

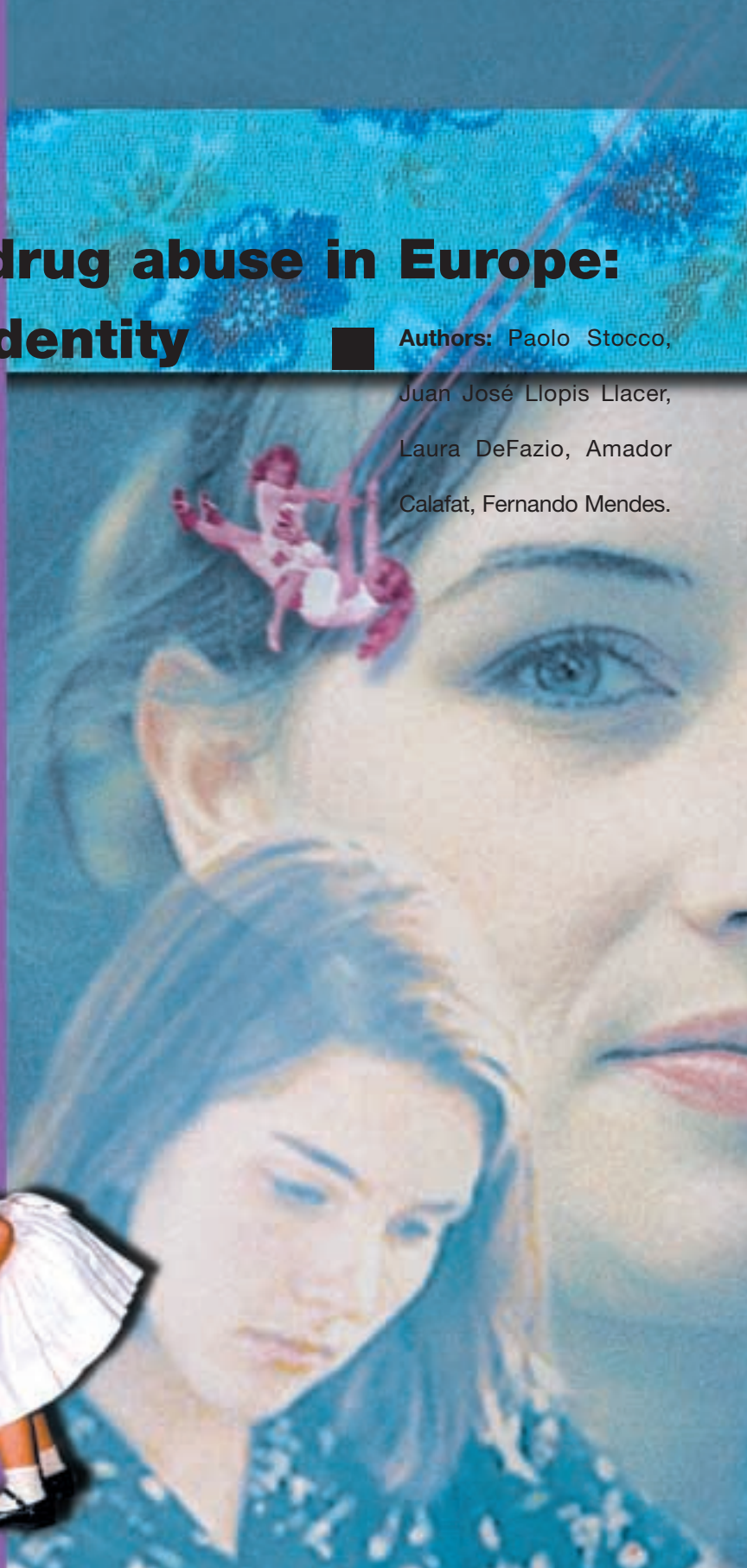
Women drug abuse in Europe: gender identity

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WOMEN DRUG ABUSE IN EUROPE: GENDER IDENTITY.

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PREFACE

This book presents a series of contributions by various clinics and European researchers who worked together on a research programme supported by the European Institute of Research on the Risk Factors in Infancy and Adolescence (IREFREA). It was supported by the European Commission.

As those involved are sadly aware, many of the clinical histories of drug addicted women reveal violence, abuse and neglect. To be able to gather information regarding the aspects which are specifically linked to the identity of gender, a complex European study was set up to focus on precisely these drug addicted women.

Many case histories were collected, the material gathered was vast and this book contains a significant part, which is, under certain aspects preliminary to the complex problem. In a successive work we will present ulterior investigation of the research which has not yet been completed. In this introductory chapter two central questions will be tackled to introduce the subject. That is, the repercussions of the development of the female identity in the use of drugs and the question of maternity in drug addiction.

There are numerous scientific contributions and clinical accounts which try to outline the interpretative path regarding the risk factors and factors of protection in the pathology of drug abuse. However, it is noticeable, that a position of such marginal importance has been given to the problem of gender identity and more specifically, femininity, which conditions the individual characteristic of women and which thus distinguishes itself from the male.

THE QUESTION OF GENDER IDENTITY IN CORRELATION TO DRUG ABUSE

Today, we live in a world which is changing rapidly and in continuation. A deeper understanding of the subject of female identity can undoubtedly contribute significantly towards the understanding of certain psychological aspects, not only at a personal evolutionary level but also regarding the social implications since they are the ones most affected by these cultural changes such as life-style with the consequent repercussions in new trends in the consumption of drugs. Going through the literature, one has the impression that the theoretical reflections on the process of female identification do not keep up with the personal and psychopathological aspects. Above all, this is true in

connection with the phenomena of drug addiction where the epidemiological importance of women undoubtedly represents a part of the problem which cannot be ignored.

In fact, the complex interaction regarding the multiple problems concerning the identity of gender in correlation to the phenomena of addiction takes on dimensions characterised by great theoretical interest precisely in reference to the study of the development of female identity. This is expressed to a greater extent during adolescence, the period in which the process of external differentiation develops with the development of secondary sexual characteristics. However, the process of differentiation, in contrast to that of the male gender, follows an interior path which is much more complex and has its roots in early infancy and follows various stages of evolutionary development in the woman with innumerable correlations of a psychological, interpersonal, behavioural and social nature.

In the light of these rapid social and cultural changes, there is no doubt that more detailed theoretical and clinical research aimed at forming stronger hypotheses regarding the formation of the female universe and the phases she goes through, would give us more solid points of reference concerning the problems of drug abuse both as regards prevention and treatment and rehabilitation. As has been shown by the branch of clinical psychology which deals with the treatment of drug-addiction, this research is of particular importance in situations of crisis with reference to their own identity of gender and thus to their female dimension and it plays a significant role in the apparition and consolidation of this problem of abuse. Besides, this phenomenological appearance reveals aspects which are visibly different in males and females of the same age.

Both aspects emerge clearly relative to the drug-addicted women whose case histories show evolutionary paths mined with a series of aggression, often, but not always physical. This inevitably damages the structure of the personality in its components of identity, thus impeding the development of a complete female psychology. At a phenomenological and clinical level, one can easily observe the serious repercussions that this series of difficulties has and which successively leads to a clearly marked auto-destructive behaviour – in particular much more than the males as regards their own corporeal dimension. These serious repercussions are evident not only with reference to the frequency of drug abuse, but also as a dissipated tendency of themselves, aimed in particular at the sexual sphere, almost as if wanting to underline how little they value their own person and their own gender identity. The clinical experience in the psychotherapeutic treatment of drug addiction has partially confirmed this – with its high frequency of ideation and higher auto-suppressive attempts in the women with respect to the men.

The more external elements, that is those linked to the body and sexual dimensions, are the ones which have been at the centre of the intervention policy in the last few years of minimalisation of the damage on the subject of drug addiction and femininity. It is almost as if they want to emphasise the dangerous ease with which a drug addicted

female exposes herself to the risk of contracting sexually transmittable diseases finding herself forced to barter her own body without taking the necessary precautions to protect her own health. Various campaigns of information and awareness-raising concerning the phenomena of prostitution have been carried out for years, which are not, however, specific to only the female world but to a much larger population.

In contrast, studies aiming at the investigation of the intra-psychic aspects which allow the construction of the feminine identity and which include both longitudinal aspects, from the age of infancy to that of adulthood and also retrospective, going from adulthood in the reconstruction of the past and of the experience which characterised them up to the present moment. In this way it is possible to notice a sort of “non-specificity” of the studies such as the politics of the intervention towards women, in particular female drug addicts, which do not grasp the characteristic of the differences between the sexes in the development as in psycho-pathology, through the emergence of the symptom.

In fact, very often theory or research on the subject of drug addiction – with the exception of the problems of alcohol-abuse – has been limited to following the evolutive path of the male including an extension to the female evolutive lines without however, any type of comparison or attention to the identification of factors which are specific to the female population.

Under certain aspects, very little interest has been shown by the operators, whereas it would have been sufficient to underline certain phenomenological circumstances concerning female drug addicts who make themselves known to the Services. This would make clear, for example, that these women often experience their own identity of gender in an incomplete form since their experience in the social circles of drugs has led them to develop defensive processes, attitudes and life styles according to progressive masculine trajectories. These tendencies are particularly clear in subjects with a long experience of drug addiction behind them and they have therefore developed defensive traits that reflect characteristics that, from an anthropological point of view, belong to the sub-culture of a predominantly male group; a predominance that is underlined both by the constancy of the male subjects involved and also in the roles of leadership.

Accordingly, without over-generalising, female drug addicts show certain typically masculine traits such as a strong tendency to aggressive reactions, outbursts of anger and all those characteristics and anti-social traits that are most common in males. These characteristics can also be accompanied by behaviour that is characterised by backing down and submitting to predominant male figures. This same type of behaviour can also be noted in social groups which are strongly anti-social, where the woman is generally inferior in respect to the man. Recognition of a female identity can be obstructed at a level of intervention of the services when the woman’s personality develops defensive forms as a way of survival in a group. This “male mask”, behind which they are hiding, makes any affirmation of a true identity of gender extremely difficult since it would mean the loss of their own defence.

On the other hand, the clinics that did pay greater attention to the problem of gender identity realised how great a role the differences between male and female drug addicts play in both the therapeutic process and how they can affect its evolution and the role they played in the resulting drug addiction.

¹With reference to the clinic, quoting as an example, the specific multiple fragility which has become evident in the last few years as a typical characteristic of some women drug addicts - adolescents who often fall in love with a partner who is already a drug addict and then dedicate themselves for a long time to adopting a behaviour which tries to “save him” from the use of drugs.

This problematic is characterised above all, by the deep feelings of frustration on behalf of the young woman who feels she is competing with the substance that causes her partner such pleasure, thus leading to the dynamics of omnipotence in the sense of underestimating the problem of drug addiction thinking that affection alone will solve her partner’s problem.

Such a problem within a relationship is characterised, above all, by the serious frustration suffered by the young women who have to compete with the drug that causes her partner such pleasure – leading to the dynamics of the jealousy experienced by a “betrayal”. Sometimes, she even attributes the status of “rival” to the substance, which is not just a serious obstacle to the relationship. It can frequently be noticed that such competitiveness can become the vehicle of fantasies and desires in the young women, leading them to experiment with the substance themselves, also in an extreme attempt to prove to themselves, but even more so to their partner, the possibility of controlling and dominating the use of the drugs. In other cases, the hidden fantasy is that of sharing a fusional relationship which is compromised by constant and repeated betrayal by the partner with the substance itself. Obviously, there can be numerous variables of this dynamic and it is a shame that so little attention has been paid to the deeper motivation that leads to the initiation of the use of drugs and to the consolidation of a pathology of abuse. In short, drug addiction of women seems to follow paths which are more drastic than men, characterised by high-risk behaviour. However, this hypothesis has, unfortunately, not been confirmed by prospective studies. These characteristics are undoubtedly points of interest and to be studied in greater detail, both as study material and also as intervention – with regards to which we are extremely behind concerning the phenomena of the development of drug-addiction.

As regards the perspectives of specialist intervention for drug addicted women, one aspect which has recently gradually attracted the attention of specialists in that area is that of pregnancy and maternity in drug addicted women. This pays attention to multiple areas of observation and psychological, medical, legal and social intervention and profound modification of the perspectives and models which are still being used today concerning drug addiction.

¹Gabriel Roldan Intuxta, **Women and Wounded Children**, Euro TC Seminar, Wien 25th and 26th May 2000.

Active drug addiction seriously effects the sphere of maternity which is often refused, not only due to the precarious existence due to drug abuse but also due to social-economical reasons. If, however, we examine the reasons which lead a woman to have an abortion more closely, we often find a certain aversion towards maternity, perhaps also due to those constitutive and reinforcing aspects of the female identity. In other cases, the chronic use of drugs means that the pregnancy is generally recognised very late, also going beyond the normal time-limit for a possible abortion. Under such circumstances, maternity is experienced ambivalently and as something unreal, often accompanied by a sense of loss regarding their feelings of being capable to handle parental duties effectively. When, viceversa, an active drug addicted woman deliberately chooses to have a child, even before it is born, through fantasy it is given the function of “liberator” almost as if it were a saviour from the drugs. Recent studies on the styles of the mother-child relationship using the micro-analytical study of interactive mother-child sequence have revealed a tendency on behalf of the drug addicted mother to intrusion and a lack of harmony regarding the behaviour of the child. In particular, the chaotic value of the mother’s behaviour regarding the needs of the child are of great prognostic importance. The most important characteristics of these mothers actually seems to be their inconsistency between relationship and investment with regards their own child. These researchers observed that their behaviour changes from moments of complete to traumatic absence and moments of great stimulation for their child who is placed in an environment which is particularly stressful due to its characteristics of incomprehensibility and the unexpected. At the same time, the behaviour of these mothers expresses the fantasy-like desire to invest emotionally in their own child, and the incapacity to do so, starting from the first every day necessities of looking after it with their difficulties in recognising not only the needs and desires of the child but also their attempts at socialisation. In particular, at a fantasy level, there is the tendency to attribute the child with a salvational value. The child appears to be the maternal representation endowed with healing powers regarding the situation of physical dependence on the mother, but also an omnipotent transformer of an inferior and social reality which is crumbling and inconsistent. In the task of looking after a child, she also seems to alternate between the characteristic phases of drug addicts in which the child is not experienced as a real individual, but rather as a malleable object which should fulfil the needs of the mother. A frequent hypothesis as regards the failure of the mother-function in these women concerns their incapability to differentiate between gratification and the management of their frustration related to their own role as parent. A very important aspect, related to the management of the interactive distances and space seems to be that of the capacity of regulation and therefore of the demarcation of mental and physical borders within which the relationship with the child takes place. In particular, the behaviour of the drug addicted mothers described here seems to show the absence of rules for both herself and the child which guides the behaviour and the mental structure of these women. It would in

fact appear that they do not have a defined and defined mental space which contains only the child and at the same time presents itself as “different from oneself”, thus creating that barrier to the outside world which the mind of the mother, and therefore her behaviour should represent to the child, especially if it is very small. A particularly problematic aspect therefore arises with the presence of these children who are special and unconscious actors in an increasingly complicated scene in which the use of drugs by their parents and in particular by their mothers, creates multiple interrogatives regarding the evolution and relational results of these dyads.

Apart from the need to pay even greater attention to the process of accompaniment already during the phase of pregnancy, it is becoming increasingly clearer that it is also necessary to improve the mode of intervention regarding maternity and the relationship with the child. Indeed, the studies in this area are extremely sporadic regarding the biological risks to which the foetus of drug addicts are exposed. In the same way in the area of the social-sanitary fields the importance for the need to supply immediate health strategies for the care of the mother-to-be has generally been underestimated, an aspect requiring close collaboration of the various competent services.

The difficulty in defining the programmes of collaboration between the various services is often due to different cultural and experiential backgrounds of the services in charge of drug addiction and those in charge of protection of minors, the latter giving greater importance to the protection of the minor and assuring him the conditions necessary for a healthy physical, psychological, affective and relational growth.

The undertaking of reconciling the various points of view of the different operators and identifying operative understandings, procedures of accompaniment and consequent monitoring of the dyad mother-child seems to be particularly complex also because the circumstances of active drug addiction immediately call for the intervention of the judicial system. The latter then responds with measures that are of a more repressive character than of social-assistance. Thus, this legal orientation which aims at adopting the protective measures of separating and removing the child from the maternal figure in the interest of the minor when there are no clear indicators of risk for the child seem to be more afflictive measures regarding the adult than actual protection of the minor. In the same way, entrusting the child to the care of the maternal grandparents seems to be inadequate as a temporary measure. In reality, the experience of the clinics shows the figure of the maternal grandparents is greatly compromised by the extremely problematic family dynamics so that they are actually not suitable figures regarding the educational behaviour of the children. Indeed, the experience of the clinics commonly notices that in the cases in which the children are entrusted to the grandparents it is the grandparents themselves who play a role in the ultimate dynamics of expropriation of the parent role as regards the mother.

A more careful interpretation of these dynamics shows that such expropriated modes hide a defensive role which is trying to compensate the experiences of experimental educational inadequacy towards their own daughter who had drug-related problems. The affective hyper-investment in the grandchild and the consequent

devaluation of the daughter is therefore not a source of support for the minor but accentuates the phenomena of feelings of ill-ease in the child. Healthy modes of relationships on behalf of the grandparents should involve an active support of the mother-child, taking care of them and leading to a progressive responsabilisation of the care of the child while respecting the distances between the generations.

Unfortunately, this rarely occurs in the cases of the clinics and the participation of the maternal grandparents as guardians often means ulterior conflicts between the generations with a consequent relapse. Thus, besides the need to pay greater attention to the process of accompaniment from the early phase of pregnancy on, it is also increasingly necessary to improve the type of intervention during the phase of maternity and the relationship with the child.

In accordance with this, numerous projects have been set up in many European countries involving the residence of drug addicted women, either pregnant or already mothers of especially young children. This growing interest bears witness to the attempt to pay attention to this fact in the surroundings of the world of the female drug addict and to respond more immediately and aimed more precisely at the needs and necessities of the women. The aspect of greater force of these projects lies not only in the attention they pay to the focus of the intervention, but also to strengthen and value those aspects of female identity which are part of the female function. In the majority of cases, this type of intervention is able to avoid the painful legal consequence of the separation of mother and child which would drive the drug-addicted woman towards the exacerbation of an already difficult existential situation. One of the greatest risks found in interventions of this type is that the child could be used as a sort of therapeutical instrument to save the mother, placing it in a secondary position in regards to the mother. On the other hand, in better cases, the responsibility takes on the dimension of a multi-focal intervention with a specific therapeutical space (individual and/or group) for the adult, and a distinct space dedicated to the improvement of the mother-child relationship. In these experiences there is the tendency to keep distinctly apart the fact that having a mother who is a drug addict can create a potential risk factor for the child without undergoing evolutive difficulties in turn. It still remains to be shown that the stage of drug addiction of a mother leads to conditions of neglect, abuse or dysfunctionality in the development of the child. In this case too, it would be useful to develop the lines of qualitative research to develop a better understanding of these problems.

From this point of view, it's useful to underline the possibility of considering femininity, that is belonging to the female gender, as a protective factor as regards the rehabilitation and the intervention of drug addiction also in situations of maternity and above all, in cases in which it was possible to maintain a healthy parental space for these women and their children.

The intention of the authors was that of presenting useful contributions towards the problematic situation of drug addicted women, to improve the quality of assistance, hoping that this volume is of interest and stimulates colleagues to pay greater attention to the problem of the identity of gender, both at a level of research and of intervention.

INTRODUCTION

Within the framework of research regarding the reduction of drug abuse and its preventive implications, IREFREA has been carrying out an international study aimed at improving the knowledge of the conditions of drug addicted women in Europe with the support of the European Commission.

The main aim of the work is to undertake a wide ranging investigation involving five European countries (Italy, France, Germany, Spain and Portugal), with comparative methodology and procedures with the aim of favouring the exchange of experiences between the operators through the collection of bibliographic and empirical data. More specifically, the empirical investigation is motivated by the aim of highlighting the importance of the research, above all of a qualitative type, in a psycho-social environment since it is an instrument with which information can be better systemised in respect to the information that emerged from the experiences of the operators that amplify the vision of the clinical phenomena and therefore allow a general reflection.

The conceptual nucleus of such an approach includes a multi-causal vision of the path towards drug addiction where not only individual choices or problems play a role but also social, economic and urban conditions which hit certain groups of people (above all younger ones) who are more vulnerable and subject to fascination. Accordingly, the preventive aim of the project unfolds when the data and information which emerge can help the operators to understand the phenomena and create interventions which are aimed at the specific needs of the target population.

In particular, within the multiplicity of the drug addicted subjects or those at risk of entering the world of drugs, the attention focuses on an extremely heterogeneous group in which the access to drugs and the evolution of paths of addiction seem to reveal particular characteristics which are united by the unifying factor of belonging to the female gender.

Indeed, when a problem of drug abuse becomes evident, the female drug addict appears in a condition of greater vulnerability than the male and is more seriously exposed to risks for her health and physical integrity. This condition, which is already at a disadvantage, is made worse by the fact that the system of the social-health services for treatment and rehabilitation does not seem to take this factor sufficiently into consideration by underestimating her specific needs and therefore proposing protocols of intervention that are the same as the males. The fact that the female drug addicts are (fortunately) a clear minority in respect to the males, with a rate of less than a quarter in

Europe, leads to the situation that together with the needs for assistance on the one hand, and the whole of the evolutionary potentiality are often conformed by an interpretation of the situation which takes on a prevalently male connotation.

Through this research IREFREA wants to verify the truth of the basic assumption regarding a certain inability, or rather the lack of attention on behalf of the services in both interpreting in greater depth the needs and in proposing perspectives of both a therapeutical and re-socialisation nature which take into greater consideration the question of gender identity.

This project, aims to investigate in greater detail the knowledge that the very people involved have as regards the subject under investigation. For this very reason our starting point is collecting information from the point of view of the female drug addict herself as regards her femininity and perception of the attention paid to it in the different surroundings of growth (such as family or school) and of being received or treated (such as the hospital, the services, etc.)

The objective is that of recognising the actual lack of information and sensitivity on behalf of the operators through a plurality of information (multiple sources methodology) since it is their role that leads to, even without wanting to, a condition of further marginality and discrimination for female drug addicts.

On the other hand, there is a lack of information regarding the successes achieved in the countries involved in the research by developing and operating a greater sensitivity towards this problematic. Indeed, if the operators are informed of the positive and fruitful initiatives regarding femininity and drug addiction and their realisation, also at a practical level, is an important support in promoting a greater awareness of the problems that exist and of the modification of certain logistics underlying the intervention, thus promoting useful changes.

At the end of the analysis of the data collected the project intends to compile a series of recommendations aimed at the operators, in the form of “vademecum”. This initiative has the aim of supplying them with greater information regarding the problem of the female drug addict and giving the incentive to pay more attention to the improvement of the social politics and interventions regarding the reduction in drug use by women.

This project is therefore part of a much larger project. The first stage was the focus on the collection and analysis of various bibliographic material found in different countries and the preliminary investigation of knowledge relative to the subject in question through interviews of the key subjects in question. On the other hand, the current phase of the project focuses on certain empirical aspects which will be outlined in the following.

It should be stated that this project qualifies as an investigation on the condition of female drug addicts within certain European countries and not as an experimental research trying to verify specific hypotheses. The choice of the instruments was

motivated by the objective of carrying out the widest possible collection of material on this subject on a, but not only, qualitative methodological basis.

Therefore, in short, the current phase of investigation is an explorative multiple-centre study divided in three areas:

1. Investigation of the needs of drug addicted women and possible situations of discrimination, in terms of experience, in respect to other women;
2. Empirical revelation of approaches of preventive and therapeutical-rehabilitative interventions that take the specificity of these needs and/or resources of the women into consideration;
3. The construction of a sort of vademecum to be used by the social-sanitary aimed at sensitising them to specific female condition in the situation of drug addiction, underlining the expressed or latent needs of women drug addicts with the aim of stimulating innovative approaches that pay more attention to this specificity.

WORK GROUP AND – METHODOLOGY

The investigation, a multiple-central study, involved five European countries (Italy, France, Spain, Germany and Portugal, within each of which the researchers individualised the collection of data.

With the aim of facilitating communication between the researchers and the execution of the project, the tasks and roles of those participating in the study were very clearly defined. This choice created a methodological approach that was of a great help in the reciprocal collaboration and clarity with respect to all the phases of the project, in the collection and discussion of the data. Furthermore, the whole group worked with complete personal responsibility and availability regarding the needs of the collaborators.

The national researchers had the task of developing and actually carrying out the investigation. They also supplied the study and the synthesis of the raw data that emerged from the material administered to the participants. Finally, each country read their own data in a comparative key using it for the compilation of their own country's report to be presented at the final seminar.

At the same time, Italy was also part of the overall co-ordination of the project that foresaw the collection and communication of the data and suggestions of the researchers from all countries, above all with the aim of supplying a necessary link between them all which otherwise would have been difficult to carry out. Furthermore, decisions were shared and the joint participation of all the researchers was a fundamental principle in the various phases of construction and execution of the project while trying to favour and encourage personal contributions.

Accordingly, the study was constructed using group discussions during the meetings organised by the co-ordinator, or the exchange of suggestions and of information using electronic means or computer support available during the intermediate stages in which each researcher worked in his own country. In this way, the modality of work allowed the direct participation of all groups of operators in the programmed activities.

AIMS OF THE STUDY

Based on the needs of further investigation and of the questions dealt with previously with respect to the study and the intervention of the female drug addict, this project defines itself as an explorative study on the condition of the woman drug addict within the participating European countries. Accordingly, it did not have the aim of verifying specific hypotheses as is the case in experimental research projects but rather of carrying out the collection of information considered of use to be able to define the phenomena in question and some of its more obvious characteristics.

Thus, the choice of the instruments was motivated by the aim of carrying out the collection of as wide a range of knowledge on this subject as possible, using quantitative type instruments together with others that allowed a more qualitative analysis of the data that emerged.

The following objects have therefore been identified in this work:

- 1) The continuation and in depth investigation of the work started by the teams already formed and enlarged by the participation of other European partners: this aspect is of particular importance due to the necessity of a conceptual and numerical amplification of the studies on such a topic and of the diffusion of the knowledge that emerges to the other partners with the aim of involving as many experts as possible.
- 2) Analysis and amplification of the information regarding the differences between the countries participating in the research, but also regarding common elements that characterise the target population in the study.
- 3) Diffusion of the information collected with the aim of facilitating exchanges between operators; currently, this is difficult due to the lack of data available to them and due to the difficulty in communicating: indeed, an important role of the empirical studies should be that of sharing knowledge, above all with those who work with such phenomena on a daily basis and who are frequently faced with the problem of the formation and of amplification of the knowledge regarding this subject.
- 4) Incentive to greater co-operation between European associations and operators.

- 5) Construction of common work methods: the consequence of the diffusion of the knowledge should be diffusion and creation of useful instruments, aimed at and based on the needs that emerge and as an operative answer to them.
- 6) Sensibilisation towards new needs, in particular those of the female drug addict with child to facilitate the creation and execution of specific interventions that also pay particular attention to the rights and needs of the child itself, above all regarding the aspects of custody and protection.
- 7) Constitution of a specific session relative to the needs of the female drug addict within the framework of a European seminar, with the aim of amplifying the knowledge and participation of other operators and encouraging a process of co-operation between European associations and operators.
- 8) Execution of pilot initiative for prevention using the studies carried out as a starting point

STUDY PLAN

Based on the objectives outlined above, a plan of research was formed that foresees the revelation of qualitative and quantitative aspects with the aim of investigating the diverse and complex aspects of the subject in question. In other words, the work group decided on a series of stages of data revelation:

- the collection of qualitative and quantitative data with (female) drug addicted subjects;
- the collection of qualitative material with groups of female drug addicts (this part will be described in a following publication),
- the collection of material pertinent to the experience of treatment and intervention focussing on the specific needs of the female population, within the environment of drug users (best practices).

The work group has therefore undertaken the construction of the following instruments:

- 1) a questionnaire interview structured according to areas and focussing above all on the study of the perception of needs, of situations of discrimination and/or marginalisation by female drug addicts, in reference to certain areas of past and present experiences (school, work, maternity and sanitary assistance, relationship with the law and institutions). This instrument is in two parts:
 - a) a series of questions with closed answers focussing on the following areas:
 - Dimension school
 - Dimension work
 - Dimension drugs
 - Affective and sentimental dimension

- Dimension of maternity
- Legal dimension
- Dimension of physical health
- Dimension of the family.

b) a series of in depth open-answer questions also pertinent to the subjects dealt with in the questionnaire. Such questions were only administered to a chosen sub-sample.

2) The outline of carrying out the interview of a focus group, with female drug addicts (between 6 and 10 people) and where possible recorded on audio or video. Such a methodology can be evaluated parallel to the questionnaire regarding the revelation of the needs shown and of the discrimination experienced by the female drug addicts regarding the most important areas of their life.

As mentioned previously, the exposition of these focus groups will be dealt with in a later publication and not here.

3) A form of revelation of the best practices present in each country regarding prevention, intervention, study etc. for female drug addicts. Such a form will be a revelation model of the different present experiences that function in this sector at a European level and that can be defined as innovative practices that favour female drug addicts.

SAMPLE DESCRIPTION

80 drug addicted women for each participating country (with a history of at least one year of drug abuse) of which 40 have children and 40 do not. (The division of the proportion of drug addicted females with and without children does not aim to be statistically representative with regard to the data found in each individual country but rather it responds to the necessity to recognise possible similarities and differences in the two sub-groups that therefore have to be the same numerically). From this general sample a sub-group of 20 subjects was selected (10 mothers and 10 without children or rather in the case of an inferior number, the proportion of 50% between the two categories) for each country in which the in-depth interview with open questions was administered.

Age of the subjects: the women participating in the study were between 20 and 35-40 years old.

Distribution: as far as the recruitment of the subjects is concerned with respect to distribution at a national level, no specific criteria were used although subjects were recruited in different areas to avoid distortions that originated in a specific place.

In order not to introduce uncontrollable variables in the study, the subjects do not belong to an ethnic or cultural minority or to particular groups.

Phase of treatment: the women participating in the study were in an intermediary phase of their treatment (approximately one year) so that a strong influence of the treatment itself was avoided in their answers (accentuating, for example, their own responsibility for the occurrence of their unpleasant circumstances) above all as far as the open questions in the interview are concerned. On the other hand, the subjects not undergoing treatment would have made up a sample with which it would have been extremely difficult to carry out an interview of this type generally due to their lack of compliance, their diffidence and aggressiveness.

The type of treatment the person was undergoing (psycho-therapeutical / methadone / day centre / residential / working-educational) is a free variable. The subject was not to undergo excessive changes during the interview (for example, high dosages of methadone > 50 mg).

Type of structure: heterogeneous sample (public, private, day and residential).

This is therefore a summary of the structure of the research project. However, the volume was structured with two introductory chapters, the first of which aims to give the reader the possibility to find certain basic information regarding the most relevant studies that have appeared in international literature on the specific dynamics of drug abuse in women. The second introductory article pays particular attention to the problems and aspects of drug abuse that are correlated to the elements that are part of female sexuality.

The volume concludes with the Annex and a collection of significant experiences in the field of prevention and of the treatment of female drug addiction. Obviously, this collection of testimonies has had to be reduced and is certainly not exhaustive. However, the aim of the editors is that of creating a significant collection of experiences from different European countries, thus inviting the reader who wishes to go into a particular area in greater detail, to get directly in touch with the address of the referees given at the bottom of each page.

Finally, there is the presentation of some suggestions we have collected during the study. These are placed in order, going from the most to the least important and reliable in the field of prevention and treatment. The editors have collected these suggestions with the intention of creating a sort of vademecum whilst, at the same time, being well aware that they simply represent an outline of the work or guidelines for the operators.

The editors hope that this vademecum will encourage reflection upon a series prominent aspects regarding female identity, aspects that should always be considered of the utmost importance, whether the operator has to intervene in the area of clinical activities, psychic support or re-insertion in a social or working context.

CHAPTER 1

WOMEN AND DRUG ABUSE. GENERAL ASPECTS

The differences between man and woman have their origins in an obvious sexual dimorphism. The majority of cultures have established a differentiation of social roles between the sexes which considers them not only distinctive but often antagonistic. Biological differences such as pregnancy in women or the greater physical strength of men have determined the assignation of traditionally dichotomised roles: one characteristic of men and the other characteristic of woman, as much on the educational plane as on that of the family, employment and even in interpersonal relationships of power. In spite of the fact that some separation on the basis of biological differences has been made obsolete by technological changes, the social system, even in more advanced societies, collaborates in the perpetuation of this dichotomy of roles.

In current sociocultural circumstances, the gender variable constitutes a key reference when analysing and understanding the significance and the effect of certain external common differences between men and women in so far as social attitudes and repercussions on the quality of life are concerned. The attitude towards a situation has been considered as a relative predictor of human behaviour and an underlying one in psychological processes and social behaviours. Attitudes towards social aspects in respect of the relationship of equality between women and men have a special and determinant affect on the objective and subjective dimensions of the quality of life and, in an overall concept of the term, health included.

The ability to develop an influential and autonomous role is a process which must not only be developed in the first years of infancy and adolescence but one which must be continued in the different stages of adult life. The experiences of participation in the family, school, work place, etc. are key factors in understanding the potential, limitations and obstacles affecting the participation of women in the social system. The assumption of an active social role is not produced in isolated subjects but in individuals linked to the everyday context of interaction between communities.

Therefore, in order to understand the differential effect between men and women in drug use, it is necessary to enter the more social terrain where the conditions of individual identity are established. The perspective of gender permits analysis of the relationships of power and influence in the configuration of the identity of women. The

traditional model of the family is based on a hierarchical relationship of power and activities. The male is allocated the role of authority and the women that of the subordinate, roles segmented by the hierarchy of the social groups with different status. In addition, the activities allocated to men and women also occupy a position in the social hierarchy, the masculine activities being of greater social value and the feminine ones the most devalued. These activities, those labelled as female, are the most fundamental in social reproduction (care of family members and domestic tasks), without which no social group would survive, and their good administration determines the quality of life. Thus, women are relegated to a subordinate social space but they are allocated tasks which are fundamental but which, paradoxically, are devalued.

Added to this model of power relationships between men and women is the constant dialectic game of transgression and use of these roles to their own advantage, by men as much as women but more so the women in order to confront their subordinate position. This game explains why new forms of domination of the masculine spaces are constantly being generated to maintain their position of power and, at the same time, the transgression of the feminine spaces. This is important for two aspects that concern this subject. In the first place, the activity of caring for others, the devotion to the family as part of the feminine identity, is a double-edged weapon, it makes the female more dependent on these others, on the males, in particular, but also gives them greater strength and power, given that the development of everyday life and the affective sphere of their families depends on them. There are many women who feel themselves identified with the role of carer, and make it the centre of their lives. Secondly, in our societies, masculine values are not only being perpetuated but they are being reinforced giving more value to the activities and spaces which have traditionally been masculine such as the employment/professional one, and maintaining the traditional feminine activities in a devalued position (Rivera 1998) although these, at the same time, are encroaching more and more on the employment space. Some women attempt to integrate themselves in the space with most prestige - the professional one - and distance themselves from the domestic and care space, but others do not achieve it and remain in the most devalued space. In the case of younger women, who are the ones most affected by the social change, some take on the traditional role positively and continue to seek refuge in the invisible power and the potential their position gives them. Others, on the contrary, experience a fragmentation of their identity. They are not integrated in the traditional role nor part of the prestigious space. In each of these positions, women are vulnerable and protect themselves in different ways and this comes to mean that they face up to the use of drugs and drug addiction with different personal and social recourses, both in respect of other women as in respect of the men in their group.

Deriving from the interaction of all these factors will be the greater or lesser ability to face fundamental daily life situations which also include the relationship of women and drugs, the development of drug dependency and its consequences. The majority of the researchers who have studied women addicts, Rosenbaum (1981, Hser et al. 1987,

Thom 1995, Nelson-Zlupko et al, Ettore 1996, Estebanez and Cifuentes 1997, etc.) find significant differentiation basics between men and women drug addicts.

Women take lower quantities of drugs but develop an addiction much faster, take more tranquillisers and sedatives, receive a greater measure of psychiatric attention and are found to be less involved than men in judicial proceedings. They present lower educational levels, have few financial resources and are more concerned than their partners about day-to-day survival. Drug addiction in women involves higher risks and has serious repercussions on their children. In addition, throughout their lives, women also suffer frequent episodes of sexual and physical abuse.

Women drug addicts have different motivations both for initiation and for continuing use and their main motivation for giving up drugs is the care and custody of their children. Finally, women present specific therapeutical necessities which, when not properly approached, become obstacles in access to treatment.

PRIOR CONDITIONING FACTORS

There is a long lists of studies which attempt to identify the factors implicated in both the acquisition as well as the development and maintenance of drug addiction but there are few publications, however, which study the factors or situations prior to drug addiction in a prospective way.

There can be very little doubt that psychological and social factors would seem to be the most determinant ones in the addiction process. Numerous studies describe different types of variables to explain the risk factors which may contribute to causing problems derived from the use of drugs, including addiction itself, (Hser et al 1987, Rhoda et al.1990, Ravdal and Vaglum 1991, Copeland, Hall and Dinwiddie et al. 1992 and García Pindado 1993, Allen et al. 1994, Power 1995, Espina et al and Sanchez and Berjano 1996 and Llopis 1997).

The effect of drugs on the individual development of the subject is mainly produced in the stage of maturation and development of the future adult roles and makes it difficult for the adolescent to acquire different abilities to confront everyday events and to produce mature individual responses.

Newcomb (1986) pointed out that uncontrolled stress, the consequence of negative everyday events, creates a sensation of loss of control which generates a reduced level of the significance of life. This situation is not very comfortable and could lead to self-medication using drugs. Other authors, such as Noguerras (1993) and Weiss (1992), were also of the opinion that drug use in adolescents would be produced within a context of self-medication or a search to alleviate earlier unpleasant situations arising either from personal problems or from difficulties in social interrelationship which would be closely associated with depression in adolescence. In these cases, it is generally found that the effect of the drug is sought as a temporary substitute while

internal confrontation mechanisms are being acquired. The big problem with these behaviours is that, with the passage of time, the use of drugs may remain as the only confrontation mechanism or means of alleviating malaise having impeded the production of this individual maturation.

PERSONALITY AND ITS RELATIONSHIP

The adolescent stage is particularly crucial for women given that social and biological forces which are going to encourage her towards assuming her own identity are different from those of the male who receives lesser pressures as a reflection of the roles conventionally assigned to each gender.

As Seiden (1989) pointed out, a woman has certain peculiar personality characteristics throughout her biological development.

- Behaviour problems emerge during schooldays although depression may not show itself at that stage; at the same time, attention-deficit disorder is more difficult to diagnose in girls as hyperkinesis is not as obvious as in men.
- In the early years of adolescence, a girl has to contend with body changes, may be the object of sexual abuse, and her search for independence may lead her to drug and/or alcohol use at this stage, unwanted pregnancies or to presenting tendencies to flight.
- At the end of adolescence and in the first years of adulthood other characteristics may also appear such as eating disorders, psychosis or affective problems which carry the risk of suicide, in addition to impulsiveness, another characteristic risk of that age.

In 1988, Block carried out a prospective study from infancy to adolescence on a general population sample, and the results showed that the personality characteristics observed in infancy are strongly related to the characteristics observed in adolescence and also with the use of psychoactive substances at this period in life. In addition, they observed a greater frequency of drug use by adolescent women.

A large part of drug-dependant women have had some experience of physical and sexual abuse in the home at early ages according to Blume (1994), so that substance abuse and associated behaviours become natural reactions to abnormal situations. Normal emotions, however, are medicated and ignored. In the opinion of Hagan (1994), natural and normal reactions are rarely externalised in the chaotic family systems in which the woman addict has developed.

A number of factors have been described in the psycho- and sociogenesis of drug addiction and include one specifically for women - codependency. From our point of view, after analysing the different authors, and particularly women authors, dealing with this subject, we consider that this is one of the keys to addiction in women. This

role of double dependency so typical of the woman heroin addict is conducive to her subordination to her male and addict companion, who is the one with whom she maintains this double dependency - on him and on heroin. In principle, codependency is not a specific phenomenon of women but social and cultural conditionants have determined the almost absolute prevalence of this problem in women.

Many factors will influence the genesis of codependency. For Bononato (1996), the development of codependency would have three keys: the family environment where it has been developed, the educational differences between men and women and the failure of the affective couple relationship. The maternal figure in the family environment is going to be fundamental. A family with an alcoholic father and codependent mother transmits this attitude to their children who grow up doubly influenced in a negative way (the figure of the father as an addict and that of the codependent mother). Thus, the woman learns how to relate and, on leaving home, will choose with excessive remarkable, consciously or unconsciously, a dependent personality to develop her own codependent personality.

In 1988, Block published a study of 105 girls from 3 to 14 years of age, to verify whether or not on the commencement of the follow up, personality characteristics and the family context, would enable prognosis of drug use in adolescence. Their results underline the psychological focus as opposed to the sociological one in the etiology of drug dependencies. They also found differences in respect of gender, in the face of environmental factors, women are more vulnerable so that the socio-family characteristics have the greatest influence in respect of drug use in adolescents.

Quite often, social genesis of addictions is related to an anomalous structure in the family of origin or to a distorted family dynamic. The family environment is another of the factors which occupies a predominant place, not surprisingly as it is the environment where the addict spend the larger part of his or her infancy and adolescence.

There are few doubts about the repercussion of a conflictive family atmosphere on the psychological development of a person. A broken home, with fighting and loss of roles is going to cause severe maladjustments in the child's social relationship. Needle and Doherty published a study in 1990 on the influence of parental divorce and a second marriage on drug use. They found that divorce has negative effects on male adolescents but not on the females. However, the father or mother having custody and remarrying influences a higher drug use in girls and a lower use in boys. Although having said this, the group with the highest drug use is that of adolescents with parents who separated during their adolescence.

In 1992 Zimmer-Höfler and Dobler-Mikola proposed the following hypothesis on this aspect, 'The absence of a parent of the same sex is a significant factor in the development of addiction'. To do so they based their findings on the fact that there is a higher percentage of male addicts where the father was missing from the broken home than female addicts where the absence of the mother in the broken home is minimal.

In 1994, the NIDA published a report on women and drug abuse in which in addition to drawing attention to essential points for the particular understanding of the woman addict, states that women who abuse drugs frequently present a low self-esteem, little confidence in themselves and feelings of weakness, loneliness and isolation from social support.

We can appreciate that addiction in women may be directly related to determined disorders which are more frequent or more difficult to diagnose in determined stages of the feminine evolutive development.

THE DEPENDENCY RELATIONSHIP

Focussing on women drug addict, we see that they are to be found at a lower economic level than male addicts and this is, normally, a reflection of society in general. The differentiated access to recourses is also reflected in the case of men and women addicts and this contributes to creating one more factor of inequality, which must be faced by the female addict.

Drug use then becomes the principal method of facing these situations. Buckstein (1989) in a work on comorbidity between substance abuse and other psychopathologies, pointed out hyperkinesia as a risk factor, principally for the behaviour disorders associated with it and the relationship between eating behaviour disorders and addiction, without analysing if this were a result of the personality type of these patients or of the affective disorders which are generally concomitant with bulimia-anorexia. The physical image is a key factor in the social integration of women and in access to benefits as, for example, finding work or social success. Coping with her own body makes a further demand on the woman, which intensifies her oppressive situation in a different way from a man (Bañuelos 1994).

Katzman (1991) reviewed all the clinical histories of women hospitalised for opiate dependency in a New York centre, and discovered that prior to the drug abuse, around one quarter had previously suffered a bulimia nervosa which, in addition, tended to reappear during detoxification periods. In their opinion, it is possible to establish a biographical sequence in these addict patients: very active adolescents who sporadically carry out bulimic behaviours, later take cannabis, increase weight and a persistent behaviour of inactivity appears. This is followed by the commencement of behaviours to lose weight such as provoking vomiting and abusing laxatives. Subsequently, they go on to using opiates and they rapidly develop dependency, reduction in weight and a drop in their preoccupation with it.

Griffin (1989) pointed out that the use of cocaine seems to have more specific reasons for women than for men in whom it only forms part of a wider social behaviour. The benzodiazepines, either hypnotics or anxiolitics are fully represented in the menus of heroin addicts and constitute a very significant clinical and health

problem. The use of benzodiazepines among IDUs seems to be associated with high risk levels of contacting HIV and a poorer social functioning according to Darke (1994). The country with a higher proportion of benzodiazepine use among women is the United Kingdom (2.3 times more than men), followed by the United States where women use twice as much as men, as Bond (1995) pointed out. The reasons for use of benzodiazepines in heroin addicts responds to a hospital provoked commencement in non-specialised treatments and, most particularly, ones which are not monitored, and which offer a continuity midway between palliative self-treatment of the anticipatory symptoms of the abstinence syndrome and the necessity of an altered state of mind which addicts call. In the case of women, Bond, (1995), states that the characteristics which influence a higher use of benzodiazepines lie in their social role.

Klee (1995) asked himself if the amphetamines were drugs which were more characteristic of women but he did not find a higher probability for their use by women. In his study, the majority of the effects were equally attractive to both sexes but, however, differences did appear in the reasons for use: they seem to have more functional value in women, who would frequently take them to increase their energy, lose weight and combat depressive symptoms, and in men to palliate the drop or rush of other drugs. These reasons imply a greater risk in women who go on to develop abuse and dependency with greater frequency.

DIFFERENTIAL PROFILE VERSUS HOMOGENEITY OF THE STUDIES

Some of the authors who have studied the woman drug addict defend the homogenous profile with no gender distinction. Perry (1979) in his analysis on the use of drugs by women, concluded that there is no specificity in addiction by women. Zimmer-Höfler and Dobler-Mikola (1992) did not observe significant differences between men and women in social functioning and adaptation during drug use, nor in the principle reason for initial use but did find them in respect of the person inducing use, age of initiation, and the pressure that environmental factors exert on women and men prior to initiation, and on relapses. These same authors point out a curious circumstance, a woman's initiation into opiates is induced by her boyfriend, something which does not happen with other drugs such as marijuana. Power (1995), in a comparative study of women addicts in the United Kingdom with a two year follow-up, pointed out that there are no differences between men and women in respect of control strategies in drug use and reduction in the consequences of using syringes nor at the point of adopting a leadership role within the group of users. On the contrary, he considers that the principle difference is to be found when considering giving up use; in women, the responsibility of looking after the children is determinant.

Ellinwood (1996), also found uniform traits between men and women drug addicts in the reasons for relapsing into use and the initiation of abstinence, the source of access to drug and the age of initiation, but they point out differential traits in the

reason for initiation, duration of addiction and initiation of treatment. Perhaps the most interesting point in this study, apart from its character as a precursor to research by gender in addicts, is one of the theories which Ellinwood formed in respect of addiction as a homogenising factor: 'prior to drug use, there are differences in attitude and behaviours between the sexes but the drug in itself is a great homogeniser which may be the cause of many of the uniform characteristics of drug addicts'.

Other authors find more differentiating than homogenizing traits between men and women. Allen (1994) stated that, in spite of the greater number of men drug addicts, women addicts suffer undesirable effects from the drugs between 50-100% more than men. Hser (1987), pointed out that unlike men, the initial use of heroin in women is influenced by a man, particularly by their sexual partner who is generally a heroin addict. The remaining differences between men and women in the behavioural antecedents prior to use reflect the conventional expectations of society of the roles attributed to each sex. Authors such as Taylor, underlined (1993), the exclusive role of the man in the initiation of the woman into drug use, the dependency of the woman on the addicted male partner with a tendency to inject together, as well as the dependency of the woman on the man for the financial upkeep of her addictive habit. Hser pointed out (1987) that this determinant participation by the addicted male partner is such that addictive behaviours are being transferred to such an extent that narcotic use patterns in women are not substantially different from those of men, including the proportion of use periods, number of abstinence periods, number of relapses, length of time on daily use and simultaneous use of other drugs. As differential features, the most notable exception to the influence of the partner is the duration of the addiction which is much shorter for the woman who goes for treatment more quickly, in what Ávila (1996) called the telescoping course in reference to the more rapid development of the addictive illness in women.

This more rapid development of dependency in woman than in man, is also referred to by Rosenbaum (1981) who emphasises as a differentiating trait that for the majority of female addicts the basic point in the development of the addiction is being involved in a family problematic and this applies to very few men.

Another of the differentiating circumstances which appears to be associated with addiction in women is the higher incidence of dual diagnosis and, particularly, in the affective disorders and anxiety, according to Blume (1994) and Ettore (1996). Addiction to alcohol or drugs has postulated its relationship with practically all the psychiatric pathology, of which the anxiety and affective disorders symptoms are notably of greater incidence in women; the behaviour disorders, antisocial personality disorders are most frequent in men and other disorders such as hyperkinesia and minimal cerebral dysfunction which accompanies it at times; the eating behaviour disorders with a higher preponderance in the female gender and even schizophrenia and other psychotic symptoms. Ignoring the possibility of a dual diagnosis and, therefore, the existence of a psychiatric comorbidity, will inevitably affect the evolution and prognosis of the therapeutic intervention, Szerman and Delgado (1994).

The effectiveness of the different resources are becoming similar according to the majority of authors such as Feldman (1992) and Ochoa (1994). Comparison of the evaluation of different treatment variables in respect of gender shows very disparate results since it depends on a complex relationship between gender, social factors, personal factors and factors inherent in the treatment according to Marxoff and Crawley (1996).

Retention is unanimously considered to be the best indicator of a favourable result in treatment,(Vaillant 1973, Copeland and Hall 1992, Machado and Girón 1993, Sánchez-Carbonell 1993, Ochoa 1994 and Condelli 1994). There has been an attempt to evaluate the predictor factors but the reason why some addicts remain longer than others in treatment is unknown. Sánchez-Carbonell suggested (1994) that the reasons would be different in each case, and would depend upon an infinity of variables.

In respect of gender, there does not seem to be unanimity in the studies, in such a way that for Markoff and Crawley (1996) and García López and Ezquiaga in (1991), women would have lower measurements of losses and giving up treatment but for other authors, however, Zimmer-Höfler and Dobler-Mikola (1992) and the NIDA (1994), women remain in treatment for a shorter period of time and have less therapeutic options than men. Authors such as Copeland and Hall (1992) and Condelli (1994), among others, give as their opinion that women are no more liable to give up treatment than men and that the inherent characteristics of the addict are weak and inconsistent predictors of retention. For Markoff and Crawley (1996), the characteristics which influence the losses during follow-ups in women addicts are directly linked to the type of treatment and the health services provided for them. For men, on the other hand, the most influential variables in losses correspond to the characteristics of the subject himself: greater depression, little self-efficiency, abuse of other substances and environmental factors associated with social support.

The majority of the researchers find differentiating characteristics in the motivation for giving up use, on the basis of gender. Blume, (1994) referring to woman addicts, gives the more frequent motivations as physical and psychic problems, and problems with their families, whereas for men the principle motivations are employment problems and legal coercion. Both Power and Taylor (1995) a symposium in held in the United Kingdom, devoted specifically to women, pointed out as the determinant difference between men and women addicts, the responsibility of caring for children and, secondly, preoccupation with health and avoiding having to enter a penal centre. Therefore, the risk of losing custody of their children from the inability to look after them is the leading cause for women taking treatment and, paradoxically, as we will see below, it is also one of the main difficulties or obstacles to be overcome by the woman addict to be able to commence treatment.

In 1994, the NIDA calculated that more than four million women throughout the world needed treatment for drug abuse. The number of women in the attention centres does not generally exceed 20% of the addicts although in certain resources which introduce programmes directed at women, these figures change. According to Barnard in 1993, women represented 27% of the IDU in Glasgow in 1989, whereas (1992) according to the type of service evaluated this proportion rose to 32 and 34%. In Spain, the proportion of women undergoing treatment is one for every four men, (Torres and Llopis 1990, García López and Ezquiaga 1991 and PNSD 1996).

Allen (1994) made a review of the women addicts undergoing treatment and observed that the admission of women addicts to treatment in the United States had remained stable between 1980 and 1990, which induced him to consider a higher percentage of women addicts who abuse substances and do not receive any kind of treatment. He proffers the idea that there must exist other factors in addition to financial ones or health cover which create obstacles or make it impossible for drug dependent women to access treatment. To us, this work in 1994 by Allen raises a question. Do the women addicts who go to treatment centres really represent the total addicts or is there a hidden population of women addicts who never go to the current assistance facilities?

According to Bernard (1993), women go less to social assistance services for drug addicts out of fear that their use will be officially notified and that they could lose custody of their children. The author is referring to the environment of the United Kingdom, but in the United States this fear has become a surprising reality and a particularly serious one for those who are pregnant, which was also pointed out by Blume (1994), to the extent that in 1992 more than 150 criminal proceedings were instigated against pregnant women accused of prenatal child abuse, homicide, or administering a prohibited substance to a minor via the umbilical cord. The author notes that the majority of the cases have been dismissed but the appearance in the press of the detentions and court hearings dissuaded American many North addicts from seeking help.

Wells and Jackson (1992) pointed out that there are few detoxification programmes specifically designed for women and even less for HIV seropositive women and responsible for children. The majority of the authors coincide that it is most probable that women encounter more obstacles to taking treatment because of their families, friends or even because of the social services themselves, than do male addicts. These barriers as they were called by Allen in 1994 are broken down as follows:

- Lack of family support, many times because of living with an addict, (dealt with in the publications of Reed 1987, the NIDA 1994, Thom 1995 and O'Brien and McLellan 1996).
- Lack of social security cover on being unemployed or sub-employed, studied by Blume (1994) and O'Brien and McLellan (1996).

- Diagnostic criteria and treatment objectives which are inappropriate for women, listed by Hagan (1994).
- Perception of the scale of costs being greater than the benefits of a social nature: loss of social respectability or relationship with the doctor on “confessing” her addiction, as Thom indicated (1995).
- Women consider prostitution, the “stigma” of the diagnosis and the domination of the male as serious problems when giving up drugs, as Sargent (1992) explained and Swift (1996).
- Higher number of concomitant mental problems in women, pointed out by O’Brien and McLellan (1996) and Hagan (1994).
- Feelings of inability to face the treatment, low concept of self-efficiency, combined with a pessimistic attitude to the possibilities of change, NIDA (1994) and Etorre (1996).
- Difficulty in access to the few residential treatment places because of pregnancy or having to look after children, Taylor (1995).

The main problems observed are the lack of child care facilities in the therapeutic programmes according to Reed (1987), Blume (1994), Allen (1994) and Taylor (1995), and the fear of losing custody of their children if their drug use and dependency is notified, (Allen 1994, Blume 1994, NIDA 1994, Taylor 1995 and Thom 1995).

It is important to take into account, that even when free of financial dependencies, role expectations in the woman addict associated with gender contribute to other forms of dependency which may complicate the phenomenon of the addiction: social role undervalued in respect of that of men, submission to the male, inability to take decisions, higher levels of depression and anxiety, low expectations, caring for children and particular medical problems. In this way, treatments addressed only at one part of feminine dependency, that of drugs, do not come close to approaching the repercussion of other situations of dependency in women.

CHAPTER 2

SEXUALITY AND ADDICTION. IMPLICATIONS IN THE WOMAN DRUG ADDICT

There are many consequences resulting from the interaction between the use of drugs and the peculiarities of the person taking them. Some of these would appear to be of particular interest in the binomial of women and heroin addiction. This is true of the implications of an addiction on the development of the sexuality of the female addict and on her reproductive facet.

Little has been written in a specific form on sexuality in addicts. We do know that the continued use of opiates leads to a reduction in libido, impotence and anorgasmia in men, and also in woman. In addition, dysmenorrhoea and amenorrhoea systematically affect the latter, as Omeñaca (1989) pointed out.

Sexual relations in heroin addicts are relegated to a secondary plane, relegated by the addictive behaviour and, in particular, by the use of the syringe. This acts as a basis for psychoanalytical theories that endeavour to explain addiction and, particularly, the attachment to the needle and the paraphernalia that accompanies it, including the rush from the substance in the vein, as a surrogate for masturbation, a mechanism of pregenital fixation in the anal-sadistic stage and a repeated thanatic urge, as pointed out by Solé Puig (1989).

In principle, the sphere of sexuality of addicts should only represent an individual problem, the result of the sexual anaesthesia that is derived from heroin addiction. However, the truth is that promiscuity, lack of hygiene and prostitution, as well as the immunological deterioration, mean that sexual diseases are frequent among drug addicts. In addition, the reports for the last few years issued by the AIDS Epidemiological Vigilance Plan in Spain

indicate an increase in cases by transmission in a heterosexual relationship, with women being more affected. In addition, the relationship between sexual activity and the risk of HIV/STD infection is not only a disquieting feature of the opiate-addicted population. Of equal concern is the increase in risk behaviours in adolescents who use drugs, particularly alcohol, ecstasy or other stimulants, encouraged by their effect of making sexual relations “easier” by producing an increase in libido, united to a disinhibition of self-control and the consequent reduction in their capacity to take measures to reduce the risk, such as using condoms, as was shown by Shapiro (1993).

The sphere of sexuality does not appear to be related to drug dependants only in respect of the risks of transmission of disease or of the consequences on the libido. It also has serious repercussions on reproduction, and some authors even relate it to initiation into drug use. In 1992, in their survey on German-Swiss drug-dependent women, Zimmer-Höfler and Dobler-Mikola found a more precocious initiation in women than in men, which they attributed to a much earlier onset of puberty in girls.

Reproduction in women who continue their addiction and/or use during pregnancy entails an increased obstetric risk but it would be difficult to ascribe this to specific causes as, normally, such women show malnutrition, smoke and live in very modest conditions, all of which, according to Gerada (1995), increases the risks. The greatest danger occurs during the first weeks with the appearance of abortions which, in many cases, the addict herself is as unaware of, as she is equally as unaware of the pregnancy. Ney (1990), endeavoured to evaluate the prevalence of drug abuse in pregnant women where there was a suspicion of abortion, and found urine positive for heroin and cocaine in 17% of spontaneous abortions compared with 3% in the control group of full term pregnancies.

Nevertheless, the use of drugs may affect the pregnancy at any stage. For example, the drugs habitually comprising multiuse, such as benzodiazepines, taken at any time up to the birth, may occasion the so-called "sleepy babies". Cocaine is particularly dangerous in the first trimester since it can induce spontaneous abortion, and in the final trimester as it can lead to premature birth as a result of the reduction in blood flow to the placenta and foetus after each intravenous injection of cocaine, as was shown by Gerada (1995). For the NIDA (1994), the biggest disorders affecting the foetus were infection by HIV/AIDS, prematurity, low birth weight, sudden infant death syndrome, microcephaly, motor disorders, behaviour disorders, etc.

In 1992, Dawe published a follow up of a specific centre for drug-dependent pregnant women and found that all those who reached the third trimester continued to term without significant complications and with a live birth. A low birth weight and the abstinence syndrome were most frequently found. Authors such as Gerada (1995), showed that it was not only the use of heroin during pregnancy that entailed high risks but also that sudden abstinence (SAO) stimulated uterine contractions and could lead to premature births in the last trimester, although it would be possible to maintain the mother on methadone, until the very last moment, with the longer the use, the less the risk of a low birth weight. The problem stems from the lack of knowledge on the prevalence of drug use during pregnancy so that screening for drug abuse is recommended in all those patients where there is a suspicion of abortion or premature birth in order to be able to implement care strategies to reduce this high risk which Ney (1990) analysed.

Nor do we know the exact prevalence of HIV infection among drug addicts, as the exact number of these is unknown since the majority of surveys on addicts are not representative of the whole group, and there may be differences between those who seek treatment and those who do not.

In any case, HIV contagion is the greatest risk for the female addict, on the one hand from the shared use of syringes and, on the other, from the spread of the virus through sexual relations and, if these take place with men who inject themselves with drugs, the risk multiplies. At the present time, 70% of the cases of women with AIDS have been intravenous drug users or have had sexual relations with men who inject themselves with drugs, according to data published by the NIDA (1994). Parras (1997) pointed out that, in Spain, this figure reaches 80% for those women diagnosed with AIDS.

Susceptibility to HIV infection by heterosexual contact is higher in women as a result of anatomical or histological factors. Estebáñez and Cifuentes (1997) gave a magnificent description of these:

- Vaginal secretions are less infective than semen because the vaginal acid pH is unfavourable to IV.
- The basic pH of semen is more favourable for HIV and, on being deposited in the vagina, it increases the pH of the latter and favours the survival of the virus.
- The semen deposited in the vagina also has a negative effect on the proliferation of T cell suppressors and cytotoxics and on the activity of the killer cells which means increased survival rates for HIV.
- In the female, the exposure time is longer as the semen remains in the feminine reproductive tract after coitus, until it is completely absorbed.
- The female genital organs present a greater contact surface, are richer target cells for HIV and the permeability of the mucosas favours contagion.
- In the male, the skin that covers the glans and the prepuce protects him from infection when there are no ulcers or abrasions.
- The existence of recurrent vaginitis and STD in the female facilitates infection.
- The use of an IUD may cause microlesions and infections in the uterine neck that facilitate transmission.
- Anal coitus and sexual relations during menstruation increase the risk of transmission to the female.
- The influence of oral contraceptives is rather debatable. On the one hand, this is not a barrier method so that it does not impede contact with HIV but, on the other hand, as a result of their progestagenic effect, they do lead to a thickening of the uterine mucosa and, in this way, they would create a certain difficulty for invasion by the virus.

Sexually transmitted diseases are frequent among the population addicted to drugs, particularly among women, as Rosemberg (1992) stated. This leads us to consider the existence of more sexual activity without protection that would lead to a higher risk of acquiring infection by HIV through heterosexual relations. In Spain, however, the National AIDS Plan shows that no differences are to be observed in the sexual

behaviour of intravenous drug addicts in comparison with the general population - heterosexuals and with a low rate of condom use, according to Parras (1997).

As for so-called safe sex, we observe that it is, in fact, unsafe sex. The authors highlight the fact that, as general norm, there is little use of contraceptives among the population both in Spain, García Más (1987), and Lacoste and Gallo (1991), and in the rest of the world, Thomson and Holland in 1996 and, particularly, among the drug dependent population where the most popular contraceptive method for both the woman and the man is not to use any method at all, as was pointed out by Marmor (1990).

In general, the use of contraceptives is lower in female addicts in comparison with non-addicts and, according to Klee (1993), the reason for this is derived from the fact that heroin interferes with menstruation, and this may mean that they are not fully aware of their fertile periods. This lower use frequency would then be understandable. In addition, female drug addicts - with a relative risk that is five times higher in women - present a lower use of condoms than male addicts, and for very different reasons. On the one hand, there is the different perception of sexual risk. Whereas men primarily perceive the risk of HIV transmission, the priority risk for women is pregnancy. In addition, there are the factors derived purely from the social role of the woman. Many women are coerced into practising risky sex by their male addict partners and, at the same time, they are aware of their lesser power and control in sexual relationships and, particularly, in the decision to use or not use a condom, as Rhodes (1995) showed.

The female addict has a slight decisive role in the election of efficient preventive methods in sexual relations. If, in spite of the fact that those who are injecting drugs adopt safety methods in their drug use, their seropositivity to HIV continues to increase, risk reduction must also be introduced into their sexual conduct since, according to authors such as Rhodes and Quirk (1995), the transmission of HIV, hepatitis B and C and other diseases by this means is becoming more and more significant among intravenous drug users and their sexual partners.

For Roseberg (1992), the use of condoms or other barrier methods of debatable safety in sex had special characteristics insofar as it would be accepted without any serious problems by men and women, particularly during the first encounter of the couple. However, in stable relationships or long term ones, unprotected sex would be the norm among addicts, Booth et al in 1991, as it would be among non-addicted youths. Thomson and Holland, in their survey of adolescents in 1996, observed that “if condoms are identified with sporadic, clandestine or inexperienced sex, the birth control pill is associated with a state of maturity, healthy sexuality, greater experience and a stable relationship”. The underlying moral in the monogamy code is the absolute trust between the couple, at the cost of safety, particularly in terms of STD and HIV. Trust and the stability of the relationship then become a decisive factor at the point when the decision is made to use a condom, at the same time as it can become a “euphemism”. If, in addition, to these circumstances the HIV negative female may be convinced by her HIV positive partner to have unprotected sexual relations, within the abusive framework of a relationship in which, as Rhodes (1995) pointed out, and Plant (1990),

the mere suggestion of using a condom could lead to violent responses or a rupture in the relationship. For the woman, unprotected sexual relations may seem safer than daring to attempt to use a condom.

In this respect, two peculiar circumstances are occurring. García Mas (1987) in his publication was already observing a change of attitude in males in the Community of Madrid, with an increase in the percentage of those using condoms regularly, after the appearance of AIDS. Among women, however, this modification was not observed to any significant extent, not even after they became aware of their seropositivity, according to the survey by Lacoste and Gallo (1991) which also indicated that knowledge of HIV transmission methods were not correlated to the use of contraceptives nor to presenting protective health behaviours. This working conclusion by Lacoste and Gallo would be in accordance with the low decisive power of the female addict or the partner of an intravenous drug user in being able to have safe sexual relations. The second curious circumstance in the use of condoms is that it is prostitutes who make the greatest use of them, according to the AIDS Control and Prevention Plan. In this respect, Plant showed (1990) that they do use them, particularly when their clients are under the influence of drugs. Again we observe the perception of a condom as equalling sporadic and clandestine sex and not safe sex, irrespective of the stability of the couple.

If we associate the coincidental data (of Klee and Bustos 1994, Booth et al, and of Lacoste and Gallo 1991), to all these factors relating to sexuality, we observe a greater tendency in the female addict to have several partners who are also generally intravenous drug users, with a higher frequency than males. This tendency explains why the percentage of women who are infected with HIV through heterosexual sex, at a world level, exceeds that of infected men, according to the National Register of AIDS Cases (1996), and in reference to the 1995 data. In conjunction with the presence of prostitution for the female addict, as a way of paying for her drug use or as a means of subsistence, having a rather higher frequency than that for male addicts, as pointed out by Gossop (1992), her partner is generally an intravenous drug user whom, the female addict maintains financially in many cases. There is a tendency to have several successive partners or promiscuous relationships and a low use of condoms, to the extent that these same women who are prostituting themselves use a condom in their professional sexual relationships but not with their stable partner, according to Seidman (1992).

The conclusion which is to be drawn from the surveys by the diverse authors is that the female addict multiplies the risks and the complications of her addiction in the sphere of sexuality and, if as Gossop (1992) pointed out in, “the seriousness of heroin dependency correlates positively with the presence and frequency of prostitution and the low recognition of these behaviours”, one of the primary objectives of prevention and therapy for women drug addicts should be sexual education and learning about safe sex methods. The use of the condom should always be consensual not an individual decision, based on trust or stability with the sexual partner and, in addition, it should be used correctly.

CHAPTER 3

GENDER IDENTITY AND DRUG ADDICTION IN EUROPE: DESCRIPTIVE ANALYSIS OF THE BIBLIOGRAPHY¹

The comparative study on the subject of gender identity and drug addiction is defined in this first phase according to an essentially bibliographical and cognitive point of view. It has enabled certain preliminary type considerations that highlight the interest from a point of view of specificity and the importance of relapses from the point of view of treatment with reference to the European context in which it was carried out (Spain, Italy, Germany, France, Portugal).

The first evident observation is that, both from a scientific and from an operative professional point of view, the problem of drug addiction was confronted in Europe from an almost exclusively masculine point of view. This was founded on the supposition that the knowledge and relative data on drug-addicted men can be generalised and no distinction according to gender is necessary.

In Europe the evolution of literature has revealed itself to be much slower and it is still actually in a preliminary stage unlike in the USA where there has been a growing awareness since the 1980's that female drug addiction should be regarded as a specific and autonomous theme making up a conceptual plan (Blume, 1990; Nelson-Zlupko, 1996).

The bibliographic research has in fact highlighted the lack of or limited supply of these cognitive elements regarding this problem even though it can also represent an important preliminary introduction and starting point for more detailed reflections and for the definition of future lines of research.

In particular, not only should the general lack of scientific contributions on female drug addiction be noted, but also the difficulty due to factors of methodological order of analysis and comparison of the other data and contributions determined by the researchers of the countries involved.

¹ The overall analysis of the European literature was based on the final reports of the individual countries participating in the research, in particular: P. Stocco, L. De Fazio, Italy; H. Broemer (Germany); A. Houel, F. Venner (France); J.J. Llopis Llacer (Spain).

With regard to this, the problematic deriving from the lack of protocol of registration of the data on drug addiction at a European level should be underlined. This has also made any attempt to quantify the phenomena in different countries difficult, both in general and according to sex. It has also contributed to a sort of “unisex” vision of the problem.

This is despite that fact that some time ago or to be more exact in 1996, the European Council noted that female drug addiction had undergone a noticeable evolution in recent years in that women are gradually consuming levels similar to men.

The first European country to show an interest in the problematic women and drugs was Germany. Already back in the 1970's in clinical circles the phenomena began to be dealt with in terms of gender identity and the opportuneness of providing specific treatment and prevention programmes which began to be experimented a short while later, starting in the 1980's (Leopold, Steffan, 1994; Broemer, Huber, 1996; Leopold Steffan, 1996).

In Spain, on the other hand, the interest shown in female drug addiction is quite low, with contributions which are above all of a popular type and limited to the affirmation of the specificity and differences with respect to the male without actually confronting the problem (Orte Socias, 1997). Similarly, in Italy the existence of specific contributions revealed itself to be quantitatively very limited paying very little interest at a qualitative level. More over, they were papers of a more popular character or were based on samples that were not representative of the actual situation in the country (Malagoli Togliatti, 1993; Coluccia, Traverso, Ferretti, 1996).

In France, the topic was developed due to the emergency that arose with the phenomena of HIV (Ingold 1996) while the Portuguese scientists brought forward contributions regarding the problem of pregnancy and maternity for drug addicts although they generally showed scarce interest in the subject women and drugs.

Due to the aforementioned difficulties of comparison dictated by the lack of uniform methodologies, the phenomena of female drug addiction in European circles outlines itself as superficial and imprecise.

Furthermore, the same consideration is true of American literature which quotes a frequency of women drug addicts equivalent to 20-25%.

From a quantitative point of view, the number of drug addicts in Germany without distinguishing the sexes varies between an estimated 100,000 and 150,000 with an average age of 25 to 35. This distribution can be compared to that found in France, Denmark and Holland where there are 100-200 consumers of hard drugs per 100,000 inhabitants. In Italy and Spain this ratio seems to be higher and corresponds to approximately 250-300 drug addicts per 100,000 inhabitants (Heckmann et al., 1993; Vogt, 1995).

As far as the distribution according to sex is concerned, the literature under examination does not allow us to hazard hypotheses even if a generic minor frequency

of female drug addiction with respect to that of the male can be confirmed and over the last ten years there has been a more rapid increase in the percentage of female drug addicts.

Furthermore, such a distribution is similar to that found in circles outside Europe and there is a generic estimate of the female population world wide of 4 million women who abuse drugs and are in need of treatment (Leopold, Steffan, 1997).

In Spain there is a ratio of women and men of 1: 4 in relation to the drug addicted subjects undergoing treatment (Llopis, 1999).

In France approximately one third of the population of drug addicts are women and a relatively recent study which estimated the number of heroin addicts at 16,000 shows a distribution according to sex equivalent to 28% women and 72% men with an average age of respectively 27,7 and 29,7 (IREP, 1996).

In Italy the participation of the female sex amongst drug addicts shows an ample variety depending on the region according to the users of the Services with a male-female ratio of 3-5:1 in the central-north or 10:1 in the region of Southern Italy (Magliocchetti, 1996).

In Germany the tendency of consumption of drugs and alcohol is substantially similar to the other European countries and the female subjects abusing drugs makes up approximately 30-40% of the total (Leopold Steffan, 1996).

In Holland, Switzerland, Denmark and Norway a percentage varying between 30% and 40% has been noted while Luxembourg, Spain and Poland report slightly lower figures of around 22%-25% (Leopold Steffan, 1997).

Nevertheless, the relative interest in the subject women and drugs does not only refer to the quantification of the phenomena but rather to other specific factors which are of crucial importance both to an adequate understanding of the problem and for the predisposition of preventive and treatment strategies.

Indeed, the literature highlights how the problem of female drug addiction does not involve the woman as an individual but rather refers to the consequences that the dependence creates in the different aspects that define the functions of the woman (procreative, maternal, social etc.) (Orte Socias, 1997).

The phenomena varies according to gender according to the various authors who have occupied themselves with this subject both as far as the type of substance used is concerned as well as in relation to the characteristics of consumption. Different motives in the two sexes have been verified regarding the start of abuse, keeping up the habit of drug addiction and the approach to treatment.

As in American literature, it can be noted that the women consume a lower amount of drugs than men but that their dependence progresses much more rapidly and that they are more inclined to sleeping tablets and tranquillisers. It is an alternative and much quieter mode of communication and expression of ill-ease which is often

accompanied by alimentary disorders such as anorexia and bulimia (Blume, 1994; Corsetti, 1996; Nelson-Zlupko, 1996).

Furthermore, the same AA. note how the female drug addicts frequently present cultural instruments connected to their level of education, which is lower than the men together with a lower financial resources (Nelson Zlupko, 1996).

One of the most interesting factors to be reported in the literature concerns the central role attributed to the influence of a drug-addicted partner during the different stages of dependence of the female, that is in reference to the beginning of consumption, through its development, to the treatment, relapses and to the risk of contracting illnesses (Llopis, 1997).

The figure of the drug addicted partner represents one of the factors which is most quoted in international literature as the motive leading to the experimentation with drugs. Such motives are based on the wish to share the same experiences or to feel more united (Llopis, 1999).

Furthermore, a marked tendency on behalf of the drug addicted women to have relationships with partners who are also drug addicts has been noted. This leads to a situation of double dependence: on both the substance and on the partner. With regard to this, literature speaks of co-dependence and has noted the presence of a very low control level in the relationship as a couple by the woman with relapses in different surroundings (Bononato, 1996).

French authors note how women often use the drugs to follow their partner whereas men show an opposite tendency, that is, to look for women who do not use drugs in an attempt to overcome their own dependence (Venner, Fourest, 1998).

Within the relationship, the woman is characterised by the attitude of wanting to help the suffering of the partner whereas the latter finds it easier to end the relationship.

Furthermore, the problem of interaction with a drug addicted partner is dominant in all of the countries including the aspect of risk involved in contracting secondary illnesses which is noticeably higher in women than in men due to a series of characteristics typical of female drug addicts (Broemer, 1998). Apart from the higher consumption by injection, literature also notes the greater tendency of the women to share syringes, above all with their partner (Lewis et al., 1996).

In Spain a multiplication of the risks in drug addicts in the sexual sphere is noted both owing to the noticeable tendency of the women to have more than one relationship with a drug addicted partner and owing to a more limited use of contraceptives with respect to the general population. The risk of contracting the HIV virus is estimated to be five times higher than for the man. This is due to a different perception of the risk connected to sexual relationships: for the men, identification of HIV is of the highest priority whereas for the women, it is an unwanted pregnancy. Since female drug addicts frequently have a modified menstrual cycle, their interest for the use of contraceptives decreases with all relapses thus increasing the risk of HIV (Llopis, 1998).

It has also been noticed that it is perhaps the stereotype associated with the use of condoms as a clandestine or sporadic sexual activity since frequently female drug addicts use condoms when prostituting themselves but do not use the same precaution when with their drug addicted partner(s).

However, prostitution, frequent in female drug addicts, represents another specific risk factor both because it is often the main source of income for the women and also because it is a means to maintain their drug addicted partner economically (Serre, 1994).

A specific aspect reported in the literature in an attempt to confirm the diverse development of drug addicts according to their sex is that of the problem of physical and sexual violence and, in general, the distortion of the relationships within the original family, factors which are reported as true factors of specific risk (Malagoli, Togliatti, 1993).

The characteristics of the multiple problems frequently found in the family are highlighted. Frequently, in addition to the problems of drug addiction of a parent or brother/sister, there is also violence and ill-treatment at home, very often at the hand of the father figure (Guasti Piovaneli, 1995).

Furthermore, nearly all the countries that participated in the study reported a noticeable percentage of ill-treatment and sexual abuse in the case histories of many of the drug addicted women. The same factor does not seem to apply in relation to the male subjects.

European literature also reports a much higher percentage of suicide attempts amongst the female drug addicts than amongst females of the same age in the general population (Coluccia, Traverso, Ferretti, 1997; Llopis, 1998).

One very important detail in the comparison of gender is obviously that of pregnancy and maternity which, not surprisingly, revealed itself to be one of the most discussed subjects in the literature of all countries. The depth of reflection, however, was not always satisfactory and it would be hoped that the subject will be dealt with in more detail.

Taking into consideration only the respective national health structures, the European literature under examination underlined the higher frequency of miscarriages and abortions amongst female drug addicts when compared to the general population. Overall, any drug addict is considered to be at high risk, not only regarding the health of the mother but also that of the foetus (Amar, 1998).

The problems related to maternity, whether gynaecological or obstetrical due to the pregnancy or to a desired pregnancy or to the child's health, help sensitise the woman to problems of a sanitary or social typology more often than the man so that she seeks the aid of these services more frequently.

A bibliographic review has highlighted a specific interest which was noticeable to a greater degree in the French contributions regarding the clinical aspects related to

pregnancy and the ensuing consequences for the child of the drug addict (Venner Fourest, 1998).

In Germany it has been estimated that there are approximately 40,000 – 50,000 children of female drug addicts. If, however, the figure is considered in relationship to the presence of drug addiction of not only the woman but also of the father, the figure rises to approximately 2,000,000 children with a drug addicted parent (Leopold Steffan, 1997).

International literature has repeatedly reported the negative effects that the abuse of drugs, alcohol, pharmaceuticals and nicotine have on the foetus – above all, dependence, slower growth, a higher frequency of premature births and a higher mortality rate (Enrion, 1995).

In particular, taking into consideration the heavy use of psycho-pharmaceuticals by the European female population, the necessity of a more adequate programme of sensitization and prevention on the subject is underlined since it is generally not well known (Venner, Fourest, 1998).

Furthermore, the analysis of the empirical research available on this subject also highlights how the major problems reported by the women are not so much related to the pregnancy but rather to the consequences for the child. This is, above all, because in pregnant drug addicts it is alarming to note that they lack a realistic perception of the higher risks related to pregnancy and the consequences for their child.

Although there is a lack of up-to-date and thorough studies analysing the development of the child of a drug addicted mother, the differences that have been noted concern mainly the language, the body growth and motility. Nevertheless, they all seem to agree that there is a normal physical development after the first year of life.

It is, however, of interest to note, as corroborated by certain French studies, the importance of also taking into consideration the middle – and long-term risks, that is, those related to the environment and life-style beyond and rather than those derived by the use of the substance (Benassouli, 1993).

There is a higher risk, also of consumption, for children coming from families with problems of dependence between the different generations and the importance of forming a correct relationship between mother and child is highlighted to favour the social and affective development of the child.

Thus, in this context, the importance of an adequate and more incisive intervention on behalf of the Services should be underlined. This should be aimed not only at the well-being of the child but should also try to sensitise the parents to the possible damage that drug abuse has on the child.

The problem of maternity is dealt with in more or less the same depth in all European countries concerning the implications for treatment. Indeed, pregnancy frequently represents a moment in which there is a reduction in risk behaviour so that

even if this should not be neglected as a possible starting point for specific interventions this reduction is generally transitory.

Related to this, French literature has underlined how the desire for maternity may sometimes also have the same result of reduction in drug consumption or even lead to stopping completely whereas, once the woman has given birth, she may feel her hopes were not fulfilled and therefore suffer a relapse. On the other hand, other AA feel that maternity may be of help in resolving dependence even though in the presence of precocious maternal dysfunction this may only be transitory. Specific intervention is therefore of great importance and to be hoped for (Venner, Fourest, 1998).

Moreover, in the woman, unlike in the man, the motives leading to undergo treatment are related to maternity with a noticeable difference between the genders: for women the main motivation is either identified with the desire to keep custody of the child or is linked to health problems. For men, more often the choice is related to work or is seen as an alternative to prison.

Furthermore, unlike for the men, the problem of care of the children is shown by many authors to be one of the most important aspects in the life of female drug addicts, from the moment it becomes of essential importance regarding the beginning of the drug dependence, the motives and the continuation of the habit.

Paradoxically, however, the presence of children is also reported as an obstacle in the decision of whether to undergo treatment or not, or at least it is named as a specific difficulty for residential treatment since there are only a limited number of places in Europe where drug addicted parents and their children are admitted together.

However, apart from these aspects, the bibliographical review does not highlight specific differences in relation to the identity of gender regarding the problem of treatment, even if they have been reported in different places.

There is no agreement on the belief that women “bear up” to the treatment more than men, or that they are more resistant to accept it but “bear up” to it more once they have started a rehabilitative path.

The European researchers have all reported how, once in treatment, the women show specific needs that may be related to not only the relationship with their family, their past as a prostitute, and the problem of co-dependence on the partner but also regarding their child.

Certainly, from this point of view, the organisation of the Services takes on a great importance including the possibility that they are able to offer opportunities that take into consideration the complexity and specificity of the needs of the drug addicted women, including emotional and affective needs. This does not necessarily assume the need for differentiated treatments but rather to foresee complementary programmes of external support which take into consideration the distinctive problems of the woman and thus favouring a more realistic planning.

CHAPTER 4

GENDER IDENTITY, DRUG ADDICTION AND PREVENTION. ANALYSIS OF A EUROPEAN SAMPLE.

INTRODUCTION

This contribution belongs to a larger study about the female drug addiction. The main aim of this study was to probe the scientific knowledge of drug addiction as regards to gender identity, in the attempt to strengthen the conceptual autonomy of the topic according to the international literature. A further aim was to certify and to evaluate specific and significant experiences.

Moreover, and keeping in mind the idea of prevention, we have tried to reach another aim: identify specific risk's and protection's factors among drug addicted women. The first part of the work, which is basically a bibliographical research, highlighted an almost complete lack of interest in the problematic of female drug addiction, that human and social sciences have shown, at a European level, in the last decades towards women's condition; on the contrary of North American literature. However, nonetheless, differences between men and women have been found, in relation to the different aspects, so that female drug addiction would seem to have different characteristics to the male one.

Furthermore, it has been seen also in cases in which the problem "women and drugs" is taken into consideration, both at a scientific and "professional" level, that the interest was directed not so much to the drug addicted woman herself (evaluated as the object of research and specific interventions), as to a potential vehicle of problems related to maternity and children, or rather, with exclusive attention being paid to the effect of relapses in drug addiction on personal and family relationships and on society in general. We have recorded that the interest towards drug addicted woman has slid from the idea of woman as a person, to the one that considers her role of mother, wife or sexual object; and an approach that seems to revert to the stereotype of a female image which is still present in our society in different nuances. The paradoxical result of such a definition, in the case of the drug addicted woman, reveals the combination of two conditions of vulnerability: one is linked to the status of drug addict; the other, strikes her as a woman, with the consequence of a greater marginality.

The analysis of specific experiences in the different countries as well as a series of structured interviews with subjects involved in the problem at different levels led us to the hypothesis when the abuse occurs, the female drug addict finds herself in a condition of greater vulnerability in respect to the male. She is also significantly more exposed to risks as regards her health and physical well being. This is also related to the fact that current therapeutic programmes are prevalently based on the male model, while keeping in mind that until a short time ago the problem of the heroin addicts saw no distinction between the genders and therefore developed no sensitivity to the problems connected to “gender identity”.

The research, on which I am currently working, aims to investigate the picture in more details, above all with reference to the needs of drug addicted women, with evaluation of their experiences that such women may experience as regards possible discrimination in respect to other women in their relationship with operators and the services.

The research is divided in two levels of analysis: one, fundamentally descriptive and the other, which is aimed at a more “qualitative” direction and aims to confirm, or not, the presence of specific risk factors, indicated in literature. Furthermore, it has the objective of recognising possible lacks and/or inadequacies of intervention as regards this particular “group” with the aim of suggesting more specific and detailed hypothesis for intervention or, at least, of contributing to a greater sensibilisation to these problems.

METHODOLOGY

The research used an appropriately constructed questionnaire which was given to a sample group of 80 drug addicted women for each country involved in the research¹. This sample was made up of 40 women who had experienced maternity and 40 without children. As established in the methodological introduction, all of the women in the sample are not older than 50 and at the moment of the interview were all undergoing treatment, independent of the type of treatment or the typology of the structure in which the treatment was taking place.

The questionnaire, which was given by a female researcher, was structured according to the following areas to be investigated. Essentially: 1) the dimension of the correlated aspects of the personal case history; 2) the domestic and affective dimension; 3) the health dimension. The data was put into a data base and elaborated with the aim of obtaining the frequency and the percentages of the variables, with reference to both the individual countries and globally, but also with the aim of comparing the different

¹ It must be noted that in this second stage of the research, only four countries participated. Portugal took part with only 21 questionnaires which have not been taken into consideration in this paper.

realities under consideration. This had the aim of highlighting possible analogues and/or differences, not only on the basis of what emerged from scientific reading on the subject but also based on the concrete view point of the drug addicted women themselves.

In the present description of the data, the percentages shown refer to the total of the European sample with the exception of the items relative to the dimension of maternity, the percentages of which refer to the sub-sample of the mothers with such experience.

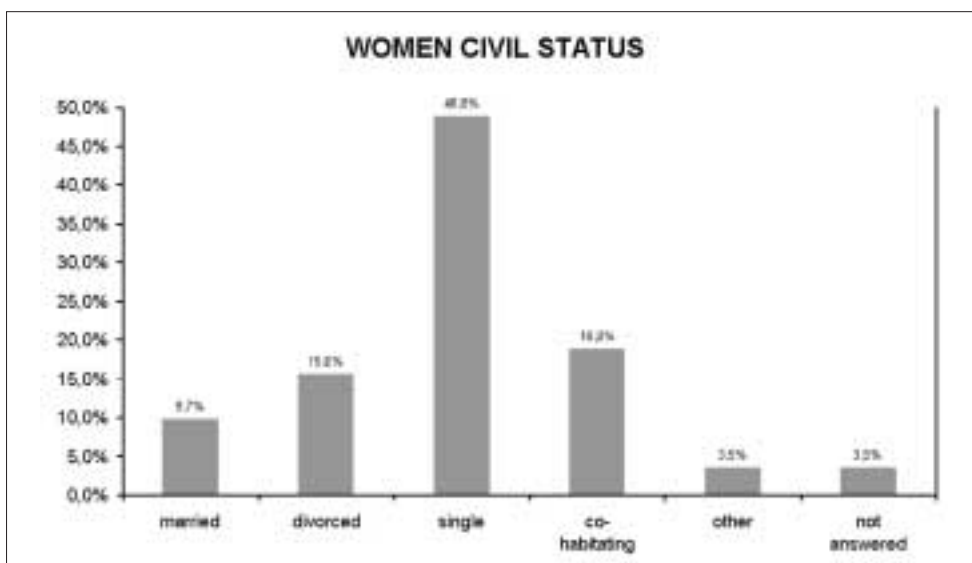
SAMPLE DESCRIPTION

ASPECTS RELATED TO THE ANAMNESTIC DIMENSION

Considering the sample globally, it consists of women with an average age of 29 of which 48.8% are single, 18.8% co-habiting, 15.5% separated/divorced and 9.7% married.

35.5% live with their partner and in 30.2% with their family. 20.8% of the women in the sample are characterised by a school-attendance history of up to the diploma of the middle school or the equivalent; 17.9% only finished elementary school; a discreet number of the subjects have a professional diploma (11.1%) and 12% have the diploma of the upper middle school.

A comparative discussion regarding these variables will not even be attempted (for example, there was no Italian subject in the sample with only the elementary school



diploma and vice-versa a high percentage of subjects with the same diploma in the German sample) since the scholastic system varies from country to country. The low percentage of school drop outs should, however, be noted, both during higher schooling and obligatory schooling. This data becomes much more relevant when one of the most common reasons for dropping out of school is connected to the use of drugs (31%); 23.2% of the cases named it as the reason for their poor scholastic performance. Another possible reason for dropping out was the lack of economical possibilities (21%), a condition that might suggest a certain correlation between drug abuse and this variable. Furthermore, the fact that this motivation is higher in countries such as Italy and Spain, or rather, in countries where a masculine-centred culture still prevails in many of the groups of the population, could point to the importance of a condition of “disadvantage” correlated to gender.

However, the sample states that their scholastic performance was as follows: good (35.2%), normal (44.7%) in the majority of the subjects and only 16.4% with a problematic performance. Furthermore, 51.4% of the sample states that their parents actively encouraged a good scholastic performance whereas only 20.8% remembers them as indifferent or even negative in regards to school and this either due to lack of interest or of time or other reasons.

Apart from what the scholastic performance might actually have been, this research tried to collect the experiences of discrimination and feelings of being different already at the moment of attending school which, however, represented for those interviewed in the sample an important moment of socialisation. Indeed, 79% recognises that they formed very close relationships with friends in this environment.

On the whole, it should be underlined that as regards their schooling experience, the interviewees expressed sentiments of marginalisation or discrimination to a much greater degree as regards their female co-scholars (European average: 37.8% with values between 45% and 27.5% in the different countries) than as regards their male co-scholars, with only 20% expressing such sentiments (with values going from 7.5% Spain to 30% Germany). This is not surprising since the period of scholastic attendance for the majority of the sample coincides with the phase of so-called “homosexuality”.

Reasons for discrimination by co-scholars of the same sex are mainly the physical aspect or “one’s looks” (40.3%), economic conditions (31%) and only 10.8% the use of drugs. It should be noted that the differences between the various countries are, however, quite big apart from the one regarding social-economic conditions. It should also be noted that in countries with a longer multi-racial and multi-religious history (Germany and France) these two aspects are also of noticeable importance.

Vice-versa the experiences of discrimination as regards the male co-scholars regard precisely the fact of “being a woman” in the majority of the cases (49.2%) and it would be of interest to question more closely why the perception of such a discriminating condition is clearly greater in the countries where female emancipation has much older roots (France and Germany). Similarly, precisely in Germany, problems correlated to

sexuality are reported much more often. On the other hand, the factor of discrimination and cultural differences seem to be of less importance and this in two countries (France and Germany) where the problem is felt most keenly.

On the whole, the degree of satisfaction expressed as regards school is quite limited since only 24.7% of the subjects express an evaluation of this experience in completely positive terms.

As regards the problem of drug addiction, about one third of the cases (35%) state that nobody knew about their addiction or at the most, only one or two of their closest friends knew about it (13.8%); in 10% of the subjects it was also known to a teacher whereas it was rarely known by everyone (6.4%). In those cases it was the person concerned to speak about it (9.1%), in other cases it came out by chance or was discovered by other school companions, rarely by the parents or other institutional figures.

The consequences once the problem was known are equally distributed between leaving the scholastic environment (5.8%), above all in France, being called to the headmaster or to the teachers (5.2%) and informing the parents (8.2%) while the police or the responsible institutions (2%) or services for drug addiction of treatment centres (1.4%) were hardly ever called in.

As regards work, 42% of the drug addicts in the sample were either unemployed or employed part-time in the six months before compiling this questionnaire. We will not dwell upon the typology of occupational activity in the sample considering the great difficulties in evaluating it due to the diverse occupational opportunities in each country. As regards the stability of the working activity, although without significant differences between conditions of stability, alternating and extreme precariousness, the prevailing condition of the interviewees was that of alternating between periods of precariousness and of commitment at work (35.8%). This leads to the hypothesis that this inconstancy or discontinuity as regards their working commitments could actually be co-related to drug addiction.

In the cases pertinent to an inconstant or precarious working situation there is a percentage of 52% to the history of drug addiction. Furthermore, it should be noted that in almost half of the cases (41.4%) it was known to the employers, either because revealed by the person concerned (25.5%) or by a third person (15.5%).

Furthermore, it should be specified that during the periods of abuse, the interviewees state that in 31.4% of the cases the increased economic income is found through illicit activities or prostitution and for only 26.7% of the subjects through work. In around half of the cases the working environment does not prove to be a source of discrimination or marginalisation (50.2%); on the other hand, amongst those with precisely those type of experiences the condition of drug addiction was the principle cause of such discrimination (60%) and this was, according to the interviewees, due to the prejudice and fear as regards their honesty (16.4%), ignorance of the problem

(11.7%), or due to indifference (10.8%). Belonging to the female sex only makes up 10.4% (although in France the percentage rose to 36.8%).

It should also be noted that, as regards the dimension of work, the German interviewees had the most difficulties acclimatising at work, and over all, they were the least tolerated by the social group in relation to their being drug addicts, an aspect that would seem to be confirmed by other items.

As far as the consumption of drugs is concerned, the sample is characterised by a multiple drug addiction in which heroin addiction is prevalent (76.7%), followed by a high percentage of cases of cocaine (41.1%) and/or psycho-pharmaceuticals (28.8%), alcohol (23.8%), methadone (15.2%) and other substances (10.8%). Furthermore, this situation seems to confirm the tendency that currently characterises the modality of abuse of drugs in both sexes. In particular, the especially high abuse of cocaine in Germany should be noted in regards to the most recent studies that analyse the changes which have occurred on the market, consumption and the typology of the consumers with reference to this substance.

The average age of the first contact with drugs in the sample of interviewees is 17 with no significant differences in the various countries whereas the start of the use of hard drugs is at an average of about 20. As regards the type of substances taken over a period of time the majority of the women said that cannabis/marijuana and alcohol were amongst the first. The use of cocaine generally follows that of heroine.

For the majority the initial contact with the substance took place with friends (58.5%), in the context of belonging to the group (23.8%) and at a lower percentage, at school (16.7%) or at work (4.7%). The motives driving them to their first contact with the drugs are distributed relatively equally and concern curiosity (5.8%), group identification (5.2%), wanting to escape family or personal problems (2%), identification with partner (1.4%).

On the other hand, the partner is given a central role in the contact with hard drugs (42.9%) even if the group of friends remains greatly responsible (42.7%). The interviewees state that in the majority of cases the first experience with hard drugs took place through inhalation (36.4%), but in another high percentage through injection (27.3%), in accordance with the fact that we are dealing with heroin addicts.

Reasons leading to the use of hard drugs are curiosity, named by half the subjects (50.8%) but high percentages of others include escaping personal or family problems (34.1%); processes of identification with the partner (31.1%) and identification with the group (21.7%). 68.2% of the cases had a drug addicted partner. He was qualified as a prevalent user of heroin (76.7%), cannabis and marijuana (59.9%), cocaine (50.8%), alcohol (37.9%), licit drugs (22.8%) with a distribution that does not differ from the one stated in the personal situation of the interviewees.

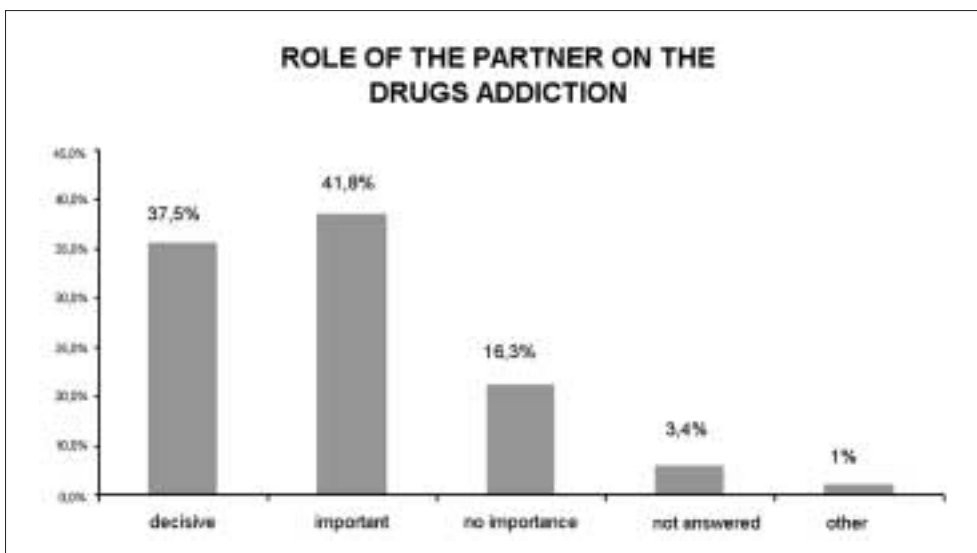
As far as the role attributed to the drug addicted partner at the beginning of the abuse is concerned, according to a high percentage of the interviewees he plays a decisive role (37.5%), or important (41.8%) whereas only 16.3% of the cases attributed

no importance to his presence. Furthermore, the presence of a drug addicted partner makes itself felt in both a possible interruption of treatment (11.1%) and in the relationship at risk of “health”. Nearly all the women in the sample had used a syringe in the course of their history of drug addiction. Compared to 22.9% of them who say they have always used their own, 32.3% admit that they sometimes shared them whereas 12.9% admit that this happened often, thus directly involving the partner. The average age at which the interviewees of the European sample had their first contacts with operators of services for drug addicts in 23 with an overall variation which is actually very high.

The main reason for interrupting the treatment seems to have been the relapse in the use of the substance (70.8%) while in 25.7% of the cases the reason for the failure was stated as the inability of the treatment to respond to the needs of the user. The relapse in the use of drugs was not only due to motives of their own which are not specified (24.7%) but also, as has already been stated, due to the partner who was addicted to drugs (11.1%).

Almost half of the drug addicted women in the sample state that they have attempted to commit suicide once or more (respectively in 16.7% and 23.8% of the cases), thus highlighting a tendency to suicide that is much greater than in the normal population. The average age at which such attempts were made is 18. Almost half of the interviewees speak of one or more episodes of overdose (17.6% and 31.1% respectively).

From a legal point of view, the majority of the women interviewed state that they do not have on-going penal suits (78.5%); however, 48.8% state that in the past they have had problems with the law. As far as the on-going penal suits are concerned, they are more or less to do with patrimonial crimes (10.2%) or with breaking the laws regarding



drugs (9.1%). The same two typologies of crime are also at the basis of preceding penalties.

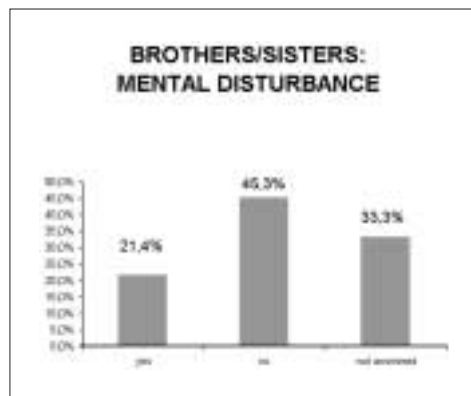
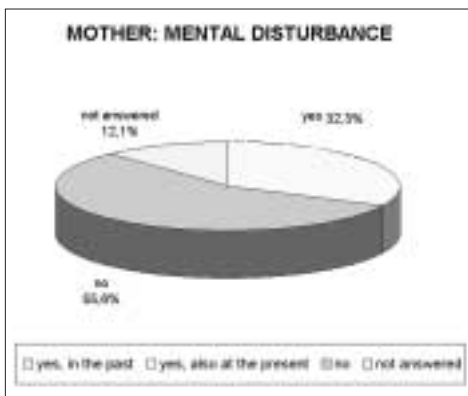
30.3% of the interviewees has undergone terms of imprisonment and 62.2% of those sentenced had, at some point in their legal history, taken advantage of conditional suspension or alternative measures to detention. Only 3.8% of the women with children state that they saw them whilst in prison while in only four cases (France and Germany) the children lived in prison with the mother.

As regards the period in detention, the needs they felt most were those usually felt by such women, or rather, fundamentally the need of psychological support (17%) and only to a lesser degree medical care (9.4%) or economic support (8.8%). The majority of the disappointments they experienced were due to the behaviour of the partner or family. 26.6% of the women who answered this item, or rather 25 out of 94, state they were discriminated against compared to the other inmates. A particularly dramatic data of the case-histories concerns the high percentage of the subjects who reported situations of ill-treatment, both physical (42.9%), psychological (41.1%) and sexual (33.5%) whereas lower figures are shown regarding exploitation (12.3% of the cases).

In relation to the age, in 26.7% of the cases the ill-treatment refers to their childhood (0-11 years old), to their adolescence (12 – 18 years old) in 30.8% of the cases and to their adulthood in 42.3% of the cases. Those most responsible for the ill-treatment are either the partner (31.1%) or the father (21.4%).

THE FAMILIAR AND AFFECTIVE DIMENSION

The families from which the women interviewed come present a series of problems which exceed those found in the general population considerably. In 17.9% the mother uses or used substances in the past – mostly alcohol (11.7%) and licit drugs (7.9%). Situations of abuse (37%) are also stated in reference to the father (mainly alcohol 34.1%).



32.3% of the cases talk about mental disturbances of the mother and in 24.6% the same problem regards the father. 4% of the mothers of the cases and 12.8% of the fathers had undergone penal proceedings. 10% of the fathers and 9% of the mothers had been supported by a public service for their problems. The brothers/sisters also showed problems of drug addiction (22.3%) and alcohol dependency (15.8%). Furthermore, 21.4% of the interviewees spoke of the presence of problems of deviation or psychological disturbances in their brothers/sisters.

As regards their affective life, when the interviewees compiled the questionnaire 46.4% (with values in the different countries varying between approximately 31% and 58%) said that they were not currently involved in any relationship whereas in 70.6% of the remaining interviewees their relationship was defined as stable or even definitive while only 25% described it as transitory or unstable. Taking the instability into consideration which emerges from literature or clinical experience in the affective lives of the drug addicts, one can think that these values can be explained by the effect of the specific condition in which many of the women find themselves at the moment of the interviews in relation to the treatment.

In 33.5% of the cases the current partner is addicted to drugs (16.7% if the value refers to the total of the interviewees) whereas this percentage rises to 40.2% if the past is also taken into consideration. As regards their sexual life, 41.7% of the women, with reference to the last semester, state they have had only one partner and 30.5% no partner (many of the women live in a community), while 25% had had approximately 2 or more.

As far as the use of contraceptives is concerned only 35% of the cases mention the use of contraceptives, at times with the exception of the stable partner (7.6%) in comparison to the high number of women who do not use them (30.5%) or only occasionally (22.3%). As regards the factors of risk, it should be underlined that 37.3% of the sample have been prostitutes.

The women interviewed in the sample who are mothers have an average of 1.5 children, with an average age of 8.4, in a scholastic context that reflects the different ages. The majority of the women are either living with their children (25%) or the children are living with their grandparents (14.7%) while there is a very low percentage for those either living together with other people or in institutions. Guardianship is generally awarded to the parents (68.7%); grandparents and social services follow with an identical percentage (10.6%) and finally, unnamed third parties (7%). More than half of the mothers stated that they had a partner at the time of answering the questionnaire, specifying that he was not the father of their child (69.8%) even if 60.7% of the interviewees state that their last child, undesired and not planned in 67.3% of the cases, was conceived in a stable relationship; only 22.7% state that the child was conceived during a transitory relationship.

At the moment of conception, many of the mothers were using drugs (66.8%), a habit which partly continued during the pregnancy (52.6%), on average until the sixth

month (overall with ample variations). In 23.1% of the cases the new born child suffered crises of abstinence making it necessary for it to remain in hospital. Only 28.9% of the cases stated that the physical well-being of their children was a source of worry for the mothers, in reference to the period of the questionnaire or to the past while 71% of the cases expressed absolutely no fear to this regards. Such worries correlate above all to periods of hospitalisation (50%), the presence of chronic illnesses (29.5%), alimentary disturbances (25%), problems sleeping (11.3%) and finally accidents (9%). As regards this data, the divergence of the French sample should be underlined which, for unknown reasons, states a greater morbidity regarding the children. In 33.3% of the cases there are behavioural problems. Temperamental (54.1%) or affective-relational (45.8%) disturbances are also mentioned. A relatively modest percentage of some women state that they perceived aspects of discrimination towards their children due to their own drug addiction.

HEALTH DIMENSION

As far as physical health is concerned, the sample presents problems in more than half of the cases (62%). These include, in decreasing order, hepatitis C (34.7%), serious dental problems (24.4%), HIV positive (23.2%), hepatitis B (15.8%), and other pathologies (15.5%). As far as the HIV-positive cases are concerned, the data from Spain (27.5%) and France (48.1%) is alarming, but this could be correlated to the choice of the sample.

The percentage of women who have not carried a pregnancy to term is quite high: in 37% of the cases it was due to an abortion while in 17% of the cases it was a miscarriage. As regards the period of pregnancy half of the subjects reduced their use of drugs (50.4%) but the percentage of those who did not change their consumption is high (35.1%) and in 14.4% of the cases it even worsened. Some women followed a programme based on methadone (31.7%) with a scaling down which lasted on average until the seventh month of pregnancy. However, in 30% of the cases, this programme was interrupted. 32.1% of the cases maintained their relationship with the services for drug addiction in this period in particular.

A statistic which should be underlined is that overall, a relatively high number of subjects did not undergo any check ups or gynaecological exams. This is even more surprising since all European countries now have public structures to protect maternity. Keeping the large variations from country to country in mind, the problem should assuredly be investigated more closely in the light of the different social-sanitary legislation, since the lack of any assistance at that stage definitely represents a large risk factor.

With reference to the birth, no particular problems are mentioned for the mother and/or child (74.1%), but complications are named, above all concerning the baby

(13.9%). In 23.8% of the cases the child was delivered with a Caesarean and in 26.7% of the cases it was premature. As far as the relationship with the health system structures is concerned, the aim was to investigate the most felt needs of the patients from a subjective point of view when they were taken to hospital in emergencies such as attempted suicide by overdose, abortions/miscarriages, giving birth. It should be underlined that rather than highlight the needs regarding their health, perhaps already discretely satisfactory, the most felt needs in the sample concerned those for psychological support and support from the family. Only subordinately is the need for economical support mentioned. Furthermore, the greatest disappointments in relation to the satisfaction of such needs concern family members and the partner, even if, in the end, these are the figures who are perceived as the most available in these situations. The frequency with which the women say they have been disappointed in relation to their own "needs" would seem to be indicative not so much of a total disinterest in the relationships themselves but rather as the insufficient capacity to meet their needs notwithstanding the help they tried to give.

As far as the experiences of discrimination are concerned while in hospital, these correlate above all to the condition of drug addiction. According to the women, this is due to ignorance of the problem and the existence of prejudice regarding their honesty, behaviour and the fear of contracting illnesses. Such experiences differ partially from those in the scholastic environment where the feelings of discrimination, as is perhaps obvious, are connected more specifically to the typical problems of that age group, such as looks and physical appearance. It could be observed that as far as dealings with the health structures are concerned, the interviews report the most experiences of discrimination when in hospital because of attempted suicide or overdose. This could make the health structures consider a different attitude but could also correlate with the more conflictual relationship of the woman herself faced with the structures.

CONCLUSIONS

Although the analysis of the data relative to the sample of the women interviewed in the different countries has not allowed the delineation of the profile of a European drug addict because the choice of the sample did not follow this aim, it has nevertheless allowed both the highlighting and the confirmation of aspects which are also suggested or reported in the literature.

The woman's figure that came out describes her as a subject with a scholastic level which does not always correspond to that of obligatory schooling; and when she drops out of school it occurs at the beginning of adolescence because of the abuse of drugs or the correlated poor scholastic performance or sometimes without any economic reasons. This last aspect is particularly interesting, most of all because international literature on drug addiction and gender identity, with reference to such variables, points

out that the female sex is characterised by a lower level of scholastic instruction compared to the male, precisely due to the lower economic availability.

The degree of satisfaction concerning school is very limited, both due to the reported problems with the teachers and to the lack of interest. Teachers and companions don't know that the condition of drug addiction, is often the reason of expulsion from school.

This draws attention to the importance of the formation and training of the category of educators who currently do not seem to be sufficiently prepared or sensitized about this problem. School seems to underestimate the importance of its own function in the timely recognition of the symptoms linked to drug consumption and/or traumatic situations, and the importance that such an early intervention would involve at a level of prevention even if secondary.

The impression given from this data is that even when the problem is recognised, the school is unable to place itself in a network intervention, for example, by activating the services responsible for childhood and adolescence support, since it recognises the family as the only privileged interlocutor and does not consider that in this case it might not be able, also emotionally, to confront the problem.

The drug addict who emerges from the examined sample describes a family with multiple problems, with parents dependent on alcohol or with problems of dependence on licit drugs, but also with psychological problems and deviance problems. In many cases the same problems can be found in the brothers and sisters who are also qualified as drug addicts and/or alcohol dependent.

In a high percentage of cases, this woman has been the victim of ill-treatment and/or sexual abuse as a child or adolescent, also in the family environment, or has never enjoyed adequate protection by the family itself. In this context it is opportune to remember that literature points out a positive correlation between sexual abuse/ill-treatment and deviant behaviour such as drug addiction, prostitution etc.

Very often, the nucleus the woman acquires is also unstable; the partner is frequently not the father of the child even if they are conceived often in the surroundings of a relationship which is characterised in terms of stability, even if not desired or planned.

As far as work is concerned, the drug addict has the tendency to be inconstant and was often unemployed in the semester preceding the interview. In the past she has made different jobs which range across the different sectors which probably reflect the different state of the work market in Europe. Above all, however, she has used prostitution as a means of earning money.

The working environment seems partially productive to experiences of discrimination and marginalization linked to drug addiction. The interviewees, fundamentally multiple substances drug addicts according to the tendency seen also at a European level, had their first contact with drugs at an average age of 17 years old (but

with some that began much earlier), above all in the context of groups, both out of curiosity and identification with the group of peers, moving towards hard drugs several years later.

In this phase, the contact with drugs often took place with a drug addicted partner who takes on role, central or at least important, in the history of the abuse.

This aspect only confirms what has already been highlighted in international literature, that is the specificity of the variable drug addicted partner in relation to the identity of gender as far as the contact to the so-called hard drugs is concerned. Indeed, it is not infrequent that the use of the substance is motivated by the desire to identify with the drug addicted partner.

The first contact with the services for drug addicts takes place approximately several years later, and the interruption of possible treatment programmes is once again due to the presence of a drug addicted partner who therefore assumes a central role in the course of the treatment as in many other problems involving the drug addicted woman.

There is a series of behavioural risks connected to this aspect such as the sharing of syringes, the restricted use of contraceptives, prostituting oneself and very often committing crimes together as a couple. The presence of women who have committed previous offences, above all patrimonial offences or the violation of the laws on drugs, is discretely high. Very often the woman states that she has enjoyed penitentiary benefits while in prison; during her stay in prison she had very limited contact with her children, showing an attitude that varied between the vital need to see them during her stay and the desire not to expose them to that very experience.

At this point it would be interesting to examine the different existing provisions in each country regarding the possibility and modality of visits and the possible permanent stay of the prisoner's children in prison. The frequent presence of suicide attempts or episodes of overdose completes the picture.

Regarding maternity, the woman seems to minimise all the problems, both related to the pregnancy and the birth itself due to her condition of drug addict, and she does not seem to be worried about, or does not want to recognise the influence that this condition has on the health and formation of the personality of her child. This could be indicative of an attitude of defence and negation of the problem, but it could also be directly connected to the fear of having the child taken away from her.

Although she has followed a programme of "scaled" methadone or has stopped using drugs during the pregnancy there are still premature births and pathologies of abstinence in the child making a consequent stay in hospital necessary. The decidedly higher proportion of abortions and miscarriages compared to the general population represent another of the problems highlighted in the study.

Furthermore, as regards her health, the woman is in a precarious state of health which once again poses the problem of prevention and health education. The failure of

the school as an institution with the task of prevention is indeed accompanied by the failure of the health structures since the drug addict often experiences discrimination in this environment, above all during hospitalization due to overdose or acting out suicides.

The experiences of discrimination when hospitalized for health conditions in the closer sense of the word, or rather correlated to pregnancy or birth, are much lower, but the number of women who state they have never undergone check ups or tests during pregnancy is alarmingly high.

In the encounters with the health service structures it should be emphasised how this group of users feel more the need for psychological rather than medical support with needs which often involve not only the sanitary structures but also family members and the partner, needs which are often not met. This fact seems to suggest the utility of using these hospital stays as a moment which favours the action of support and “mending” of more general family ties.

In conclusion, the profile of the European drug addict which this research has outlined underlines certain problems which may also be of specific importance in relation to gender identity. These include sexual abuse and ill-treatment during childhood or adolescence as well as the importance of the partner, both with regards to drug addiction and to the health case history of the woman with reference to acts of deviating or delinquent behaviour. It should further be noted that prostitution is one of the most important factors at the level of gender identity, also for its specific relapses as regards treatment.

Finally, our data has confirmed the importance and the incidence of the moment correlated to maternity which, although it represents an important motivation to undergo treatment of drug addiction, in reality it presents only an interruption in the course of consumption. Nevertheless, this could refer to the inadequacy of the Services and it is definitely a problem which should be investigated in greater depth with prevention in mind.

As far as this aspect is concerned, as for all the other problems which emerged, although not completely exhaustive, the European study nevertheless represents the starting point for further research and reflection. This is not only out of interest that the subject has at a scientific level but also for the consequences at the operative level in relation to the planning and the study of preventive, educational, sanitary politics as well as those of treatment.

ANNEXE - 1

BEST PRACTICES(*)

The aim of this part of the research was to determine and describe the activity projects regarding the public and/or private organisations that carry out initiatives of prevention and assistance for women with problems of drug abuse and/or of psycho-active substances, including the abuse of psycho-pharmaceutical substances and alcohol.

It is the authors' intention that the schematic collection of this information favours the circulation of the situations experienced with the aim of a greater recognition of their contribution, stimulating the operators to promote analogue initiatives and to discover reference points in theory and experience.

A list of the various operating structures in the different European countries now follows. Useful ideas in context can therefore be found according to the corresponding local situation.

The most prominent characteristics have been described to give the most complete and immediate picture, thus allowing a comparison.

These points include:

- a) the aims of the project and description of the target;
- b) Survey of innovative aspects;
- c) Resources used;
- d) The methodology adopted;
- e) Evaluation of the results;
- f) Co-operation at a local, national and international level; interaction networks to promote, consolidate or develop the project;
- g) Possible other aspects of the case.

In this manner, the knowledge of the operator is extended by creating also possible interaction between both the innovative experiences and the formation initiatives of the operators themselves.

Due to obvious reasons of space the following information will be summarised, giving the reader, if interested, the chance to deepen his knowledge regarding the specific programme by getting in touch with the structure that is carrying out the particular project that is of interest and asking for further details and documentation. Obviously the research of interesting programmes that could have been presented in this work was very demanding and the authors are aware of the objective limits in this panorama of the various projects, and have therefore selected the aspects they considered of particular innovative importance.

(*) Compiled by P. Stocco, L.DeFazio, E. Steffan, H. Broemer, J.J.Llopis Llacer, M. Carvalho, F.Venner, G. Bruchage

Furthermore, it is evident that by having to make choices there is the risk of neglecting significant experiences. This is partly due to the fact that it is difficult to find explicit material that gives thorough and reliable information on many of the cases. Our presentation has therefore selected only those structures that could not only supply an exhaustive documentation but also known experiences that could be verified by the authors.

FRANCE

1. Programme of risk reduction

Location:

Médecins du Monde-France 32 rue Marcadet, 75018 Paris.

Tel. 01 44 92 15 15

Aim:

The creation of a coherent distribution model of methadone that reaches a part of the population it is difficult to reach (including many women), who, for various reasons have no contact with the competent structures. Reduction of risk of infection of HIV and hepatitis.

For whom:

The most needy and destitute people of Paris and Marseille.

Intervention methods:

“Bus méthadone médecins du monde-distribution, free throughout France” which foresees the distribution of methadone and one-way syringes.

Team:

Each bus has at least three nurses, a doctor, a specialised educator and interventionist from the vicinity.

2. Centre of day-care treatment

Location:

Structure Horizons

C/o Horizons

210 rue du Fbg Saint Denis, 75010 Paris

Tel: 01 42 09 84 84

Aim:

To help mothers and parents in general with problems of drug addiction and who find themselves in the situation of having to decide whether to stay with their children or to carry out treatment at the centre.

For whom:

Mainly mothers and their children but also their partners.

Intervention methods:

Network structure which takes care of the children when the mothers undergo treatment.

Team:

2 psychiatrists, 1 psycho-therapist, 2 social workers, 2 specialised educators, 1 educator for children, 2 nurses and 1 co-ordinator.

Result evaluation:

Annual report (1997, 51 pages)

Network support:

Maternity, paediatric services, services specialised in drug addiction, social services, housing services, services for child care, prisons and charity associations.

3. Programme to help drug users

Location:

Structure Clinique Liberté
Centre hospitalier de Villejuif
54, avenue de la République, 94806 Villejuif Cedex.

Aim:

Reconciliation between location of treatment and domicile of patient, humanisation of the programme.

For whom:

Men and women who use drugs and are undergoing substitution treatment.

Intervention methods:

The CHS of Villejuif is made up of 14 sections, the offer of treatment covers a population of about 900,000 residents in 28 communes.

Result evaluation:

Annual report.

4. Association of reception and psychological and social support

Location:

Structure Silò
5 rue Victor Massé, 75009 Paris

Tel. 01 48 74 13 04

Fax. 01 48 74 41 35

Aim:

Located in Pigalle (a quarter where prostitution is very frequent), the association is a place open for meetings and exchange between children and adults, new and old drug addicts.

It is “directed at the quarter”, aiming at social reintegration.

For whom:

The people of all ages who live in that quarter. In 1996 63% of the drug addicts were men and 37% women making a total of 290 people.

Intervention methods:

The social operators work in the squats, abandoned houses, and with prostitutes and the homeless. More than half of the drug addicts are homeless. The association works with very motivated people and the quarter is very aware of this presence that offers not only scholastic prevention but also preventive measures.

The principal activities are: psychological and social-educational reception and orientation; the people who are supported are given accommodation (9 Locations). The team offers a correspondence service for prison inmates upon request.

Team:

1 director, 3 educators, 1 social assistant, 1 psycho-analyst, 1 secretary, 16 volunteers offering scholastic support.

Result evaluation:

Annual report.

5. Association of “Street access to treatment”

Location:

Structure Ruptures
36, rue Burdeau, 69001 Lyon
Tel. 04 78 39 34 89

Aim:

Access to treatment and basic services; reduction of risks.

For whom:

Drug addicted people without fixed abode. People in need and their relatives.

Intervention methods:

Reception and orientation: proposal of free services such as showers, meals...; medical consultation; reduction of risks (availability of syringes, sterile materials, condoms or coins for machines) and prevention (free periodical interventions).

Team:

1 director, 1 animator for prevention, 1 prevention agent, 1 nurse, 1 administrator and 15 volunteers.

Support network:

In 1997 the association organised meetings with the Lyon periphery to talk about drug addiction with young people who had had direct experiences in that area and made themselves available.

SPAIN

1. Treatment centre for drug addicted prostitutes, programme of damage reduction.

Location:

Pis Petit

C/Petit, n°6. Palma de Mallorca.

Aim:

Information and orientation, damage reduction, treatment and rehabilitation.

For whom:

Female prostitutes, part of the project was specifically aimed at those who were drug addicts.

Intervention methods:

The women with problems of drug addiction were contacted on the street and informed of the different support programmes. The programme starts with those who have given their consent.

Team:

1 sociologist, 1 social operator, 4 volunteers, 5 collaborators.

Result evaluation:

The final objective is the improvement of quality of life, sometimes the results are a little more limited; in 70% of the cases there is an improvement for the women under treatment in the centre.

Support network:

- Proyecto Hombre;
- Pis Balanguera;
- Centro de dispensación de metadona (Conselleria de Sanitat)
- Sa Locationta;
- Médicos del Mundo;
- ALAS;
- Comedor de transeúntes;
- Centros de Salud y recursos específicos de INSALUD;
- Atención primaria del Ayuntamiento y CARITAS.

Other aspects:

It is a project that is personalised and immediate once the woman decides to undergo treatment.

2. Treatment of damage reduction in pregnant drug addicts and their children.

Location:

Programa de atención a la gestante drogodependiente

Unidad de desintoxicación del Hospital Son Dureta.

C/ Andrea Doria, 53. 07011 Palma de Mallorca.

Tel. + 34 971 793 750.

Aim:

Special attention to babies, with particular care paid to the needs of the pregnant women.

For whom:

Pregnant women who use drugs, in particular heroine.

Intervention methods:

Upon request, orientation and agreement of the programme to be carried out. The structures of the programme include an advice bureau, a detoxification unit and a methadone distribution centre.

The attention paid to the patient is immediate and individual; after confirmation of the pregnancy the possibility of abortion is considered; otherwise a maintenance programme with methadone or detoxification is started.

Preferential treatment is PMM.

Team:

1 clinical psychologist, a doctor, a gynaecological team and an internal medical team.

Result evaluation:

Good participation to facilitate access to programme. High drop out rate from the programme by some of the women; improves if they are supported by their family.

Support network:

With all the teams on the island who work with drug addicts.

Other aspects:

Specific programmes for pregnant drug addicts did not previously exist on the island.

3. Protected apartments for female drug addicts

Location:

Pis Balanguera
Palma de Mallorca

Aims:

to offer orientation, information and support for female drug addicts undergoing treatment and in need of accommodation. It is the completion of the therapeutical work carried out by other structures.

For whom:

Women addicted to any substance, over 18 or emancipated minors, under treatment and need of accommodation.

Intervention methods:

The therapy contract from the respective centre is signed and they are enrolled in PIS while maintaining contact with the latter.

The PIS has four double rooms, two singles, 2 large rooms, 2 kitchens, 1 room for the educator, 6 bathrooms and a communal terrace.

Team:

1 social operator and a further two operators who can be psychologists, pedagogists ... and various volunteers.

Result evaluation:

Criteria for valuation are being determined.

Support network:

Co-ordinating activities are organised at least once a month involving the CARITAS and the treatment structures (Proyecto Hombre, Servicio Municipal de Drogodependencias).

4. Therapeutic apartment for women with alcohol problems

Location:

Piso terapéutico para mujeres con problemas relacionados con el alcohol y otras drogas. Cordoba-Andalucia

Aims:

Treatment and rehabilitation for alcohol dependent women without a supportive family background.

For whom:

Women with serious alcohol problems and grave social detachment. The women must be over 18 years old, residents in the Comunità Andalusia and not dependent on any other substance. They must come voluntarily, accept the living conditions and have overcome the phase of detoxification.

Intervention methods:

An intensive intervention that does not last longer than 6 months. There is an individual treatment plan for each guest with specific aims and timing. The 100 sq.m. apartment has four dormitories, a dining room, two bathrooms and a kitchen.

Team:

3 observers (a clinical auxiliary, a teacher and a social operator), a psychologist and doctor.

Result evaluation:

The evaluation is both individual and of the overall structure.

Support network:

Centro ambulatorio Cruz Roja de Córdoba

Centro civico di quartiere

Centro di salute di quartiere

Ayuntamiento de Cordoba.

5. Female therapeutic Community

Location:

Asociación benéfico-social "ARCO IRIS". Comunidad Terapéutica y Centro de desintoxicación "El prado de Santa Maria".

Cordoba – Andalucía.

Aims:

Promotion of personal, familiar and social restructuration of the patient to allow abstinence from drugs. Individual objectives are set for each patient. The areas of intervention are as follows:

learning a normative behaviour, habitual re-education, health education, progressive responsabilisation, healthy activities in free time, analysis of personal conflicts, personal autonomy, the capacity of self-management and resolution of problems.

For whom:

Drug addicted women over 18 years old.

Intervention methods:

Interaction, the continual following and evaluation by the treatment team. The patients' stay generally is between 9 and 10 months and the therapeutic programme covers the following areas:

physical preparation;
areas of responsibility;
social-educational areas;
psycho-therapeutical areas;
social-cultural areas.

Team:

1 doctor, 1 psychologist, 3 educators, 1 group animator, 1 occupational observer, 2 volunteers.

Result evaluation:

There are three weekly meetings with the psycho-therapist and the educators. Furthermore, there is a register which is used daily by the educators. A monthly report is written for each patient regarding the various areas of this evaluation and a monthly report is also given to the therapist in charge.

Support network:

Servicio de Coordinación Asistencial del Comisionado para la Droga de la Junta de Andalucía (and other services connected to drug addiction); Centro Provincial de Drogodependencias de Cordoba.

Innovative aspects:

Since the beginning of 1997 a limited number of patients who use methadone and have expressed the wish to stop have been accepted. This initiative is the consequence of the difficulty of abstinence from other drugs that many of them presented during the ambulatory treatment.

6. Comunidad terapéutica femenina

Location:

Programa terapéutico SPIRAL
Valle de Peón. Villaviciosa (Asturias)
Tel. 985 111 111

Aims:

Programme free of drugs. Detoxification and rehabilitation at all levels, with the final objective of complete autonomy.

For whom:

Drug addicted women of all ages.

Intervention methods:

Group therapy, individual therapy, family therapy, couple therapy. In the head office in Madrid there is an interview before being accepted, also a protocol of initial evaluation, the signing of the contract and of the regulations.

In the therapeutical community (Asturias) the following takes place: the first interview (alone and with the family), personal register, assignation of a tutor, detoxification, reception, supervision, integration, maturation and re-insertion. The therapeutic community is a semi-open residence.

Team:

1 part time doctor, 1 psychiatrist, 1 social operator, 1 intendant, 3 educators, a monitor of corporeal expression, 1 co-ordinator.

Result evaluation:

Internal records and evaluation of the team.

Support network:

Centros de atención a toxicómanos del principado de Asturias y de la Comunidad de León.

Asociación de Familiares de Madrid (FERMAD)

Centros privados.

Innovative aspects:

Since dealing with a female population, a suitably adapted treatment is necessary. Furthermore, psychiatric treatment of any other additional pathology is foreseen.

GERMANY

1. Prevention programme in schools

Location:

Schule + Sucht (School and addiction)
Berlin, Kreuzberg

Aims:

Drug prevention in schools.

For whom:

Pupils and teachers of the schools involved in the project.

Intervention methods:

Contact with schools and administration, development of concepts and organisation of training. Operates through the co-ordination of primary prevention projects in many schools at different levels, the organisation of training for pupils and teachers, advisory bureau, class work and information for parents.

Team:

Operators in the sector.

Result evaluation:

A prevention group works permanently in 25 schools in 2 districts of Berlin.

Network contacts:

Other districts and scholastic administrations, treatment centres, psycho-social institutions, therapists ...

Innovative aspects:

The development of modern preventive approaches, the involvement of schools with this aim in mind.

2. Consultant Programme for female drug addicts

Location:

Drogennotdienst e.V.

Ansbacherstr. 11

10787 Berlin

Tel. +49 030 19237

Aims:

The creation of a place for drug addicted women "drug addicts off the streets/prostitutes"

For whom:

Female drug addicts.

Intervention methods:

An "open door" centre where there is a café which is open every day, the possibility to eat cheaply, to relax and to obtain information and advice from the social operators.

Team:

Different social operators.

Result evaluation:

The project has been very successful since it has created a place in which female drug addicts have no difficulty in contacting those responsible for treatment.

Network contacts:

Close co-operation with the larger consultation centre “Drogennotdienst” with possible contacts with other centres of detoxification and treatment.

3. Centre for drug addicted women and children

Location:

Iglu
Hamburg

Aims:

Specific treatment of consultation for drug addicted women with children.

For whom:

drug addicted mothers

Intervention methods:

long-term results, including MMP with PSB, with reference to treatment of abstinence, information, consultation – also personal, including children.

Result evaluation:

Development of treatment plans and individual aims.

Support network:

System for drug addiction in Hamburg, other treatment centres.

4. Programme of “street intervention”

Location:

Suchtberatung LDS – centre – Koenigs Wusterhausen

Aims:

Information and consultation “on the road” for people with problems of addiction.

For whom:

People with problems of addiction, above all of alcohol, even if the number of young consumers has risen slightly.

Intervention methods:

Direct contact with groups or also individuals in the meeting points (for example at kiosks, small fast-food and drink stands); it is believed that this approach is more effective than offering the same service in a centre.

Result evaluation:

The people who accept the first contact then start to visit the centre and begin treatment.

Support network:

The team works closely with public administration and other treatment centres.

Innovative aspects:

An approach of this type aids the understanding of how problems of dependence develop from “street life”, on the other hand, the people with these problems realise they have not been abandoned.

5. Centre for female drug addicts

Location:

Extradry (Counselling for addicted woman)
Corneliusstrasse 2
80469 Munchen
tel +49 89 236063
fax. +49 89 236069

Aims:

Information and treatment exclusively aimed at the female gender and at the dynamics and specific problems of this category.

For whom:

Women with problems of addiction.

Intervention methods:

Information, individual consultation – also for the children – working with the family, planning of individual treatment (with reference to AOP).

Very often these women have suffered violence and sexual abuse, an element that should not be underestimated in the approach.

Result evaluation:

High degree of acceptance by the women, intensive work with the children.

Support network:

With public administration, families, doctors, structures for treatment.

Innovative aspects:

Attention paid to the women with problems of addiction, a group that requires differentiated treatment.

6. Community for addicted women.

Location:

Bremen Hilfe zur Selbsthilfe E.V.
Schmidstrasse 34
D 28203 Bremen
Tel. +49 0421 78767/78600
Fax. + 49 0421 76031

Aims:

Sanitary treatment for women with problems of addiction.

For whom:

Women with babies.

Intervention methods:

A group of midwives who are community operators collaborate with social operators of a consultation centre. They visit the houses inhabited by women and their small babies, give information and help the mothers/parents and observe the living environment of the children.

Result evaluation:

Women are reached who would not otherwise come to ask help of this kind; the project answers some of the more “hidden aspects” of drug addiction and pregnancy.

Support network:

Hospitals, doctors, nurses, families, public health administration, treatment centres.

Innovative aspects:

The midwives are trained to deal with the drug related problems of their patients; furthermore, there is a close participation with the consultation and treatment centre and with the public health system.

7. Centre for individual requests

Location:

Clearingstelle für Substitution
(Arztekammer Berlin) Office for question about methadon substitution
Stephanstrasse 17
10559 Berlin Tiergarten
tel +49 30 3959021
fax +49 30 3959023

Aims:

Clarification centre for individual requests of MMP with PSB.

For whom:

Individual drug addicts.

Intervention methods:

Groups of experts examine and co-ordinate each request officially; consultation and psycho-social support is also foreseen.

Result evaluation:

The Ethical Commission supervises the results; the Centre of clarification also prepares 150 doctors as regards the aspects of drug addiction.

Support network:

Intensive co-operation with doctors from the Medical Chamber of Berlin together with social operators of the PSB centres.

8. Detoxification centre

Location:

Bellavista, Bargfeld (Hamburg)

Aim:

Detoxification

For whom:

People dependent on substances

Intervention methods:

Structured programmes of detoxification, relaxation, medical support, individual or group consultation.

Result evaluation:

Active daily support during the process of detoxification, help in overcoming individual problems, reference to treatment that is underway.

Support network:

Intensive collaboration with the treatment systems.

Innovative aspects:

Multi-professional team, activation of the patients' motivation regarding therapy.

9. Centre for dependent women.

Location:

St. Vitus Hospital
Vechta, (Nieder Sachsen)

Aim:

In-patient treatment for women with different types of dependence, including psychological disturbances, bulimia...

For whom:

Women who have these characteristics.

Intervention methods:

Individual consultation or group therapy.

Result evaluation:

In-patient treatment with the conscious acceptance of a large variety the problems of dependent women.

Support network:

Consultation centre, doctors, families.

Innovative aspects:

Multi-focal approach regarding the problems of women, including children and past experiences (e.g. episodes of violence).

10. Programme for women with problems of dependence and children

Location:

Tannenhof, Drogenhilfe
Kinderhaus Tannenhof
TALI I-III
Wihelmsaue 116-117
10715 Berlin
Tel. +49 030 8649460
Fax. + +49 030 86 494633

Aims:

Network of in-patient therapy to recover and re-insert the women/parents with children and problems of dependence.

For whom:

Women-mothers with problems of dependence.

Intervention methods:

Combination of treatment of adults and taking care of their children. The structure offers social support, planning of individual treatment, long- and short-term – also for women with problems of substance abuse.

Care of the patients foresees therapy as in-patients, living together as a family in the Therapeutic Community; diagnosis of the development and treatment of the child.

Result evaluation:

Acceptance of programme, high levels of rehabilitation and care of children, long-term re-integration of women with children.

Support network:

Department of the association, consultation and detoxification centres, families, schools ...

Innovative aspects:

Co-operation with different teams (rehabilitation, care of children, school, education at work...) in a single association; the children are treated and helped while the parents are supported in the daily care of their children.

11. Help-Help Group

Location:

Narcotic Anonymous (NA)
Various cities in Germany and also in Europe.

Aims:

Reciprocal help between people who have problems of addiction.

For whom:

Ex-addicts

Intervention methods:

Periodical meetings of the participants; there are 12 “conceptual stages” that the group has to pass.

Result evaluation:

A large number of people who are interested participate in the groups.

Support network:

NA world service.

Innovative aspects:

Offers a model of live through the 12-stage programme for the people in abstinence who used to be dependent on substances.

12. Ambulatory therapy combined with the substitution method.

Location:

MAT (Therapiehilfe Hamburg, e.V.)

Geschäftsstelle

Hasselbrookstr. 94

D 22089 Hamburg.

Tel. +49 040 2000100

Fax. +49 040 2002057

Aims:

Offer ambulatory therapy combined with substitution methods (MMP and methadone).

For whom:

People dependent on substances.

Intervention methods:

Individual treatment and setting with a professional team.

Result evaluation:

Welcomed by participants, reference with good results regarding use of AOP.

Support network:

Within the Therapiehilfe Hamburg and with the therapeutic community of detoxification and rehabilitation.

Innovative aspects:

Acceptance of changes in motivation of the patients offering MMP or detoxification with methadone together with consultation/therapy, co-operation with AOP's.

13. Project School

Location:

Tannenhof Schule (School of former addicts)

Mahlower strasse 23/24

12049 Berlin

tel.+49 30 6921782
fax.+49 30 69506189

Aims:

Scholastic education, fundamental for the rehabilitation, above all for the younger addicts.

For whom:

Young people with problems of addiction.

Intervention methods:

Training by one or two teachers in small groups of pupils who come from treatment and cure centres, daily visits to school. At the end they take the public school exams.

Result evaluation:

High degree of acceptance of the school and teachers by the young people at whom the project is aimed.

Support network:

Close collaboration with the Therapeutic Community and the school administration.

Innovative aspects:

New educational model for a new type of learning.

14. Programme of re-insertion

Location:

Drogenhilfe Tuebingen e.V.
Friedrichshof (Therapiezentrum 3)
D 74182 Obersulm Eichelberg
Tuebingen
Tel. +49 07130 473 30
Fax. +49 07130 473 333

Aims:

reinsertion in society, work education.

For whom:

Participants of the Therapeutic Community with an almost finalised programme.

Intervention methods:

During the last phase of the treatment the participant may choose amongst various choices of reinsertion; the Therapeutic Community offers apartments and work training.

Result evaluation:

Acceptance of programme of reinsertion, work on behalf of participants.

Support network:

Close collaboration with the Therapeutic Community, families, work administration ...

Innovative aspects:

Reinsertion, work training and ability training are an important part of reintegration.

ITALY

1. Programme for drug addicted women

Location:

Comunità Incontro

Via S. Biagio, 114

51100 Pistoia

Tel. +39 0573 26004

Fax. +39 0573 975388

Aims:

Treatment of drug addicted women. Care and elaboration of their problems which are, above all, due to sexual abuse – experience of traumas, problems of identity and with the other sex. Group dynamics are favoured with the aim of creating closer a relationship between the participants through sharing their problems and the discussion of subjects such as female friendship and social relations.

For whom:

female drug addicts.

Intervention methods:

The group is considered a mode of therapeutic treatment. The operators are also co-ordinators as regards how the group is conducted; they are therefore experienced as the first model of positive identification.

On the other hand, the subjects to be discussed are proposed by the participants.

Team:

Two psychologist operators co-ordinate the project.

Result evaluation:

Good evaluation of the intervention presented at a European conference on female drug addiction.

Support network:

Continual information exchange with the operators following the women in the other phases of treatment.

Contact with external services, above all during the phase of re-insertion.

Innovative aspects:

Experiencing the operators as the first model of positive identification helps cover the spaces at a therapeutic level.

2. Programme for sero-positive drug addicted mothers and children

Location:

Comunità Madre-Bambino S. Mauro
Gruppo Abele
Via Giolitti, 21
10100 Torino
Tel. +39 011 8395442/830448

Aim:

Therapy with the aim of re-elaboration of motherhood and rehabilitation from drug addiction.

For whom:

Sero-positive drug addicted mothers and children.

Intervention methods:

Upon arrival at the centre there is an evaluation and then approximately 50 days without any external contacts.

The community treatment lasts 10 months after which there is a phase of re-insertion lasting 6 months.

There are weekly individual and group therapeutic interviews/meetings and a group of help-help run by a psychologist and an ex-drug addict. Women who have just left the community also participate. Furthermore there is a series of activities involving also the children.

Team:

Community operators, 1 psychologist, 1 doctor, 1 professional educator and some volunteers.

Result evaluation:

The team meets once a week to discuss the process of changes in the women and children. The supervision of the cases takes place once every three weeks.

Support network:

Sert, a neuro-psychiatrist, Tribunal

3. Sanitary and social prevention programme

Location:

Centro Stranieri, Comune di Modena
Modena

Aims:

Sanitary prevention (AIDS and sexually transmitted diseases) and social prevention for foreign women who prostitute themselves on the street, also looking for alternatives to prostitution.

For whom:

Foreign women who prostitute themselves on the street.

Intervention methods:

The programme foresees two weekly outings of the team (usually an educator and a mediator) with the bus of “Unità di Strada” to reach/find the prostitutes and to distribute informative material in their own language amongst them, also pharmaceutical products (vaginal jelly and condoms). They offer basic advice regarding illnesses and the social-sanitary services offered by the city. There is the possibility of being accompanied to the services, the aim being to put them in touch with the structures only with their knowledge.

Team:

3 professional educators, 2 cultural mediators.

Result evaluation:

Contact with 90% of the prostitutes of which 50% turned spontaneously to the Clinic and Social Services, the others were accompanied.

A workshop took place, thematically based on the prevention and cure of sexually transmitted diseases in collaboration with a doctor from the clinic. The satisfying result allowed the planning of further meetings. One of the limits is, however, the lack of cultural mediators who would make it easier to meet the people.

Support network:

Comitato per i Diritti Civili, Centro Antiviolenza, USL, Servizi per minori del Comune, ECAP (Centro Formazione Personale), Centro Ascolto AIDS dell’ARCI.

Innovative aspects:

The contact on the street helps develop an important link with the city and can contribute to a new start for different lives.

The presence of cultural mediators represents a new modality of relating to the phenomena of prostitution, allowing a contact that is more oriented towards listening.

4 Sanitary prevention programme

Location:

Città di Bologna
Comune di Bologna
Bologna

Aims:

Prevention of sexually transmitted diseases using the Unità di Strada (Street unit)

For whom:

Prostitutes and transsexuals.

Intervention methods:

The operators work in pairs – one local together with a multicultural operator. Together they approach the women. The majority of the prostitutes are foreigners (drug addiction was found in only one case); the service operates from 22 to 2.

Team:

7 social operators of which 2 are transsexual.

Result evaluation:

Overall positive even if certain relationships are complex to manage (in particular with the institutions and police).

Support network:

Services with analogue experiences (Torino, Modena, Rimini, nelle Marche), Centro Donna an the Comitato per i Diritti Civili delle Prostitute (Committee for Civil rights of Prostitutes), Assessorato delle Politiche Locali).

5. Programme of rehabilitation for drug addicts

Location:

CEIS

Via Toniolo, 125

41 100 Modena

Tel. +39 059 315331

Fax. +39 059 315353

Aims:

Therapeutic intervention of rehabilitation from drug addiction and the re-elaboration of affective and sexual problems with the aim of achieving awareness and acceptance of the abuse suffered so as to be able to change certain aspects of oneself.

For whom:

Women drug addicts.

Intervention methods:

After approximately 5 months in the community, groups of 4-5 women are formed (Sonda Groups) which, together with two operators, work on the affective and sexual problems using the mode of mutual aid and the use of the technique of psychodrama.

The numbers of the group are variable, and continue parallel until they reach a genuine re-elaboration of the problems with a concrete future projection.

Team:

Educators, social assistants, pedagogists, psychologists all with the same formation of community operators.

Result evaluation:

Positive results of remission from addiction, favouring the development of new ways of life.

There are further projects still in the stage of experimentation.

Support network:

Sert, Services for minors and mental health, Tribunal of minors, CSSA, Polyclinic of Modena, schools, social co-operatives.

6. Programme for rehabilitation from addiction

Location:

Comunità Terapeutica Il Sorriso
Via Codrignano 1/6
40021 Borgotossignano (BO)
Tel. +39 0542 914445

Aims:

Rehabilitation from addiction paying special attention to the subject of parenthood.

The intervention has the aim of studying in depth the theme of parenthood thus encouraging the woman to evaluate her own sensitivity and tendency towards maternity considering if necessary other paths such as fostering and adoption.

For whom:

Addicted mothers who reside in the community with their children.

Intervention methods:

Monthly meetings with group therapists; an operator is always present (mutual aid).

Other individual meetings are also foreseen, based on the needs of the individual client.

Team:

Sociologists, pedagogues, psychologists and educators.

Support network:

Sert, Social services, Services for minors, school, tribunals, companies dealing with work possibilities.

7. Rehabilitation programme for addicted mothers.

Location:

Progetto Aurora
Cannaregio 4753/A
30100 Venezia
Tel. +39 041 5224619
Fax. +39 041 5221182

Aims:

Residential treatment with therapeutic and education initiatives; interventions of formation are added to favour the social and working rehabilitation of the women. The therapeutic project is elaborated with a series of services who are directly responsible for the care of the child and the services for addiction who take care of the adult.

For whom:

addicted mothers and their children.

Intervention methods:

Specialised therapeutic community, drug free to a great degree. The women admitted are already pharmaceutically “weaned”.

Therapeutic approach: individual and group psycho-therapy with a psycho-dynamic orientation. Sessions of interactive guidance are carried out to sustain the relationship with the child.

There are other group activities of an educational type to encourage the emancipation of the woman.

Team:

1 psychologist and psycho-therapeut director, 1 individual psychiatrist, 1 psychologist, 5 educators, 1 infant nurse and various volunteers.

Result evaluation:

Semestral follow-up, much therapeutic success notwithstanding the psychosocial gravity of the cases undergoing treatment.

Support network:

Commune di Venezia, public institutions (e.g. IRE), and a network of volunteer city archipelago. The programme is part of the interventions promoted by the Regione Veneto and is monitored by the University of Padua.

Innovative aspects:

It should be emphasised that reuniting the mother with the child is not understood as a therapeutic instrument in itself and is avoided for any therapeutic instrumentalisation of the child with regards the mother.

ANNEXE - 2

VADEMECUM

One of the main aims of this research is the wish to supply operators of the sector, doctors and all people who are involved or interested in this field with an instrument with which they can make comparisons and use for new ideas or suggestions. This includes the intention of a more detailed knowledge of the subject matter and improving their work.

Such an instrument presents itself in the form of a vade-mecum and was shaped by a collection of data that emerged from the best practices, focus groups, research results and personal experiences regarding the needs of female drug addicts and by certain preventive and therapeutic measures in the future.

In the construction of this vade-mecum items and suggestions regarding possible indicators that the sanitary operators should take into consideration when interacting with women with problems of drug addiction were chosen.

41 items were obtained from a selection of these indicators from different European countries and the connected welfare models. These vade-mecum were distributed amongst the participating researchers who weighted each item (variable from 0 to 10) according to two indicators. The first concerns the importance of the subject under examination, whereas the second concerns the extent the item can actually be carried out in a programme of intervention.

As is often the case, it is understandable both in relation to the programme and to the context in which we find them, that these two indicators will not always be in total harmony (for example, a suggestion may be of great importance but not very practical in a given situation).

The first 12 items that the researchers found to be of greater importance will now be outlined with the aim of supplying the operators with recommendations and more information regarding the problem of drug addicted women and therefore with the objective

of improving social politics and interventions and leading to a decrease in the request for drugs amongst women.

Item no. 9

Drawing more attention to the gender identity especially to women's problems in the training of professional programmes in drug-addiction services. The intervention programmes should provide different methodologies and approaches, while paying particular attention to the female dimension.

Item no. 31

Institutions such as schools, hospitals and youth administration should be made much more aware of recognising early symptoms of drug consumption and traumatic behaviour.

Staff training about drug addiction and difficult child development are very necessary in many institutions.

Item no. 20

Carrying out campaigns of sexual information for those groups at risk. The improvement of information about the responsibility of motherhood and contraceptive methods in one possibility to reduce this problem

Item no. 36

Proposing examples which explain that a drug addicted female is exposed to more dangers, threats and abuse than a male.

Item no. 37

Children of addicted parents need the full attention of health and youth administration, family members, teachers, counsellors, etc. Very often they are left alone with the addiction of their parents.

Item no. 32

Establishing different treatments according to the sex of the patient in order to improve the capacity of the individual's decision and to avoid the condition of women's passive dependency in order to be the real protagonist of the treatment.

Item no. 26

Negative behaviour or characteristics are not exclusively a problem of drug addicts, but in many cases they are produced by a disoriented family environment (alcoholism of the father). In these cases, the intervention programmes can interrupt the circle of violence which starts from infancy and avoids the acceptance of the negative forms of behaviour of many women.

Item no.8

In parental meetings/programmes it is important to draw special attention to educational aspects of children/grandchildren, studying the lack of trust and fear regarding new uses of the patient and her waive of maternal responsibilities. It is necessary to train the parents to help them get used to the new status of their children and the progressive recovery of the children's protection.

Item no. 18

Awaken a better comprehension of the problems of their children in families of drug addicted women to help them overcome the sensation of shame, intolerance and betrayal regarding their expectations towards women (which are always higher than a man).

Item no. 34

During pregnancy addicted women need better help: very often they receive methadone. Women expressed the expectation that institutions such as hospitals should improve their care and treatment of women with problems of addiction.

Women expressed the need of an attendance that considers their circumstances of living and their abilities to quit the habit of drug consumption.

An MMP is seen as contra-indicated when there is a lack of co-operation on behalf of the pregnant woman, the consumption of other drugs continues and there is no chance to detoxify within a certain time.

Item no. 12

Prevention programmes must awaken teachers' understanding of certain emergency behaviour (which seem to be real requests for help). The marginalisation or expulsion from the school environment emphasises the problems.

Item no. 28

The treatment of young addicts requires much more than all the normal offers such as school education, well balanced pedagogical approaches (especially for "free time"), co-operation with family, consideration of traumatic experiences, good housing, stable

VADEMECUM

Objective: relevant items, results of the research, personal experiences and best practices collected in the field of drug-addicted women's needs and some future preventive and therapeutic actions.

*(DE = Germany; ES = Spain; IT = Italy)

N. ITEMS	Importance 0-10	Feasibility 0-10
1) Drug addiction of women shows a specific development that is quite different from the addiction process of men. (DE)		
2) It is desirable to develop educational and working programmes for women in order to improve their skills and elevate them at the same level of men. (ES)		
3) Improvement of epidemiological and quantitative knowledge about female drug-addiction in order to do comparative analyses between different countries with similar social and economic conditions, in the European Union and not. (IT)		
4) Female addicts show significantly more primary personal disorders. The rate of ‚borderline‘ disturbance is very obvious among addicted women. (DE)		
5) Each treatment must include also the family of drug-addicts in order to establish again the parental roles. (ES)		
6) Improvement of qualitative knowledge about the female drug-addiction in order to permit a better understanding of the this complex phenomenon. (IT)		
7) The high rate of personality problems derives from the circumstances of the upbringing of girls and juveniles: self destructive behaviour as symptom and response to aggression against girls (physical abuse, emotional abuse). (DE)		
8) In the parental meetings/programmes it is important to draw special attention to educational aspects of children / grandchildren, studying the lack of trust and fear about new uses of the patient and her waive of maternal responsibilities. It is necessary the training of the parents to get used to the new status of their children and the progressive recovery of the children protection. (ES)		
9) Drawing more attention to the gender identity especially woman's problems in the training professional programmes in drug-addiction services. The intervention programmes should provide different methodologies and approaches, with particular attention to female dimension. (IT)		
10) Addiction among women is often a secondary disturbance like bulimia etc. Also prostitution is often a symptom of early burdens in their families, and only a source to get money, easily. (DE)		

- 11) Improving the activity of information and changing behaviours of women, which have a drug-addicted partner in treatment, in order to avoid that women become drug-addicted for the identification with their partner. **(ES)**
- 12) Prevention programmes must awaken teachers about the understanding of some emergency behaviours (which seem real help requests). The margination or expulsion from the school environment emphasises problems. **(IT)**
- 13) Drug consumption is therefore a substitute / a medium to overcome personal fear and traumatic experiences. **(DE)**
- 14) Development of health education programmes especially concerning the obtaining of the syringes, in order to avoid sharing material. **(ES)**
- 15) Establishing protected jobs in order to facilitate contacts with services operators. Awaken operators about the work problems: which should become a relevant part of the therapeutic and rehabilitation programme. It is desirable to take into account individual needs. **(IT)**
- 16) Symptoms like misbehaving in schools and learning deficits or attention deficit syndrome (ADS) are often consequences of severe problems during the individual development of girls. **(DE)**
- 17) The sexual education and the easy obtaining of contraceptive methods in sexual relations of drug-addicted women and also men partners is extremely important. It is necessary to make revisions systematically to drug-addicted women in treatment and also to those women who don't want or can not give up with drugs. **(ES)**
- 18) Awaken families of drug-addicted women about a better comprehension of problems of their children, help them to pass sensation of shame, intolerance and betrayal concerning the expectations towards women (which are always more than a man). **(IT)**
- 19) Women who tend to develop an addiction also tend to create symbiotic relationships very often. This can be called co-addiction. Co-addiction has to be treated like addiction. **(DE)**
- 20) Realizing campaigns of sexual information for those groups at risk. The improvement of information about the maternity responsible and the contraceptive methods is one of the possibility of reducing this problem. **(ES)**
- 21) Within the drug-addiction services, establishing places of comparison and conversation especially for women, in order to create proposals, suggestions, ideas directly to the "patients" without the intermediation of services. **(IT)**

- 22) Treatment of juvenile female addicts requires much higher efforts than treatment of women who developed addiction being adults. **(DE)**
- 23) Improving the help for basic needs of women could facilitate the access in the treatment services. Establish the contact with their family can improve a better treatment. **(ES)**
- 24) Promote the work between networks with a interaction of treatment services, social service and magistracy. This collaboration among services is directed to protect women and their underage children. **(IT)**
- 25) The prescription of methadone or codeine to juvenile people is a total fault of physicians and should be forbidden.
- 26) The negative behaviours or characteristics are not exclusive a problem of the drug-addicts, but in many cases they are produced by disoriented family environment (father's alcoholism). The intervention programmes in this cases can interrupt the violence spiral which exits from the infancy and avoid the acceptance of the negative behaviours of many women. **(ES)**
- 27) Analysing the needs more relevant and the replies of services. **(IT)**
- 28) Treatment of young addicts needs much more all the normal offers like school education, well balanced pedagogical approaches (especially for 'leisure time'), co-operation with family, consideration of traumatic experiences, good housing, stable relationships between team of therapists and client, etc. **(DE)**
- 29) Co-ordinate the different public services in order to offer a complete treatment concerning all the aspects of drug-addiction especially in relation to the female condition. **(ES)**
- 30) Analysing of the discriminations suffered by women of our sample-group and their way of supporting this problem of exclusion. **(IT)**
- 31) Institutions like schools, hospitals, youth administration should be much more aware to discover early symptoms of drug consumption and traumatic behaviour.
Staff training about drug addiction and difficult child development are very necessary in many institutions. **(DE)**
- 32) Establishing different treatments following the sex of patient in order to improve the capacity of individual decision and to avoid a condition of women's passive dependency, in order to be the real protagonist of the treatment. **(ES)**
- 33) Awaken operators about the possibility of using personal resources of women during the rehabilitation and revalue the femininity aspects, which were very often hidden during the drug-addiction. **(IT)**

- 34) During pregnancy addicted women need a better help: very often they receive methadone. Women expressed their expectation that institutions like hospitals improve their way of care and treatment in regard to addiction problems.

Women expressed their need of an attendance that considers their circumstances of living and their abilities to quit the habit of drug consumption.

A MMP is seen as contra-indicated when there is a lack of cooperation of the pregnant woman, the consumption of others drugs continues and there is no chance to detoxify in a certain time. **(DE)**

- 35) Development of intervention programmes in order to improve the work skills and education level: protected working programmes, social working rehabilitation programmes for women, development of the aftercare treatments in order to reduce the difficulties for women, when they have to pass from a drug-addicted behaviour to a social adapted normal behaviour. **(ES)**
- 36) Proposing examples, which explain as a drug-addicted is more exposed to dangers, threats and abuses than men. **(IT)**
- 37) Children of addicted parents need their full attention of health and youth administration, family members, teachers, counsellors etc. Very often they are left alone with the addiction of their parents. **(DE)**
- 38) Employing specialised and professional skills staff within treatments services. **(IT)**
- 39) There is a need for more abstinence orientated programs (AOP) especially for addicted women with children; like outpatient treatment or Therapeutic Communities (TC). **(DE)**
- 40) To support the re-integration of addicted women with children means to establish a program consisting of inpatient, abstinent therapy, good care for children, development of new relationships between mother and child, aftercare (housing), (part time) job offers or school courses, partner therapy, including the family, co-operation with paediatricians, long term day care for children. **(DE)**
- 41) There are new and exciting treatment projects for women / with children including the addicted / non-addicted partner that should be brought into public attention and into the attention of political responsible people.

The model of a professional structured TC can be seen as approach and as an intra-net for rehabilitation and re-integration of addicted women with children: a social model that is needed for so many people who still remain without effective help. **(DE)**

ANNEXE - 3

IREFREA:

Drug-addiction and gender identity

N. Questionnaire (reserved for the data processing)		ID
Country	A.1. Italy	<input type="checkbox"/> A.1
	2. Spain	<input type="checkbox"/> .2
	3. France	<input type="checkbox"/> .3
	4. Germany	<input type="checkbox"/> .4
	5. Portugal	<input type="checkbox"/> .5
Structure:	B.1. public	<input type="checkbox"/> B.1
	2. private	<input type="checkbox"/> .2
	C.1. in patient	<input type="checkbox"/> C.1
	2. diurnal	<input type="checkbox"/> .2
	3. out patient	<input type="checkbox"/> .3
Period of treatment:	D.1. from 0 up 6 months	<input type="checkbox"/> D.1
	2. from 6 months up 1 year	<input type="checkbox"/> .2
	3. from 1 year up 2 years	<input type="checkbox"/> .3
	4. 2 or more years	<input type="checkbox"/> .4
Type of treatment:	E.1. out patient	<input type="checkbox"/> E.1
	2. in patient	<input type="checkbox"/> .2
In treatment for (present substances of addiction): (<i>multiple choices</i>)		
	F.1: Heroin	<input type="checkbox"/> F.1
	2: Cocaine	<input type="checkbox"/> F.2
	3: Alcohol	<input type="checkbox"/> F.3
	4: Methadone	<input type="checkbox"/> F.4
	5: Psychoactive medicines (temgesic/roipnol/ecc.)	<input type="checkbox"/> F.5
	6: Other (specify)	<input type="checkbox"/> F.6

SCHOOL

1) How old are you? _____	1
2) Education: (admitted only 1 answer)	
1: Primary school	<input type="checkbox"/> 2.1
2: Secondary school	<input type="checkbox"/> .2
3: She didn't finish the compulsory education	<input type="checkbox"/> .3
4: She didn't finish the secondary school	<input type="checkbox"/> .4
5: Vocational school (2 - 3 years certificate)	<input type="checkbox"/> .5
6: Secondary school certificate	<input type="checkbox"/> .6
7: She didn't finish the university	<input type="checkbox"/> .7

- 8: Degree .8
- 9: Illiterate .9
- 10: Other (specify) _____ 2.10

3) Age of probable school interruption _____ 3

4) Which were the reasons of this interruption? (multiple choices)

- 1: Being a woman 4.1
- 2: Poor marks 4.2
- 3: Economic problems 4.3
- 4: Race 4.4
- 5: Politics 4.5
- 6: Culture 4.6
- 7: Religion 4.7
- 8: Drug misuse 4.8
- 9: Other possibilities (specify) _____ 4.9

5) How was your situation at school?

- 1: Good 5.1
- 2: Average .2
- 3: Insufficient .3

• When did your school problems start? _____

6) Are there any relation between these problems and your initiation to drugs?

- 1: Yes 6.1
- 2: No .2

If yes, in which sense? _____

7) Did your parents encourage you to attend school?

- 1: Yes, actively 7.1
- 2: Yes, but without particular interest .2
- 3: No, they was indifference .3
- 4: No, they interfere with me .4
- 5: Other (specify) _____ 7.5

8) If yes, why did they do it? (multiple choices)

- 1: personal convictions (education is important) 8.1
- 2: Discipline, severity 8.2
- 3: ambition/pride 8.3
- 4: other (specify) _____ 8.4

9) If no, why? (multiple choices)

- 1: personal convictions (education is not important) 9.1
- 2: disinterest 9.2
- 3: lack of ambition 9.3
- 4: lack of time 9.4
- 5: other possibilities (specify) _____ 9.5

10) At school, did you have close friends?

- 1: yes, a lot 10.1
- 2: yes, some .2
- 3: no, nobody .3
- 4: Other (specify) _____ 10.4

11) At school, have you ever felt discriminated against compared with other girls?

- 1: yes, often 11.1
- 2: yes, sometimes .2
- 3: No (*if no, go to n. 13*) .3

12) If yes, in your opinion which were the reasons of this discrimination? (multiple choices)

- 1: poor marks 12.1
- 2: socio-economic level 12.2
- 3: race 12.3
- 4: Religion 12.4
- 5: physical aspect/look/clothes 12.5
- 6: politics 12.6
- 7: culture 12.7
- 8: being a woman 12.8
- 9: drug misuse 12.9
- 10: Other (specify) _____ 12.10

• Could you explain the reason of your choice?
Please, give some examples? _____

13) At school, have you ever felt discriminated against compared with other male school-fellows?

- 1: Yes 13.1
- 2: No (*if no, go to n. 15*) .2

14) If yes, in your opinion which were the reasons of this discrimination? (multiple choices)

- 1: being a woman 14.1
- 2: physical aspect/look/clothes 14.2
- 3: culture 14.3
- 4: sex problems 14.4
- 5: Other 14.5

• Could you explain the reason of your choice?
Please, give some examples? _____

15) Do you think school answered to your idea of education?

- 1: yes, completely 15.1
- 2: Yes, partially .2
- 3: No, not at all .3

16) Are there some personal needs which school didn't satisfy? Which were they? (admitted only 1 answer)

- 1: Cultural 16.1
- 2: Social .2
- 3: friendly relations .3
- 4: relations with teachers .4
- 5: Othe .5

• Could you explain the reason of your choice? _____

17) At school, did they know about your drug-addiction? (multiple choices)

- 1: Yes, everybody 17.1
- 2: yes, just some close friends 17.2
- 3: yes, just some teachers 17.3
- 4: No, nobody 17.4
- 5: Other 17.5

18) If yes who informed them about your situation? (admitted only 1 answer)

- 1: yourself 18.1
- 2: other people .2
- 3: your parents .3
- 4: your teachers .4
- 5: Othe .5

19) What was the result? (multiple choices)

- 1: expelled from school 19.1
- 2: counselling through teacher 19.2
- 3: drug therapy 19.3
- 4: prosecution 19.4
- 5: parents informed 19.5
- 6: Other 19.6

// **Questionnaire incomplete in the school dimension** (if yes put a cross)

WORK

20) What was your job occupation during the last six months? (admitted only 1 answer)

- 1: unemployment 20.1
- 2: part-time .2
- 3: full-time .3
- 4: Other (specify) _____ 20.4

21) What kind of job? (admitted only 1 answer)

- 1: employee 21.1
- 2: free lance .2
- 3: commercial .3
- 4: worke .4
- 5: Other (specify) _____ 21.5

22) How do you describe your job situation?

- 1: stable 22.1
- 2: period of stability and period of instability .2
- 3: unstable .3

• Could you briefly describe your work situation during the last years? _____

• Did you have any problems? Which were they? ____

23) If your situation is unstable, are there any relations between these problems and your situation of drug-addiction?

- 1: Yes 23.1
- 2: No .2

• If yes, which are they? _____

• If no, why do you think there isn't any relation? ____

24) Does/Did your employer know about your drug-addiction?

- 1: Yes 24.1
- 2: No .2

25) Who informed him about your situation? (admitted only 1 answer)

- 1: yourself 25.1
- 2: other people .2

• What reactions were there? _____

26) At work, have you ever felt discriminated against compared with other people?

- 1: Yes, often 26.1
- 2: Yes, sometimes .2
- 3: No .3

27) If yes, in your opinion which were the reasons of this discrimination? (multiple choices)

- 1: being a woman 27.1
- 2: insufficient production 27.2
- 3: socio-economic level 27.3
- 4: Race 27.4
- 5: politics 27.5
- 6: culture 27.6
- 7: physical aspect/look/clothes 27.7
- 8: religion 27.8
- 9: drug misuse 27.9
- 10: Other (specify) 27.10

• Could you explain the reason of your choice?
Please, give some examples? _____

28) If you have ever felt discriminated against because you abused of drugs, in your opinion which were the reasons of this discrimination? (multiple choices)

- 1: insufficient production 28.1
- 2: physical aspect/look/clothes 28.2
- 3: being a woman 28.3
- 4: fear and prejudices about the honesty 28.4
- 5: fear and prejudices about the diseases 28.5
- 6: poor knowledge about the problem 28.6
- 7: absenteeism 28.7
- 8: Other 28.8

• Could you explain the reason of your choice?
Please, give some examples? _____

• As a woman, what are your occupational needs (in
the field of job)? _____

• Are your occupational needs (job needs) satisfied?

// Questionnaire incomplete in the work dimension (if yes put a cross)

DRUGS

29) When did you start using drugs? (age)? 29

30) Indicate with a progressive number the sequence of drugs in temporal order

- | | | |
|---|--------------------------|------|
| 1: Cannabis/marijuana | <input type="checkbox"/> | 30.1 |
| 2: heroine | <input type="checkbox"/> | 30.2 |
| 3: Cocaine | <input type="checkbox"/> | 30.3 |
| 4: hallucinogens | <input type="checkbox"/> | 30.4 |
| 5: Ecstasy | <input type="checkbox"/> | 30.5 |
| 6: Alcohol | <input type="checkbox"/> | 30.6 |
| 7: Methadone | <input type="checkbox"/> | 30.7 |
| 8: psychoactive medicines (temgesic/roipnol/ecc.) | <input type="checkbox"/> | 30.8 |
| 9: Other (no coffee or tobacco) | <input type="checkbox"/> | 30.9 |

31) Where did you do your early experiences? (*multiple choices*)

- | | | |
|--------------------------|--------------------------|------|
| 1: at school | <input type="checkbox"/> | 31.1 |
| 2: with friends | <input type="checkbox"/> | 31.2 |
| 3: in the street | <input type="checkbox"/> | 31.3 |
| 4: at work | <input type="checkbox"/> | 31.4 |
| 5: Other (specify) _____ | <input type="checkbox"/> | 31.5 |

32) Why? (*multiple choices*)

- | | | |
|----------------------------------|--------------------------|------|
| 1: curiosity | <input type="checkbox"/> | 32.1 |
| 2: identification with a group | <input type="checkbox"/> | 32.2 |
| 3: identification with a partner | <input type="checkbox"/> | 32.3 |
| 4: escape from personal problems | <input type="checkbox"/> | 32.4 |
| 5: Other | <input type="checkbox"/> | 32.5 |

• What did you feel? _____

33) How old were you when you started using hard drugs?

33

34) Who did you share your first experiences of hard drugs with? (*admitted only 1 answer*)

- 1: Partner 34.1
- 2: a friend (male or female) 34.2
- 3: some friends 34.3
- 4: some strangers 34.4
- 5: brother or sister 34.5
- 6: Other (specify) _____ 34.6

• Why? _____

35) Why? (*multiple choices*)

- 1: Curiosity 35.1
- 2: identification with a group 35.2
- 3: identification with a partner 35.3
- 4: escape from personal problems 35.4
- 5: Other 35.5

• What did you feel? _____

36) Did your partner of that period take drugs?

- 1: Yes 36.1
- 2: No .2
- 3: I didn't have a partner (*go to question n. 39*) .3

37) If yes, what kind of substance did he take? (*multiple choices*)

- 1: Cannabis/marijuana 37.1
- 2: heroin 37.2
- 3: Cocaine 37.3
- 4: hallucinogens 37.4
- 5: Ecstasy 37.5
- 6: Alcohol 37.6
- 7: Methadone 37.7
- 8: psychoactive medicines(temgesic/roipnol/ecc.) 37.8
- 9: Other 37.9

38) If your partner used to take drugs, do you think his situation influenced your initiation to drugs?

- 1: Yes, completely 38.1
- 2: Yes, partly .2
- 3: No, not at all .3
- 4: No, I have never thought about it .4
- 5: Other .5

• In which sense? _____

• When was your worse moment? _____

39) Have you ever attempted suicide?

- 1: Yes, once 39.1
- 2: Yes, several times .2
- 3: No, never .3

40) If yes, how old were you your first time? _____ 40

41) Are there any episodes of overdose during your history?

- 1: Yes, an episode 41.1
- 2: Yes, different episodes .2
- 3: No, never .3

Could you explain how it happened? _____

Could you describe your personal situation in that moment? _____

42) For the reason of overdose or for the attempted suicide were you hospitalised?

- 1: Yes 42.1
- 2: No (*if not, go to n.49*) .2

• How did doctors and the staff behave towards you?

- 43) Do you remember what you needed in that moment? (multiple choices)**
- 1: medical treatments 43.1
 - 2: psychological support 43.2
 - 3: economic support 43.3
 - 4: family support 43.4
 - 5: Other 43.5
- 44) In your opinion, did anybody answer to your needs in that moment? Who? (multiple choices)**
- 1: Partner 44.1
 - 2: relatives 44.2
 - 3: friends 44.3
 - 4: doctors 44.4
 - 5: nobody 44.5
 - 6: Other 44.6
- 45) Are there any needs which were disappointed?**
- 1: Yes 45.1
 - 2: No (*if not, go to n.47*) .2
- 46) If yes, by whom? (multiple choices)**
- 1: Partner 46.1
 - 2: relatives 46.2
 - 3: friends 46.3
 - 4: doctors 46.4
 - 5: Other 46.5
- 47) If you have ever felt discriminated against compared with other patients, in your opinion which were the reasons of this discrimination? (multiple choices)**
- 1: being a woman 47.1
 - 2: physical aspect/look/clothes 47.2
 - 3: Race 47.3
 - 4: socio-economic reasons 47.4
 - 5: attitudes 47.5
 - 6: drugs misuse, overdose 47.6
 - 7: suicide attempt 47.7
 - 8: Other 47.8
- 48) If you have ever felt discriminated against compared with other patients, because you were addicted drugs, which were the reasons of this discrimination? (multiple choices)**
- 1: physical aspect/look/clothes 48.1
 - 2: age 48.2
 - 3: socio-economic reasons 48.3
 - 4: attitudes 48.4

- 5: danger of diseases 48.5
- 6: bad knowledge of problem 48.6
- 7: prejudices about the honesty 48.7
- 8: type of visitors 48.8
- 9: Other 48.9

• How did people react? (Parents, friends, partner)___

49) How old were you when you start to be in touch with drug-addiction services?

49

• Which were they? _____

50) Have/had you any other addictions? (multiple choices)

- 1: Alcohol 50.1
- 2: psychoactive medicines 50.2
- 3: Other (specify) _____ 50.3

51) During your drug-addiction, have you ever use syringes?

- 1: No 51.1
- 2: Yes, but it always my syringe .2
- 3: Yes sometimes exchanged with other people .3
- 4: Yes often exchanged with other people .4

52) During your early experience of hard drugs, which have been the modalities of assumption? (admitted only 1 answer)

- 1: injection 52.1
- 2: oral administration .2
- 3: inhalation (to sniff) .3
- 4: oxidation (to smoke) .4

53) Did you follow any other treatments before?

- 1: No 53.1
- 2: from 1 to 3 .2
- 3: more than 3 .3

54) If you left the last treatment, which were the reasons? (multiple choices)

- 1: economic troubles 54.1
- 2: difficulty of following the treatment and my children 54.2
- 3: it didn't answer to my expectations 54.3
- 4: relapse on drug-addiction 54.4
- 5: Other (specify) _____ 54.5

55) Which were the reasons? (only 1 answer)

- 1: personal reasons (desire, etc.) 55.1
- 2: to reaction of external causes (family, work troubles, etc.) .2
- 3: my partner used drugs .3
- 4: Other .4

• Specify your answer? _____

56) In the time when you were using drugs, what were your main resources of income? (only 1 answer)

- 1: My own income from regular work 56.1
- 2: Support by the State (welfare, unemployment support, etc.) .2
- 3: Financed by steady partner .3
- 4: Financed by parents or mother/father .4
- 5: Financed by relatives or friends .5
- 6: Not legal sources of income (dealing, rubbery, prostitution) .6

Questionnaire incomplete in the drugs dimension (if yes put a cross)

AFFECTIONS AND FEELINGS

57) Civil status:

- 1: married 57.1
- 2: separated/divorced .2
- 3: single .3
- 4: cohabitant .4
- 5: widow .5
- 6: other .6

58) Accommodation: (multiple choices)

- 1: with your family 58.1
- 2: with your partner 58.2
- 3: on your own 58.3
- 4: with your child/children 58.4
- 5: Other 58.5

59) Conditions:

- 1: good 59.1
- 2: acceptable .2
- 3: sufficient .3
- 4: poor .4
- 5: nothing .5

60) Present relationship: (only 1 answer)

- 1: Partner (man) 60.1
- 2: Partner (woman) .2
- 3: husband .3
- 4: nobody (go to question n. 66) .4

61) When did your present relationship start?

- 1: less than 1 year ago 61.1
- 2: more than 1 year ago .2

62) How do you consider it? (only 1 answer)

- 1: Stable 62.1
- 2: unstable .2
- 3: temporary .3
- 4: Definitive .4
- 5: Other .5

63) Does your present partner take drugs?

- 1: Yes 63.1
- 2: No .2

64) Did your present partner take drugs?

- 1: Yes 64.1
- 2: No (go to question n. 66) .2

65) If yes what kind of substance? (multiple choices)

- 1: Cannabis/marijuana 65.1
- 2: heroine 65.2
- 3: Cocaine 65.3
- 4: hallucinogens 65.4
- 5: Ecstasy 65.5
- 6: Alcohol 65.6
- 7: Methadone 65.7
- 8: psycho active medicines(temgesic, roipnol, ecc.) 65.8
- 9: Other 65.9

• Do you think the drug-addiction of your partner had any influence on yours? In which sense? _____

66) How many sexual partners did you have in the last six months?

- 1: nobody, I didn't have any sexual relations 66.1
- 2: one partner .2
- 3: from 2 to 3 partners .3
- 4: more than 3 partners .4

- 67) Do you use any contraceptives during your relationships?**
- 1: nothing 67.1
 - 2: sometimes .2
 - 3: always, except for my habitual partner .3
 - 4: always .4

- 68) Have you ever prostitute yourself?**
- 1: No 68.1
 - 2: Yes, cause of my drug-addiction .2
 - 3: Yes, for other reasons .3

// **Questionnaire incomplete in the drugs dimension** (if yes put a cross)

MATERNITY (if she hasn't any children go to n. 79)

- 69) How many children have you got?** _____ 69

- 70) How old are they?** (write 0 if less than 1 year) _____ 70.1
- _____ 70.2
- _____ 70.3
- _____ 70.4
- _____ 70.5

- 71) How is their school situation?** (put a cross for each child)
- 1: nothing 71.1
 - 2: nursery (0-3) 71.2
 - 3: nursery school (3-6) 71.3
 - 4: primary school (7-10) 71.4
 - 5: secondary school (11-14/15) 71.5
 - 6: secondary school (15-19/20) 71.6

- 72) Do your children give you cause to worry regarding their physical health?**
- 1: Yes 72.1
 - 2: Yes, in the past .2
 - 3: No .3

- 73) Which were your worries?** (multiple choices)
- 1: food 73.1
 - 2: sleep/waking 73.2
 - 3: chronic diseases 73.3
 - 4: accidents 73.4
 - 5: hospitalisations 73.5

- 74) Do your children give you cause to worry regarding their behaviour?**
- 1: Yes 74.1
 - 2: Yes, in the past .2
 - 3: No .3

75) Which were your worries? (multiple choices)

- 1: language 75.1
- 2: character 75.2
- 3: deambulation 75.3
- 4: emotional troubles 75.4

76) Who do your children live with? (multiple choices)

- 1: yourself 76.1
- 2: grandparents 76.2
- 3: father 76.3
- 4: relatives 76.4
- 5: in an institute 76.5
- 6: with a guardian family 76.6
- 7: other 76.7

77) Who take the parental authority?

- 1: parents 77.1
- 2: relatives .2
- 3: grandparents .3
- 4: social services .4
- 5: other .5

78) Is your present partner their father?

- 1: Yes 78.1
- 2: No .2

79) Have you ever had any termination of pregnancy? (spontaneous or voluntary) (multiple choice)

- 1: Yes, spontaneous 79.1
- 2: Yes, voluntary 79.2
- 3: No (*if not, go to n. 89*) 79.3

80) The last one termination, at which month of pregnancy? _____ 80

81) How was the last termination? (only 1 answer)

- 1: spontaneous 81.1
- 2: individual choice .2
- 3: necessity (not physical health problems) .3
- 4: physical problems .4

• If voluntary, is it related to your drug-addiction? __

• Could you describe your personal situation in that moment? _____

82) For the last termination, have you been hospitalised?

- 1: Yes 82.1
2: No (*if not, go to n. 89*) .2

• How did doctors and the staff behave towards you?

83) Do you remember what you needed in that moment? (multiple choices)

- 1: medical treatments 83.1
2: psychological support 83.2
3: economic support 83.3
4: family support 83.4
5: Other 83.5

84) In your opinion, did anybody answer to your needs in that moment? Who? (multiple choices)

- 1: Partner 84.1
2: relatives 84.2
3: friends 84.3
4: doctors 84.4
5: nobody 84.5
6: Other 84.6

85) Were there any needs which were disappointed? By whom? (multiple choices)

- 1: Partner 85.1
2: relatives 85.2
3: friends 85.3
4: doctors 85.4
5: Other 85.5

86) If you have ever felt discriminated against compared with other patients, in your opinion which were the reasons of this discrimination? (multiple choices)

- 1: physical aspect 86.1
2: age 86.2
3: race 86.3
4: socio-economic reasons 86.4
5: attitudes 86.5

- 6: drug-addiction 86.6
- 7: prejudices about honesty 86.7
- 8: Other 86.8

87) If you have ever felt discriminated against compared with other patients, because you were addicted drugs, in your opinion which were the reasons of this discrimination? (multiple choices)

- 1: physical aspect/look/clothes 87.1
- 2: age 87.2
- 3: Race 87.3
- 4: socio-economic reasons 87.4
- 5: attitudes 87.5
- 6: danger of diseases 87.6
- 7: bad knowledge of problem 87.7
- 8: prejudices about the honesty 87.8
- 9: Other 87.9

Concerning your last pregnancy:

88) How old is your baby? (write 0 if less than 1 year) _____ 88

89) Your baby was conceived during:

- 1: occasional relationship 89.1
- 2: stable relationship .2
- 3: relationship with your present partne .3
- 4: Other .4

90) It was:

- 1: planned 90.1
- 2: not planned .2

91) Did you take any drugs before pregnancy?

- 1: yes 91.1
- 2: No .2

92) Did you take any drugs during pregnancy?

- 1: Yes 92.1
- 2: No .2

93) If yes, until which month? _____ 93.1

94) Did you notice any variations of your drug-addiction during your pregnancy?

- 1: decrease 94.1
- 2: increase .2
- 3: no variations .3

95) During your pregnancy, did you follow a methadone programme?

- 1: Yes 95.1
2: No .2

96) If yes, until which month did you follow this therapy with “scaling down”?

_____ 96

97) Did you interrupt it??

- 1: yes 97.1
2: No .2

98) Were there any problems?

- 1: yes 98.1
2: No .2

• If yes, what kind of problems? _____

• Which where your main problems during your pregnancy? _____

• Where did you live during your pregnancy? _____

99) During your pregnancy, did you do any control or gynaecological tests?

- 1: Yes 99.1
2: No .2

• If yes, what kind of tests? _____

• If no, why? _____

100) During your pregnancy and the birth, did you rely on drug-addiction services?

- 1: Yes 100.1
2: No .2

• If yes, which services? _____

• If no, why? _____

• Could you describe your personal situation in that moment? _____

• How did doctors and the staff behave towards you?

101) Did you remember what you needed in that moment? (multiple choices)

- 1: medical treatments 101.1
- 2: psychological support 101.2
- 3: economic support 101.3
- 4: family support 101.4
- 5: Other 101.5

102) If there were any needs which were disappointed, By whom? (multiple choices)

- 1: Partner 102.1
- 2: relatives 102.2
- 3: friends 102.3
- 4: doctors 102.4
- 5: Other 102.5

103) During your pregnancy control, have you ever felt discriminated against compared with other patients?

- 1: Yes 103.1
- 2: No 103.2

104) If yes, in your opinion which were the reasons of this discrimination? (multiple choices)

- 1: physical aspect/look/clothes 104.1
- 2: age 104.2
- 3: race 104.3
- 4: socio-economic reasons 104.4
- 5: attitudes 104.5
- 6: drug-addiction 104.6
- 7: Other 104.7

105) If you have ever felt discriminated against compared with other patients, because you were drug-addicted, in your opinion which were the reasons of this discrimination? (multiple choices)

- 1: physical aspect/look/clothes 105.1
- 2: socio-economic reasons 105.2
- 3: attitudes 105.3
- 4: danger of diseases 105.4
- 5: bad knowledge of problem 105.5
- 6: prejudices about honesty 105.6
- 7: Other 105.7

106) How was the birth?

- 1: caesarean birth 106.1
2: Eutocia .2

107) Your baby was born:

- 1: At term 107.1
2: Premature birth .2

• How did doctors and the staff behave towards you?

108) Were there any complications for your baby and you during or after the delivery?

- 1: Yes, for me 108.1
2: Yes, for my baby .2
3: Yes, for both .3
4: No .4

109) Was the baby on abstinence crisis?

- 1: Yes 109.1
2: No .2

110) Was the baby hospitalised in paediatrics?

- 1: Yes 110.1
2: No .2

How long? _____
How did doctors and the staff behave towards your baby? _____

111) Do you think that your baby was discriminated against compared with other patients?

- 1: Yes 111.1
2: No .2

If yes, in your opinion which were the reasons of this discrimination? _____

112) Have you ever thought that your baby was discriminated against cause of your drug-addiction?

- 1: Yes 112.1
2: No .2

// Questionnaire incomplete in the maternity dimension (if yes put a cross)

LEGAL DIMENSION

113) Have you actually pending prosecutions?

- 1: Yes 113.1
2: No (*if not, go to n. 116*) .2

• If yes, could you describe your present situation? _____

114) Typology of the crime (multiple choices)

- 1: crime against property 114.1
2: crime against person 114.2
3: crime against drug law 114.3
4: Other 114.4

115) Duration of the punishment (write 0 if less than 1 year) _____ 115

116) Have you got judicial problems?

- 1: Yes 116.1
2: No (*if not, go to n. 126*) .2

117) Typology of the crime (multiple choices)

- 1: crime against property 117.1
2: crime against person 117.2
3: crime against drug law 117.3
4: crime against public administration 117.4
5: Other 117.5

118) Did you benefit from probation?

- 1: Yes 118.1
2: No .2

119) Did you spend any detention periods?

- 1: Yes 119.1
2: No (*if not, go to n. 126*) .2

120) How long was the last one? (write 0 if less than 1 year) _____ 120

121) Did your children visit you?

- 1: Yes 121.1
2: No .2

• If no, why? _____

- Which of them visited you? _____

- What did these visits mean to you? _____

- What did these visits mean to your child? _____

122) Have you ever spent any periods in prison with your children?

- 1: Yes, one time 122.1
- 2: No .2
- 3: Yes, several times .3

- Did your children suffer any consequences after your imprisonment? _____

- How was prison? _____

- How did the staff behave? _____

- How were the other prisoners? _____

123) Do you remember what you needed in that moment? (multiple choices)

- 1: medical treatments 123.1
- 2: psychological support 123.2
- 3: economic support 123.3
- 4: Other 123.4

124) If there are any needs which were disappointed, by whom? (multiple choices)

- 1: Partner 124.1
- 2: relatives 124.2
- 3: friends 124.3
- 4: doctors 124.4
- 5: Other 124.5

125) Have you ever felt discriminated against compared with other prisoners?

- 1: Yes 125.1
- 2: No .2

- If yes, in your opinion which were the reasons of this discrimination? _____

• Have you ever felt discriminated against compared with other prisoners, because you were addicted to drugs? _____

• If yes, in your opinion which were the reasons of this discrimination? _____

// **Questionnaire incomplete in the legal dimension** (if yes put a cross)

PHYSICAL HEALTH

126) Do you have any severe health problems?

- 1: Yes 126.1
2: No (*if not, go to n. 128*) .2

127) If yes, what kind of problems? (multiple choices)

- 1: seropositive 127.1
2: hepatitis B 127.2
3: hepatitis C 127.3
4: dental problems 127.4
5: Other 127.5

128) In your life, have you ever suffered any abuses?

- 1: Yes, often 128.1
2: Yes, sometimes .2
3: No (*if not, go to n. 132*) .3

129) What kind of abuse did you suffer? (multiple choices)

- 1: psychological 129.1
2: physical 129.2
3: sexual 129.3
4: exploitation 129.4
5: Other (specify) _____ 129.5

• Which were the reasons? _____

• Are there any relations with your condition of drug-addiction? _____

• Could you consider one of these abuses as a real assault? _____

130) If yes, from whom? (multiple choices)

- 1: father 130.1
- 2: brothers 130.2
- 3: relatives 130.3
- 4: friends 130.4
- 5: Partner 130.5
- 6: people known by chance 130.6
- 7: strangers 130.7
- 8: mother 130.8
- 9: Other 130.9

131) When did it happen?(multiple choices)

- 1: Infancy (0-11 years old) 131.1
- 2: Youth (12-18 years old) 131.2
- 3: Adult age (after 18 years old) 131.3

Questionnaire incomplete in the physical health dimension

(if yes put a cross)

FAMILY

MOTHER:

alive

 M.1

dead

 .2

132) Age _____ 132

133) Civil status:

- 1: married 133.1
- 2: separated /divorced .2
- 3: single .3
- 4: cohabitant .4
- 5: widow .5

134) Does/did she has any problems of abuse of substances:

- 1: Yes 134.1
- 2: No *(if not, go to n. 139)* .2

135) What kind of substance? (multiple choices)

- 1: hard drugs 135.1
- 2: soft drugs 135.2
- 3: Alcohol 135.3
- 4: psycho active medicines 135.4
- 5: Other 135.5

136) How old were you when you realised your mother started taking drugs? 136

- 137) How old were you when you realised your mother was drinking alcohol? 137
- 138) How old when you realised your mother was taking psycho-treatments? 138
- 139) Emotional troubles (psychological/psychiatric)?
- | | | |
|-----------------------------|--------------------------|-------|
| 1: Yes, in the past | <input type="checkbox"/> | 139.1 |
| 2: Yes, also at this moment | <input type="checkbox"/> | .2 |
| 3: No | <input type="checkbox"/> | .3 |
- 140) Does/did she has any problems of commission of crimes?
- | | | |
|-----------------------------|--------------------------|-------|
| 1: Yes, in the past | <input type="checkbox"/> | 140.1 |
| 2: Yes, also at this moment | <input type="checkbox"/> | .2 |
| 3: No | <input type="checkbox"/> | .3 |
- 141) Has she ever been followed by any health services?
- | | | |
|--------|--------------------------|-------|
| 1: Yes | <input type="checkbox"/> | 141.1 |
| 1: No | <input type="checkbox"/> | .2 |
- FATHER:
- | | | |
|---------|--------------------------|------|
| alive | <input type="checkbox"/> | PV.1 |
| dead | <input type="checkbox"/> | .2 |
| unknown | <input type="checkbox"/> | .3 |
- 142) Age _____ 142
- 143) Civil status:
- | | | |
|-----------------------|--------------------------|-------|
| 1: married | <input type="checkbox"/> | 143.1 |
| 2: separated/divorced | <input type="checkbox"/> | .2 |
| 3: single | <input type="checkbox"/> | .3 |
| 4: cohabitant | <input type="checkbox"/> | .4 |
| 5: widowed | <input type="checkbox"/> | .5 |
- 144) Does/did he has any problems of abuse of substances:
- | | | |
|---------------------------------------|--------------------------|-------|
| 1: Yes | <input type="checkbox"/> | 144.1 |
| 2: No (<i>if not, go to n. 149</i>) | <input type="checkbox"/> | .2 |
- 145) What kind of substance? (*multiple choices*)
- | | | |
|----------------------------|--------------------------|-------|
| 1: hard drugs | <input type="checkbox"/> | 145.1 |
| 2: soft drugs | <input type="checkbox"/> | 145.2 |
| 3: Alcohol | <input type="checkbox"/> | 145.3 |
| 4: psycho active medicines | <input type="checkbox"/> | 145.4 |
| 5: Other | <input type="checkbox"/> | 145.5 |
- 146) How old were you when you realised your father started taking drugs? 146
- 147) How old were you when you realised your father was drinking alcohol? 147

148) How old when you realised your father was taking psycho-treatments? 148

149) Emotional troubles (psychological/psychiatric)

- 1: Yes, in the past 149.1
2: Yes, also at this moment .2
3: No .3

150) Does/did she has any problems of commission of crimes?

- 1: Yes, in the past 150.1
2: Yes, also at this moment .2
3: No .3

151) Has he ever been followed by any health services?

- 1: Yes 151.1
1: No .2

BROTHERS AND/OR SISTERS

(if she haven't brothers or sisters the questionnaire is end)

152) Drug addiction:

- 1: Yes 152.1
2: No *(if not, the questionnaire is end)* .2

153) What kind of addiction? (multiple choices)

- 1: drugs 153.1
2: Alcohol 153.2
3: psycho active medicines 153.3
4: Other 153.4

154) Brothers/sisters with psycho troubles or diseases, suicide attempts, commission of crimes

- 1: Yes 154.1
1: No .2

Questionnaire incomplete in the family dimension *(if yes put a cross)*

QUESTIONNAIRE COMPLETE in each dimension *(if yes put a cross)*

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