

Is the 'community as method' approach gender sensitive?

Client and treatment characteristics in European therapeutic communities. Results of the BIOMED II (IPTRP) project

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The BIOMED II project, 'Improving Psychiatric Treatment in Residential Programmes for Newly Dependent Groups through Relapse Prevention', provided a large database of characteristics of men and women in European therapeutic communities (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 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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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. Other European studies (listed in the Web of Science) also largely ignore a gender perspective, which could be because of 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, 1999a; 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 in order to meet the specific needs of women in treatment (Ashley, Marsden & Brady, 2003; Bride, 2001).

The authors (De Wilde, Soye, Broekaert, Rosseel, Kaplan & Larsson, 2004) have already published one article on the basis of the BIOMED II data, focusing on gender differences in the psychiatric status of TC residents. They developed a female psychiatric profile and suggested some specific treatment interventions. However, they did not take the treatment characteristics of the different participating TCs into account.

The European TC, after the American example, started its development in the 1970s. 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, D'Oosterlinck, Kooyman & Van Der Straten, 1999b). During the mid-1980s, 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 et al., 1999a; Vandeveld & 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, Vandeveld, Schuyten, Erauw & Bracke, 2004). Since the 1990s, 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 (Vandeveld, 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 whether the TC programme considers the differences between men and women and if the 'community as method' approach is gender sensitive.

Material and methods

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: 85).

All clients entering a participating treatment centre between 1 May 1997 and 31 October 1998 were 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, no date), the Video Addiction Challenge Tool (VACT) (Broekaert & Soye, 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, 1981–1982). In

traditional long-term residential TCs, there are three main programme stages: introduction, primary treatment and re-entry (De Leon, 2000: 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 'detoxification residential' (first phase) and 'drug free residential' (second phase), respectively.

The EuropASI is the European version of the Addiction Severity Index (McLellan, Luborsky, Woody & Obrien, 1980; McLellan et al., 1992), 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 seven areas of functioning: medical status, employment and support status, drug and alcohol use, legal status, family history, 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., no date) 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 the criteria of residential programme using 'community as method'. The BioMAPS consists of a unit and a client's 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 and so on. 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 seven areas in which different treatment interventions are provided during the programme. The areas refer to the seven problem domains in the EuropASI.

Study sample and methodology

The study sample consists of 863 clients in 30 different TCs: 76.7 per cent are men, 23.3 per cent women. In

the first overview (see Table 1), the differences between men and women in several interesting EuropASI items are presented in percentages. Because of 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), 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 3) and between gender and the main treatment orientation (see Table 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.

Results

Gender differences in the client characteristics

Table 1 shows the gender differences in the characteristics of the TC clients. They are presented conform to the different life area 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 per cent). This could be explained by the selection of the different centres, as one of them takes only 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.

Table 1. Gender differences in client characteristics.

	Norway		Sweden		Belgium		France		Germany		Scotland		Greece		Italy		Spain	
	M n = 70	W n = 32	M n = 46	W n = 39	M n = 98	W n = 19	M n = 52	W n = 15	M n = 47	W n = 13	M n = 83	W n = 40	M n = 158	W n = 23	M n = 87	W n = 12	M n = 19	W 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 licence	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
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
Living situation (%)																		
Living together with partner with or 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 someone who has an alcohol problem or uses drugs	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
Experienced 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
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

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 licence (range 58.6–73.7 per cent). More men than women generally hold a valid driver's licence.

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 per cent versus 80 per cent) and German (85.1 per cent versus 76.9 per cent). 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 per cent for the men and 23.7 per cent for the women). In most TCs, more men than women have used cannabis. Well in excess of 50 per cent 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. A large proportion of the male residents of the Norwegian TCs injected drugs (97.1 per cent).

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 per cent and 67.7 per cent) and Germany (72.3 per cent and 84.6 per cent). 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 per cent for men and 84.6 per cent 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 concerning only 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 and 27.5 per cent 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 per cent). 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 per cent, 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 per cent of the men and 86.7 per cent of the women). More women than men have serious problems, except for Belgian TC residents (62.2 per cent of the men and 57.9 per cent 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 per cent of the women cohabit with someone who has an alcohol problem or uses drugs (50, 73, 56.5 and 58.3 per cent, 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 per cent versus 57.1 per cent). 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 than men. The rate of abuse of women is high, particularly for emotional (range 50–97.4 per cent) and physical abuse (range 53.3–76.3 per cent), but sexual abuse (range 23.1–55.3 per cent) 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 than men. The percentage of both men and women who have ever been treated as outpatients is very high for the French TCs (41.2 per cent for men and 81.8 per cent 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 per cent for men, 93.3 per cent 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 13.6–86.7 per cent). This could probably be explained by their more serious psychiatric condition. The percentages are again particularly high for France (59.6 per cent for men versus 86.7 per cent for women). Female TC residents have experienced more serious thoughts of suicide during their lives (for France as many as 93.3 per cent 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.

Treatment characteristics of the participating centres

Table 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. 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 admit alcohol and medication abusers and poly-substance abusers. Half of them admit dual-diagnosis clients. They show interest in the assessment and treatment of different psychiatric disorders.

The 'target group' of a TC shows 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 that 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, 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.

Gender differences in the treatment characteristics

Twenty-five of the 30 TCs are mixed treatment centres. Tables 3 and 4 present the gender differences respectively in the main orientation and in the main treatment orientation.

A significant gender difference ($\chi^2 = 0.008$, $df = 4$) 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 (independence implies that the proportion of females does not change across the levels of 'main orientation'). More women were observed in the educational orientation.

Although the chi-square test ($\chi^2 = 0.130$, $df = 4$) 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.

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, Marsden & Brady, 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

Table 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: dual diagnosis (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 1: DD 1: criminality	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
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: benzodiazepines 3: anti-depressants 3: anti-psychotics	1: alcohol 1: benzodiazepines 2: anti-depressants 2: anti-psychotics	5: methadone 1: benzodiazepines 5: anti-depressants 5: anti-psychotics	1: anti-depressants 1: anti-psychotics	2: methadone 2: benzodiazepines 2: anti-depressants 2: anti-psychotics	2: no 1: missing	1: methadone 2: benzodiazepines 3: anti-depressants 2: anti-psychotics	1: methadone 1: benzodiazepines 1: anti-depressants 1: anti-psychotics

Table 3. Gender differences in main orientation.

Main orientation		Gender	
		Men	Women
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

Table 4. Gender differences in main treatment orientation.

Main treatment orientation		Gender	
		Men	Women
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

the differences between men and women into account. Is the 'community as method' gender sensitive?

Women still under-represented 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 under-represented in TC treatment (Eland-Goossensen, van de Goor, Benschop & Garretsen, 1998; Hinojal Fonseca, Martinez & Rodriguez-Hevia, 1988; Kokkevi, Stefanis, Anastasopoulou & Kostogianni, 1998; Pouloupoulos & Tsiboukli, 1999; Ravndal & Vaglum, 1999; Ravndal et al., 2001). This is also the case in our study. As shown in Table 2, 25 of the 30 TCs indicate that women are their target group; however, on the basis of Table 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 (Table 1). 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. However, 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 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 explanations, 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, woman 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.

Gender differences in client characteristics

The men in our data set 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, Marsden & Brady, 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 than men 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 licence 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 Pouloupoulos 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 data set. There was no significant gender difference in medication abuse, contrary to what is found in the general population (van Oosten, Kok & van Basel, 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 per cent of the men and 45 per cent 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 (1991) and Ravndal and Vaglum (1994) have stressed the importance of parents, partners and peer relationships for positive treatment outcome of women in hierarchic TCs. Ravndal 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 cohabit 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 can 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, Hawke & Yagelka, 2000; Ravndal et al., 2001). However, this is also the case in the general population, and the abuse of men may be under-reported. We should endeavour to detect these problems at the beginning of treatment and take them into account when organising treatment.

As confirmed in a previous study by the authors (De Wilde et al., 2004) and in the literature (De Leon & Jainchill, 1991; Hinojal Fonseca et al., 1988; Jainchill, Hawke & Yagelka, 2000; Ravndal & Vaglum, 1999), in our data set 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 we should deal with it in treatment.

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 educa-

tional 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 (Vandeveldt & Broekaert, 2003). It seems that women prefer other treatment approaches to 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.

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.

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, focusing on themes and events that are important for women during their lives. It was recently developed at the Department of Orthopedagogics, with the help of women in TC treatment (Broekaert & De Wilde, 2005). 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 focusing 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.

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 interpreted with care. Another limitation concerns the use of the BioMAPS questionnaire. As a result of 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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