the temperance movement, Alcoholics Anonymous (AA), the Therapeutic Community (TC)… On the other hand, he promotes behaviour therapy that is based on an empirical analytical model and restricts treatment by meaningful action (Gielens, 1992). In this way he segregates the clinical intervention from its scientifically adapted methodology and weakens his basic theory and his position towards believe-based approaches. It is a fact that qualitative evidence-based studies on the treatment of substance users are seldom reported in scientific literature. Only a few can be found on the "Web of Science." Qualitative research with clinicians (semi-structured interviews) has begun to identify the factors that influence treatment placement decisions. Ethnographic tree modelling seems to be adequate in predicting (85%) new referral decisions (Breslin, Gladwin, Borsoi, & Cunningham, 2000). Drumm and colleagues examined the elements of the decision-making process involved in accessing formal health care among chronic and injecting street drug users. Twenty-eight in-depth interviews provided the data for the analysis, but his study

is part of a large quantitative study of 1.479 injecting and chronic drug users and non drug users in Miami, Florida (Drumm et al., 2003). Ethnographic fieldwork, carried out in a Kenyan Coastal town, utilized a range of qualitative research methods and identified an urgent need for harm reduction strategies (Beckerleg & Hundt, 2004). Bradizza and Stasiewicz assessed high-risk alcohol and drug use situations in dually diagnosed individuals using focus group methodology. This information facilitates the development of relapse assessment instruments and treatment strategies, appropriate for this population (Bradizza & Stasiewicz, 2003). Brun and Rapp used qualitative data collection methods to gather individuals' experiences of participating in strengths-based case management, implemented in a substance abuse aftercare programme. Implications for social work practice were discussed (Brun & Rapp, 2001).

The core of our question and the relation between scientific empiric analytical approach and phenomenology and action goes back to "Methodenstreit" of the 19th century. The question was raised whether we have to rely on objectivism or subjectivism, on a nomothetic or idiographic approach, and whether the methodology of the exact sciences is applicable for social action. It was argued that human motives, social interaction and human beliefs are far too complex to be open to statistical analysis and purporting theories of human action to be universally valid (Smith, 1990). Weber stated that in order to reach a scientific and causal explanation of the proceedings and the effects, there is a need for an interpretative understanding. He insisted on rational evidence and "Erklärendes Verstehen". Nowadays, post-positivism in qualitative research still follows to some extent those Weberian modernist and rational tendencies. It favours a precise methodology method and avoids explicit subjective interpretations (Clarck, 2004). Post-modern theory, however, challenged the rational evidence of the "grand narrative." Precise methodology was replaced by irrationalism and relativity, and gave rise to a new belief in "subjectivity." The subject became the keynote player of the decision-making with the "why" and "how" of treatment and success as focal points. Inclusion, collaboration, self-advocacy and emancipation of the subject concerned became quintessential (Best & Kellner, 1991). In qualitative research, post-modern theory led to constructivism, where the social construction of knowledge is now considered as a collaborative effort of the researcher and the researched. Constructivist research is carried out in relation to context and situation (Schwandt, 1994).

7.2 METHODS

7.2.1 BACKGROUND

The Department of Orthopedagogics at Ghent University found itself in the middle of these challenges while developing the "Video Addiction Challenge Tool" (VACT) (Broekaert et al., 2001). When starting the development of the tool during the mid-nineties, the authors used a classic qualitative evidence-based modernist phenomenological methodology and were still partially stuck in an analytic empiric methodology. They used a video depicting the "average" life story of a resident of a TC for substance abusers. The tape was used as a clinical method for assessment and individual treatment planning. Out of 456 questionnaires 200 were selected through systematic random sampling and the characteristics that cropped up persistently in 25% or more of the investigated files, were kept back.
They compared the selected characteristics with a systematic sample of 1000 Belgians which resulted in 42 profile characteristics. The life stories of the 10 residents whose own characteristics corresponded the most with the common ones, were kept back. Two of those residents were willing to discuss their life in depth. On the basis of those interviews a script was written and discussed with the actual residents (n=14) of the TC. Later, the script was adapted and made into a video. It was believed that if "new" residents were confronted with the video this would quickly give them a wider knowledge and better understanding of their problems. This knowledge should be the basis of further and more individualized treatment. At the end of the study the authors analysed the statements of the researched population and compared those results with the facts already established from social anamnesis and life story of the residents. They clearly demonstrated that they gained new and more profound knowledge because of the VACT (Broekaert et al., 2001). For the analysis of the statements they applied the "case-oriented quantification approach" of Udo Kuckartz. This "case-oriented quantification approach" constitutes the scientific model behind the text analysing tool WinMAX, and is based on the methodological work of Max Weber and Alfred Schütz (Kuckartz & Prein, 1995). It is a tool to analyse texts and to categorize the context within well (socially) constructed typology on the basis of a search to understand the meaning of the transcribed action. When the VACT was further developed in a drug-free TC for substance abusers as part of a major European research project entitled "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups" (IPTRP) (Broekaert et al., 2002), it came in for some criticism: the VACT was considered to be too

confrontational during the first stages of treatment and should be used as a therapeutic tool only after the initial stabilization of the resident. Secondly, it was considered female-unfriendly, as the "average" life story relates to the common male resident. It is the goal of this paper to describe the development of a female-friendly version of the VACT. This aim will be discussed from a constructivist and collaborative perspective, with less emphasis on the dichotomies rationality and subjectivity. In this study we will be concentrating more on the subjective meaning and beliefs of the stakeholders: "women in TCs". The used qualitative methodology will be explained in depth and transparently to serve as an example on how phenomenological research can be a part of treatment while researching it at the same time. The proposed procedure can be of use to other researchers and practitioners.

7.2.2 DEVELOPMENT OF THE NEW VACT FOR WOMEN

The development of both the "old" and "new" VACT took place in the TC "De Kiem" in Belgium. In 1976, TC "De Kiem" was established, modelled on the American drug-free programmes such as Daytop Village and Phoenix House, and was based on the principles of the "drug-free concept" or hierarchical TC. The programme of "De Kiem" is designed for drug users who want to adopt a different way of life. It consists of a residential induction, a TC, a reintegration/ rehabilitation, after-care and graduation phase. This programme involves "the community" as a primordial method, confrontation of negative behaviour and self-help (Broekaert, Van der Straten, D'Oosterlinck, & Kooyman, 1999). "De Kiem" expanded its programme with a section for women and children and increasingly focuses on special groups, such as "women groups". It pays more and more attention to individual treatment planning. It is believed that those moves determine the actual (1/3) female/male residence rate (De Wilde et al., 2004).

In the development of the VACT for women, there were nine distinct phases.
During the first phase in November 2003 the six women who stayed in TC "De Kiem" at the time were asked for their comments on the original video. The VACT was viewed in a group, but the women wrote down their findings individually. Afterwards, their views were discussed. The comments of the women dealt on the one hand with the content of the story, on the other hand with the way in which the story was told.
The most important criticisms were: not dealing with some "female" issues such as pregnancy and abortion; the lack of background information on family history

and childhood; the exclusion of subjects which were too painful to speak about; the aggressive and defensive way in which the story was told; the failure to invite them to participate in the project and to open up themselves. The most recognizable themes were: going out all night, relapsing after treatment, bad relationship with parents, violent and abusive relationships, feelings of loneliness and pain, …

During the second phase, the women were asked to tell their life story. Six women participated in this research phase: five told their story, one only listened. The women who told their story were more or less stable residents who had already been participating in the programme for some time. The woman who only listened had been in treatment for a short time only. One female staff member and two female researchers were also present. They were female because the sessions were part of the women groups of the TC and males were excluded. Three sessions were held; one woman left the TC after the first session. She had already told her story. The five life stories were videotaped. At the end of this phase, we had collected nine hours of footage.

During the third phase, the various themes in the stories were systematically selected and coded into "old" (of the original version of the VACT) and "new" themes. This was done after each session by two independent groups of each two researchers (master-level students at the Department of Orthopedagogics). Each group constructed a list with main and sub-themes, which was discussed with the other group until agreement was reached. The "discussed" list was again used by the two groups separately to code the next session of videotaped stories. After the third and last session, one inter-subjective accepted and widely applicable list remained, which incorporated old and new themes (see table 7.1). This means that, as shown in table 7.1, themes of the VACT for women were represented in the original version of the VACT but new female-oriented ones were added.

During phase four, we ranged the different themes in order of importance, based on frequency and continuation of occurrence. Once again we followed the procedure of inter-subjective discussion on the basis of an initial sorting by the two separate groups. We continued the procedure until a final agreement was reached. This led to a final list of all the main-themes plus the most important sub-themes.

During the fifth phase, using our same inter-subjective methodology, parts of the women's stories that best illustrated a specific theme, were selected and assembled

on a DVD. This formed the basis for writing the new video script. Visualizing the stories was important for the scriptwriter and the actresses.

Table 7.1: Main-themes of the old and new VACT

Old VACT – main-themes	New VACT for women – main-themes
1. Maltreatment / abuse	1. Maltreatment / abuse
2. Substance abuse	2. Substance abuse
3. School (problems)	3. School (problems)
4. Employment	4. Ways to earn money
5. Ways to earn money	5. Dating
6. Dating	6. Suicide
7. Suicide	7. Treatment
8. Admission	8. Relapse
9. Relapse	9. Loneliness
10. Loneliness	10. Family situation
11. Family situation	11. Social network – relationships
12. Social network – relationships	12. Legal situation
13. Legal situation	13. Characteristics / behaviour
14. Characteristics	14. Living situation (movements)
15. Living situation (movements)	15. Sense of guilt
	16. Feeling of being unwanted
	17. Mourning
	18. New family
	19. Pregnancy
	20. Abortion
	21. Relationship with their own children
	22. Depression

During phase six, a first attempt was made to write a script. The writer based the text on the images of the DVD, which showed the emotions, expressions and phrasing of the women while they told their story. The script was then discussed with the women and some staff members of the TC. After that, it was fine-tuned and finalized.

As an illustration, consider these two parts of the script:

…Then my brother was born. That brings back mainly bad memories because the fighting between my parents got even worse. My dad used to drink …sometimes he lay around in his chair for days. My mom then told us to be very quiet. Or she sent us out in the street to play. Sometimes he took off and stayed away a few days. My mom was left with my little brother and us. She was often crying. Her behaviour was so unpredictable. Sometimes she was really nice and

my sister and I could snuggle up to her, or she let us hold my little brother. But other times she would be angry for no reason and we had to be quiet, or go out in the street or somewhere. Sometimes she sent us away together with our father. He was rather nice to us. We used to do something together we quite liked…or he bought us a present. But in the evening it was the same old story again, fighting and yelling…
…It couldn't last and one day Johan was arrested for dealing and smuggling. He didn't give me away then, but I was left with these other guys… He was in jail and that's when it all went wrong. One of those guys, Frank, he was so strong physically and he knew I couldn't do without the heroin any more. He raped me. Then he put me on the streets. I would never have thought it. Drugs, that's what they do to you. I needed my fix, I couldn't go without. Frank was my pimp. It all began in a bar. At first I just had to drink with them or dance. But it didn't stop there. It went from bad to worse. If I used a lot, I didn't feel anything. I knew he would beat me up if I didn't bring in the money. One day the place was raided and closed down. Frank was arrested and so was I…

In the seventh phase, the final script and DVD were given to two actresses. We chose two actresses of different ages (20 and 28 years) in order to facilitate the residents to identify with them. The actresses studied the script and watched the DVD before performing on the new video.

During the eighth phase the video was recorded. The actresses were pictured with a mirror in the background, instead of a plain, dark wall. They wore a neutral T-shirt, so as not to distract the viewers. They each acted out the script in their own way, in order to make the story more vivid and natural. The style of the video is animated, but not too emotional. The residents watching the VACT must be given the impression that they are being addressed directly. The actresses looked straight ahead in the camera to achieve this. We did not use many time-indications, because we wanted to avoid the possibility that some residents could drop out.
We made several recordings, in Dutch and in English, until we had a satisfactory result. The video lasts for about 30 minutes. The script was also acted out in English to make it available to an international audience.

During the ninth phase, the video was shown to the residents. Before starting the video, we gave the residents a list with the main-themes, as shown in table 7.1. They all liked the way in which the story was screened. Only one woman said that the acting in the sexual abuse scene was too stilted and not emotional enough. As regards the content of the video, it was noticeable that most themes were recognizable for the women. The themes that some women found more difficult to identify had to do with emotions: sense of guilt, loneliness, depression, a feeling

of being unwanted. They were not explicitly mentioned in the story. One theme, mourning, was not included at all.

7.3 DISCUSSION

If we define "evidence" (Lat. evidentia, evideri: to appear clearly) as search for the truth, and "belief" (Mid Eng. beleven, Old Eng. belEfan) as a conviction regarding the truth, it seems clear that it is the role of research to ground our convictions, assertions and statements in "what really works." To find evidence for our belief, science usually starts from empirical observation and/or experiences, and tries to get valid and reliable answers.

Reliable, evidence-based quality research depends on first-rate, qualitative data that makes use of focus groups, Delphi and nominal group studies, participant observation, meta ethnography and systematic review studies (Davies, 2004). It is based on systematic data collection, using "acceptable" research procedures and allowing the procedures and findings to be open to systematic critical analysis from others: triangulation or comparison of findings from different sources, transparency of the data gathering process and analysis, "grounding" of the findings in the raw data. Replication to see if the same findings emerge, transparency in the reporting, checks on consistency in the understanding of the findings by the stakeholders (Denzin & Lincoln, 2000), and inclusion of factual evidence and reasonable doubt. It includes the relativity of reported successes of treatment interventions, and is actually part of the ongoing treatment procedure itself.

Validity in qualitative research is mostly defined as "representing accurately those features of the phenomena, that are intended to describe, explain or theorize" (Hammersley, 1987, p. 69), or as the "degree of approximation of reality" (Johnston & Pennypacker, 1980, p. 190-191). As qualitative research is based on the (subjective) interpretation of the ever-changing reality, some qualitative authors appeal not to use the notion of "validity" (Lat. valEre: to be strong to be of value) – as it is linked too much to a positivist methodology. They prefer to use the term "understanding" (Wolcott, 1990) and consider "accuracy" as its best definition (Winter, 2000). "Understanding" on the other hand is often an integral part of phenomenology and implies a careful search for reality. In social constructivist research, collaboration and (inter)subjectivity play a more important

role. The reliability (Lat. religare: to tie back) of the study has to be seen within a qualitative perspective too. Where "validity" is best approached in terms of "accuracy", "reliability" is best-defined as "replicability" (Winter, 2000). Multiple tape viewing and listening sessions, multiple transcriptions and corrections of the script by a person or team were used to enhance the replicability of the study.
The methodology of the new VACT is transparent and easy to repeat. The addition of gender-specific data is based on discussions and dialogue in order to reach a more genuine understanding of reality. During the development of the VACT, the operators were in the middle of the transition from modern towards more post-modern approaches. The female residents, facilitators and researchers followed "their own style", and by doing so contributed to the more collective, inter-subjective and interconnected methodology, in which the attributed meaning depends on the global context. The new VACT is not searching for an ultimate answer to all specifically female problems, but finds its justification in looking for concrete solutions for specific problems in a TC context (Kunneman, 1998). The VACT can be regarded as a mirror in which the particular life story of the resident is reflected. Their "own" narrative becomes part of an interactive search for a remedy, shared by the group. Often people identify with the narrator. But this process of identification is in sharp contrast with imposing an imperative value system. In the TC for substance abusers one always has to be careful not to impose the ultimate truth and one must also be aware of the danger of indoctrination and charismatic leadership (Ottenberg, 1984). For this the TC has to act as an open system and it must permanently question its reason of existence (Broekaert, Kooyman, & Ottenberg, 1998). Introducing female-friendly therapeutic tools goes together with the adjustment of the hierarchic structure, and the replacement of harsh confrontational methods with dialogue (Broekaert, Vandevelde, Schuyten, Erauw, & Bracke, 2004). It could be a way to challenge the classic hierarchical and behaviourist TC and to make it a more open environment that continuously questions its reasons for existence. Last but not least, it could contribute to a more woman-friendly TC with a higher female/male resident ratio. It is an example of female-oriented research where the question is no longer whether treatment has to be based on evidence or belief, but how belief and evidence can play their part within the context of treatment (Weber, 1962).

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8

Discussion [26]

Abstract. This last chapter will summarize the main results of this dissertation and discuss their clinical relevance for the treatment of substance abusing women. The different studies revealed that women have other and more substance-related problems than men and that the connection between their substance abuse and other areas of functioning is much stronger. However, we must carefully consider how we look for differences between men and women. Women seem to manifest their problems in a different way, but they also differ in the way they develop and cope with their addiction. Therefore, women need another treatment approach. Suggestions for a more gender-sensitive treatment system will be discussed. Finally, the limitations of the study and directions for future research will be presented.

[26] This chapter is based on: De Wilde, J., & Trulsson, K. (submitted). Women in European therapeutic communities: conclusions of the BIOMED project. Manuscript submitted for publication.

8.1 INTRODUCTION

This dissertation focused on women, because they have been excluded from substance abuse research for a long time. Since substance abuse has been seen as a male problem, research, treatment and service provision has been designed from a purely male point of view. Gradually, clinicians and researchers became interested in women, which resulted in several, mainly American, studies focusing on the characteristics of women only, or on differences between men and women. However, substance abuse treatment still seems not always to meet women's specific needs. In Europe, this gender-focused research tradition is less prevalent and the availability of women's services is scarce. Women are still a minority among the substance abusing population. However, in order to learn more about women's characteristics, and in this way about their different treatment needs, we had to study a treatment population that consisted of both men and women.

The major aim of this dissertation was, therefore, the development of a gender-specific profile of substance abusing women in therapeutic communities (TCs) in Europe. The BIOMED II "Improving Psychiatric Treatment in Residential Programmes for Emerging Dependency Groups through Relapse Prevention" (IPTRP) project provided a database of both men and women in TC treatment and made it possible to search for gender differences, which was the main aim of the first four studies. In the first study *(chapter 2)*, this aim was complemented with studying the treatment characteristics of the different participating TCs; additionally it was discussed whether the "community as method" approach differentiates between men and women. In the second study *(chapter 3)*, the psychiatric status of men and women was the object of research, as a first screening illustrated that this life area showed important gender differences. A psychiatric profile for women was developed. In continuation of the previous study, the third study *(chapter 4)* searched for gender differences in TC client profiles in other than the psychiatric life area. These three studies together, in which the EuropASI interview was used, provided a global picture of differences between men and women at treatment admission. The fourth study *(chapter 5)* used the SCID-I to explore the lifetime prevalence of psychiatric mood and anxiety disorders among the men and women in TC treatment. It also gave the possibility to deepen the psychiatric profile that was previously developed *(chapter 2)*.
Since the previous studies illustrated the under-representation of women in TC treatment, the fifth study *(chapter 6)* intended to explore possible barriers women feel to enter and remain in residential treatment. As we were interested in the views and opinions of the women themselves, women in a low-threshold

substitution programme were interviewed about what they like and do not like about residential treatment. The last study *(chapter 7)* reported on the development of the Video Addiction Challenge Tool (VACT) for women. Since the original VACT did not include female-specific characteristics, and as a result, was not gender-sensitive, a new instrument was needed.

Since not only substance abuse treatment is male-dominated, but even screening instruments – widely used in research – include a male-as-norm bias, in this dissertation quantitative positivistic methods were varied by qualitative methodologies.

In the following, the main findings of the different studies will be summarized, and their clinical implications for the development of a gender-sensitive treatment approach will be discussed. Finally, the limitations of this dissertation and recommendations for future research will be presented.

8.2 MAIN FINDINGS

8.2.1 TREATMENT CHARACTERISTICS OF THE EUROPEAN TCS: IS THE "COMMUNITY AS METHOD" GENDER-SENSITIVE?

In this first descriptive study (*chapter 2*), an overview was presented of the programme characteristics of the different participating TCs, and this separately for each of the nine countries. The study aimed to explore whether the "community as method" approach differentiates between men and women.
Since the TC was introduced in Europe in the 1970s, much has been written about its evolution (Broekaert, Kooyman, & Ottenberg, 1998; Broekaert, Van der Straten, D'Oosterlinck, & Kooyman, 1999; Broekaert, Vanderplasschen, Temmerman, Ottenberg, & Kaplan, 2000; Broekaert, Vandevelde, Soyez, Yates, & Slater, in press; Ravndal, 2003; Soyez & Broekaert, 2005; Vandevelde & Broekaert, 2003). The most important changes are clearly outlined in the overview presented in this chapter. Since the TC was challenged by a changing society in the mid 1980s and therefore encompassed other target groups and problems, its method was expanded to encompass other treatment and therapeutic interventions. While most TCs went through the same evolution, the overview also illustrated that the TC programmes, spread over the different European countries, all developed their

own identity (mixed-gender, single-gender, taking clients from the age of 15, taking clients from the age of 20 , …).
Although at that time the attention for women increased, this chapter criticized the European TC treatment situation. Women are still underrepresented in TC treatment and far outnumbered by men. The situation seems to be slightly better in the Northern European countries, mainly because one of the selected TCs to participate in the study was a women-only programme. However, generally spoken it can be concluded that there are some barriers stopping women from seeking help for their substance abuse problems.
Of the 25 mixed treatment centres, there was not much to differentiate between men and women with respect to the main orientation of the TCs studied. Women were significantly more often observed in TCs with an educational orientation, men in the self-help movement. We could conclude that women prefer other treatment approaches to the self-help orientation of the traditional TC. There were no significant gender differences concerning the treatment approach of the different TCs. There was only a small difference in the cognitive/behavioural treatment orientation, illustrating that this one is less appropriate for women.
The study concluded that not only in research, but also in daily practice TC-treatment, a gender-inclusive framework is almost inexistent.

8.2.2 GENDER DIFFERENCES IN TC CLIENT PROFILES: INFLUENCE OF PSYCHIATRIC AND OTHER LIFE AREA PROBLEMS

The first study of this dissertation *(chapter 2)* also presented an overview of the characteristics of men and women, and this separately for each of the nine countries. The influences of other variables (age, country) were not considered in this study. It became clear that some of the differences in client characteristics between countries could be attributed to small differences among the different TC programmes, as for example concerning the age of the clients. TC clients in the Northern European countries seemed to be the oldest, especially in Sweden, which was due to the selection of the Swedish TCs. Since these programmes were compulsory care centres (LVM-institutions), their clients were mostly in the last phase of their treatment careers. Clients in Belgian TCs were the youngest, because these programmes allowed clients from the age of 15. Another difference between clients of different countries concerned their alcohol and drug use. In most countries, more than 50 percent were injecting drug users, except for the clients of the Swedish TCs and the women in the Belgian TCs. The former was explained by the fact that one of the Swedish programmes did not deal with illicit

drug users. The latter could be due to the female clients in the Belgian TCs being younger than the clients in other countries.
In most countries, the differences between men and women showed the same direction: women having more severe characteristics, except for the legal status. However, this study illustrated that women, besides prostitution, might be charged more often for the possession and the dealing of drugs.

Since we were interested in gender differences in TC client profiles, two studies *(chapter 3 and 4)* were executed using a logistic regression model controlling for possible confounding effects of both country and age.

In the first of these two studies (*chapter 3*), the "psychiatric status" area was selected for further study because, after a first screening of the database by means of the EuropASI composite scores, the area revealed some important differences between men and women and it also showed clinical significance as several studies illustrated a strong relationship between psychopathology and substance abuse, and the long-term chance of success after treatment.
According to the regression model, a number of problems could be identified as being reported more often by women in TC treatment. Combining these "female-specific" items, it was possible to construct a psychiatric profile for women in TCs and to offer suggestions for a more targeted treatment, focused on the more acute psychiatric needs of women.
There were two "psychiatric" items that could be considered as the best items to differentiate between men and women: "being prescribed medication" and "having attempted suicide." Women in TC treatment were also more likely to report serious depression, difficulty in understanding, concentrating or remembering and serious contemplations of suicide. Women also found treatment for these psychological problems more important.
For the development of the profile, the "abuse" items were also included, since these are related to psychopathology. The "abuse" items showed that men and women could be differentiated on all abuse items, but most on sexual and physical abuse. This led to the conclusion that a woman in TC treatment: is sexually and physically abused, has attempted suicide and is being prescribed medication for a psychological problem during her lifetime (items listed in decreasing order of importance).
The second study *(chapter 4)* on gender differences in TC client profiles focused on all life areas of the EuropASI. Many gender differences were found in the life area "family history" and "family and social relationships." Women reported more often than men that they have mothers with a drug problem and they also

experienced more problems with their mothers. Women tended to be more satisfied with their marital situation and the way in which they spend their free time. They lived together with their partner, with or without children, more often than men, who lived alone or with their parents more often. Their partner, however, was more often someone who also uses drugs.
There were no differences between men and women regarding drug and alcohol use. There were actually more instances of women overdosing on drugs than men and they had been treated in outpatient substitution programmes for their drug problems more often than men. Women had been prescribed medication for psychiatric problems as well as physical problems more often. More people relied on female TC clients for their livelihood.
The only life area for which men scored a more severe status was the "legal status" area of functioning. Men had been charged with crimes of violence, disorderly conduct, driving while intoxicated, major driving violations and other crimes more often than women. Women were more likely to be charged with prostitution.
The study showed that women have other and more substance-related problems. It seemed that the connection between their substance abuse and other life areas is much stronger than it is for men. However, the differences found between men and women should be understood considering the socially constructed roles for men and women and how these could affect one's substance-related problems.

8.2.3 THE PREVALENCE OF PSYCHIATRIC DISORDERS AMONG MEN AND WOMEN IN TC TREATMENT

Since there was a lack of research illustrating the extent of psychiatric problems in European TCs, and a need to get more insight into gender differences concerning comorbidity in the TC population, the fourth study's (*chapter 5*) aims were threefold. The primary aim was to explore the lifetime prevalence of mood and anxiety disorders using the SCID-I. The second aim was to focus on related gender differences. The authors wondered whether the previously developed psychiatric profile on the basis of the EuropASI was confirmed. Finally, client characteristics measured by the EuropASI were related to the mood and anxiety disorders measured by the SCID.
The study illustrated that nine out of ten substance abusers treated in a European TC programme have an affective disorder. Significant gender differences were noted for two anxiety disorders: men have more obsessive compulsive disorders; women more post traumatic stress disorders. There were no significant

differences between men and women in the prevalence of mood disorders. In the previously developed psychiatric profile, women were found to report more serious depression than men. This finding couldn't be confirmed when using the SCID indicating that screening instruments such as the EuropASI seem to inflate the difference in prevalence of depression between men and women.
Different client characteristics were related to the prevalence of any mood or anxiety disorder. Clients with a mood disorder more often reported that they had been prescribed medication for a medical problem as well as for a psychiatric problem. They suffered from depression and seriously thought about suicide more often. They were also more frequently treated in drug-free residential programmes and more often charged with crimes of violence. Clients with a mood disorder were less likely to spend their free time with family or friends who also have alcohol or drug problems. Clients with an anxiety disorder were more often poly-substance abusers. They more often had a history of being sexually abused as well.

The study revealed that other client characteristics as well as gender should be taken into account when organising treatment. The TC is an appropriate treatment model, but psychiatric problems should be detected early in the treatment process and become part of an individualized treatment approach. The study also contributed to the discussion on which instruments to use at the beginning of treatment.

8.2.4 WOMEN'S VIEWS ON RESIDENTIAL SUBSTANCE ABUSE TREATMENT

Most substance abuse research studies ignore the views of the women themselves, therefore, the fifth study *(chapter 6)* let the women talk freely about their treatment experiences. Since the previous studies illustrated the under-representation of women in TC treatment, we were especially interested in gaining insight in possible barriers women experience to enter and remain in residential treatment.

The study illustrated that most women had an external reason to seek help, although they were convinced that if you really want to quit your abuse you have to want it yourself. The women were not always supported by their partners in their choice to seek help for their problems. The women's parents could be a source of support, not only because they came to visit the women in the programme, but even more because their parents' home was a place to rely on when there was no other way out.

The study showed that not only the women's partners, but especially their children were an important barrier for entering and staying in (residential) treatment. It became clear that women's treatment careers are hampered by the existing societal expectations of women. Women's drug abuse is "sicker" and forms a contrast with what is seen as her traditional role as wife, woman and mother.
The women's previous (residential) treatment experiences were mainly based on their experiences with TC treatment. For some of the women the TC had a bad image, others were more positive, since they had learned there to talk and speak up for themselves and they had picked up things about parenting their children. Women experienced it as encouraging that their children could stay with them during treatment, however, they stressed that it has to be "safe" for the children. They did not like confrontational techniques used by some programmes.
The women were in need of unconditional support, their pregnancies seemed to be crucial moments.

8.2.5 A FLEXIBLE TOOL FOR THE TREATMENT OF WOMEN: THE VIDEO ADDICTION CHALLENGE TOOL

The last study of this dissertation *(chapter 7)* reported on the construction of the Video Addiction Challenge Tool (VACT) for women, which is a flexible tool for the treatment of substance abusing women. The tool was developed in separate distinct phases, which contributed to a more collective, inter-subjective and interconnected methodology. It relied on the methodology used for the development of the original version of the VACT (Broekaert et al., 2001).
The female TC clients, who participated in the development of the new version of the VACT, had several objections as regards the old VACT: 1) the story did not deal with "female" issues such as pregnancy and abortion, 2) the women thought there was a lack of background information on the client's childhood, 3) subjects which were too painful to speak about were avoided. The women also criticized the way in which the story was told: i.e. aggressive and defensive, not conductive to open up themselves, etc. However, some of the themes of the old VACT they recognized: staying out all night, relapsing after treatment, violent and abusive relationships, feelings of loneliness and pain.
The new themes that were added to the newly developed VACT were: feelings of guilt, feelings of not being wanted, mourning for the loss of a significant other, new compound family, pregnancy, abortion, relationship with their own children and depression.

Where it was the intention of the original VACT to confront "new" clients with the video in order to get a quicker, deeper knowledge and better understanding of the client's problems, the newly developed VACT is meant to be used after clients have been in the (TC) programme for some time. Previous studies illustrated that the VACT was considered to be too confrontational during the first stages of treatment and it should be used as a therapeutic tool after initial stabilization of the resident (Broekaert et al., 2001). The VACT for women intends to deal with the "female" client characteristics and to make them a subject of discussion during the treatment of women.

8.3 CLINICAL RELEVANCE OF THE STUDY

8.3.1 WHY A BIOMED II IPTRP RESEARCH PROJECT?

The BIOMED II IPTRP project aimed to identify and address the needs of the emerging European substance dependence groups. The project put together a cross-border scientific network, engaging nine different European countries. It crossed the borders of the cultures of collaborating, "community as method" treatment programmes and academic research departments.
Since effective treatment should not only cure and stabilize the client but also prevent a relapse after treatment (Kaplan, 1996), innovative and qualitative methodologies, such as the Video Addiction Challenge Tool (VACT), were developed during the project to improve the sensitivity of the diagnosis and the effectiveness of treatment planning (Broekaert et al., 2001).
Although the results of the BIOMED II project were promising, none of the first studies did distinguish between men and women.

8.3.2 WHY A BIOMED FOR WOMEN?

To our knowledge, the BIOMED II project was the first large-scale European research project that was allowed to focus on gender differences in a systematic way. Since women are underrepresented in TC treatment, their needs are less noticed (Eley Morris, Yates, & Wilson, 2002). They have escaped the attention of researchers for a long time. Kaplan and colleagues (1998) describe a population as "hidden" when the problems of imperfect sampling frames and non-valid estimation techniques confront the researcher. According to that definition, the emerging dependency groups are a "hidden" population. However, among these groups, women seem to be even more "hidden".
One of the first IPTRP articles of Kaplan, Broekaert and Morival (2001) described the European situation as facing a bimodal distribution of emerging dependency groups. The first group consists of the older adults admitted to TC treatment, the sample if the IPTRP study belongs to this group. However, we should note that there were some country differences: e.g. the Belgian sample was much younger *(chapter 2)*. The second group is younger and is enrolled in special treatment facilities that are not classified as substance dependence services, or they are not utilising any treatment services at all. Two Dutch studies illustrated that there were more women in that group (van Oosten, Kok, & van Basel, 2000; Vanderplasschen, Colpaert, Lievens, & Broekaert, 2003). This was confirmed in American literature (Brady & Randall, 1999).

This study revealed that women in TC treatment were treated as an outpatient for their psychological problems more often than men. They have also been treated more often in outpatient substitution programmes. This implied that women were more at risk of dropping out.
There are often significant barriers for women to enter TC treatment. It could be that they have children in their custody, which prevents them from going into residential care (Duckert, 1989). They can be afraid that their children will be taken from them, as they don't live up to the demands of the society of being a good mother (Trulsson, 2003). Research showed that women wait to ask for help for their substance abuse problems until they are in a really bad way, which is confirmed by this study (see for instance *chapter 4*).

8.3.3 DIFFERENCES BETWEEN MEN AND WOMEN

This dissertational study has shown that we must carefully consider how we look for differences between men and women. In the 1990s, when the attention for substance abuse in women increased, some researchers suggested that societal structures can predispose persons to develop addictions. Living in a patriarchal culture induces societal inequality between men and women. Women do not have equal access to the means for acquiring legitimacy, status and wealth. This can produce feelings of inferiority and an addiction can develop as a way to numb and deny a feeling of powerlessness (Van Den Bergh, 1991). Many substance abusing women have a low self-esteem, which may be the result of a conflict between values and behaviour (Gutierres, Patton, Raymond, & Rhoads, 1984; Trulsson, 2003).

Men and women also seem to manifest their substance-related problems in a different way. The study exploring DSM-IV affective disorders revealed that some differences between men and women may manifest themselves in response styles and not actual symptomatology *(chapter 5)*. This means that we should be critical in our instrument choice, since some instruments may not be gender-sensitive and therefore do not reflect the patriarchal society in which the data are gathered (Graham, 1983): "women are weak and emotional, men have to be strong."

Finally, men and women appear to cope with their problems in a different way. Several studies have reported on how men and women deal with abusive experiences: women tend to internalise the trauma, while men externalise it (Jainchill, Hawke, & Yagelka, 2000). For women, this could result in self-destructive behaviour (Trulsson, 2003; Van Den Bergh, 1991), or as shown by this study, in suicide attempts *(chapter 3 and 4)*. Men were more often charged with crimes of violence *(chapter 4)*. It seems that women direct their aggression towards themselves, men to someone else. Men and women are different in their acting-out behaviour.

All this means that men and women have other treatment needs and therefore, need a different treatment approach (Brady & Randall, 1999). A study of Weiss, Kung and Pearson (2003) illustrated that the behavioural modification techniques often used by TC programmes may be re-traumatizing to women who have a history of physical or sexual abuse, but may be appropriate for men, particularly those with a history of externalising behavioural disorders.

8.3.4 NON-DRUG-SPECIFIC CHARACTERISTICS VERSUS DRUG-SPECIFIC CHARACTERISTICS

The BIOMED II IPTRP project revealed that non-drug-specific characteristics are as important as drug-specific characteristics. This dissertational study illustrated that women have other and more substance-related problems and that the connection between their substance abuse and other areas of functioning is much stronger.

More research is needed to map the linkages between client characteristics and (the risk of) substance (ab)use, but we will try to list some guarded conclusions based on both BIOMED studies. There seems to be a strong correlation between psychopathology and addiction. Several studies confirm this and Axis I mood and anxiety disorders are reported to be the most common comorbid psychiatric disorders (Hendriks, 1990). However, it is not clear which disorder starts first. The addiction could be an outcome of "self-medicating" psychiatric symptomatology or the cause of it. The former seems especially true for women (Van Den Bergh, 1991). It is important that this is cleared at treatment entry and that both disorders are treated in an appropriate way, particularly since psychopathology is related to the clients' long-term chance of success in remaining abstinent after TC treatment (Broekaert, Raes, Kaplan, & Coletti, 1999).

Both studies also revealed an important correlation between traumatic abusive experiences and the client's psychiatric status. The failure to identify and treat the underlying trauma is one of the greatest unacknowledged contributors to relapse (Eley Morris, Yates, & Wilson, 2003). This means that those clients may need more intensive and focused interventions.

One of the key concepts of the BIOMED II project was "history", i.e. the discovery of any family factors that increase the risk for substance dependency, psychiatric problems or childhood maltreatment (Kaplan et al., 2001). Women seem to be more disadvantaged than men, since this study showed that women are more likely to have mothers with drug problems *(chapter 4)*. Other studies reported that the rate of alcoholism within the family of origin is significantly greater for female alcoholics than for male alcoholics (Van Den Bergh, 1991).

Frank et al. (2001) concluded in their study that exposure to addicts in the family seems to do no good. The same study showed that exposure to addicts among friends lowers the risk for help, however, the effect seemed to be mediated by the clients' better psychiatric status. In line with this, *chapter 5* revealed that clients spending their free time with substance abusing family or friends are less likely to be diagnosed with a mood disorder. This could have an important clinical

consequence as it shows that spending time with other substance abusers could have a self-regulating effect. It is an important protective factor, since social exclusion is indicated as a risk factor (Bryssinck, 2003; Reichmann, Kaplan, & Jansson, 2001).
Chapter 4 showed that men often live alone, while women tend to live together with their (substance abusing) partner. In a state of abstinence it is better to live in a "clean" environment. A Swedish study illustrated that women stop their drug abuse with the support of family members and/or children, while men quit their addiction with the support of drug-free women (Hedin, 2003; Kristiansen, 1999; Rosenbaum, 1981).

The above learns that we should focus on the interaction of genetic and environmental variables in substance dependence when organising TC treatment. This seems especially true for the treatment of women.
More clarity about the direction of the correlations could be an important starting point for different kinds of prevention activities[27].

8.3.5 PROFILE-DEVELOPMENT

The six different studies all had their own contribution to the major aim of this dissertation, i.e. the development of a gender-specific profile of substance abusing women in TCs in Europe. In this way, it was intended to increase the attention for women in European substance abuse research and treatment. When comparing our profile with the characteristics of women in other treatment settings, there is much to like about it. However, we have to be aware of the heterogeneity among the female substance abusing population. A study of Stevens, Arbiter and McGrath (1997), for example, illustrated that women may have very different profiles and treatment needs depending on whether they had children at the time they entered treatment. Ezard (1998) stressed the importance to incorporate other characteristics such as class (socio-economic status, social background) and ethnicity (cultural background), in addition to gender, in order to fully understand a person's addiction. It is, therefore, impossible to develop one profile that fits all women. With our profile-development we detect a range of gender-specific characteristics that should be taken into account when organising

[27] See also Vanderplasschen, W., Autrique, A., De Wilde, J. (2005). Drugverslaafde ouders. In A.A. van der Zeben (Ed.), *Handboek Kinderen en Adolescenten: problemen en risicosituaties*. Houten: Bohn Stafleu Van Loghum.

a female-dominated treatment system, as an alternative to the traditional treatment system developed by men for men. However, due to individual differences among the substance abusing population, treatment approaches should be adapted to encompass variation among clients (Grella, Polinsky, Hser, & Perry, 1999). Translated to the community-based approach of the TC programme, this implies that there should be space for a more individualized treatment planning tailored to a client's specific needs.

8.3.6 WHAT IS GENDER-SENSITIVE TREATMENT?[28]

The way in which society looks at men and women reflects the way in which women are treated within the substance abuse treatment system. For a long time drug abuse has been seen as a disorder affecting men and therefore treatment programmes have been designed for males. Women have to adapt to a male-based treatment system. Due to the changing roles of women, which made them more visible in the social and economic domains of our society, i.e. in public life, there has been an increased awareness of their substance abuse problems (Ettorre, 1994). However, it is the patriarchal society's tendency to give low priority to the needs of women in general (Ezard, 1998). Women are still underrepresented and under-treated in treatment programmes today, especially in TC programmes *(chapter 2)*. This is even more true for women of childbearing age (Vanderplasschen et al., 2003).

Nevertheless, research showed that (the prospect of) motherhood is an important driving force for women to seek and accept treatment (Trulsson, 2003). As these women are overcome by feelings of shame and guilt, we must be careful in the way we try to reach them. During the early stages of giving up drugs, women need special help and support, because they tend to view themselves through the eyes of others (Goffman, 1963). Trulsson (2003) found in her doctoral research that women may benefit from the support of other women with whom they can build positive relationships. Professionals could also play an important role, but supportive relationships should be built slowly and with great care (Trulsson & Hedin, 2004), as there might be a danger of unequal relations of dependence (Young, 1997). Research showed that women who receive considerable social

[28] Based on the experiences coming from the therapeutic centre Sofia in Malmö, Sweden. The residential all-female programme was started in 1990 after several studies have shown bad results for women treated in mixed treatment programmes. Karin Trulsson was assigned as director of Sofia and started the actual planning of the centre. The treatment consists of environmental therapy with a psychodynamical approach developed from the perspective of gender.

support during their pregnancy, or when their children are small, are more likely to cease their drug abuse (Trulsson, 2003).

A first step in creating a more female-friendly treatment system is to understand the barriers there are for women to go into treatment and to recognise the differences between men and women in the development of their addiction, in the manifestation of their substance-related problems and in their coping strategies. We need to understand how substance abusing men and women relate to society's expectations and what it means to break with these through drug abuse (Trulsson, 2003).
Schliebner (1994) describes gender-sensitive therapy as an alternative approach to the treatment of substance abusing women. It does not only focus on the intrapsychic causes of problems, but also on the impact and consequences of societal oppression and victimization. We should give women insight into the processes that are responsible for the development and maintenance of their addiction.
Since many women develop their addiction because of feelings of inferiority and have a low self-esteem, we should avoid treating them within a hierarchic treatment system. This is especially true for women who come from abusive relationships. Women can learn from each other by sharing their experiences and it can make them feel stronger (Dahlgren & Willander, 1989). However, this should happen in a safe, non-threatening atmosphere and the question is whether this can be guaranteed in a male-dominated environment. We should create a female-based (gender-sensitive) treatment system (Trulsson, 2003).

Chapter 6 illustrated that most women have already had a lot of (negative) treatment experiences, therefore it is important to treat them in a non-judgmental way. This implies that when they slip-up within the treatment programme – using drugs or engaging in a relationship – they should not be rejected, but they should be given support and the opportunity to discuss it (Trulsson, 2003). Clients need to learn that they are responsible for their own behaviour, in contrast to their learnt helplessness (Bryssinck, 2003; Van Den Bergh, 1991).

Considering the importance of family, partner and children, TC programmes should provide the opportunity to stay in touch with them (Reichmann et al., 2001). *Chapter 2* on the characteristics of European TC programmes showed that here things have changed for the better. Whereas in the beginning clients were taken away from their natural environment, there are now family groups and meetings (Soyez, Tatrai, Broekaert, & Bracke, 2004). However, about the partners

of the women there is less consensus, especially when it concerns partners who also (ab)use drugs. Research illustrated that the actual support addicted male partners offer to keep their female partners into treatment is usually passive and inconsistent, which has a negative influence on the women's retention in treatment (Laudet, Magura, Furst, & Kumar, 1999). This seems to be especially true for women who are more controlled by their partners (Riehman, Iguchi, Zeller, & Morral, 2003). Therefore, the women's substance abusing partners should be motivated to enter treatment themselves and efforts could be undertaken to increase the balance of power and control in relationships, which may include efforts to reduce a partner's control over the treatment participant.
Women should get the opportunity to bring their children into treatment, however, there are still few programmes providing childcare *(see chapter 9 – annexe)*.

The above-mentioned shows that substance abusers benefit by living in group and supporting themselves, since it gives them a stable day structure and contact with other people. However, this should include additional individual therapy to work things through. Trulsson (2003) found that where women are concerned, these individual sessions hope to strengthen the women's self esteem and try to help them to talk about their ambitions and hardships. Some issues may also be difficult to share in the group (Wallen, 1992). The Video Addiction Challenge Tool (VACT) for women[29] could be used at this stage, because it was developed in group together with the women in TC treatment, and thereby proved its relevance. The women were confronted with their "own" stories, and by sharing these with the group, reached a closer understanding of reality *(chapter 7)*. However, themes which were brought up for discussion within the group could be applied to start an individual therapeutic session.

Considering the high medication use among women admitted to TC treatment, we want to mention that it is a positive development that more and more TCs allow the use of medication, but although this can help to stabilize the client's situation, we must not forget that it does not heal the underlying causes.
Finally, gender-sensitive treatment also entails an aftercare programme and long-term planning of the treatment. The women leaving treatment should get support and the possibility to stay in contact with their individual therapist to help them organise and manage their "new" lives.

[29] The VACT for women was introduced to people in the clinical field at a seminar on the 25th of May, 2005.

8.3.7 A GENDER-SENSITIVE TC TREATMENT MODEL: IN CONCLUSION

The emerging dependency groups are characterised by a huge range of different problems, which deserve attention in TC treatment if we want to prevent a relapse. These groups could benefit from a long-term, community-based residential programme using a holistic approach. However, at treatment intake women differ from men in several ways and therefore need another, more gender-sensitive treatment approach, which implies that besides the group there is more attention for individual client characteristics from the perspective of gender, and moreover, the way in which these have contributed to the development of a person's addiction. Whether this treatment model should be provided in a single-gender programme is not clear. However, men may profit more from having women within the programme than the other way around (Ravndal, 1994). Within mixed treatment programmes, there is an increased risk for the development of sexual relationships between men and women, which could hamper the possibility among the women to relate to each other in a personal and intimate way. A study of Ravndal illustrated that the engagement of women in destructive relationships with male co-residents, instead of building positive relationships with other women, negatively influenced treatment outcome (Ravndal & Vaglum, 1994). The same study revealed that the latter may give women the possibility to break the destructive patterns of relationships with men they have had before treatment.

Whether treatment is organised in a mixed or single-gender setting, the above-mentioned suggestions could help to organise a gender-sensitive TC treatment model, but the good intentions of individual providers will not suffice. The structure, rules and institutional boundaries must be redesigned to make substance abuse treatment more gender-sensitive (Young, 1997). Or to say it with the words of Nelson-Zlupko and others (Nelson-Zlupko, Dore, Kauffman, & Kaltenbach, 1996): "treatment programmes that simply layer specialized women's services over male-normed philosophies fail to provide a treatment atmosphere sufficiently responsive to female clients (p. 58)."

8.4 LIMITATIONS OF THE STUDY

Although most of the restrictions regarding the different studies were already mentioned, in this section we will focus on some overall limitations of this dissertation.

The first limitation concerns the several missing variables within the BIOMED II data. Some were caused by clients interrupting the interview, or specific questions that were not filled in properly. Other, more systematically missing variables were due to the fact that different instrument versions were implemented in the different countries. Therefore, the effective sample size used for the analyses was smaller than the number of men and women mentioned at the beginning of each study.

The BIOMED II project involved nine different European countries, which made it possible to collect a relatively large database. However, another limitation was the unequal distribution of clients over the various countries. For some of these countries we only had a small amount of data, therefore, it was not possible to say something meaningful about the client profiles within specific countries. Instead, we have controlled for possible main and interaction effects of the variable "country."

The third limitation concerns the kind of instruments that were implemented within the BIOMED II project. Although the EuropASI is widely used as an assessment instrument in substance abuse research and clinical practice, it might be not the best choice when searching for differences between men and women in general, or to assess characteristics of female clients more specifically. It was clearly revealed by this study that the EuropASI instrument was developed for the male substance abuse treatment population. It does not provide information on issues which might be of importance when organising treatment for women, such as information related to pregnancies, care-giving responsibilities, family and partner relationships, and issues related to victimization (Comfort, Zanis, Whiteley, Kelly-Tyler, & Kaltenbach, 1999).
Since the end of the 1990s, a female version of the Addiction Severity Index (ASI-F) is available (Friedman & Brown, 1997). Several items were added covering information about e.g. pregnancies, children, other medical and psychiatric problems. Other items were expanded with additional information, for example the abuse items now include the abuse by strangers. Although the new items of

the *ASI-F* refer to types of problems and situations that are more likely to be relevant for women, some of the new items may also be relevant for men.
However, one overall drawback of the ASI is that it assesses a person's problems and not his or her strengths. The latter would give treatment providers the opportunity to also take a client's healthy behaviours into account when organising treatment. Only a holistic view of the individual client can facilitate realistic goal-setting and treatment strategies tailored to personal and family needs and life circumstances (Comfort et al., 1999).
Our profile was also complemented with the information provided by the SCID. However, the choice for the SCID as a diagnostic tool within the BIOMED II project was problematic. Due to the time needed to conduct the interview, the complicated layout and structure of the instrument, and the extensive training needs for the interviewers, it could only be administered from a subgroup of clients within selected TCs. Therefore, the findings of the fourth study *(chapter 5)* should be handled with care.

Because of the limitations of quantitative instruments, two studies were executed using a qualitative approach. However, these two studies also have their restrictions. The first study on the views of women on residential treatment was limited because of its small number of women, which may reduce the generalization of the results. The interviews were analysed by six researchers, however, it would have been better if the final arbiter of whether the data were interpreted accurately would have rested with the women themselves (Brun & Rapp, 2001), like it was accomplished for the VACT study.
Finally, although the VACT may be a promising instrument for the treatment of substance abusing women, its application may be restricted by the intensive timeframe needed to work with the instrument.

8.5 DIRECTIONS FOR FUTURE RESEARCH

More European studies are needed to bring women under the attention of researchers, service providers and policymakers. This study illustrated that women have other treatment needs, which are not met within the traditional treatment system. Organising a more gender-sensitive treatment system will only be possible when giving more priority to women as a minority group in substance abuse treatment (Ettorre, 1994).

Considering the increasing amount of young girls starting to use (experiment with) drugs, it would be interesting to gain insight in the reasons why they get involved in drug use. This could help us to develop gender-specific prevention activities and more appropriate and effective interventions. Since standard instruments do not give the possibility to focus on gendered characteristics (Wilke, 1994), a qualitative approach could be applied. In such research study, a multidimensional framework (gender, sexual orientation, social background, ethnicity, …) should be used to understand the girls' drug use (Ettorre, 1994).

More research is needed on which instruments to use for the assessment of women at treatment intake. Most screening tools give an initial, global picture of the person, but may not focus on gendered features. Diagnostic instruments will provide a more in-depth analysis, but they are often time-consuming and need to be administered by a trained psychiatric clinician.

Qualitative methodologies could be used to study the treatment needs of women more in detail, however, we should involve them in the whole research process, as indicated in the limitation section. It would be appropriate to conduct more than one interview with the women in order to give them the chance to think things through and eventually correct their statements (Trulsson, 2003).

In America, the first outcome studies on gender-sensitive treatment have been published, illustrating how treatment programmes meeting women's service needs more effectively can yield improved treatment outcomes (Grella, Joshi, & Hser, 2000). However, not a lot is known about what specific programme components are related to the improved outcomes for women and whether gender-sensitive treatment should be provided in a single-gender environment (Pelissier & Jones, 2005). Women-only programmes seem to have promising results (Hodgins, El-Guebaly, & Addington, 1997; Stevens et al., 1997; Wobie, Eyler, Conlon, Clarke, & Behnke, 1997), especially for the most vulnerable groups, such as women with a

history of trauma, those who have worked as prostitutes, and lesbian women (Copeland & Wayne, 1992). Therefore, it would be interesting to conduct a large-scale outcome study in order to identify what programme characteristics are related to improved treatment outcomes for women, with special attention for different subgroups of clients.

Finally, there is a lack of research on the gender-awareness of service providers and policymakers. As they are co-responsible for the provision of gender-sensitive treatment, it would be highly desirable to know their gender-related attitudes towards the substance abuse of men and women (Kauffman, Silver, & Poulin, 1997).

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9

Annexe

Illegal drug use in Belgium: Gender differences and gender sensitiveness of the available data [30]

Abstract. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) will address the topic of gender in its 2006 annual report. This last chapter (annexe) will present our contribution to this report, namely about gender differences and gender sensitiveness of the available data on illegal drug use in Belgium. The first part will report on the interpretation of gender data on consumption in the general population and young people, mortality and drug-related deaths, treatment demand data, infectious diseases and crimes and arrests. The second part will describe the gender-specific responses in prevention activities, harm reduction, treatment organization, social reintegration and criminal justice system. It can be concluded that the awareness of gender as a mediating feature in drug use is fairly unknown and not taken into account in Belgian research studies and drug-related interventions.

[30] This chapter is based on: Colpaert, K., De Wilde, J., & Van der Elst, D. (in press). Illegal drug use in Belgium: Gender differences and gender sensitiveness of the available data. In S. Sleiman (Ed.), *Belgian National Report on drugs 2005*. Brussels: Scientific Institute of Public Health.

9.1 INTRODUCTION

Someone's "gender" is an imaginative condition that indicates the incorporation of behaviours and values that culturally have been defined as male or female.

"Genderstudies" assess existing scientific theories and perspectives on their gender sensitiveness and employability for the study of women and other oppressed groups. They criticise the androcentricity and overgeneralization from a male standard in traditional sciences and look for alternatives (Davies, 1999). "Women studies" on the other hand focus on the discriminatory effects that the oppression of women has on sciences and on social life and try to reassess women's interests (Becker-Schmidt, 1999). An important trend in this kind of research is to explain gender-ratios or differences in male and female behaviour.

Both types of studies are scarce when it comes to drug use. Although it is possible to determine the gender-ratios in the prevalence of drug use and in drug-related conditions and behaviours, finding gender-sensitive explanations to understand these differences is much more difficult. Within the Belgian literature we did not find any theoretical of methodological pieces, explaining the gender-ratios found in recent research on drug use.

Feminists have argued for decades that drug use and drug misuse are gendered (Van Den Bergh, 1991). They often point out that the social position of female drug users differs from the one of men and leads to different patterns of problematic drug use. Further, the traditional gender-role provokes different norms and values about intoxication and addiction for men and women. Nevertheless, the academic and knowledge-producing world doesn't pay a great deal of attention to this. They either stay away from the subject by pretending to be "gender-neutral" or they primarily address stereotypical gender-role aspects like motherhood or the alleged female psychological and physical weakness.

Thus, in this chapter we can merely try to describe gender-ratios in the Belgian drug use situation on the basis of recently published studies. After all, we can already conclude in advance that the awareness of gender as a mediating feature in drug use is fairly unknown and not taken into account in Belgian research studies and drug-related interventions. However, a few studies are currently ongoing, e.g. on the gender-specific profile of substance abusing women in therapeutic communities in 9 European countries, including Belgium (De Wilde, in preparation).

9.2 SITUATION

9.2.1 INTERPRETATION OF GENDER DATA

- Consumption in the general population and young people

Although the Belgian National Report on Drugs focuses on illegal substances, we also want to include a few comments regarding gender differences in the use of alcohol and tobacco. After all, alcohol and tobacco are legally forbidden for youngsters under the age of 16 years old and are also among the most popular substances. Overall we can carefully conclude that girls tend to exceed boys in both lifetime prevalence and daily use of tobacco. The "Health Behavior in School-aged Children study" (HBSC) demonstrates that by the age of 15, Belgian girls have a higher lifetime prevalence of tobacco use than boys: 58.8% vs. 56.9% in the French Community and 55.4% vs. 52.0% in the Flemish Community (Currie et al., 2004). Girls in the French community appear to have the highest prevalence of tobacco use among 15-year olds in Belgium. In the "European School Survey Project on Alcohol and Other Drugs" (ESPAD) a lifetime prevalence of tobacco smoking of 60% for boys and 62% for girls was found (Hibell et al., 2004). For smoking during the past 30 days, these figures were 32% and 33% respectively. More than a quarter (28.3%) of adult men and 20.1% of adult women are daily smokers according to the results of the "Health Interview Survey" (HIS) of 2001 (Demarest et al., 2002).
Overall, no important gender differences can be found with regard to the lifetime prevalence of alcohol use. However, gender differences do become relevant when looking at the patterns of alcohol use. The ESPAD shows a general lifetime prevalence of alcohol use among youngsters of over 90% (93% of boys compared to 90% of girls). These proportions are similar to those of alcohol use during the past 12 months (87% of boys compared to 85% of girls). The HIS did not measure lifetime prevalence but does provide figures on alcohol use during the past 12 months. The large majority of the population (81%) had consumed at least one drink but when subdivided by sex, a quarter of all women in the survey (26%) didn't drink alcohol during the past year compared to 12% of all men. The HBSC study only measured the weekly use of alcohol per age cohort: 33.6% of the 15-year old girls and nearly 44.7% of the boys in the Flemish Community appear to use alcohol on a weekly basis, in the French Community those figures are 22.4% and 35.6% respectively. As opposed to the figures on the prevalence of alcohol use, all three surveys show clear gender differences in the patterns of alcohol use, with more moderate patterns of use for girls as well as women. Girls

and women use smaller amounts of alcohol and drink less frequently than boys or men. In the ESPAD, 77% of the boys and 69% of the girls had used alcohol in the past month, for beer these figures were 64% for boys and 46% for girls respectively. The same differences can be observed in the HBSC study: 33.2% of the 15-year old boys in the Flemish Community as opposed to 17.9% of the girls drink beer on a weekly basis, in the French Community these percentages are 25.9% and 15.5% respectively. The HIS did not specify by type of alcohol.

Only the ESPAD provides figures on the lifetime prevalence of "any illicit drugs": 37% of the boys and 28% of the girls appeared to have used illicit drugs at least once in their life.

With regard to the consumption of cannabis during the past 30 days or 12 months and with regard to the lifetime experience of cannabis, the conclusions of all three studies are comparable: boys/men use cannabis to a larger extent than girls/women. It also appears that among youngsters, the majority of those who have ever used cannabis, also used it during the past 12 months. In the HBSC study the figures for lifetime prevalence of cannabis use within the cohort of 15-year-olds were: 23.1% for girls and 27.1% for boys in the Flemish Community and 21.8% for girls and 30.7% for boys in the French Community. With regard to cannabis use during the past 12 months the figures are: 19.8% and 28.4% (French Community) and 20.5% and 23.0% (Flemish Community). The ESPAD figures on lifetime use of cannabis are about 37% for the boys and 28% for the girls. Regarding cannabis use during the past 12 months, the figures are 32% for the boys and 22% for the girls respectively. During the past 30 days, 20% of the boys and 13% of the girls had used cannabis. In the HIS study, the lifetime prevalence for cannabis use is 10.8% for adult men and 6.6% for women while for recent cannabis use the figures are 3.1% and 1.4% respectively. Furthermore it appears that while men in the age categories "15-24 years old" and "25-34 years old" have equally experimented with cannabis in about one quarter of the cases, women in the age category "15-24 years old" have experimented considerably more than women between 25 and 34 years old, respectively 21% versus 6%. The numbers are also higher in the Brussels capital region, especially for men. Besides urbanization, which is also relevant for other types of drug use, we see that in the adult population cannabis is more popular with those who have a higher education or a university degree. (Demarest et al., 2002).

Among the 15-year olds, 9% of the boys and 7% of the girls had ever used illicit substances other than cannabis (ESPAD). Further, 6% of the boys and 4% of the girls in this survey appeared to have consumed those substances also during the past 12 months and 4% of both boys and girls have used during the past 30 days.

Besides cannabis, xtc appears to be the most popular drug for girls (a lifetime prevalence of 4%) and second most popular for boys (a lifetime prevalence of 5%), who have hallucinogenics on top (magic mushrooms: 8% among boys vs. 3% among girls). In addition, 3% of the boys and 1% of the girls had ever used amphetamines. With regard to illicit drug use (other than cannabis) during the past 12 months, 2% of the boys had used LSD, 3% xtc and 4% magic mushrooms. For girls these percentages are 1%, 2% and 1% respectively. For all other illegal substances the 12-month prevalence is 1%, except for GHB that had not been used by the youngsters in this sample. In the HBSC study approximately the same findings are reported. Finally, in the HIS study 2.1% of the male respondents had ever used xtc and/or amphetamine (both substances were combined in one variable). For the female respondents, this percentage was 1.4%. Recent use of xtc and/or amphetamines was 0.4% to 0.2% respectively.

- Mortality and drug-related deaths

Over a period of eleven years (1987-1997) figures from the Belgian general mortality register show a steady decrease in the percentage of all female drug-related deaths. Whereas in 1988 almost half of all deaths related to drugs were women (41.2%), in 1997 women consisted only one fifth (21.1%) (Jossels & Sartor, 2004). Possibly the high percentages in the eighties are due to the relatively small overall number of registered drug-related deaths, i.e. less than 20 in 1987. Furthermore one has to be aware of the fact that due to methodological reasons (i.e. the ICD-9 codes used in the operational definition of drug-related deaths), the study might contain deaths related to the use of prescribed or non-prescribed medicines, and not only of illicit drugs. A study on amphetamine-related deaths between 1976 and 2002 showed that overall 9.1% of these fatalities were women. (De Letter, 2002)

- Treatment demand data

Thus far, no uniform national treatment demand registration system exists. Treatment demand data are registered through various registration systems or research projects, which are limited in time (Colpaert & De Clercq, 2004). However, when we examine the available figures, although in a fragmented way, and check the gender distribution, we can conclude that the percentage of women varies between 15 and 26% of all registered treatment demands

(Colpaert, Vanderplasschen, Van Hal & Broekaert, 2005; INAMI, 2001; Raes & Lombaert, 2004; Thienpont & van Zuijlen, 2004; Vanderplasschen, Colpaert, Lievens & Broekaert, 2003).
Important differences in gender distribution can be seen between different treatment modalities, whereby more women were registered in ambulatory low-threshold services (De Wilde & Vanderplasschen, 2003; Thienpont & van Zuijlen, 2004; Van Dijck, Bruggeman, Demey, Todts, & Van Hal, 2000), which is consistent with the results from other international research.
Almost no data are available that can demonstrate changes over time. The sources that can be used show no changes over time (Thienpont & Van Zuijlen, 2004; Van Dijck et al., 2000): the share of women remained relatively stable.

- Infectious diseases

With regard to the new cases of HIV infection registered in Belgium, a decreasing trend can be observed with regard to the presence of IV drug use as a risk factor for infection since the beginning of the registration in 1986, this in men as well as women (Sleiman, 2004). Of all people who reached the stage of AIDS and who have the Belgian nationality (n=1.591), 12.9% of all women had IV drug use as a risk factor for infection while in men this factor only represented 3.7%. For people with another nationality (n=1.574) the opposite can be observed: 10.9% of all men had IV drug use as a risk factor while for women this factor was only present in 3.8% of all cases (Sasse & Defraye, 2004). If we observe injecting drug users who are in substance abuse treatment, an overall percentage of HIV-infected between 1.5% and 6% can be observed in those who were tested (Sleiman, 2004). The absolute numbers are too small to draw conclusions on gender differences.
Percentages for hepatitis b and c infection among injecting drug users demanding treatment differ greatly according to the type of treatment centre, the region and the methods used (self-report or biological testing). For hepatitis b, figures vary from 9 to 62%, for hepatitis c from 43 to 79%. With regard to gender differences we can observe that the percentage of hepatitis b infection is remarkably lower among female injectors than among male injectors. For hepatitis c infection, no solid or conclusive statements can be made with regard to gender distribution. In some studies or in some reference years, males have higher percentages than females, while in other studies the opposite was found.

- Crimes and arrests

Police arrests

When someone is arrested for drug-related issues, often this person will be charged with multiple offences (e.g. possession, use and sale of drugs). A serious shortcoming in the *"Algemene Nationale Gegevensbank (ANG)"* or general national database of the Belgian police is the fact that it cannot yet automatically link offences that are committed by the same person. As a result, only official figures on the number of "offences" are available, not on the actual number of unique "offenders". When we would draw conclusions on the basis of the number of registered offences, this would tend to magnify and overestimate the extent of the drug phenomenon. Consequently, these data can also not provide us with information on the gender-ratio in drug-related arrests. Therefore we requested the statisticians of the Central Cell for Drugs of the federal police to carry out a number of secondary analyses[31].

In these analyses another type of registration was used, in which only the major offences were counted and linked with the sex of the arrestees. So, if someone was arrested for possession, use and sale of illegal drugs, only the major offence 'sale' was registered and counted as an offence. This reduces the number of offenders that are counted more than once, but is not fully watertight since sometimes more than one major offence was committed and it is also possible that someone got arrested more than once in the same year. Below, we will briefly discuss some of the figures that these secondary analyses have generated.

When taking only the major offences into account (see Table 9.1), 33.532 offences were registered in 2004. Men committed 89.3% of these offences, women were responsible for 10.6% of the offences. The proportion of male and female arrestees stays equal over time but the general number of arrests shows an increase of over 6.000 between 2002 and 2004.

[31] Source: "*Algemene Nationale Gegevensbank (ANG)*" or general national database of the federal police – DGJ/DJP/Drugs – Downloaded by the Central Drug Service.

Table 9.1: Number of major offences in 2002, 2003 and 2004, divided by sex[32].

	2002		2003		2004	
	N	%	N	%	N	%
male	23.891	*89,0*	26.751	*89,5*	29.956	*89,3*
female	2.936	*10,9*	3.147	*10,5*	3.561	*10,6*
unknown	3	*0,0*	2	*0,0*	15	*0,0*
total	26.830	*100*	29.900	*100*	33.532	*100*

Table 9.2 on cannabis-related offences shows that for use, sale and traffic the proportion of women varies between 8.7% and 10.2%. In 2004, most male and female arrestees for the "use" of cannabis were between 15 and 20 years old. For offences regarding the "sale" of cannabis this is between 15 and 23 years old and for "traffic" between 18 and 23 years old.

Table 9.2: Cannabis-related offences in 2002, 2003 and 2004, divided by sex and type of offence.

	Cannabis use		Cannabis sale		Cannabis traffic		All cannabis related offences	
	N	%	N	%	N	%	N	%
2002								
male	10.602	*90.9*	1.492	*90.1*	3.571	*91.1*	15.665	*90.8*
female	1.067	*9.1*	165	*9.9*	349	*8.9*	1.581	*9.2*
unknown	1	*0.0*	-	-	2	*0.0*	3	*0.0*
total	11.670	*100.0*	1.657	*100.0*	3.922	*100.0*	17.249	*100.0*
2003								
male	12.282	*91.3*	2.102	*89.8*	3.888	*90.6*	18.272	*91.0*
female	1.174	*8.7*	240	*10.2*	402	*9.4*	1.816	*9.0*
unknown	-	-	-	-	1	*0.0*	1	*0.0*
total	13.456	*100.0*	2.342	*100.0*	4.291	*100.0*	20.089	*100.0*
2004								
male	13.904	*91.3*	2.374	*91.1*	4.855	*90.9*	21.133	91.1
female	1.335	*8.7*	231	*8.9*	489	*9.1*	2.055	8.9
unknown	2	*0.0*	-	-	-	-	2	0.0
total	15.241	*100.0*	2.605	*100.0*	5.344	*100.0*	23.190	100.0

[32] The percentages in table 9.1 and the following tables are rounded off to one decimal place after the comma. It has to be noted that 0.0% does not exactly equals zero, but refers to a small value between 0.0 and 0.1%.

The proportion of women that was arrested for heroin-related offences (see Table 9.3) is higher than for cannabis-related offences. This difference is very significant for the offence of "use" of heroin. Women's share in this type of arrests increases yearly. We can observe an evolution from 14.8% in 2002 to 16.6% in 2004. Most people, both male and female, that got arrested for the "use" of heroin are between 21 and 23 years old. The number of interventions for the "sale" of heroin doubled between 2002 and 2003. This provokes a change in the age groups responsible for this type of offence. While in 2002, the age groups of 21-23 and 30-35 years old were responsible for most heroin sale interventions, in 2003 all age cohorts between 23 and 30 years old show an increase in interceptions and this becomes even more apparent in 2004.

Table 9.3: Heroin-related offences in 2002, 2003 and 2004, divided by sex and type of offence

	Heroin use		**Heroin sale**		**Heroin traffic**		**All heroin related offences**	
	N	%	N	%	N	%	N	%
2002								
male	903	*85.2*	374	*89.5*	190	*90.9*	1.467	*87.0*
female	157	*14.8*	44	*10.5*	19	*9.1*	220	*13.0*
unknown	-	-	-	-	-	-	-	-
Total	1.060	*100.0*	418	*100.0*	209	*100.0*	1.687	*100.0*
2003								
male	1.305	*86.2*	808	*88.5*	244	*87.8*	2.357	*87.1*
female	209	*13.8*	105	*11.5*	34	*12.2*	348	*12.9*
unknown	-	-	-	-	-	-	-	-
Total	1.514	*100.0*	913	*100.0*	278	*100.0*	2.705	*100.0*
2004								
male	1.565	*83.4*	983	*89.4*	249	*89.6*	2.797	85.9
female	312	*16.6*	107	*9.7*	29	*10.4*	448	13.8
unknown	-	-	10	*0.9*	-	-	10	0.3
Total	1.877	*100.0*	1.100	*100.0*	278	*100.0*	3.255	100.0

Contrary to heroin use, the proportion of female arrestees for the "use" of cocaine appears to decrease over the years (17.4% in 2002 vs. 14.7% in 2004), although the total number of arrests continues to rise (1.170 offences in 2002 versus 1.854 in 2004). On the other hand, we can observe an increase in the proportion of women that got arrested for the "traffic" of cocaine (11.4% in 2002 vs. 15.6% in 2004). This can be explained by the fact that the number of

male arrestees decreased between 2003 and 2004, whereas the number of female arrestees increased over the years. For cocaine "use" offences most arrestees, both men and women, can be situated in the age cohort "21-23 years old". With regard to "sale" and "traffic" the percentages in the various age categories vary, but the age group "30-35 years old" appears to take up a large share, for both men and women.

Also the number of amphetamine-related offences shows an overall increase between 2002 and 2004 (from 3.817 to 5.263) and this also applies to the actual number of female arrestees (from 320 to 457). The proportion of female arrestees for "use" as well as "sale" and "traffic" of amphetamines is largest in 2002 (resp. 18.6%, 13.8% and 15.5%). In all three categories, there is a decrease of almost 2% in 2003 and then again a small increase of about 1% in 2004. The overall dominant age group for all types of amphetamine-related offences is between 18 and 20 years old. Although in 2004, slightly more female "sale" and "traffic" offenders were between 21 and 23 years old.

Public Prosecution

The next question is how many of the drug offences recorded by the police are handled by the public prosecution in Belgium. Standard figures on the activities of the public prosecution are available since 2003 (OM, 2005). But just as the data on police arrests, the data on public prosecution are based on the number of offences and not of offenders, so official publications do not provide gender-specific information. It was also impossible for the analysts to provide us with offender related information, therefore we could not use official data.

Since 1995 however, research data on the public prosecutions' handling of drug use offences have been gathered by the Department of Epidemiology and Social Medicine at the University of Antwerp (Van Hal et al., 2001). Each year, data are collected during a period of three months, from September to December. Only data concerning the caseload on the offence of "use" of drugs are collected, not on the final decision (e.g. court, other types of settlement) or on other types of drug-related offences (e.g. production).

In 2004, 12 public prosecutors in Flanders[33] and 1 in Brussels participated in the registration project (in total Belgium has 27 public prosecutors).

In Flanders 2.957 cases of drug use were presented to the public prosecution between September and December 2004, 367 (12.4%) of them were women. In

[33] Mechelen, Tongeren, Turnhout, Brugge, Veurne, Ieper, Leuven, Kortrijk, Gent, Oudenaarde, Dendermonde, Antwerpen

general Bruges had the highest number of cases (n=446), of which 11.7% (n=52) were committed by female offenders. The public prosecution of Dendermonde handled most female cases: 15.0% (55 out of 367 cases). Most offenders were transferred by local police corpses and had the Belgian Nationality. Only 44 out of 367 women had a foreign nationality (12.0%) and only 4 of them came from a country outside the European Union, while 14.7% of the men (n=382) had a foreign nationality, of whom about 85% lived within the European Community and another 2% had a Magreban nationality. In Brussels 170 cases have been reported of which 16 females (9.4%). Almost half (n=78; 45.9%) of the cases were related to drug users who did not have the Belgian nationality, of which 4 women. Here also the local police was responsible for most of the interceptions, although a high number of 'other' institutions were indicated as well. This may be due to specific actions of the subway and railway police, that don't exist in smaller cities. Concerning the age of the offenders, it can be observed that the largest group is between 21 and 24 years old, although the largest amount of female arrestees can be found in the age-group "18-20 years old". With regard to the type of substances, 61.3% of the female arrestees and 75.8% of the males appeared to be arrested for the use of cannabis. Proportionally more women appeared to get arrested for xtc (14,7% of all women to 11,5% of all men), amphetamines (18,5% of all women to 10,8% of all men), heroin (9,8% of all women to 5.6% of all men) and cocaine (8.5% of all women to 7.3% of all men). Some drug users were arrested for the use of multiple drugs. In Brussels all 16 women were arrested because of the use of one single type of drug: cannabis (n=11), amphetamines or xtc (n=3) and cocaine (n=2).

Convictions

We requested the Statistical Focal Point of the Ministry of Justice for data on convictions for drug offences. They provided us with tables on all criminal convictions, differentiated by type of offence and by sex. Based on these data, the figures below give an indication of the proportion of men and women and trends over time. However, we have to stress that these data are far from complete, especially concerning the drug offences.[34]

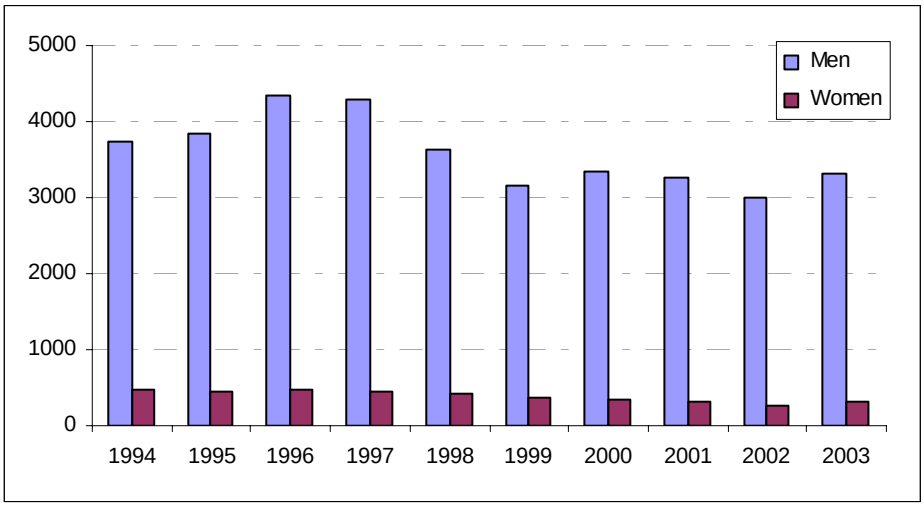
First, we can observe that the overall number of drug-related convictions has descended since the end of the nineties and then slightly increased again in 2003 (cf. figure 9.1). The proportion of women has decreased from 11.0% in 1994 to 8.9% in 2003.

[34] Note by dr. W. De Pauw analyst at the Statistical Focal Point of the Ministry of Justice

Data on the type of drug-related offence are subdivided into 'use of drugs' and 'trading of drugs', but again, since a person is often convicted for more than one violation of the drug legislation, it should be kept in mind that these figures do not represent the actual number of uniquely convicted persons but merely the number of convictions. Furthermore, when examining the figures that were provided to us on drug trading offences, a number of contradictions were found[35]. This has been reported to the Statistical Focal Point, but for now we can only discuss them with the necessary caution.

A steady decreased can be observed with regard to the number of offences related to the "use" of drugs: from 1.752 in 1994 to 950 in 2003. The proportion of women has decreased from 13.6% in 1994 to 10.2% in 2003. Offences related to the "trading" of drugs on the other hand are not unambiguous: small decreases are alternated with small increases in the total number of offences, but overall also here the proportion of women that committed these offences is declining: from 11.1% in 1994 to 8.7% in 2003 [36].

Figure 9.1: Sender differences in convictions for drug-related offences (1994-2003) [37]



[35] The sum of the total number of offences for "use" of drugs and "trading" of drugs is sometimes higher than the figures of those in Figure 9.1 (all drug-related offences).

[36] Source: v / IV.1. Min. Just. - DSB – Statistisch Steunpunt with thanks to dr. Walter De Pauw (3/6/2005)

[37] Source: v / IV.1. Min. Just. - DSB – Statistisch Steunpunt with thanks to dr. Walter De Pauw (3/6/2005)

Imprisonment

On the 1st of March 2005, the total prison population in Belgium consisted of 9.330 persons, of which 391 women (4.2%), divided over 34 prisons (NIS, 2005)[38]. Seven of these prisons have a women-section.

There are no official statistics available on the number of these persons that are imprisoned for drug-related offences. Again, we have to rely on secondary data analysis or dossier studies that focus on these specific offences, but few exist. Furthermore few of these studies provide gender-specific information. We do want to mention an older study from 1995, which stated that 13% of all men and 40% of all women in prison were convicted for drug-related offences (De Maere, 2000). Of course this doesn't signify that more women than men commit drug offences since these percentages are influenced by the fact that women don't commit as much other types of crimes, such as violent crimes, as men do.

In the summer of 2003, prisoners and prison staff of ten Belgian Prisons (five Flemish and five French institutions) were questioned on drug and health problems (Sleiman, 2004).[39] The results have not yet been published but the authors have provided us with a provisional report. This study concerns the situation of drug users in prison, consequently not all respondents were actually convicted for drug-related offences. Almost one quarter (24%) of all prisoners in those institutions agreed to participate in the study (886 out of 3.691 inmates). It appears that women where more willing to participate in the study since they make up 11% of the study sample whereas the average proportion of women in the total prison population is 4,2%. In the report it is stated that 24,9% of all respondents was convicted for possession or selling of drugs, but no gender-specific information was provided. The lifetime prevalence of drug use did not show significant gender differences: 53% of all female respondents and 50% of all male respondents had ever used illegal drugs. Further 24% of the women and 13% of the men had a lifetime prevalence of injecting drugs and finally 17% of the women and 11% of the men had injected the month prior to their incarceration. These figures have to be put in perspective. Not only are women over-represented in the study sample, other figures show that the percentage of female prisoners who have committed a drug-related offence is much higher than for men. Therefore, it is not surprising that in a prison environment more women show lifetime prevalence of drug use and injecting behaviour than men.

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[38] Belgium has a total of 10.370.000 inhabitants, of which 48.9% men and 51.1% women (NIS, 2005).

[39] Prisons of: Arlon, Brugge, Hoogstraten, Ittre, Lantin, Marneffe, Merksplas, Mons, Oudenaarde, and Dendermonde.

9.3 RESPONSES

9.3.1 GENDER-SPECIFIC RESPONSES ON CHILDREN AND YOUNG PEOPLE

- Universal prevention, girls'/boys' role behaviour

In Belgium universal prevention targeting the school population mainly focuses on the boys and girls in secondary education. Gradually efforts are being extended and prevention activities become more and more diversified. The core objective of these activities is the development of life skills; often drug prevention is integrated in health education. Furthermore, schools are encouraged to frame their prevention activities in a global school drug policy (Sleiman, 2004). Overall, no gender-specific approach can be found in these school prevention activities, except for a didactical material package called *"Unplugged",* which was developed in the framework of the European EU-DAP trial project[40] and is being implemented in Flemish schools through De Sleutel. Unplugged is a pilot drug prevention programme aimed at the development of life skills for pupils in the first four years of secondary school. Recently a new module was introduced in this programme aimed at discussing gender differences in among others friendships, choice of study and employment and alcohol and drug use (van der Kreeft, 2004).
Other universal preventive efforts are aimed at parents/families or at the larger community (Sleiman, 2004). Also there, few gender-specific measures can be found except for the Flemish campaign *"boodschap in een fles (message in a bottle)"*, which is oriented towards all people between 25 and 45 years old. Through the campaign general information is given about the use of alcohol, but also specific messages are given to employees, people practising sports and to women. Also in their previous campaign *"gratis drank (free drinks)"* specific information for men and women was provided about the risks of alcohol use (VAD, 2005a).

- Selective prevention in recreational settings, girls'/boys' peer groups, also related to alcohol and specific pharmaceutical products

Selective prevention takes place in youth associations, non-institutional contexts (music festivals, bars, streets, …) and in sports clubs (Sleiman, 2004). Within this framework, no gender-specific approaches were found.

[40] More information on the EU-DAP Trial Project on: http://www.eudap.net.

- Selective prevention among socially vulnerable groups girls/boys: early sexuality/pregnancies, early criminality

"'t Mussennest" is a preventive project aimed at youngsters in part-time vocational education. This group is known for having many problems, among others drug use. With this learning-working project the initiators want to combine work (renovation of a farm) with the training of attitudes and drug prevention and hope that these vulnerable young people can better find a place in society. Specific attention is given to girls. Research was carried out to understand why girls participated less in the project, bottlenecks were analysed and appropriate gender-specific measures were taken to attract and keep more girls in the project. 't Mussennest is a project of the European Social Fund (ESF) and is being carried out by De Sleutel (De Sleutel, 2005).
A number of specific projects offer drug prevention for the specific group of *migrant women* (predominantly Turkish and Moroccan mothers with adolescent children). These projects rely heavily on key figures in the different communities, who than act as hostesses and invite their female family members, friends and acquaintances in their homes. A prevention worker of the same ethnic origin assists and sensitive topics such as drug use can be discussed within a familiar surrounding. Projects of this type are sometimes called "tuppercare projects".

9.3.2 RESPONSES TO PROBLEM DRUG USE AND GENDER; GENDER-SPECIFIC HARM REDUCTION RESPONSES - PROVISION AND COVERAGE OF GENDER-SPECIFIC INTERVENTIONS

- Reduction of injecting

The centres responsible for the reduction of injecting of problem drug users are the *low-threshold substitution programmes* (Medical-Social Care Centres, Free Clinics), located in the larger cities of Belgium. Their RIZIV[41]-convention states that they cannot discriminate between sexes. They do not provide a gender-specific approach, but work client-focused, which means that they address the client's individual needs.

41 RIZIV: *"Rijksdienst voor Invaliditeits- en Ziekteverzekering"* (National Service for Medical and Disablement Insurance)

- Reduction of risk of sexual transmission of infectious diseases

Sensoa is a Flemish coordinating organisation, providing services and expertise regarding sexual health and HIV. They organise several campaigns with the intention to raise awareness concerning the risk of sexual transmission of infectious diseases (Sensoa, 2005a). People being under the influence of alcohol and or drugs can be a high-risk group. Most of the time these campaigns are not gender-specific. However, Sensoa also publishes a free magazine (BEND) with prevention messages specifically directed to gay men.

- Male and female sex workers health

Several organisations spread over Belgium, such as Payoke in Antwerp and Adzon in Brussels, promote the medical health of male and female sex workers (Sensoa, 2005b). They provide their clients with gynaecological check-ups, blood tests, distribution of condoms, etc. These centres are not *"drug-specific"*, but have many drug users among their clients. They do not provide a gender-specific approach. Generally, they have or *a male or a female public.* Their medical services are related to the specific health risks connected to male or female prostitution (N.N., 2004).
On the other hand, some substance abuse treatment centres have an increased attention for drug abusers who are involved in prostitution. For example, at the Flemish side, *"Free Clinic Antwerp",* established in the prostitution area around the Central Train Station, has many female clients prostituting themselves. Their interventions are linked to the specific risk these women run (safe sex advice, provision of condoms, needle exchange, …).

- Pregnant problem drug users

Pregnant drug users receive a preferential treatment within several programmes. One project *"Bubbels & Babbels"* of Free Clinic Antwerp specifically focuses on pregnant drug users (Rombouts, 2002). Case management is the central activity of the project, which can be seen as a method for managing the provision of different services to meet the *client's specific needs.* Before the child is born, the first concern is to make sure that the child is born as healthy as possible and to prepare the women for the birth of their child.

Further, the Flemish Association for Alcohol and Other Drug Problems (VAD) has developed several leaflets, among which one specific leaflet on *"Drugs en Zwangerschap* (Drugs and pregnancy)".

- (Problem drug using) parents with small children

The project *"Bubbels & Babbels"* also provides the essential support to the *parents* regarding the welfare and the basic needs of their child. The case management model is used in order to improve the cooperation between various services, such as childcare, social welfare, substance abuse treatment, etc. (Rombouts, 2002).
Two of Belgium's therapeutic communities for illicit drug users (De Sleutel & Trempoline) participated in the European project *"Vulnerable People, addicted mothers and their children" (*van der Kreeft, 2002). As a result of the project a manual was published providing answers to 4 questions:
- What exactly are the problems of addicted parents and their young children?
- What impact does the attitude of the caretaker have on the parent or child?
- How can treatment be developed and improved?
- How can prevention be developed or improved for this particular target group?

In 2003, the therapeutic community Trempoline organised training modules for the staff of the "*Office de la Naissance et de l'Enfance (ONE)*" on *dependence and parenthood*. Through pre- en post-natal consultations, these staff members (e.g. nurses) come in contact with almost all families with newborn children (Sleiman, 2004).

- Prevention of drug-related morbidity and mortality

Different types of *needle exchange* programmes are available in Belgium. They do not provide a gender-specific approach. Other harm reduction / prevention activities, such as *"Partywise"*, *"Modus Fiesta"* and *"Responsible Young drivers"* are specifically oriented towards the *"party public",* but do not differentiate between genders (Modus Vivendi, 2005; VAD, 2005b, RYD, 2005).

9.3.3 GENDER-SPECIFIC TREATMENT DATA AND APPROACHES – DIFFERENCES IN TREATMENT ORGANIZATION

- Availability of gender-specific treatment

From an international point of view, the last two decennia an increased attention for female substance abusers can be observed, which is reflected in services targeting women's special needs (Hedrich, 2000). Most of the woman-specific services are established less than five years ago and organised within existing programmes. In Belgium however, there are *no women-only* substance abuse treatment *programmes*. Nevertheless, a few gender-specific initiatives were set up, which are described below.

Two Belgian therapeutic communities (TCs), "*De Kiem*" (Flemish Community) and *"Trempoline"* (French Community), started a programme for mothers with small children (respectively the *"Tipi"* and *"Kangoroo"*). Within the programme there is special attention for the relationship between the mother and her child(ren) and parental skills training is provided. The woman lives together with her child(ren) in a separate building and during the day, when her child(ren) goes to day nursery or school, she follows the programme in the therapeutic community together with the other women and men. Within the mixed therapeutic programmes there is also some extra attention for the minority position of women in general. They are given some special activities and privileges. For example, women-only groups are organised on a weekly basis, where women can discuss issues which are important for them, this in a safe, non-threatening way, without the supervision or presence of men. Also in the evening or in the weekend, the women can spend some time together, separated from the men.
Recently the Video Addiction Challenge Tool (VACT) for women was developed, together with the female residents of the TC *"De Kiem"* (Broekaert & De Wilde, in press). The first version of the VACT was developed ten years ago, as an instrument for (individual) treatment planning in the TC (Broekaert et al., 2001). The original instrument, which confronted residents with the life story of an "average" male to reach therapeutic openness and dialogue, was regarded as female-unfriendly and not gender-sensitive. Therefore, a new version was constructed to address typical female characteristics, in order to contribute to the individual treatment planning of women. The instrument can be a way to challenge the "traditional" hierarchical and behaviourist TC and it can contribute

to a more women-friendly TC with a higher female/male resident ratio. The VACT can also be used in other categorical substance abuse treatment settings.

In the French community, the residential substance abuse treatment programme *"Les Hautes Fagnes*" organises treatment in *five subgroups*: three separate groups for men and two for women. In each of the five subgroups the *same four therapeutic programmes* are provided: relational, psychosocial, social and familial, and medical programme. A part of the building is reserved especially for the women and for one mother with her child.

In the *psychiatric hospital "Broeders Alexianen Tienen"* separate groups are organised for men and women with an alcohol addiction. The reason is that within mixed-groups men and women take up their traditional gender roles (for example women cleared the tables), and in addition it also became clear that women talk easier about their abusive experiences within a *women-only group.*
Most centres for general social work, the "*Centra Algemeen Welzijnswerk (CAW)"*, e.g. CAW Stimulans in Kortrijk, provide housing *separate for men and women (with children)*. They are not directed to substance abusers in the first place, but sometimes their clients use drugs. They organise group- and individual therapy. The women for example learn to stand up for themselves and get help to raise their children.

- Feministic approaches or approaches relating to female role behaviour in treatment

For a long time drug abuse has been seen as a disorder affecting men and therefore substance abuse treatment programmes were designed for males (De Wilde, et al., 2004). Together with the increased attention for women, a *women-centred approach* was adopted within several TCs in Belgium, which means that women receive special attention within the mixed treatment programmes (Martens, 1999). However, it can also be observed that only a very limited number of women actually demands for treatment in a therapeutic community, which could imply that they experience important barriers to entering such programmes (De Wilde, et al., in press).
Since women are still greatly outnumbered by men and some TCs only have a few women, a *monthly inter-TC women's day* is also organised. The purpose of this day is to make the TC more suitable for women by encouraging the solidarity between them and give support for their minority position in their own TC.

Women can also benefit from the role model function that is available in a bigger group with elder women and women who have been participating in a therapeutic programme for a longer time. During the women's days, the women can choose and organise their own programme of the day. If necessary, they can get assistance and support from the staff members (Martens, s.d.).
One of the Flemish mixed TCs *"De Spiegel"* utilizes the FORT ("*Feministische Oefengroep voor Radicale Therapie*" or feministic practice group for radical therapy)-techniques when there are women in their programme. The discussion techniques are inspired by Transactional Analysis and Radical Psychiatry and stimulate the *emancipation process* of the participants not only on a personal but also on a social level. The techniques are made to address women's problems here and now in the group (negative self-esteem, difficulties with expressing anger, receive positive feedback, …) (Martens, s.d.).
The mixed TC *"Trempoline"* organizes *men- and women-only groups* on a two weekly basis. The themes discussed in the single-gender groups are for example prostitution, sexual abuse, the person's sexual identity, …
In psychiatric treatment, e.g. in the *psychiatric hospital "Broeders Alexianen Tienen",* the group sessions provided in the single-gender groups for alcoholics start from the fact that *men and women* have been *socialized in a different way*. Therefore, their alcohol abuse has another function ("men drink to strengthen a good feeling, women to get rid of a bad feeling"). Men and women gain insight into the *gender-specific coping strategies*. The women also receive a group session on their self-image and the way in which they see their own body.

- Approaching masculine role behaviour in treatment

The programme provided in the *mixed TCs* is described as *male-dominated*: hierarchic structure of the programme, confrontational techniques, self-help orientation, … (De Wilde, et al., in press).
One Flemish TC *"TGG De Sleutel"* for substance abusers with a comorbid psychiatric disorder, only allows men. The structure of the programme is comparable to the one provided in the mixed TCs, however, the therapeutic programme is less confrontational and works more individualistic. The men also receive *social skills training* and could talk about their previous relationships with women and/or men. The men learn to have respect for their female staff members.

9.3.4 GENDER-SPECIFIC REINTEGRATION APPROACHES

Reintegration projects for drug users can be part of the aftercare a treatment centre provides for clients that have been discharged. Some residential treatment centres have so-called "halfway" houses that try to support a person's reintegration process. Besides, there is a lively debate going on about case-management and integral care provision for drug users. These projects are highly client-focused and for as far as we could find gender is not an explicit issue.

9.3.5 GENDER-SPECIFIC ASPECTS IN THE CRIMINAL JUSTICE SYSTEM

- Responses to petty crime

There are no special responses to petty crime of drug users in Belgium. The last constitutional amendment of 21st February 2002 explicitly warrants women-men equality under art.10. Thus, a difference in social reactions based on sexes is illegitimate. The institute for men-women equality is authorized to take legal action when equality rights are violated.

- Gender-specific prison responses, differences in culture or practices in men's/women's prison settings

None of the prisons with a women-section offered drug treatment, except for methadone maintenance treatment. In Ghent and Bruges they had tried to set up treatment projects for both men and women but because of a lack of interest by the inmates, these projects had been cancelled.
The Flemish prison of Bruges has a special unit for mothers with young children up to the age of 2,5 years old, which is the age that children can start pre-school. In Flanders the prison of Bruges hosts all pregnant women that have to give birth in Prison. They normally stay there except when it is not practical, like when it is to far to receive visitors. Walloon prisons provide this kind of service individually. Last, we want to mention the pretherapeutic 'BELIEVE' project for drug users at the prison for men in Ruiselede. Ruiselede is a Flemish 'open regime' prison, which has an eight months project in which 16 prisoners with drug problems can participate. The objective of the project is to reach abstinence through individual, group- and family counselling (P.L.C. Ruiselede, 2005).

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