

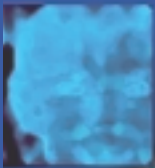
Family: the challenge of prevention of drug use

■ **Authors:** Fernando Mendes, A. P. Relvas, A. Olaio, M. Rovira, G. Broyer, S. Pietralunga, K. Borhn, J. L. Recio



Financed with the assistance of the
EUROPEAN COMMISSION

I R E F R E A



**FAMILY:
THE CHALLENGE OF
PREVENTION OF DRUG
USE**

Research Coordinator: F. Mendes

Book Coordinator: A. P. Relvas

FAMILY: THE CHALLENGE OF PREVENTION OF DRUG USE

Authors: Fernando Mendes, A. P. Relvas, A. Olaio, M. Rovira,
G. Broyer, S. Pietralunga, K. Borhn, J. L. Recio

Translation:
Raquel Mendes



Financed with the assistance of the
EUROPEAN COMMISSION

I R E F R E A



This book and other IREFREA books can be downloaded in www.irefrea.org

ORGANISATIONS, INSTITUTIONS AND NATIONAL RESEARCH GROUPS PARTICIPATING IN THIS RESEARCH

IREFREA AUSTRIA

President: Karl BOHRN
Institute for Social and Health Psychology/
Institut für Sozial- und Gesundheitspsychologie
(ISG)
A-1060 Wien (Austria); Linke Wienzeile 112/4
Tel. (+431) 786 18 10 - Fax (+431) 786 18 10-7
E-mail: IREFREA@chello.at
isg@chello.at
ISGWien@gmx.net

IREFREA DEUSCHTLAND

President: Horst Brömer
Mellener Str. 53
12307 Berlin-Germany
Tel. +49 30 7440213 - Fax: +49 30 76403229
E-mail: irefrea.d@gmx.de

IREFREA SPAIN

President: Amador Calafat
Researchers: Juan Luis Recio, Enrique Gil,
Montserrat Juan, Cesáreo Fernández
Rambla, 15 (2-3)
07003 Palma de Mallorca-España
Tel. +34 971727434 - Fax +34 971213306
E-mail: irefrea@correo.cop.es
irefrea@irefrea.org

IREFREA FRANCE

President: Gérard Broyer
Universite Lumiere Lyon 2
Institut de Psychologie
5, avenue Pierre Mendes France
CP 11 69976 Bronx Cedex - France
Tel. +33 47872433 / +33 478772319
Fax +33 478722217
E-mail: broyer@univ-lyon2.fr

IREFREA GREECE

President: Anna Kokkevi
President of OKANA (Organization Against
Drugs)
Associate Professor
Averof 21
104-33 Athens
Tel: +301-8253763
Fax: +301-8225663
E-mail: president@okana.gr

IREFREA ITALIA

President: Paolo Stocco
C.T. Villa Renata
Via Orsera, 4
30126 Lido di Venezia - Italy
Tel. +39 041 5268822 - Fax +39 041 5267874
E-mail: irefrea@villarenata.org

IREFREA PORTUGAL

President: Fernando Mendes
Urb. Construr Lote 6 (7-B)
Predio Bascal
3030 Coimbra - Portugal
Tel. +351 (0) 39 483081 / +351 (0) 39 981202
Fax +351 (0) 39 487265
E-mail: irefrea@esoterica.pt

ISTITUTO DI MEDICINA LEGALE

Prof. Francesco de Fazio,
Dra. Susana Pietralunga
UNIVERSITA DI MODENA
Policlinico. Via del Pozzo, 71
41100 MODENA - ITALIA
Tel.: +39 59 422088 /89 /90 /91
Fax: +39 59 371393
E-mail: medlegmo@unimo.it

© IREFREA

I.S.B.N.: 84-931947-1-9

D. Legal: V-3771-2001

IREFREA ESPAÑA

Rambla, 15, 2º, 3ª E

07003 Palma de Mallorca (ESPAÑA)

Print: MARTIN IMPRESORES, S.L. • Pintor Jover, 1 • 46013 Valencia

INDEX

	Pág.
1. INTRODUCTION	11
2. DRUG USE AND PRIMARY PREVENTION	15
2.1. Social and Historical Framework	15
2.2. From the Idea of Prevention to the Science of Prevention	16
2.3. The State of the Art	19
3. THEORETICAL MODELS AND DRUG USE PREVENTION	23
3.1. Informative – Communicative Model	24
3.2. Humanist Model	25
3.3. Integrative and Comprehensive Models	27
3.3.1. Social Learning Theories – neo-behaviourist perspectives	28
3.3.2. Interactional Approach	29
3.3.3. Behaviour-Problem Theory	30
3.3.4. Social Development Model	30
3.3.5. Life Style Model and Risk Factors	31
3.3.6. Ecological Model	32
3.4. Conclusions	33
4. STRATEGIES AND PREVENTION PROGRAMS	35
4.1. Prevention Programs	37
4.1.1. Definition and Principles	37
4.1.2. Articulating Risk and Protective Factors	38
4.2. Application Contexts	40
4.2.1. Family Context	40
4.2.2. School Context	43
4.2.3. Community Context	44
4.3. Final Considerations	44
5. META-ANALYSIS OF THE PRIMARY PREVENTION FAMILY PROGRAMS IN FIVE EUROPEAN COUNTRIES	47
5.1. General Considerations and Research Goals	47
5.2. Construction of a Description and Evaluation Grid of the Prevention Activities or Programs	48
5.3. Methodology	52
5.4. Analysis and Discussion of the Results	53
5.4.1. Procedures and Sample	53
5.4.2. Comparative Analysis per Country	55
5.4.2.1. Level I Activities	55

	<u>Pág.</u>
5.4.2.2. Level II Activities	58
5.4.3. Meta-analysis of the Five Countries' Projects	63
5.4.3.1. Level I Activities	63
5.4.3.2. Level II Activities	64
5.5. Conclusions	66
6. CONTRIBUTIONS TO PRIMARY PREVENTION FOCUSED ON THE FAMILY	69
6.1. Introduction – The Logic Underlying IREFREA’s Investigation	69
6.2. Prevention and the Search for Spiritual Support as a Family Coping Dimension: a psycho-analytic perspective	71
6.2.1. The Research Conducted by IREFREA	71
6.2.2. Family Coping in Adolescence: a psychoanalytic approach	72
6.2.2.1. Our Relationship to Reality	73
6.2.2.2. The Reality of Family Relationships in Relation to Psychosexuality	74
6.2.2.3. Family Coping	76
6.2.3. The Search for Spiritual Support	77
6.2.3.1. “Drink to Seek God”	78
6.2.3.2. Reflections on the Prevention of Natural Catastrophes	80
6.2.4. Conclusion: prevention and coping as seeking for spiritual support ..	82
6.3. Primary Prevention Initiatives in Family Contexts: the changing family ..	82
6.3.1. The Birth of the Family: the significance of “change”	82
6.3.1.1. Cultural and Structural Changes in Italian Families: the analysis in scientific literature	82
6.3.1.2. Current Custom’s “Trends” and Their Incidence on the Basic Assumptions for Starting a Family	83
6.3.1.3. The Birth of the Family: new dynamics between the partners ..	85
6.3.1.4. New Dynamics, Not New “Models”: the lack of cultural reference models	86
6.3.1.5. The Influence on Prevention Initiatives	87
6.3.2. Family Life Dynamics: from “change” to “conflict”	88
6.3.2.1. Family Life Cycle: family dynamics and cultural transition ..	88
6.3.2.2. The Extent of “Change”	89
6.3.2.3. The Shifting from “Change” to “Conflict”: reflections on social policies in primary prevention interventions	90
6.4. The Family Life Cycle: a Framework for Primary Prevention of Drug Use ..	93
7. FAMILY FOCUSED PRIMARY PREVENTION: WHAT FUTURE? A FINAL REFLECTION LINKING THEORETICAL PERSPECTIVES AND EMPIRICAL DATA	101
7.1. Some Conclusions and Some Questions for Future Studies	101
7.2. Final Conclusions	105
8. BIBLIOGRAPHY	107

1. INTRODUCTION

Everyone more and more acknowledges the importance of the family involvement in primary prevention of drug addiction. Families and society face challenges imposed both by new economic, cultural and social realities, and by the demands of a society in constant evolution and transformation, where all is questioned and discussed.

Parents, educators and children are confronted with new and different situations, for which they do not have answers, due to their own incapacity or to the lack of references, models or orientations. This is the source of the hardship adapting to new ways of perceiving and living life.

The concept of *family* is broader and wider than the group usually formed by parents and their children, regardless of what we call *new families* (single parent families; foster families; socially excluded families, absent families, and other). It is common to hear and read about the necessity of rethink the family, models and educational practices, in order to be able to answer these new challenges. However, it is very interesting to realize that, in way or the other, we all are responsible for these changes or transformations, despite the fact that some of us are more responsible than others.

To understand the family as a system is to consider that the total is more than the sum of the parts and that each one of the family members' behaviour cannot be seen separately from the rest of the family, but that same behaviour will affect all the other members of the family.

Maybe because of these reasons we have to be aware of what we call *socialization process*, through which the individuals learn, assimilate, work out and assume rules and values of the society they live in, by the interaction with the surrounding environment, especially with the family.

This process should be perceived under two perspectives: from its *socialization agents*, who pass on values, beliefs, rules and life-styles; and from the individual who has processes of learning and integration, through which he/she becomes aware of, critical and with the capacity to participate and influence their environment. In fact, the child does not passively absorb the influences of the surrounding reality; he/she is, since birth, an active being in this process, however it depends on our participation as stimulators/stimulants.

Bearing in mind these two perspectives, it is important to acknowledge that the *family* is the first socialization agent with crucial importance as a context of mediation, communication and transmission, namely in the first years of life.

The patterns of the family life are a strong factor, which conditions the personal and social individual's path. If the bounds between the members of the family are, as the result of their own nature, inspired and guided by affection, attendance, support and participation, then the reception, the dialogue, the impartial availability and solidarity are favoured in each and every of its members. This constitutes a solid base for the active and responsible insertion of children in the broad horizon of society.

School, on the other hand, even because of the time it occupies in children and young people's everyday lives, also plays an extremely important role. Teachers, educational practices, colleagues, good and bad experiences, school success or failure help to shape and determine the future of all. It would also be important the parents would closely follow the educational process, reinforcing it.

Similarly the *peer group* is an important socialization agent. The social interaction of children with colleagues of the same age or older begins earlier and earlier, much before than the start of the school activity, although the socialization action of that group of colleagues, friends and neighbours does not have an institutionalised character like the family or school, it has obvious importance in the child's and particularly in the adolescent's world.

Another socialization agent is the *mass media*, especially television, to which we give greater relevance because of its importance and influence. In Western societies the percentage of families who do not have a more or less regular contact with this means of communication is residual. It is evident the fact that children of younger and younger ages start watching television, they efficiently use the remote control at an early age and they watch, in a more passive or active way, the television shows not only designed for them but also those meant for the public in general. On the other hand, the representational and narrative nature of television, as well as the built character of its product allows the message flow to be apprehended with interest and greed. With the constant broadcast of messages at home, television constitutes one of the most significant experiences of the individual's life from the early years of his/her life, which makes it more legitimate to suppose that such experience is one of the factors that shape each one's lifestyle.

The question is, then, to know the degree of influence of the media contents in people's lives, concretely in the children and youngster's information and formation, and what is the role that parents can play (first responsible for formation) so that their children enjoy in an active and critical way those contents.

We would conclude this socialization process issue by referring to computer games and Internet, which are more and more present and conspicuous, without forgetting about the growing importance of mobile phones and their several possible uses.

In IREFREA's study – *Family relationships and primary prevention of drug use in early adolescence* (Mendes, F *et al*, 1999) we verified the existence of a small amount of family prevention programs in Europe, as well as the lack of research studies in this area.

We clarify that when we refer to *family prevention* programs we are talking about those programs targeted at the members of a nuclear family (parents and children) as a whole, thus excluding those informative and training of personal and social skills programs, targeted only at youngsters/adolescents; or the informative programs; or those programs designed to establish educational skills, targeted at parents and/or educators.

Many prevention programs do not achieve their aims precisely because they do not involve the different intervenients, such as parents and educators, without whom it is not possible to reinforce the informative contents, leading to the loss or reduction of the impact of the preventive messages, especially when these activities are targeted at the younger group.

Since we are talking about primary prevention, the concept itself implies the development of different strategies that aim:

- a) to avoid the use/abuse of substances;
- b) to retard as much as possible the up surge of legal and illegal drug use;
- c) to reduce the problems associated to the misuse of those substances.

Thus, an early intervention, involving the *universe* of those upon whom we want to intervene, with a thorough theoretical frame which supports the action will make it more effective.

The need to make a study on the *state of the art* in what concerns family prevention programs was the aim of this new IREFREA's research in five European countries (Austria, Italy, France, Portugal, and Spain). This new work reinforces the commitment that we have dedicated to the study and understanding of the role played by the family in what regards drug consumption.

The knowledge and the evaluation of the different family prevention programs will help us to understand:

- a) the answers given to prevent drug use/abuse;
- b) the involvement of the family as a whole, trying to see how far all the family members are an active part in this process;
- c) the applicability of the prevention programs at the different moments of the family life cycle.

The relevance given to all this matter is so big that the European Union, in their 2000-2004 strategy, present as one of their aim “*to reinforce the importance of the family as a target-group, where more actions should fall upon*”.

We conclude by quoting J. Bergeret (*Bulletin de Liaison*, CNDT, 1991) – «Une méthode de prévention n'a rien de magique. Elle nécessite un effort permanent de la part de chacun. Elle prend du temps. Elle doit s'insérer dans les milieux naturels et les

méthodes naturelles d'éducation et de formation et, en particulier, de formation permanente des parents, des maîtres et des éducateurs. Une véritable prévention primaire doit porter très précocement sur les enfants, leurs parents et leurs maîtres.

C'est à ce niveau que nous devons être entendus si nous voulons que quelque chose change dans l'avenir de nos enfants».

CONTENTS OF THE BOOK

From the original research for the knowledge and evaluation of family prevention programs in the five European countries we decided to enrich our study with different contributions in this field. Thus, some researchers have contributed to the organization of this book, having participated in the elaboration of some chapters.

In the first chapter a description and a socio-historical framework of the evolution of the prevention concept are made. Throughout the years we have been learning how to better define and interpret the true meaning of drug use primary prevention. From the information to prevention as science a long way has been covered in a short period of time.

In the second chapter we mention and describe all the existing theoretical models. We remind you that only some time ago preventive interventions were performed according to the idea that information on drugs was necessary and sufficient to avoid youngsters using them. The prevention models give support and frame the different preventive interventions, justifying the options made.

In the third chapter, and based on the wider and deeper knowledge on protective and risk factors, we present the prevention strategies more often used. We also describe the preventive programs mentioned in the three areas we highlighted: Family – School – Community.

In Chapter 5, after the definition of our research aims, we present the grids used in the reading of the selected projects in the five countries. They are two distinct grids that help us to understand the different levels of preventive intervention:

- a) one, which we call Level I grid, that refers to all the preventive interventions so-called *occasional*;
- b) Level II grid, which mentions long time actions with a theoretical framework. We also present and discuss the obtained data.

In the fifth chapter we present the contribution of three of our researchers, approaching several themes. Professor Boyer, bearing in mind the results of IREFREA's research (Mendes & Relvas *et al*, 1999) develops the issue of religion/spirituality as a protective factor. Dr. Susanna Pietralunga describes the preventive activities in family context and their evolution, from the Italian reality. Professor Paula Relvas approaches the family life cycle: a framework for primary prevention of drug use.

In Chapter 7 the conclusions of our work are presented and a series of orientations are suggested, taking into account future preventive activities in family context.

2. DRUG USE AND PRIMARY PREVENTION

By M. Rovira, IREFREA, Portugal

2.1. SOCIAL AND HISTORIC FRAMEWORK

The (ab)use of substances has changed throughout the last few years: new drugs have appeared, the consumption of legal and illegal drugs has increased and the number of new abusers has become greater and greater.

The use of legal and illicit drugs is, nowadays, one of the main public health problems. The consumption of alcohol, tobacco and other drugs is responsible for more deaths and disabilities every year than any other cause which can be prevented (Institute for Health Policy, 1993).

Since the effectiveness of treatment models is not achieving the results we would expect, we should consider the importance of the development of prevention programs. Prevention is essential to avoid drug use becoming a social problem (Becoña, 1999). According to Martín, drug use prevention is an “active process of initiative implementation, in order to change and improve the individual’s personal development and quality of life, promoting self control and collective resistance to drugs supply”(1995: 23).

The history of prevention and its related concepts are much wider and older than we find in existing bibliographies, in psychopathology, psychiatry, public health, preventive psychology manuals (Fernandez-Rios, 1994).

Since the beginning of the 20th century, but especially since the sixties, the prevention concept has progressively acquired a broader, more theoretical and practical meaning. We can see, then, that there are several moments of organization of the theoretical models and preventive drug (ab)use techniques.

Actually, intervention in psychiatry and mental health reveal, on one hand, the adoption of medical concepts and, on the other hand, an autonomy movement regarding the approaches of this public health model. This emancipation movement has taken place due to the inadequacy of the public health model on the prevention of mental health, because the complexity of the causes, the influence of psychological, social and cultural factors weaken this initial model.

However, this changing movement of the interventions from the individual to social contexts becomes visible only with the contributions of psychology; contributions that, in the eighties, made possible the emergence of preventive psychology.

Two guide lines underlie preventive psychology: one focuses on the individual, its strategies aim to enhance the ability of stress adaptation and tolerance; and the other focuses on social systems, and its goal is to evaluate the impact of some aspects that social systems have on the individual's adaptation, and also the creation, by the individual, of strategies of adequacy to the environment. Consequently, preventive psychology's development inevitably leads to changes in the prevention concept.

2.2. FROM THE IDEA OF PREVENTION TO THE SCIENCE OF PREVENTION

The field of prevention is characterized by several terminological doubts and by a certain confusion concerning expressions and concepts (Negreiros, 1998). Therefore, we consider it pertinent to present here some significant moments in the history and evolution of the prevention concept.

In the health model, the concept of prevention is quite broad. Classically, since Caplan (1980) there have been three prevention levels: (1) primary; (2) secondary, and (3) tertiary.

According to Caplan, "primary prevention is a community concept; it implies that there is a reduction in the percentage of new cases of mental disturbances in a population over a certain period of time (...) it does not avoid a particular individual becoming ill, but concentrates on reducing the risk of all the population getting the disease" (1980: 43).

Bower (1969) considers that primary prevention in mental health is any social and psychological intervention which promotes emotional functioning and reduces the occurrence of disorders in the population in general.

To Goldston, (1977: 27) primary prevention in mental health constitutes a set of activities specifically targeted to identify risk groups, so that it is possible to introduce measures with the goal of avoiding the beginning of the emotional disturbance and/or promoting mental health.

Catalano and Dooley (1982) distinguish two types of primary prevention: proactive primary prevention and reactive primary prevention. The first one is formed by a series of actions whose goal is to prevent the upsurge and development of risk factors, *i.e.*, to bear in mind the individual's attributes and/or characteristics, specific conditions and/or the environmental context which increase the probability of the problem's manifestation. On the other hand, reactive primary prevention aims to prepare the individual to react in an effective way when facing a stressful situation.

In the same way that Catalan and Dooley (1982) make the distinction between proactive and reactive prevention, Cowen (1985-1986, *in* Fernández-Ríos:141) distinguishes primary prevention at a system level, from primary prevention focused on the individual. Primary prevention at a system level intends to reduce sources of stress and to promote the opportunities for a healthy life in a particular society. As regards primary prevention focused on the individual, its main goal is to develop in the individual, skills to resolve stressful situations successfully.

The double goal of promoting health and avoiding the upsurge of a certain disease is already present in the traditional theoretical formulae of primary prevention. Cowen (1983: 12) defined primary prevention, as it has already been mentioned, as a set of interventions, which aim to avoid the upsurge of emotional disturbances and psychological malfunctions, and also to strengthen psychological health (Goldston, 1977).

More recent theories, namely in the areas of psychology and education, have given preventive interventions a meaning that goes beyond the mentioned duality of goals. Thus, we verify a shifting of preventive actions from a register based on the dichotomy of health – disease to a register centred on the binomial behaviour - learning (Negreiros, 1998).

It is appropriate to go back to Caplan (1980) and remind you that he defines secondary prevention as the one whose goal is to reduce the occurrence of a disease, reducing the percentage of new cases, whose origin could have been avoided with primary prevention measures. Finally, as regards tertiary prevention, the same author states that it is an intervention whose goal is to reduce, in the community, the consequences of mental disorder, focussing then on treatment and rehabilitation procedures.

Besides the qualitative differences, these three prevention levels also reveal a time dimension, *i.e.*, primary prevention precedes the manifestation of the adverse situation; secondary prevention appears a little after the first signals of the problem have manifested themselves; and finally tertiary prevention occurs long after the problem's manifestation.

It is, then, with the removal of the simple “prevention” concept and with the adoption of the terms “primary, secondary and tertiary prevention” that prevention is taken to a scientific context. (Springer and Uhl, 1998). Using that base, the goal of prevention science is to prevent or diminish important human mal-functioning by focusing investigation on the systematic study of potential forerunners of pathology or health, called respectively “risk factors” or “protective factors”.

It is also important to stress that “the specific types of malfunctioning are typically associated with various risk factors, and that the exposure to several risk factors has cumulative effects. Often, the probability of becoming ill increases because of the number, duration and toxicity of risk factors. On the other hand, a particular risk factor is rarely specific to a unique disorder, because disease causes tend to scatter their effects

about the different adaptability functions throughout the development sequence” (Coie *et al.*, 1993: 1013). We can, at this stage, talk of “generic risk factors”, commonly preceding various kinds of disorders.

In different investigations, several researchers have identified some generic risk factors, which are classified by Coie *et al.* (1993) in seven different categories: family circumstances; emotional difficulties; school problems; ecological surrounding; bodily handicaps; interpersonal problems, and delayed developmental skills.

It is also known that risk factors do not reveal the same predictive capacity throughout the system’s development. If some of them foretell disorders or malfunction in one or several development stages only, others can predict effective disorders during most of the developmental path. For instance, the contact with devious peers is associated with anti-social behaviour only during adolescence, but poor parental control is related, in a consistent way, to behavioural disorders, both in adolescence and in childhood (cf. Coie *et al.*, 1993).

Until now we have only mentioned risk factors, but there are some personal and social characteristics that perform protective or preventive functions and that can act in two different ways:

1. by interacting with the risk factors, thus minimising their effects by breaking their chain-reaction performance;
2. by preventing the appearance of risk factors (Digman & West, 1998; Wheaton, 1986). Coie *et al.* refer to the fact that, when it is difficult to identify or eliminate the risk factors (such as extreme poverty, for instance), the only intervention strategy possible is, probably, the multiplication of protective factors. It is understandable, then, those authors recommend that the Science of Prevention should promote the knowledge of the protective factors: psychological resilience, strengths, skills and environmental advantages.

In the same way, Hawkins, Arthur and Catalano (1995) state that in a prevention program, namely illegal toxic substances use programs of prevention, it is essential to *reduce* the risk factors and to *increase* the protective factors. In short, in this fight against drugs use, if we want to act by preventing, then we must promote public health; empirical knowledge of the risk and protective factors (specific, predictors or inducing factors). Only then will we be able to develop consistent and credible prevention programs that may guide us to the reduction of risk factors and, above all, the promotion of protective factors.

Coie *et al.* (1993) redefine the concept of primary prevention, presenting it as a new research area in the interface of psychology, criminology, psychiatry and human development (Mendes, 2000).

It is this dimension of investigation, according to the parameters usually recognised as necessary to give a scientific character to any study or discourse, that comes to transform “prevention” into a set of articulated data and assumptions with a science status.

It is also for the same reason that prevention, namely the one classically called primary prevention, needs to find conformity / coincidence in a clear and concrete definition, in whose core one can identify the problems and variables of study, which must be investigated using credible and organized methodologies in the search for an answer, adequate, as much as possible, to the goals that same prevention suggests.

It is also in this context that theoretical models necessarily arise and develop in order to explain the factors involved and that, in some way, frame and inform those same investigations. It is also in this scientific movement that preventive actions can and must be considered and that, finally, can be articulated and become possible of an accurate evaluation.

The data and the problems arising by this development are, then, what we are going to discuss in the next section and chapters.

2.3. THE STATE OF THE ART

The prevention of drug (ab)use has been assumed as an effort of the whole society. Despite all the theoretical and practical progress, the prevention progress remains vague, poorly defined and sometimes wrongly used (Seidman, 1987, cit. by Fernández-Ríos: 144). An example is the distinction between primary, secondary and tertiary prevention concepts, distinction that has had some critics. Thus, Wagenfeld (1972, cit. by Fernández-Ríos: 142) suggests that the terminology used before Caplan (1980) should be adopted again to divulgate these new concepts. That is the reason why Wagenfeld distinguishes prevention, that is, primary prevention in health and treatment, as a premature intervention, immediately after the manifestation of the disorder, from rehabilitation, that is, to repair the consequences provoked by the manifestation of the disorder.

However, when we use the prevention concept in a broad way, the variety of meanings can be infinite (Burguess, 1997, cit by Becoña). That is the reason why the term prevention has been used both in the education, treatment and traffic repression areas. According to Becoña (1999) preventive interventions are grouped into two major blocks, namely the one of consumption reduction (search) and the one of offer reduction. It is in the search reduction field that we find preventive measures, which are introduced in schools, families, the community, etc..

If we want to use more recent terminology, the three types of prevention described earlier are equivalent to what we call prevention (primary prevention), treatment (secondary prevention) and reintegration (tertiary prevention). In the context of drug use, primary prevention consists of adopting a set of procedures so that individuals do not take drugs. Secondary prevention consists of a set of actions directed to groups/individuals who one knows have already begun to take drugs, avoiding, in this

way, them becoming a bigger problem. Tertiary prevention focuses on treatment and reintegration of individuals whose drug consumption has led to a series of problems associated with drug addiction.

This is the reason why, according to Santacreu *et al.* (1992) there are only two possibilities for preventive prevention – primary and secondary -, since primary prevention aims “to know the relationships between the kind of behaviour and the effects on the individual’s health”; and secondary prevention consists of “acting, effectively changing the inadaptative behaviour”. Tertiary is considered to be a psychological and treatment intervention, not a preventive one.

In the preceding decades there have been several drug (ab)use prevention measures. However, we often inadequately use the prevention concept, as well as the preventive program concept. A preventive program, according to Escámez (1990, cit by Becoña) is a project formed by a set of actions whose goal is quite specific, that is, to prevent the upsurge of the problem. Thus, in the area concerning drug addictions, a preventive program intends to stop or delay the upsurge of consumption behaviours, drug use and abuse. A program is more specific when it is guided by concrete goals, targeted to clearly defined groups, which allows the adoption of well directed measures and, above all, to evaluate the impact of the problem.

As such, preventive interventions today adopt (besides the “key-components” mentioned by Cowen, such as proactivity, that is, having as goal to avoid the upsurge of a disturbance in a population, to intervene before it happens) the focus on healthy or risk populations and intentionality. This is what distinguishes them from preventive psychology’s interventions (whose goal is to strengthen the individual’s psychological adaptation), for the intention defines the intervention’s goals.

Today, evaluation presents itself as a fundamental condition in a preventive action, both for methodological and ethical reasons. Several authors have tried to define the characteristics of the evaluation process, distinguishing then, three different levels of primary prevention programs: evaluation of needs, of the process, and of the results (impact). According to Becoña (1999) evaluation must always be intimately connected with any preventive program.

Recently, and when applied to the prevention of drug addiction, we may distinguish three kinds of prevention, that is, universal prevention, selective prevention and indicated prevention. This distinction was initially suggested by Gordon (1987), and accepted afterwards by the National Institute of Drug Abuse (NIDA) and National Institutes of Health.

Universal prevention interventions are directed to the population in general and aim to prevent or delay the age of the beginning of drug consumption. According to Martín (1999) one assumes that all the inhabitants of a certain area have the same probability (or risk) of taking drugs.

Selective prevention is directed to a specific group of a certain population with a higher risk of taking drugs, that is, it is targeted to a risk group. These risk groups can

be identified through several variables, such as family characteristics, area of residence, etc.

Finally, *indicated prevention* focuses on well-defined risk groups (Mendes, 2000). It's a more direct type of prevention, focused on high risk populations that take drugs or have problems related to drug use, whether they are users or people who have tried drugs. The goals of these types of prevention are related to the reduction in substance consumption, of its frequency of quantity, as well as of the problems associated to the consumption (Martín, 1999) and of non-specific risk factors, such as failure at school, familial malfunctions, etc. Specific prevention interventions have as their goal to prevent drug addictions, *i.e.*, they only have one goal and it is limited in time. In other words, non-specific prevention (universal or selective) can also include specific goals of drug use prevention, but they are part of global goals of health promotion.

An important number of experts in this field defend the primacy of specific prevention since it allows, in the long term, changes in society, and also because of its possibility of reducing contra-preventive effects. As Calafat defined (1995), "specific prevention will be any action, activity or program which approaches the drug issue in a clear, concrete and explicit way". On the other hand, non-specific prevention seeks to change consumption, but indirectly, through programs or activities in fields which, in principle, have nothing to do with drug use. Nevertheless, according to Calafat (1995), the possibility of synthesis between specific prevention and non-specific prevention should not be set aside. However, to this author prevention should be, above all, mainly specific, liable to be evaluated and clearly directed to the goal it wants to achieve with a population, which is also clearly defined.

There isn't a lack of arguments in favour of specific prevention, for the social interest the issue "drug" origins is high, and it is, therefore, urgent to reformulate this search (by parents, associations, teachers, students, etc.), because that reformulation may allow the approach of other, more general, questions, such as education and family communication. In the same way, this specificity is useful to dissipate stereotypes, and wrong or insufficient information. According to FAD (Fundación de Ayuda contra la Drogadicción, 1997) offering concrete and reasonable contents, adjusted to the receiver is not a reason to stimulate a negative result.

The contexts in which prevention takes place can be of all kinds. However, what practice has shown us during the last few years, leads us to the reality of school. It is in school that we find youngsters at the maximum age of risk of substance consumption. Thus, school presents itself as a privileged space for preventive interventions of use / abuse of legal and illegal substances.

Recently the need for a broader intervention in family context, as well as in the work places and through the media, has risen. We don't know the future of prevention, however, we believe it will be problematic. This conclusion is based on the gap between the potential of the goal we hope to achieve and what we are actually able to achieve. Despite this, whether the suggested goals are achieved or not, we may consider prevention a primary good (Fernández-Ríos, 1994).

We may conclude, then, that despite all the theoretical advances and development, today there isn't a consensus concerning the prevention concept. Nevertheless, it is also important to highlight the usefulness of that concept, when we mention health promotion.

3. THEORETICAL MODELS AND DRUG USE PREVENTION

By A. Olaio, IREFREA, Portugal

In the context of the science of drug use primary prevention, a theoretical model must support every kind of intervention. This model must derive from the observation of the facts, it must allow the confirmation of those observations and, finally, it must predict the design of a conceptual reference, which enables the understanding of that reality, on which we elaborate the theory. With it we should also be able to predict and intervene, if necessary, in that reality (Becoña, 1999). According to Rudner (1996) a theory is a set of systematically related principles, which includes some generalizations in the shape of natural law. This set of principles has to be empirically confirmable. Consequently, a *model* is a theory or group of theories applied to a specific area or situation (Mitchell & Jolley, 1992). Thus, the goal is to describe the exact mathematical relationship between variables in a given situation. (Becoña, 1999)

In the drug addiction field, one does not always verify a coincidence between prevention, preventive programs and the theoretical model that supports the interventions. According to Donaldson, Graham and Hansen (1994), if a program is based on a theory there are some advantages, both for the program itself and for its evaluation. The use of a theoretical base helps to identify the most important variables related to the problem and how, when and who should evaluate them; it helps to identify and control the external variance sources; it alerts the researcher to what is in fact important or to some intrusive interactions; it helps to distinguish between the reliability of the program and the reliability of the supporting theory and, finally, it helps to develop a base of knowledge on how and when the preventive program works.

According to Flay and Petraitis (1995), theory is important because, without it, we would be lost by the time of developing effective prevention programs; at the same time, the advance of theory will lead us to more effective programs in the future.

Before the 1960's, it's hard to see the existence of a model which would supply a solid theoretical base to the interventions developed in the context of primary prevention. A superficial analysis of changes and theoretical development, which occurred up until the end of the sixties, shows that the authors focused mainly on the exposure of theoretical fragility, or even on a tendency to an interventive "compulsion". These interventions would be essentially oriented to the control of the dramatization of the drug addiction problem, through information on drugs, moved by the desire of pushing away the distress that the issue arises, but without a conceptual base consistent enough to support these interventions. Thus, the first preventive interactions were based

on the belief that teenagers didn't have enough information on the negative effects of the psychoactive substance use. So, giving them that information would be enough to solve the problem. The first preventive models emerge in this context.

In this chapter we will try to analyse the different theoretical models that have guided drug use primary prevention since the 1960's. We find three types of approaches which we will describe next: the *Informative - Communicative Model*; the *Humanist Model* and the *Integrative and Comprehensive Models*.

3.1. INFORMATIVE - COMMUNICATIVE MODEL

This model, also known as the Rational or Informative Model, is based on the assumption that information centred on negative aspects and consequences of consumption would be sufficient to lead the youngsters to make the rational decision of not taking drugs. The Informative Model is often called the Traditional Model, because it has been used since the beginning of preventive interventions and because it has been kept, until now.

At the beginning of the seventies a few steps were taken towards theoretical and empirical validation of this model. These initiatives appeared in the social psychology field. Thus, Kohn and Snook (1976) and Smart and Feger (1974) tried to evaluate the persuasive impact of messages about drugs as a way of preventing its consumption. These authors focused on the study of problems related to the change of attitudes, for example: the emissor credibility, the use of fear inducing messages and the role of some individual's characteristics.

So, in practical terms, this model supports the interventions, which intend to highlight the negative consequences of taking different substances, both legal and illegal, in the short, medium or long term. Initially, the programs based on this model appealed to fear and had a moralist content.

What lies beneath this model is the premise according to which knowledge changes attitudes. This change of attitudes allows the individual to have intentions and behaviours consistent with his/her knowledge, *i.e.*, there is positive correlation between knowledge, attitudes and behaviour.

However, the Informative Model has some limitations. The first one has an epistemological nature. Thus, when this "convergent approach" (convergent because it is based on the triad of knowledge, attitude and behaviour) (MacGuire, 1976) on attitude's changes was used in the drug use prevention area it had already reached its peak in social psychology, a decade before (McGuire, 1986). This model starts declining when it shows a concentration of fairly inconsistent data about the influence of factors connected to the emissor, the message and the receiver on attitude's changing.

The second limitation is related to the characteristics of drug (ab)use behaviour itself which one tries to change, resorting to persuasive communication methods. The adequacy of persuasive methods is questionable, when applied to problems such as psychoactive substance use, which imply a strong emotional involvement. In this case a well formulated message will “produce an immediate persuasive impact, but that doesn’t mean that the anti-drug attitudes will be maintained or that there is a reduction in drug use” (Shleffel & Norris, 1980: 123).

McGuire’s Persuasion-Communication Model (1976) identifies, in the process of persuasion, six levels, that is, six sequential stages: presentation; attention; comprehension; adhesion; retention and behaviour. The focus of this model is on the analysis of the changing attitudes process, inside a series of components underwritten on the processing of information. Thus, according to McGuire (1976) it is possible to make predictions about the relation between a determined independent variable and the change of an attitude. The attitude’s change will be achieved by analysing the effect of that independent variable on the stages of processing of information.

The most important theoretical guideline in the Informative Model’s is the evolution is represented by the psychological inoculation approach, concerning the change of attitude suggested by McGuire. This approach suggests that certain attitudes can be “protected”, by inoculating the individuals with to contrary arguments, to the ones which they might have to be confronted with.

Within this conceptual framework the beginning of drug use is no longer seen as an issue due to lack of knowledge about substances, but rather a behaviour whose origins are rooted basically in social and inter-personal factors.

The development of “social inoculation” strategies (Evans, 1983) applied to drug use, shows a rupture movement concerning research and practices directed at the area of attitudes change. These new concepts related to drug use come from different studies areas, such as social psychology (Evans, 1976), social learning (Bandura, 1986) as well as from the studies on the antecedents of drug consumption (Jessor & Jessor, 1977). These studies consider the existence of three risk factors that are fundamental to the development effective preventive programs (Perry & Kelder, 1992): environmental, personality and behaviour risk factors. Social environment is very important because behaviour is general and drug use or not in particular, occur in a concrete social environment with parameters which are liable to facilitate or not, that use.

3.2. HUMANIST MODEL

This model essentially reflects the influence of psychology’s humanist dimension (Maslow, 1968; Rogers, 1961) in the area of drug addiction prevention. Maslow’s contribution to psychology’s humanist dimension was, fundamentally, the drawing of

the human needs pyramid. Besides the need for air, food, etc., Maslow establishes five broader categories of needs. Thus, at the bottom of the pyramid Maslow puts the physiological ones, which include our need for oxygen, water, protein, salts, the need for activity, sleeping, avoiding pain, etc.. The second level would be the need for security, which is expressed by the search for secure circumstances, stability and protection. After that, we have the need to belong, that is, after satisfying our physiological and security needs, we need to have friends, a partner, children, in other words, we need to establish affective relationships. Afterwards, comes the need for esteem, which presents itself in two levels: the lower level would be the need for respect from others, the need for status, fame, glory, recognition, attention, dignity, etc.; at a higher level we would have the need for self-respect, which includes such feelings as confidence, competence, independence and freedom. At the top of the pyramid is the need of self-actualisation, which involves the constant desire to achieve goals, of being everything we can be. In conclusion, Maslow's major contribution was to be a pioneer in the devolution of the human being to psychology and the person to personality.

Around the sixties we see the rising up of another movement. This movement was inspired by some aspects which were rejected by Maslow: computing and information processing, as well as the rationalist theories. It is there that cognitive movement in psychology emerges. Another author who can be referred to in this context is Carl Rogers (1974) who theorized, the concept of the human organism as a whole stating the belief in human capacities. Carl Rogers was able to gather this perspective with therapeutic proposals and the belief, born from his practical experience that usually the client knows better how to act. This author, as a therapist, saw himself as a facilitator, that is, someone who creates the necessary environment for the development of the client. Carl Rogers gave the educators important contributions on what concerns the relations with a target-public, as well as with techniques that could be used.

Contrary to the characteristics of the previous model (Informative - Communicational), based on the supply of information on drugs, the Humanist Model claims that preventive interventions must be settled on an "affective" base. Thus, this model suggests that, in order to produce changes in behaviour and attitudes concerning drugs, it would be necessary to produce modifications in the emotional and affective aspects, responsible for the teenager's initiation of psycho-active substance use. The methods suggested by this model are essentially active ones by implying a high degree of participation and affective involvement by the youngsters.

By the end of the sixties and the beginning of the seventies, some authors like Unterberger & DiCcio (1968) and Swicher & Crawford (1971) had already implicitly suggested this approach in some prevention programs. These programs, although essentially centred on the Informative Model, suggest some techniques that allow an intervention in the control of feelings area, and also in the "destruction of myths", still proposing that such techniques should be based on small group discussion techniques. All along the seventies, we saw the emergence of some preventive approaches which are typically humanistic, with the predominance of affective and non-specific programs,

like, for example, the personal development programs. One should stress the reliance on three preventive approaches: clarification of values, decision-making process and construction of alternatives to drug use.

The clarification of values is strongly characterized by some theories where we can notice the social influence (Bandura, 1986). Appropriate behaviour and adequate skills facing risk situations so as participation in alternative activities to drug use, are elements of high importance to avoid the occurrence of consumption. This is the reason why psychosocial programs give a lot of importance to the learning of social skills.

The clarification of values doesn't focus on the contents of values, but rather on the mechanisms through which these values are acquired and applied. Thus, according to Rath *et al.* (1966) the values are clarified when the individual is able to choose between several alternatives, after analysing the consequences of each one of those alternatives. The assumption of the use of values clarification methods in prevention programs is the fact of assuming that the origin of drug use can be a system of values which are not clarified.

Another humanist approach used in drug use prevention tries to promote the learning of decision-making skills. What lies beneath this kind of approach is the premise that it would be impossible to irradiate drugs from nowadays societies, therefore the most effective approach would be to help the youngsters in a process of learning decision-making skills, taking into consideration, simultaneously, the alternatives to and the consequences of drug use.

The concept of alternatives to drug use was formulated by Cohen (1968) and later reformulated by Dohner (1972) and it underlines the principle that drug use may occur to satisfy certain needs or may be related to the desire of experiencing new sensations (Chamin, 1969). Therefore, in giving the teenager the chance to practise certain activities it would be possible to satisfy the needs he/she would try to satisfy by taking drugs.

This approach, although initially accepted with enthusiasm started declining, mainly due to the imprecise character of the activities selection criteria, in other words, any activity could be considered an alternative to taking drugs.

We may conclude that the approaches based on the humanist model emphasize that drug use is essentially determined by affective variables (values, beliefs and attitudes), although they do not reject cognitive variable (decision-making process, information processing mechanisms).

3.3. INTEGRATIVE AND COMPREHENSIVE MODELS

In this group of models we include a set of approaches which propose a multifaceted and pluri-determined comprehension of drug addiction and its causes. Thus, the

correspondent prevention suggestions aim, themselves, to focus on and to articulate several aspects more or less directly related to substance use / abuse.

3.3.1. Social Learning Theories – neo-behaviourist perspectives

Neo-behaviourist perspectives emerged by the end of the 1970's. These perspectives have the assumption that adolescent drug use is the result of learning, that is, drug consumption may result from the lack of adequate social skills. The promotion of skills is seen as one of the most important goals of prevention, because it faces legal and illegal drug abuse by focusing on techniques, through which one intends to give the individual, both at a social and at an emotional level, skills that will allow him/her to give an adequate answer to drug use. The concept of social *skills* was originally developed in the United States by Botvin (Botvin, 1988; Botvin *et al.*, 1990) and it was initially centred on the prevention of tobacco. This concept has also its origin in social influence theories and behavioural theories (Jessor & Jessor, 1983), giving the idea that drug use is the result of a social learning process combined with personal factors, such as knowledge, attitudes and beliefs. This concept aims, fundamentally, to produce changes at a behavioural level. However, it also aims to develop general coping strategies and the increase of several social skills, aspects that, as we have already seen, were contemplated in the development of humanist models.

Specifically, the goals of this approach are the following: to supply information and specific training to resist social influences liable to promote drug consumption; to transmit fundamental social skills; to teach personal techniques of coping. Thus, preventive programs seek to promote healthy behaviours and, at the same time, to promote the necessary skills to resist to social influences (Rabes, 1987).

Botvin and collaborators created a program based on these perspectives called “Life Skills Training”, between 1980 and 1987. This program consists in a twelve-unit-curriculum developed along fifteen sessions in school context. Each unit has a main goal; some specific goals directed to the students and some contents and activities to be developed in the classroom. The program may be included in any area of the school curriculum. However, the areas for Health Education and Education on drugs are the most suitable.

The main goal of “Life Skills Training” is to stimulate personal growth and social skills, focusing mainly on the development of competences, which allow to face social influences to smoke, drink and take drugs. It intends to give the students cognitive-behavioural skills in order to promote self-esteem and to resist to the influence of advertisement or to deal with anxiety-inducing situations, to have a clear communication, and to maintain adequate relationships and levels of assertivity. These skills are taught by using demonstration techniques, role-playing reinforcement feedback and tasks prescription to be performed outside the classroom. Besides, the program also supplies information on tobacco, alcohol and other drugs and it promotes

skills to deal with specific problems, such as, for example, to apply general assertive abilities to real situations like the ones that might occur when there is an interpersonal pressure for smoking.

What stands out in this program and also what makes it different from traditional prevention programs is the fact of giving little information on the consequences of drug use to health, in the long term. Instead it is given a kind of information considered to be more important to adolescents, in other words, the negative and immediate consequences of drug use, the reduction of drug users' social integration and the prevalence of drug use among adolescents and adults. In practical terms, this program dedicates four lessons to information, two to decision-making training, social skills and assertivity; and one to the treatment of advertisement influence, self-control techniques and communication skills.

These perspectives support the need for creating preventive intervention models capable of promoting the acquisition of skills likely to contradict certain social-environmental conditions, which may facilitate drug use.

3.3.2. Interactional Approach

Brook and collaborators (1983,1986,1988,1990) studied the influence of several isolated influences from each one of the four major socialization areas in the American society (family, peer group, school and area of residence) on the risk of starting drug consumption. Having this goal in mind, they tested three interaction models among the different micro-systems: the independent model, according to which the elements belonging to each one of those socialization contexts (family, peer group, school and area of residence) have a direct effect on adolescent drug use; the mediator model ascribes to one or all of those areas both a mediator role between the areas, and a dominant role towards the others, in the process leading the adolescent to use drugs; the interdependent model, according to each it is necessary that a certain number of variables, from each area, are simultaneously present so that the tendency to take drugs occur.

From several studies, Brook and collaborators came to the conclusion that the mediator model was the one which best reflected a predictive capacity concerning drug use.

Thus, while the family and peer group have a direct influence in the adolescent's disposition to take drugs, school environment shows its influence through peer group and the area of residence's influence is mediated by the other three areas (school, family and peer group). They also verified that factors related to the peer group (especially legal and illegal drug use by the peers), followed closely by family factors (especially the affective emptiness of the relationship with parents or the frequent conflicts between the adolescent and the parents) are the variables most significantly associated to drug consumption. These authors also emphasized the protective role that a favourable

school environment (school as socialization space) may have in a pressure situation, put on the adolescent by the behaviours and attitudes of the peer group's elements. Thus, school environment free of conflict, with a good physical, social and pedagogic quality, contributes to a significant reduction of the influence of the peer drug users. It is important, then, to stress out the worth not only of the measures targeted to the prevention more directly connected to the risk of drug use, but also of those measures targeted to the promotion of psychosocial conditions capable of facilitating a balanced relationship between the adolescent and the environment.

3.3.3. Behaviour-Problem Theory

This theory is centred on the dynamics between personality, environment and behaviour (this being the result of the interaction of personality and environmental influence). These three systems (personality, environment and behaviour) are inter-related and organized between them to explain the occurrence of the behaviour-problem (Jessor & Jessor, 1977). These authors defined "Behaviour-problem" as a socially inadequate behaviour in relation to rules set by society, this becoming an undesirable factor, disapproved by the authority institutions. The personality system is formed by the control structures and personal beliefs. The environment system determines the way the behaviours are understood both by the subject and the others. The behaviour system distinguishes the socially acceptable behaviours from the problematic ones.

Previous to these three systems are the demographic characteristics, such as parents' education, parents' religion, family structure, and socialization process (parental ideology, family environment, peer group's influence and media). These characteristics play a fundamental role both on the way the three systems individually evolve and on the interaction process between them.

The behavioural system's activation and the specific behaviours are the result of demographic and socialization process variables, which influence both the tendency to the certain behaviour self control, the perception of its adequacy of a certain behaviour and the way the manifests itself and the classification of that behaviour in relation to the environment perception.

3.3.4. Social Development Model

This model, suggested by Hawkins & Catalano and collaborators (1996), tries to explain the anti-social behaviour through a specification of developmental predictive relations, giving special importance to risk and protective factors.

The goal of this model is to explain and predict the beginning, the way up, the maintenance and the drop out of such behaviours as delinquency and legal and illegal drug use (Catalano & Hawkins, 1996; cit. by Becoña, 1999).

The social development model assumes that anti-social conducts are the result of multiple factors, which can be biological, psychological or social intra-individual, or inter-individual factors related to family, school, peer group or community. This model has three basic elements: 1) a development perspective which assumes specific sub-models to the different ages (kindergarten, primary school, high-school, university); 2) it includes delinquency and drug use in the same model; 3) it includes some risk and protective factors both to delinquency and drug consumption (Becoña, 1999).

The authors claim that anti-social conduct occurs when the socialization process is interrupted, because the person is denied the opportunity to participate in social-life or because their skills are inadequate to enable pro-social behaviours that can reinforce his/her skills or even when the environment does not reinforce pro-social conducts. Besides that facing social bonds, the cost-benefit analysis leads the individual to a disposition to illegal actions or the child live in an immediate socialization unit like family, school, community or peer group that have anti-social beliefs or values (Catalano & Hawkins, cit. by Becoña, 1999).

From the components identified by this model it is possible to design prevention programs, that is, focusing on the aspects that lead to drug use, through preventive measures, these aspects can be interrupted. It is possible, then, to interrupt the causal processes that lead to drug consumption.

According to the authors of this model, preventive interventions show the following characteristics: each one of the causal models is a potential intervention element; it may be necessary to use multiple interventions, since there are several ways, direct and indirect, leading to anti-social behaviour; the influence of a previous bound and the intervention in a future conduct suggest the importance of intervening as soon as possible in the development; interventions must be suitable to each development stage.

3.3.5. Life Style Model and Risk Factors

This model, suggested by Calafat and collaborators, is supported by risk and protective factors related to drug use. It is especially centred on the prevention of both legal and illegal drugs. According to Calafat, Amengual, Guimeráns *et al.* (1995) the causes or factors that lead to or facilitate the individual's interest in drugs are related to the whole personal and social dynamics, prior to the contact with drugs. The authors claim that the main idea of this model is the definition of drug addiction, which is seen as the result of the relation between the user and the product used, that creates a need (psychic dependence) for maintaining the consumption of a certain drug, aiming to take benefits from its effects.

Besides, it is know that with certain drugs and through its repeated consumption, when its use is interrupted physical distress may appear (manifestation of physical addiction), which will disappear when the consumption is resumed (Calafat *et al.* cit. by Becoña, 1999).

The authors suggest a sequential scheme to the surge up of risk factors of drug use. Thus, risk factors start with the difficulty of the relationship with the parents, particularly with the lack of identification with them. This leads to depression and other damages, as deviance and immaturity.

From here derives a major need for belonging to a group during adolescence, leading to a bigger permeability to the group's directions (in this case, the adolescent would have a better relationship with the group members than with his/her parents).

These factors lead to an increase of the possibility of starting taking drugs, through life style and to a higher probability of abusing, through depression and/or other personality's characteristics. All this leads to the presence of depressive symptoms, due to the failure of the depressive personality and the contact with drugs. Drug use leads to changes in the individual's activities and behaviours, including his/her life style (Becoña, 1999). This model also emphasizes the importance of the family environment, on one hand and the personality characteristics, on the other.

3.3.6. Ecological Model

The ecological model, suggest by Bronfenbrenner in 1979, as an explanation of human behaviour in general, proposes a systemic approach that focus on the interaction of different areas which are part of the individual's social environment, through a process that leads to his/her psychological grow, from childhood to adulthood.

Bronfenbrenner considers the family, the school, the peer group, the community or the culture micro-systems, whose interactions constitute a wider system – a mega-system. Each one of these micro-systems has a unique influence on the person, the interactions between the different micro-systems are so important to his/her development as the events that occur in each of them, due to the impact provoked by the characteristics of those micro-systems on the others and on the total system as a whole (cit. by J. Brook *et al.*, 1987).

According to Dishion and collaborators (1995), Kellam (1990), Magnusson (1998) and Rutter (1989), the ecological model would be the more suitable to understand risk behaviours in adolescence, and it also would serve as a guide to the creation of prevention programs during the different development stages.

One of the implications of the ecological model is the fact that a preventing program, in order to have effective results in the reduction of risk factors, must pay attention to the contextual factors that influence the causal processes and it must be done in relevant contexts (Bigland, 1995).

With this model, health starts being considered as a dynamic process, which is continually developed inside the transactional systems. The individual should perform a series of normative and non-normative tasks throughout his/her life cycle, as a consequence of the internal and external needs and demands. Each person puts at stake

different adaptative strategies based on the interactions of different biological, psychological and social variables (Diez & Peirats, 1999).

According to these authors the ecological model intends to surpass the partial and insufficient perspective of other drug abuse models: the Juridical, the Distributive, the Medical, the Psychosocial and the Sociological¹. This model re-dimensions the drug use problem as a global phenomenon and a social problem, which include the individual, the family, the community, the society, the historical-cultural system, the political system, the economical system, the juridical system, the product itself and its effects on the individual who develops his/her behaviour in an environmental space defined by the previous contexts.

This model sees the users and factors not in an individual or isolated way, but rather as integrated in a broader environmental structure, which gives them sense. Thus, this model implies the necessary assumption of multidisciplinary of the preventive work.

According to this model, prevention should direct its action to the causes of the problem and not just to the symptoms. In this perspective, drug consumption is re-dimensioned as a social problem, with different but integrated economical, juridical, psychological, sanitarian and cultural aspects (*Idem*).

Bronfenbrenner supplies, with the ecological model, a coherent and organized theoretical support, by considering the network of findings related to anti-social behaviour's ethiology. The ecology of children's development is an hierarchy of systems fitted into each other, starting with face to face interactions, continuing with behavioural contexts where the relationships occur and with the influences of a macro-system as cultural and community practices.

3.4. CONCLUSIONS

The different prevention strategies have, as we have previously seen, underlying models which refer to the way of conceptualising the factors that determine drug abuse. Thus, strategies based only on information supply emphasize the importance of cognitive factors, such as knowledge or information. According to the humanist approaches, drug use is essentially characterized by affective variables as beliefs, values and attitudes. The ecological approach underlines the impact of certain social influences in the initialisation and maintenance of drug consumption.

¹ Diez & Bergano present the following classification of models: The juridical model, which criminalizes the drug use problem; the distributive model, which reduces it to a problem of substance availability; the medical model, which gives the problem a medical dimension; the psycho-social model, which individualizes the problem, and the sociological model, which stigmatises the less privileged classes.

The existing theories and models should be the support to practice, that is, to the design and application of preventive models. Simultaneously, practice must allow the improvement of theories and models suggested to explain drug use ethiology. Thus, it is fundamental and indispensable a mutual feedback between theory and practice.

4. STRATEGIES AND PREVENTION PROGRAMS

By M. Rovira, IREFREA, Portugal

In this context, the word strategy should be used to “designate what characterizes a preventive intervention, in what consists the set of activities, actions and/or services that constitute the intervention, so that strategy and model of intervention coincide a great deal” (Martín, 1999:18). Thus, we must distinguish the strategies according to their generic goals, that is, the reduction of drug supply and reduction of drug seek or consumption.

In what concerns supply, any strategy that has a goal to reduce the presence of drugs can be considered a preventive strategy. The majority of these prevention strategies have a normative nature, being always imposed by the authorities.

The analysis we propose to do in this chapter concerns the reduction of offer.

Concerning the reduction of drug-seeking strategies, in a general way, we may classify the existing strategies in five categories:

- a) strategies centred on the divulgation of information on drugs characteristics, their effects, highlighting the negative effects of the consumption;
- b) strategies centred on the supply of alternatives to drug consumption, including alternatives of occupation of free time;
- c) strategies based on affective components, focusing on the enhance of self-esteem, as well as change of attitudes, beliefs and values related to drugs and consumption;
- d) strategies based on social influence. Their goal is trying to foresee and face social pressures, identifying the inter-related factors that increase the risk of consumption, revealing, thus, the social influence and intending to develop activities of resistance;
- e) strategies of development of general skills (“Skills for life” [Martín, 1999]).

There are other classifications and typologies that complete those five strategies, such as the classification given by the “Centre for Substance Abuse Prevention” (1997), which presents as strategies of prevention:

- 1) the *spreading of information*, thus increasing the knowledge on substances and their effects on individuals and on society;

- 2) *strategies of education*, which try to develop social skills, decision-making, capacities of resistance to stress, critical analysis, etc.;
- 3) *alternative strategies* suggesting alternative activities, which do not include drug use;
- 4) strategies directed to *risk populations*;
- 5) *community strategies*, which give the community some skills to develop measures of prevention;
- 6) *actions directed to the environment*, which try to produce changes at a code level and community attitudes.

The European Council in *The Handbook Prevention*, 1998 (cit. by Martín: 23) presents another classification for strategies of prevention, according to Gerstein & Green. Thus, we have:

- 1) strategies that identify *risk factors*;
- 2) strategies with an *evolutive focus*, that is, strategies centred on family dynamics during the process of primary socialization and also in school;
- 3) strategies based on the *Social Influence Model*, where the main goal is to supply information on drug effects, as well as on the processes of social influence ;
- 4) strategies *focused on the community*, which propose a synthesis of the three previous strategies;
- 5) strategies related with *school programs*;
- 6) strategies of *compromise with the media*, which, without producing any effects on the attitudes, can sensitise and inform.

The ‘Fundación de Ayuda contra la Drogadiccion’ (FAD 1997, cit. by Becoña, 1999) presents only three preventive strategies, namely:

- 1) the *informative* strategy, which supplies objective and true data according to the targeted population;
- 2) the *formative* strategy which is centred on the human being so that he/she, through his/her own decision, renounce to take drugs;
- 3) strategies centred on *the supply of alternatives* to drug use.

As we can see, in what concerns strategies based on the reduction of drug-seeking, there isn’t a consensus in what concerns a single typology or if we should use just one of those strategies (Martín, 1999). Nevertheless, to select the adequate strategy implies a previous knowledge of the reality and its needs. According to Becoña (1999) we should always start from a theoretical model, because “to clarify the base theoretical model helps us to identify the variables on which we should work upon”.

Through the development of investigation on the preventive interventions based on different theoretical models, it is possible to demonstrate that, when applied in an

adequate way, certain preventive interventions on drug (ab)use were able to «promote negative attitudes towards drug use, to reinforce social rules contrary to (ab)use, to promote affective bounds with socializing institutions, and also to change the perceptions on social acceptance of drug, developing social skills of the target-groups in these interventions, so that they can resist to multiple pressures that allow the beginning and maintenance of drug consumption. As a conclusion, we could state that these “preventive interventions” proved to be effective in reducing drug use (in target-populations) comparatively to what we expected in the same context when there was no intervention» (National Institute on Drug Abuse, 1997 a, 1997 b, cit. in *Catálogo de Programas de Prevenção de Abuso de Drogas*, 2000:1)

4.1. PREVENTION PROGRAMS

4.1.1. Definition and Principles

A drug addiction prevention program may be defined as a “organised, coherent and integrated set of activities and actions, carried out simultaneous or sequentially with the purpose of reaching pre-determined goals (to prevent or delay the surge-up of consumption behaviour, drug use or abuse) in a certain population (Martín, 1999:17).

Thus, every prevention program must be based on the knowledge of the problem on which one wants to intervene, as well as on the diagnosis of the needs considering the specific context of the geographical area where it is going to be applied, the target-population’s characteristics, etc..

Due to the variety of the preventive programs, since they all have as function to prevent, the National Institute of Drug Abuse (1997), in an attempt to homogenize some of the principles which guide the preventive interventions, suggested several assumptions that should be considered in the elaboration of a preventive program.

Table 1 – Prevention Principles (NIDA, 1997)

1) prevention programs must be designed in such a way as to increase protective factors and to annul or reduce risk factors;
2) prevention programs must has as goal every way of drug abuse, including legal drugs;
3) prevention programs must include strategies which allow the subject to resist to drug supply, reinforce the personal commitment against drug abuse and increase social skills, among others (skills of communication, peer relationships, self-efficiency and assertivity);

4) prevention programs adolescent-targeted must include interactive methods (group discussion, more than isolated teaching techniques);
5) prevention programs must consider parents and tutors, to reinforce what children are learning, giving the opportunity of discussing in the family legal and illegal drug use and helping them to assume a position on the matter;
6) prevention programs must be in the long term, during school age in order to reinforce the goals of the original prevention (for example, in prevention programs implemented in primary and secondary school the existence of sessions, which support the students during phases of transition from one level to the others);
7) family centred prevention measures have higher efficiency than the ones which only consider the parents or the children;
8) community programs (campaigns in the media or policy changes, like new laws on the access to alcohol, tobacco and other drugs) are more effective when they are followed by interventions in school and family;
9) community prevention programs must reinforce the rules against drug use near all prevention targets (family, school and community);
10) school is a privileged environment since it allows the understanding of different populations and also facilitates the identification and action in certain risk sub-populations (group of children with behaviour problems or with learning difficulties may become marginalized later on);
11) the prevention design should be adapted to the specific nature of the most evident problem in each community;
12) the higher the risk of the target population, the earlier and the more intense the preventive measures should be;
13) preventive programs must be adapted to the age, level of development and culture of the target groups.
(Adapted from National Institute of Drug Abuse)

Thus, preventive programs can be developed in different contexts, namely in family, school, community and others.

4.1.2. Articulating Risk and Protective Factors

Bearing in mind the diversity and specificity of contexts, when selecting which prevention program is going to be implemented, there must be a previous knowledge of a series of factors, namely specific and protective factors of the environment.

Although the researchers on drug use and abuse are not completely conclusive it is possible to identify a set of variables related to the main factors liable to influence the beginning of consumption.

It is important, before anything else, to identify risk factors, that is, “an attribute and/or individual characteristic, situational conditions and/or environmental context which increases the probability of drugs use and/or abuse (beginning) or a change at the level of implication with them (maintenance)”. By protective factor we mean “an attribute or individual characteristic, situational condition and/or environment context which inhibits, reduces or weakens the probability of drugs use and/or abuse or the change at the level of implication with them (Clayton, 1992:15-16, cit. by Becoña, 1999).

The healthy development would result, in this way, in the balance between risk and protective factors. From the relation between these factors, it results a bigger or smaller “capacity of the individual to a successful adaptation, positive functioning or skills facing an adverse situation, involving multiple risk and internal and external threats or even the skills of recovery in the sequence of a long traumatic experience (Soares, 2000: 28).

Recently Pollard, Catalano, Hawkins & Arthur (1997) and Muñoz (1998, cit. by Becoña, 1999) grouped risk and protective factors of drug abuse and divided them into four areas: community, school, family and peer group. In what concerns community, the risk factors we should consider are: a disorganised community, laws and norms favourable to drug use and drug accessibility. Protective factor is the positive reinforcement for the involvement in the community. In school context the factors considered as risk factors are low success, as well as the little involvement in school activities, while the main protective factor is the positive reinforcement from school involvement. As regards family, risk factors are a low level of affectivity between the family members, lack or diminished family discipline, familial conflicts, family background of anti-social behaviours, and permissive parental attitudes towards drug use. As protective factors family affectivity and involvement are pointed. Finally, in individual and peer group contexts, risk factors are: violent and anti-social behaviour, experience at an early age, and weak resistance to group peer’s pressure, seeking new sensations. As protective factors we have religion, belief in moral order, social skills and closeness to peer group.

Quite recently, Muñoz (1998) has done an exhaustive revision of the risk and protective factors, and grouped them in:

- (1) environmental / contextual;
- (2) individual /genetic, biological and psychological;
- (3) socialisation factors.

According to Clayton (1992 cit. by Becoña, 1999), when one designs drug use prevention programs one should take into consideration that risk factors may not be present, and when they are, the possibility of drug use surging up is bigger. However, it is convenient to point out that the fact of just one factor being present, doesn’t mean that drug use will occur, because this behaviour will result from the interaction of several

factors, since risk and protective factors have multiple dimensions and each one influences, directly or indirectly, drug (ab)use.

Moncada (1997, cit. by Becoña, 1999) also made a revision of risk and protective factors in the ambit of drug addiction prevention, having presented the following conclusions: “one can state that there are factors associated with drug use, and there are others which are associated to abstinence”. These factors were classified as factors related to the individual and his/her relation with environmental or context factors. Another of her conclusions is that there exist different risk factors for different drugs, such as, “a high level of depression is associated with the consumption of heroin or alcohol”. The influence of some risk factors varies according the stage of the life cycle. Finally “we find some risk and protective factors common to a large number of problematic or inadapted attitudes, like unwanted pregnancy, school failure, juvenile violence and delinquency. Some of these attitudes predict drug use.” (Moncada,1997, cit. by Becoña, 1999).

None of the risk factors has a preponderant character on the other, nor are they the only cause to the up surge of drug addiction. *We can only speak in terms of probability, but never in terms of causality or determination.*

The several risk factors cannot be considered in an isolated way, for drug use implies a dynamic interaction between the individual (age, low self-esteem, low tolerance to frustration, poor assertively, etc.) context (related to family, school, environment and peer group) and substance (substance *per se* is not important, only when it fulfils a certain function to the individual). As such, the importance of several characteristics as risk factors varies from personal to person, according to the evolution moment he/she is and the surrounding environment.

The identification of risk and protective factors is, thus, of major importance to understand the target-context of a preventive interaction, allowing in this way, the implementation of strategies that stimulate protective factors and annul or reduce risk factors. Only in this way would it be possible to select the most suitable strategy(ies) to stop or to make it difficult the up surge of a particular phenomenon. Otherwise, we would continue to have occasional and out of context interventions, without any kind of evolution of its effectiveness.

4.2. APPLICATION CONTEXTS

4.2.1. Family Context

The family is a unit present in any society. One of its main functions is education and transmission of values to the offspring, and it is also a privileged learning place and

affection experience. It's in the family that the bases of education and personality's formation arise, and it is from the family relations with the environment are established.

Since it is in the family that one acquires and develops attitudes, beliefs, values, life styles and behaviours, we should consider the family context as a priority area of preventive prevention. In the last few years we verified an evolution in the concept of family, as well as changes in the structure and functions of family. We stopped having extended families and started having nuclear families, *i.e.*, formed by the couple and their children. We also verified that new types of family have emerged, especially single-parent families²; reconstructed families³; foster families⁴ and community families⁵.

Another phenomenon we have verified in the past few years is that children leave their parents' homes later than before. The changes and the crisis of traditional values have provoked some confusion in the families "we no longer know which values we should pass on to our children, we don't know whether to be strict or effectuate, we are afraid of being too severe or too tolerance, that is, sometimes we don't know what's best for our children (Ríos *et al.*, 1997).

The lack of experience on children's education, the reduction of the number of family members, the integration of women in the work world, all this has contributed to delegate the family's educative function to school and other institutions, instead of being shared with them. The traditional role of family, as a vehicle of transmission of values, family history and tradition was also replaced, partially, by TV, means of communication and community (Ríos *et al.*,1997). However, the role of the family as a socializing agent is still maintained, and that is why preventive interventions give the family a fundamental role, although they don't consider the family as the only aspect to consider.

Preventive models focused on the family assume that there are multiple risk factors, which contribute to the up surge and maintenance of psychoactive substances consumptions

Merikangas and collaborators (1998) distinguish between specific and non-specific family factors, being the previous ones related to drug exposure, that is, parental models of drug use (coping mechanisms), acceptance of addiction behaviours, as well as accessibility to drugs. From several studies, Duncan and collaborators (1995) and Patterson (1986) stress the idea of coping with maladaptative skills [cit. by Merikangas (1998)]. The family's destructureation, bad relationship between the couple, exposure to

² "We call single-parent families those where the parents generation is represented by only one member. This may happen because one of the parents leaves home and the one who stays does not get remarried or because the single mother stays with the children" (Alarcão, M., 2000:212)

³ Constituted by people who had another nuclear family in the past and have built a new nuclear family. (*idem*:204).

⁴ Families that take in children or adolescents with whom they do not have blood bounds, but to whom they are connected to by affective or legal bounds (*idem*:218)

⁵ Families in which the "predominance of horizontal relationships makes (...)the big subsystem to be the fraternal: solidarity is incentivated, whereas competition and relation complementarity is put at the community's service and not at the individual's.(...) The educational model is not the one from biological parents, but rather from the community (*idem*:230).

family stress situations, existence of psychopathology in the family, neglection, psychological and sexual abuse and social exclusion are mentioned as non-specific factors.

Thus, we verify the urgent need of developing preventive interventions focused on the family, with an educative focus, promoting in the family the development of healthy habits, attitudes and values. Besides reinforcing the parents and other educators' education models, preventive interventions must necessarily give information and formation to parents and educators, in order to reduce the impact of risk factors and to promote protective factors.

Having as a goal to evaluate whether the family programs are effectively adjusted to educational and health promoting models, Kumpfer studied about 500 programs of Family Prevention. From her conclusions, namely the ones focused on enhancing the effectively of new programs we highlight (Mendes, 2000):

- (1) family focused programs must be comprehensive programs, that is they should present clearly defined goals, which outcomes they wish to reach, and which instrument must be used in order to correctly achieve those goals. It is important that those who received the messages are able to understand them, so that they can conveniently and effectively assimilate them;
- (2) programs must be target to the whole family and take in to consideration the moment of the life cycle the family is going through. The family involvement, of parents and children, in several activities is one of the major contributions to the programs effectiveness;
- (3) the time factor is fundamental, that is why programs should be long term ones, stimulating the change of attitudes and behaviours;
- (4) the support (base) of family focused programs must be centred on the knowledge of risk factors and protective factors. In prevention actions, it is not enough trying to solve the physical and psychological consequence of substance consumption. According to Mendes (2000), it is important to understand and discuss all the factors, present or past, that are related to drug use (family functioning, the role of school, school success or failure and community);
- (5) finally, programs must be adapted to each community's need, bearing in mind the specificity of each micro-reality, which implies a deep knowledge at an economic, social and cultural level.

Bearing in mind these conclusions, Kumpfer (1995) defined five types of family focused preventive interventions:

- 1 – school for parents;
- 2 – programs focused on family development and education programs;
- 3 – family therapy;
- 4 – intervention programs in family crisis;
- 5 – programs of rehabilitation targeted to youngsters with juridical problems.

Thus, primary prevention programs must try to evaluate individual and environmental family risk factors that can be associated with a higher risk of using psychoactive substances.

4.2.2. School Context

With the change of the family concept, school is, correlatively, getting sooner and sooner a more important role in children socialisation, starting not only to complement some family functions, but also to take its place. Primary socialisation, earlier carried out by the family, in a context of personalisation of values transmission and of relationship' affectivity, is nowadays assured by the school.

School is seen today as one of the most credible fields to implement prevention programs which reduce some risk factors, reinforce health as a fundamental value of all people and promote the youngster's personal and moral development, since it is in school that students, parents and teachers interrelate themselves. Teachers play a preponderant role as models and mediators in preventive interventions.

The recognition of the fact that school is a privileged context in designing preventive strategies, is also present in the studies of National Institute of Drug Abuse, when they mention that "school offers the opportunity of reaching all populations and it is also an important scenario to specific subpopulations in risk, such as children with conduct problems or difficulties and who are possible marginalized" (NIDA, 1997).

School may give an important contribution to the construction of an adaptive organisation at the level of emotional regulation, cognitive and behavioural systems. Drug addiction prevention programs may offer great contributions to that organisation.

School education on drugs should take into consideration the total development of the individual. According to the *20th Report of the OMS Committee Techniques on Drug Addiction* "education is a bilateral process in which the facilitation of learning and maturation are more important than the acquisition of knowledge. Its purpose is to increase the capacity for decision-making, for clarifying values, facilitating its practical application and for developing skills to face several situations" (Prevencción de las Drogodependencias, 1997: 69).

Thus, strategies should not be limited to the supply of information, because information results only when it is part of formation actions. The basic strategy of school prevention must be supported in the construction, in the school itself, of its own preventive program (educational project) fully integrated in the curricula project. By inserting a prevention program in the educational project of the school, together with other contents and with the same impartiality, we avoid the surge up and/or the creation of myths related to drugs. At the same time, it allows an interdisciplinary focus of the drug phenomenon, and the contents adequacy to age, level of maturity and actual

context of the target population. Besides it guarantees the continuity of the program. We diminish, then, the risk of indiscriminate information.

We can classify school-targeted interventions in two groups: specific and non-specific drug addiction prevention interventions. In specific prevention, programs have as a goal to prevent drug addiction, in other words, they have only that particular goal and, at the same time, they are limited in time. Non-specific programs are global and have as a goal the promotion and development of general skills (training of abilities). The specific goals of drug addiction prevention can be included but they are part of more global goals.

4.2.3. Community Context

Primary prevention of drug addiction focused on the community should have as a goal to reinforce the community's messages and rules against drug abuse and to facilitate the healthy ones.

Interventions focused on the community may be classified into two categories:

- 1) programs whose main goals are related to the prevention of psychoactive substance abuse;
- 2) programs of health promotion; their goal is related to promotion and development of healthy life styles.

Community interventions must promote the mobilization, implication and participation of the community's institutions and organizations in the diagnosis of the intervention needs, as well as in the creation of answers. Community programs must also be comprehensive, that is, supported on other programs developed in their environment, such as school and family programs. They must also be multifaceted and adapted to the populations' characteristics.

We include here both the campaigns meant to inform and sensitise the community and the measures implemented through the media. We know that the campaigns are not prevention programs *per se*, however, they are absolutely indispensable to promote the society's participation in debates and decisions, which involve the whole community. On the other hand, these campaigns are also a means to enhance the preventive role of the family and a way of inviting young people to have fun without the need of taking drugs.

4.3. FINAL CONSIDERATIONS

“Human beings are like trees, they grow if they are let to grow, there is no need to pull. It's enough to give them adequate soil and to take out the surrounding weeds”. [Jaime Milheiro (1988)].

Drug addiction prevention should involve all the education agents and the contexts in which people grow and develop. Most existing programs are thought of to be applied to adolescents. However, literature and a great number of social epidemiological studies show that the consumption of certain substances start around twelve/thirteen years old.

On the other hand, the outcomes of more recent investigations suggest that in such an early stage as the first school year, children reveal behaviours, like aggressivity which are predictors of adolescent drug use. At the same time, they also show that there are high risk behaviours and characteristics of drug use in the first stage of life and may be used to identify some of the individuals who should get special attention from preventive interventions (Cazares, 1994; cit by Prevención de las Toxicodependencias, 1997).

Thus, we are conscious that we should anticipate preventive interventions back to earlier ages than adolescence. In the same way, we should bear in mind the developmental moment which the target-group of the intervention is going through. All this implies an adequacy of the educational strategies to each stage of the children's life cycle as well as to the definition of specific and different strategies to young people who have never used drugs and to those who have already used them.

Family should always be called to participate and integrate preventive programs. School and community are other scenarios as important as family in this preventive path. Having this relevance of the family as a context of prevention in mind and also taking into consideration the specificity of our involvement in the global research project of IREFREA, we developed a research on Primary Prevention Programs focused on the Family, which we will present in the next chapter.

5. META-ANALYSIS OF THE PRIMARY PREVENTION FAMILY PROGRAMS IN FIVE EUROPEAN COUNTRIES

By A.P. Relvas; A. Olaio; F. Mendes; M. Rovira; IREFREA, Portugal

As previously mentioned, this chapter constitutes, essentially, the presentation and discussion of the field research conducted by IREFREA's team (research Area "Family and Drug Use Prevention") throughout 1999- 2000.

5.1. GENERAL CONSIDERATIONS AND RESEARCH GOALS

The need to carry out a research on the state of art as concerns prevention programs at the family level in five European countries was one of the main goals of this study.

In fact, in the context of the research we undertook two years ago (Mendes, Relvas *et al.*, 1999) we made an initial survey of the existing programs and studies regarding this target group. The outcome pointed to a deficiency and lack of studies or research and available programs at a family level.

Thus, we intended to conduct a survey and an analysis of the programs or activities in course in those five European countries, that help to understand what kind of answers are given, in order to prevent drug use, involving the family, in part or as a whole, and trying to realize how far the family members are an active part in this preventive process. We know that most times parents and educators are not consulted or called in to participate in the existing preventive activities. This gap leads to a loss or decrease of the impact of the preventive messages, especially when these activities are pre-adolescent-targeted, for the parental involvement could reinforce the conveyed messages. Thus, from a meeting in Lisbon with all the research teams involved in the project (Portugal, Spain, France, Italy and Austria), two main goals were established:

- 1) the construction of an analysis / evaluation instrument of the primary prevention programs, *tout court*;
- 2) a comparative study of the prevention programs and activities in the five countries mentioned above, through a meta-analysis based on the application of that instrument.

The items, which would be included in that same instrument, were also identified, defined and operationalized in that meeting.

5.2. CONSTRUCTION OF A DESCRIPTION AND EVALUATION GRID OF THE PREVENTION ACTIVITIES OR PROGRAMS

In the sequence of what has been said before, it is our purpose to do a survey and an analysis of the different primary prevention activities focused on the family that take place in the five European countries involved in this project. Our aim is not an evaluation of those activities, since there wasn't enough time to do so, but it is the creation of an assessment instrument that helps the understanding and logic of the interventions undertaken.

We keep in mind that the evaluation of the programs, projects or activities implies a systematic analysis and interpretation of the results, bearing in mind the work done. Thus, we proposed to create a grid of analysis where we could frame and characterize what we designate as Level I Activities and Level II Activities that will help us reading the interventions in this area.

Getting into more details: the goal of this analysis grid elaboration is also to build an instrument that, in the future, will allow us, in a fast and uniform fashion, to describe any primary prevention project, namely in what concerns drug use, whether it is at a planning level or in an implementation stage, or even if it is bound to a retrospective analysis.

Such an instrument will correspond, in our view, to the possibility of surpass an important gap in the prevention area, such as the lack of consistent, articulated and global information on what, in a sparse way and in a more or less invisible manner, has been made or planned in this matter. That is, it will be an instrument which can facilitate a more thorough and balanced knowledge of the state of the art in this field.

In fact, the availability of this information to a whole range of agents in the prevention area – from practitioners and researchers to the decision-making entities and institutions – may lead to a broader knowledge on this matter, in order to draw the necessary implications, whether theoretical, political or pragmatic. It is in this way that the kind of information given by the application of this instrument may become an important and necessary element for the adequate and accurate justification of a prevention policy, in a wide sense.

In fact, if it was not like this, we all know that such a policy will have much less possibility of being effective, because it won't have been developed from the knowledge and previous study of the situations and factors involved in or related to them. Certainly, in this context, what is or was done, or what is planned to do in the field, as regards preventive activities, is one of those factors.

Finally, the design of this instrument has, logically, global evaluative goals, namely those related to credibility and organic, theoretical and methodological consistence of the considered preventive programs or actions. This dimension will be easily clarified through the description of the items in the grid.

As one may deduce from what has been said previously, it is important to point out that this instrument intends to have a broad character, as regards preventive activities, whatever their target object or context might be, although in the present investigation its application is restricted to the issue we are concerned about – activities and programs focused on the family or family targeted.

Returning to the grid, let's focus on its description and organization criteria: the distinction between Level I and Level II implies the development of some criteria that can organise our perception of the different preventive activities, “sorting them out” into distinguished settings, and that can help the practitioner or the researcher to understand their range and their technical consistency in informative and formative terms. In other words, those criteria may help us to see if a program arises a real change in the perspective of someone who will always have the option between the licit or illicit substance abuse, but who comes to rationalize through logic not to use them, or if he/she does it, to reduce the negative effects of that use.

Thus, in our perspective there are two main groups of preventive activities:

Level I- Occasional Activities, / limited in time/; they are not part of a broader logic of other activities.

Examples :

- informative and divulgation materials;
- playful and recreational activities whose goal is to prevent the drug use;
- occasional informative actions;
- some wide ranging information campaigns via the mass-media.

One should not forget that in this type of intervention – that we call Level I – the idea is just to inform or to act in order to prevent, but there isn't any theoretical framework that grounds or guides the interventions, nor even a time concerned goal.

Level II- Long-term activities that are integrated in a systematic logic of several kinds of activities, including different agents, with an evaluation concern and based on theoretical models that sustain the preventive logic.

Examples :

- prevention programs in a school environment with a curricular level intervention, developed through out the years and grades.
- national programs or plans that foresee the intervention of several “partners” (governmental and NGO's) at different levels (society – school – courts of law – police forces, etc) and with a precise number of years defined goal on what concerns the reduction of new drug users.

Level I Programs

Once again, when we created this grid we kept in mind the many occasional and local informative preventive activities that take place, sometimes only answering to the

schools or parents / educators groups requests or even other professional ones. The idea that lies under these activities is to respond mainly to requests or to react to some event that causes the “action”.

For this level we have grouped the following items: Promoting Institutions – Goals – Time Scope - Intervention Level – Methodology – General Description - Work Team - Evaluation. As we have already mentioned, the identification and operationalization of these items was, in a first moment, the result of a meeting with the whole research team and, in a second moment, it was revised by the coordinating team (cf. Table 1).

Table 1. Level I Activities	
Name of the project	
Promoting Institution	
Goals	
Time scope	
Level of Intervention	
Methodology	
General Description	
Work team	
Evaluation	
Observations	

Promoting Institutions – In their essence these activities are whether developed by several governmental services, especially the Ministry of Education and the Ministry of Health, or under the responsibility of NGO’s, that most times don’t carry out a specific task in this work area. Determining who is in the origin of these activities, knowing their goals and supporting structure may help us to bring credibility to these preventive interventions. We are aware that in some countries the NGO’s outside the drug addiction area apply to funds in order to promote some informative activities without credibility in this area.

Goals – To know exactly the action goals, trying to understand how they are defined and why (as a response to requests or as a reaction to a specific situation that came out and to which a more structured and defined reply is expected, for example). The goal definition implies that the strategies used should be also defined.

Time Scope – duration of the project in what time is concerned.

Intervention Level – To make sure we are referring to local, regional or national activities helps us to understand the program’s or project’s dimension: it may show its importance even if it is only a geographical one. This doesn’t mean that a merely local

project or action doesn't have quality, interest or that it is not efficient. *Think global, act local* is a truth that implies that the different realities of the phenomenon may have an adequate reply to each situation.

Methodology - Having defined the goals and selected the strategies, one still has to know how its application will be carried out, bearing in mind the methodologies choice. The use of pedagogic methodologies, whether they are expositive, demonstrative, interrogative or active is vital to reach an understanding of one's purposes. Drawing programs / projects that aren't comprehensive, due to its deficient methodology, may lead to its failure.

The methodologies become a very important element in this preventive building. To ally the knowledge to action, evaluating every moment the way we intend to act, is a project / action evaluative factor *per se*.

Description of the project - With this item we intend to have a description of the project's course, its timing, its component phases, helping us to visualize the whole set.

Work Team – It is common to hear that “this prevention thing is not only a problem concerning all of us, but we all know how to act”. This is a half-truth, for when acting is concerned, it is necessary a technical competence. Informing or intervening just for the sake of it doesn't justify the name “prevention”. The lack of qualified technicians in this specific area doesn't contribute to a quality work. That is the reason why we wanted to be aware of the qualifications of the work team, who carried out all the activities. Many European and North American authors recognise the need to have a prevention which is more and more seen as a science.

Evaluation – It has been demonstrated how the evaluation is a fundamental process so that prevention is more effective and its practice more efficient. To determine which activities require an evaluation it is also important to understand the intervention efficiency and relevance. We dare say that evaluation should happen before and after the intervention. *Before* to justify, organise and frame the action. *After* in order to evaluate the action's outcomes. We also know that evaluations may be qualitative or quantitative. To understand how many of the studied actions have been evaluated became an important element of this research.

Level II Programs

We have already defined the assumptions that should be found in Level II projects. A long time range, a theoretical framework, clear aims, strategies and methodologies and also the practice of a rigorous evaluation are some of those items. The idea is also to evaluate those projects or programs' “quality”.

Besides the existing Level I items: Promoting Institutions – Goals – Time Scope - Intervention Level – Methodologies – Team work – Evaluation, we add one more item – Theoretical Model - that, we think, will make the difference in the distinction of these two broader categories (see Table 2).

Table 2 - LEVEL II ACTIVITIES	
Name of the Project	
Promoting Institution	
Goals	
Time Scope	
Intervention Level	
Methodology	
General Description	
Work Team	
Theoretical Model	
Evaluation	
Observations	

Theoretical Model - The description of the theoretical model that supports our intervention is quite important since it frames, grounds and justifies the option of the actions / activities that we intend to carry out.

In drug prevention field there are several theories and there is not one that we can emphasise. Sometimes each one of them justifies only one of the phenomenon's several variables' aspects and shapes, in its three more important components:

- a) the factors that enable the drug experiment and use;
- b) the evolution from legal to illegal drug use;
- c) the evaluation of the different importance of biological, socio-cultural and psychological variables of the phenomenon's break out.

To understand how and why some individuals use drugs and others don't, means that we are capable of drawing programs and of developing strategies, so that one can introduce activities that may be applied to different groups (cf. Chapters 3 and 4).

To realize, then, how far family prevention programs in our countries are theoretically supported and to know if there are different models in the different countries, taking into account the different realities, became a challenge.

5.3. METHODOLOGY

To each of the countries participating in this research project it was sent the analysis grid previously designed and it was asked each team to identify, in their own country,

the higher number of prevention projects / activities focused on the family and conducted in the last decade (1999 – 2000). The goal was to get a sample as close as possible to the universe of the developed prevention projects, in a family context, in each country. For that, the teams from each country could use, for the collection and identification of the sample, the procedures they considered more appropriate to their reality. Once the sample was identified, that is, once projects to be included in the study were identified, they should be characterized through the fulfilment of the items of the grid built for the Level II activities. This procedure was considered useful since: 1) the characterization asked predicted the possibility of missing answers; that is, the absence of response to one or more items of the grid wouldn't lead to the elimination of the project in this analysis. 2) the specific distinction between Level I and Level II actions should be done by the investigation coordinators so that the criteria followed in that distinction were accurately uniform and similar from country to country.

After each national team had characterized the identified projects, by using the grid items, all the collected information was sent to the research coordination, including the necessary and corresponding work-field reports.

After the Portuguese coordinating team had gathered all this material it was time to analyse it. Thus, in what concerns the application of the grid, the following procedures took place:

- 1) all the projects were analysed and classified as projects of Level I or Level II activities, depending on their characteristics
- 2) next, a grid (Level I or Level II) was used for each project individually;
- 3) again, following the items of the grid, a meta-analysis of the different projects from each country was done. So, it was possible filling in a first grid (Level I activities) and a second grid (Level II activities) for each country. At this stage, ten grids were filled in, two for each country, one of each level;
- 4) finally, in a second process of meta-analysis, which gathered the obtained data from each of the five countries, two grids (one of Level I and the other of Level II) were filled in, in order to achieve a global final conclusion.

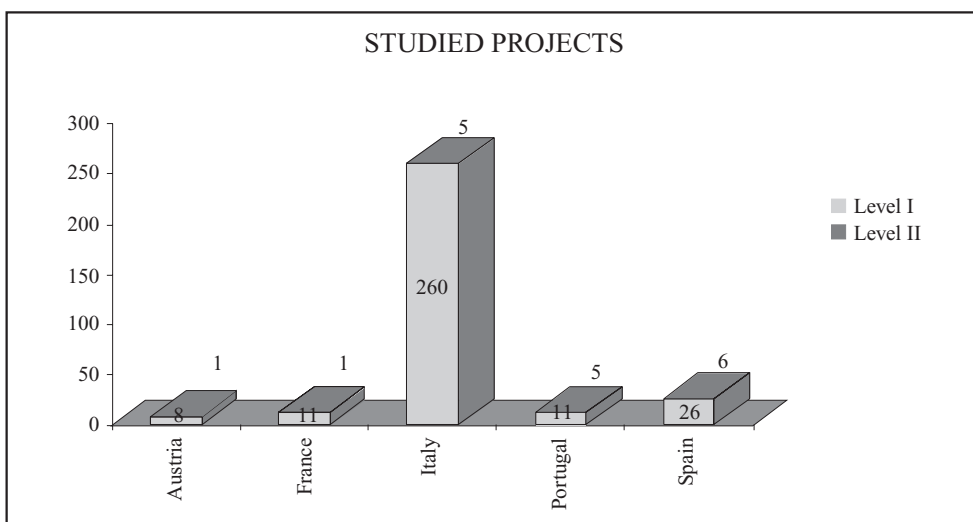
From the informative material in the field-work reports were also drawn some generic conclusions.

5.4. ANALYSIS AND DISCUSSION OF THE RESULTS

5.4.1. Procedures and Sample

From the qualitative analysis of the material and in what refers to the generic data and procedures we may conclude:

- 1) two research teams built their own questionnaires, more or less detailed and differentiated, but that obviously included the items of the grid (*e.g.* France and Austria);
- 2) in one country, the questionnaires were sent to the largest number of institutions with probabilities of developing or acknowledging the development of the type of projects to be included in the research (*e.g.* France). In the other countries the researchers themselves identified the projects in a direct way, using reports or other type of previous information that lead them to the research targets (*e.g.* Portugal, Spain, Italy). Still in another country a combined procedure of the other two was carried out (*e.g.* Austria);
- 3) the items filling in process was correlated to the procedures performed in the identification of the projects. Thus, in the case of France, the contacted institutions filled the grid themselves; in the case of Portugal, Spain and Italy, the answers to the items was established by the researchers themselves, and in the case of Austria there was a mixture of institutions self-filling (six projects) and researchers completion of the items (three projects);
- 4) there was some difficulty in collecting information, especially in the identification of the projects. That is shown, for instance, in the non-return of many questionnaires by the contacted institutions, associated with their devolution without any answers;
- 5) it is not possible, from the data and information we have gathered, to get a precise idea of the statistical relation between the n of the sample and the n of the universe of the existing projects in each country;
- 6) the sample is composed by 334 prevention activities and / or projects. Its distribution is the following: Austria - 9; France – 12; Italy – 265, Portugal – 16; Spain – 32. The big discrepancy between the number of projects in Italy and in the other countries may be due, among other factors, to the fact that the Year of Prevention of Drug Use was in course in that country. By another hand, the Italian political central power is, at the moment, quite aware of the issue of prevention in the family; this leads them to impose on the great majority of the institutions the need to develop that kind of projects throughout the year. It is, then, a contextual aspect or factor, whose future implications are impossible to determine at this point.
- 7) the distribution of the projects into Level I or Level II activities per country may be seen in Graphic 1. On the whole, we may say that 316 projects belong to Level I and only 18 are Level II projects.



5.4.2. Comparative Analysis per Country

In this section we will present the data collected in the third stage of the methodological procedures which were followed to analyse the information, as explained in the previous section (3: Methodology). Thus, our reflections' operational base are the ten grids (five of Level I activities and five of Level II activities) resulting from the first meta-analysis per country.

5.4.2.1. Level I Activities

We will present a comparison between the goals, level of intervention, methodologies used, general description of the projects, their extent in time, the responsible team constitution and finally the projects' evaluation.

We would like to point out that it wasn't always possible to collect all the necessary data to characterise some of the categories in study. However we will try to give a general view of the reality in each country, in what Level I projects are concerned.

- *Promoting Institutions of Primary Prevention Projects*

Analysing the nature of the institutions that promote primary prevention we verify that in Portugal, Spain and France there is a large heterogeneity, that is, in those countries we find public as well as private institutions that promote the projects. In the case of Portugal, we find projects developed by private entities, but which have the financial support of a State structure, named "Projecto Vida". In Spain, most of the

projects studied are promoted by the Autonomous Governments and Municipalities within the National Drug Plan.

In Austria, according to the collected data, the projects are entirely under the responsibility of private entities.

On the other hand, in Italy there is a broader intervention from the State in the prevention area; so the State is responsible for all the projects.

- *Projects' Goals*

Concerning the goals, we will start by distinguishing general purposes and specific purposes. Thus, the general goals are expressed in terms of the skills that need to be acquired and comply with a broad, global or complex ability. The specific purposes express an expected behaviour after an action or a set of activities. They should be formulated in operational terms, *i.e.*, integrating the fundamental components of the goals: behaviour, performance conditions and success criteria.

According to Elisardo Becoña (1999) the more recent studies of drug abuse primary prevention show that the majority of drug (ab)users have started to take drugs when they were 12 /13 years old. Many researchers (Hawkins *et al.*, 1999; Hundleby & Mercer, 1987) have found out that young adolescents change from legal drug use (such as tobacco and alcohol) to illegal drug use. Therefore, it's not surprising that the majority of preventive programs have as a goal the global prevention of tobacco, alcohol and illegal drugs. Thus, after comparing the projects' goals we may conclude that the only goal they have in common is the one we call "consciousness / awareness raising" about drug addiction prevention.

The projects presented by Portugal, Spain and Austria mention, as an important purpose, the development of social and personal skills, *i.e.*, they intend to teach the families how to resist internal and external pressures.

Another goal that emerges in almost every project of the countries studied, especially Portugal – "Projecto Pais Sabedores, Filhos Reconhecedores" – France – "Point, Écoute Parents - and Italy – "Sostegno della famiglia" – is to prepare families as prevention agents.

Some of the presented Austrian projects mention as a goal the project divulgation prior to the implantation itself. Another important goal of one Austrian project is the recovery of drug addicted mothers ("Mother-Child House"). This aspect is obviously connected to the secondary prevention. Nevertheless, it is mentioned here because it embodies a primary prevention branch at a family level, through awareness raising and accompaniment of the whole family.

In general we may conclude that the objectives of Level I projects are set in a health promotion perspective.

- *Intervention Level*

In what project intervention level is concerned we found out that all of them have a local range. This conclusion leads us to the importance of social and cultural context in which the behaviour takes place, reinforcing the idea that it is not possible to move on to a preventive intervention without a notion of the contexts. This logic is part of the subsidy culture concept that is flooding European Union policies and, according to that concept, all the social problems are preferentially solved at a micro level.

- *Methodologies*

All the countries presented active and participative methodologies except Spain, where it wasn't possible to gather data in this category. The use of these methodologies is related to goals definition, since they seek the development of personal and social skills. Therefore, interaction is a means of learning itself. Here, the development and acquirement of knowledge, abilities and skills take place in the direct social relationships context, taking the form of peer interaction, and in the indirect social relationships context, through the cultural instruments and social representations construction.

Besides the methodology mentioned above, the projects presented by Austria show psychotherapeutic methods and parent group techniques, similar to those in France and Italy. It is important to point out that Italy mentions the use of active and participative methodologies, with the help of playful and pedagogic material.

- *General Description of the Project*

In this category it was only possible to gather data from two countries: Portugal and Austria.

In Portugal, most projects have as contents parental and educators awareness raising and information sessions. Besides these actions, we emphasise the occupation of youngsters' free time, school holiday programs, "youth to youth" programs, informational material production and the organization of thematic debates and seminars. Austria specifically refers the realization of parental group targeted seminars.

- *Time Scope of the Projects*

We have come to the conclusion that there is a big discrepancy between the projects of the countries involved in this study regarding their time scope. Thus, Portugal presents one-year-long projects, over-a-year projects and more than two- year projects ("Projecto Prevenção na Família" – "Aprender em Família").

The projects presented by Spain last from two months to one year.

It wasn't possible to determine the time scope of the projects presented by Austria.

In France the projects that are being studied take from six months to a year, but most of them usually lasts longer than a year.

In Italy the prevention projects usually have a triennial schedule, since they are promoted under the guardianship of State institutions.

- *Work Team*

Only in Portugal and Italy was it possible to reach some conclusions regarding the project's work team. In these two countries there is a multidisciplinary perspective, concerning the technicians formation (psychologists, social workers and social animators). According to several authors, this multidisciplinaryity is very enriching, for the sharing of different knowledge and know-how contributes to a better understanding of the phenomenon we are studying.

- *Evaluation*

To evaluate an intervention, prevention project or program means a systematic gathering, analysis and interpretation of the information on the way the interventions act and the effects it may have (EMCDDA, 1998). The information gathered may be used to enrich an intervention, whether to enlarge or reject it.

Despite the need of an intervention evaluation being commonly accepted, very few primary prevention interventions have been evaluated in Europe. One of the reasons that justify this lack of evaluation have probably to do with the following reasons:

- the lack of previsibility of an evaluation;
- the non-adjustment of the programs and projects to an evaluative design;
- the hardship in designing assessment instruments that can “read” the interventions results;
- the non-prediction of control groups to compare the results.

Nevertheless, we can find in the studied projects some references to the evaluation actions and studies. We verify, then, that in Portugal, Spain and Austria the projects' evaluation is done mainly through data treatment, both at a qualitative and quantitative level. As regards evaluation, France mentions that it is scarce and unelaborated. Only in Italy wasn't it possible to gather data related to this issue.

5.4.2.2. Level II Activities

In this chapter we will do a comparison between the projects classified as Level II. Unlike Level I projects, we consider Level II the long term projects that are based on a precise theoretical model and that show a result evaluation concern.

Thus, regarding Level II, Portugal presents five projects, Spain has six projects, Austria and France have one project. Italy presents two Level II projects.

- *Promoting Institutions of Primary Prevention Projects*

The nature of the promoting institutions / entities is not different from those of Level I programs, *i.e.*, in Portugal, Spain and France they are fairly heterogeneous, we can find both public and private entities. The Level II project presented by Austria was promoted by a private entity. The Italian projects were developed in public institutions and regions.

- *Projects' Goals*

Portugal, Spain and Austria presented in their projects the aim to develop personal and social skills.

An intervention based on the facilitation of healthy and functional relationships between individuals, allowing them to learn and practice social skills, emerges, then, as an useful suggestion in the prevention of unadjusted social and personal behaviour in children. Nevertheless, the intervention should not be limited to children but it should include parents, teachers and other relevant elements of their relational sphere.

Social behaviour is, in a wider sense, a set of actions, attitudes and thoughts that the individual shows towards the community, other individuals and him/herself. "The intervention in the social behaviour problems has changed from a perspective of diminishing inadequate behaviour, and now it focuses on helping the individuals developing as much as possible their relational and personal skills trough new social skills acquisition" (Goldstein *et al.* 1980, 1989; Spence, 1980). The need for an intervention, which clearly includes acquired skills generalization strategies, in the context of the individual, is emphasised by several authors (Vaughn, Meintosh & Hogan 1990). One of the goals presented by Portugal is informative material production. The majority of this material will be used later on as an instrument for prevention agents' training. This is what we can see in the "Antes que seja tarde" project which supposes the organization of a Parental Training Manual to be used in the context of training.

Prevention agents' training is a goal referred to by Portugal, Spain and Italy.

Family skills promotion is mentioned by Italy, France and Austria. Here the families are seen as competent, to go through and solve their evolutionary crisis.

Italy indicates the well-being and health promotion as goal, that is, the health education has been focusing mainly on behaviour change, in order to promote a better health. Spain and France propose the development of supporting and counselling settings for families.

Portugal and Spain present, in some projects, the need for research actions prior to the program's implantation itself. This aim formulation is related to the analysis of the problem one wants to solve, diagnosing previously the existing needs.

Spain mentions also as a goal the evaluation of a previous project, already in course, namely the "Formación de Padres en Prevención del Abuso de Drogas" project.

- *Intervention Level*

Similarly to Level I, we verify that the programs intervention level is mostly local. Note that Italy presented many projects / programs, but the majority were concentrated in the northern part of the country.

- *Methodologies*

Portugal, Austria and Italy mention that in the projects implantation and development were used active and participative methodologies, that apply the learning through activities carried out by trainees and through confrontation between them and the real situation experiences along the process. A broad and various set of pedagogic techniques, such as group techniques (the "Prevenir para Agir" project in Portugal and the "Toyfree Kindergarten" project, in Austria), role-playing and brainstorming is associated to the active methods.

- *Theoretical Models*

One of the criteria used to classify Level II programs is the existence of a theoretical model underlying the project. According to Flay and Petraitis (1995) theory is important because without it we would be even more lost by the time of the preventive effective programs development. Simultaneously the theory progress leads us to more effective programs in the future. Furthermore, the prevention science wouldn't have come so far without theory; in fact, thanks to it, prevention science moved on rapidly in this last decade and will move even further and quicker when the time to clarify, rehearse and improve the present knowledge comes.

From the projects of the five countries we are studying we may conclude, concerning the support theoretical model, that all of them fit into the Group of Integrative and Comprehensive Models, namely the Ecologic Model, as it is classified by Kumpfer and Turner (1990-1991). This model comes from the Human Ecology Theory and was adopted as a framework that integrates several influences of the development of substance abuse and other behaviour problems context, such as poverty, bad neighbourhood and the cultural impoverishment. (Ex: "Prevenir para Agir", a Portuguese project).

Nevertheless, we can also find in these projects important influences of some other theoretical models. Actually, we can find some traces of Simon's and collaborators.

Social Learning Model (1988), which integrates the social learning processes and some intrapersonal characteristics.

In parallel, we verify that there is also an influence of the Family Interactional Approach (Brook, Brook, Gordon *et al.*, 1990) in the presented studies. This is a complex theory that embodies family, social learning and intrapersonal characteristics factors that, we know, affect the substance use. We may give as an example the project presented by France –“Point Écoute Parents”– although it has a strong systemic and family models emphasis.

Becoña (1999) criticises this set of theories because they don't take much into account the cognitive processes roles in experimental use. Nevertheless, we can find here and there in the projects presented by the five countries, the cognitive theories assumptions. These theories focus on the role of the perceptions of drug use among adolescents, on decision-making related to the beginning and maintenance of psychoactive substance use. The attitude, normative beliefs and use expectation, as well as self-efficiency, influence the decision-making evaluation in terms of costs-benefit (for example: the “Ordago” project from Spain).

We can also find in some projects the influence of the Social Adjustment Theory which claims that a strong commitment to society, family, school and religion inhibit each individual from deviant behaviour (Ex: the “Prevenir é Comunicar” project from Portugal).

The projects presented by Italy, besides some Ecologic Model influences, also reveal some influence from the Prevention Science assumptions, namely: (1) the need to specify the phenomenon; (2) knowing the system that regulates and grounds the phenomenon evolution; (3) building an abstract system that directs the phenomenon to a specific direction; (4) building technology that applies the modified system; (5) integration of intervention technology with the phenomenon that's being studied; (7) verification of changes (or not) in the phenomenon.

By analysing the projects presented by these five countries, we may conclude that there is not only present one theoretical model. In fact, they show the coexistence of several explanatory models / theories, mainly included in the set of Integrative and Comprehensive Models, although the emphasis goes to the Ecological Model.

• *General Description of the Projects*

In what concerns the projects' description, we realize that Portugal and Austria have a significant educational component focused on parents and, in some cases, on parents, teachers and students followed by dynamic methodologies.

Portugal mentions in some projects, such as the “Antes que seja tarde” project, the production of informative material.

The actions described by Level II project from Austria refer to situations meant to inform parents on drug use, drug use prevention and drug use situations. The same goes

for French projects, especially the “Point Écoute Parents” project which supplies information on recreational substance use and abuse, by doing conferences and seminars as well as periodic meetings of parent groups.

In Spain and Italy it wasn't possible to assess data on these projects' description.

- *Time Scope of the Projects*

One of the aspects that distinguishes Level I projects from Level II projects is their extent in time. Thus, in Level II projects we find that they last longer and are composed by regular actions. (Ex: Italian projects that have a triennial schedule).

In Spain there are programs continued for three or four years, namely the “Programa Piloto de Atención Familiar”, as well as the “Programa de Prevención das Drogodependencias”.

The Austrian project has a maximum extent of one year.

As far as we could see, the French situation doesn't have a conclusive extent in time. However one guesses that the actions described have a regular and continuous character.

- *Work Team*

In what concerns the constitution of the work team, Portugal reveals multidisciplinary teams (psychologists, social workers and street-animators); France refers practitioners with family therapy training as project's managers. As for the rest of the countries, it wasn't possible to gather any kind of information.

- *Evaluation*

Generally, the projects are submitted both to quantitative and qualitative evaluation.

In drug abuse prevention area the programs' evaluation may have as purposes:

- the selection of preventive strategies, that better fit the profile of the phenomenon upon which the intervention will focus;
- to facilitate the implantation of the program, so that it reaches, in fact, the final target group; to guarantee that the activities reach that target group with the necessary quality and quantity;
- to check if the previously selected strategy works or not, *i.e.*, if it complies with the pre-defined goals;
- to contribute to the quality of prevention programs and help in their design.

In qualitative approaches of evaluation, the goal is to understand a program or its particular aspects, as a whole. Emphasis is given to detailed description and deep comprehension of how it emerges from direct contact with the programs. The qualitative techniques are mainly established on observation, interviews and case studies. This approach may be applied exclusively or combined with quantitative approaches.

Quantitative data supports itself on a great number of observations, represented in a numeric form, such as the information that comes from structured questionnaires. This kind of approach aims, then, to measure a finite number of specific results. The emphasis is on measurement, synthesis, aggregation and comparison of measures and also on the meaning interpretation of quantitative analysis. In these approaches it is common the use of control groups. This technique is particularly important when the main goal of the evaluation is to define the projects' efficiency and efficacy (EMCDDA/OEDT,1998).

The analysed projects, classified as Level II projects, present a more regular and accurate evaluation with a previously defined structure. Thus, we verify that in Portugal there is a program whose evaluation was undertaken by an external entity, the "Programa de Prevenção do Consumo de Drogas no Âmbito Familiar", and is supervised and technically evaluated by the Fundación de Ayuda Contra la Drogadición (FAD).

The Spanish projects reveal a great concern on evaluation and one can see the existence of evaluation both at a quantitative and qualitative level.

In France, the studied Level II project, shows an evaluation carried out by a state organisation that we may consider to follow the criteria accepted nowadays in Europe as fundamental to carry out an efficient evaluation: the evaluation of the project's design, the evaluation of the process and the evaluation of the results (Martín, 1999).

The Austrian Project, similarly to other countries, also reveals some concern with evaluation both at a quantitative and qualitative data treatment. Italy doesn't present any data concerning evaluation.

5.4.3. Meta-analysis of the Five Countries' Projects

In this point we will proceed with the analysis of the reported data, starting from the two final grids of this study (cf. point 3 of this chapter – 4th stage of the methodological procedures).

5.4.3.1. Level I Activities

By making a brief characterisation of the Level I projects in the five countries (see Table 3) we realise that, as regards *goals*, all of them are concerned especially about information and awareness raising on drug use / abuse, that is, in an educational and health promoting perspective.

Concerning the *time scope* of the projects, we find that they are characterized by actions limited in time and not as a part of a broader logic of other activities, which complement the preventive activity, such as the intervention whose target group is the family as a whole. In what concerns the *intervention level* of Level I projects, we may conclude that all of them have a local range, thus emphasising the importance of the social-cultural context in which the behaviour occurs, reinforcing the idea that it is not possible to undertake a preventive intervention without knowing the contexts.

The *evaluation* of these projects is made by means of data treatment, both at a qualitative and a quantitative level. However, in this kind of actions, the evaluation is scarce and little elaborated.

The heterogeneity of the *institutions* responsible for these activities, as well as the difficult task that it is to get a *general description* of those projects and activities are important facts one should highlight. Also the lack of knowledge on the *work team* composition contribute to the hardship of a clear definition of these activities, especially in what concerns their praxis (except on what concerns the *methodologies*, predominantly active and group centred).

Thus, we would say that the Level I activities are focused, articulated and basically defined around their goals, being the rest of the items much more unclear and less concrete.

Table 3. Level I Activities (n = 316)

Promoting Institution	Goals	Time Scope	Intervention Level	Methodology	General Description	Work Team	Evaluation
<ul style="list-style-type: none"> • Private • Public (national or regional) • Heterogeneity 	<ul style="list-style-type: none"> • Consciousness / awareness to drug use prevention • Development of individual and social skills • Training of prevention agents (from technicians to families) • Health promotion and education goals • Production of informative and formative material 	<ul style="list-style-type: none"> • Short term • Time average: 6 months to 1 year 	<ul style="list-style-type: none"> • Local • Regional 	<ul style="list-style-type: none"> • Active and Participative • Using pedagogic and recreational material 	<ul style="list-style-type: none"> • Sensibilization and information sessions (seminars; debates, palestras) • Mostly not referred (unknown) 	<ul style="list-style-type: none"> • Mostly not referred (unknown) • Multidisciplinary 	<ul style="list-style-type: none"> • Quantitative and qualitative • Scarce and irregular

5.4.3.2. Level II Activities

The most common *goal* of these Level II projects (see Table 4) is to develop personal and social family competences, as we can see in:

- Portugal, in the “Programa de Prevenção do Consumo de Drogas no Âmbito familiar” project, which aims to provide the families with situations of interaction in order to enhance the family relationships and communication;
- Spain, in the “Ordago” project, which intends to promote family communication and the ability to resist pressure;

- Austria, in the “Systemic Prevention of Addictive Behaviour” project, whose goals focus on the identification of risk and protective factors and in early intervention within the family;
- France, in the “Écoute Parents” project, whose aim seeks to promote family dynamics and to give a privileged listening space for the parents and the youths;
- Italy, in the “Per La Pomozione dell’Agió” project, which intends to promote the comprehension process and the re-elaboration of the parental roles and of the educational role models.

Another goal referred to in Level II projects is the training of families as preventive agents (such is the case of Portugal, Spain and Italy).

Similarly to Level I projects, Level II projects also have an *intervention level* with a local range. Still comparing with Level I programs, and besides the expected difference in what concerns the existence of a theoretical model and a longer time scope, we may mention a more careful *evaluation* and more clearly defined *goals*, associated to the family dynamics. Concerning the support *theoretical models* we won’t make any more comments, since the predominance of the Ecological Model and the contribution of other models were sufficiently explained in section 4.2.2 of this Chapter.

Table 4 – Level II Activities (n = 15)

Promoting Institution	Goals	Time Scope	Intervention Level	Methodology	General Description	Work Team	Theoretical Model	Evaluation
<ul style="list-style-type: none"> • Private • Public (national or regional) • Heterogeneity 	<ul style="list-style-type: none"> • Consciousness / awareness to drug use prevention • Development of individual and social skills • Training of prevention agents (from technicians to families) • Health promotion and education goals • Production of informative and formative material • Goals clearly related to family dynamics 	<ul style="list-style-type: none"> • Long or medium term • Time average: 1-4 years 	<ul style="list-style-type: none"> • Local • Regional 	<ul style="list-style-type: none"> • Active techniques • Pedagogic methods and techniques • Therapeutic methods • Group techniques 	<ul style="list-style-type: none"> • Pedagogic actions directed to parents, educators and youths (schools) • Informative actions (conferences, seminars, etc.) 	<ul style="list-style-type: none"> • Mostly not referred (unknown) • Multidisciplinary • Technicians trained in family therapy (France) 	<ul style="list-style-type: none"> • Ecological Model (Kumpfer and Turner (1990-1991)) • Family Interactional Approach (Brook <i>et al.</i>, 1990) • Some other approaches also included in the set of Integrative and Comprehensive Models 	<ul style="list-style-type: none"> • Quantitative and qualitative • Regular character • Previous definition of criteria

5.5. CONCLUSIONS

From the reading and analysis of the projects in this research, that involved five European countries, we may reach some conclusions which, in our perspective, may be presented at two levels:

- a) the ones that come directly from the reading of the projects, from Level I and Level II charts;
- b) the ones we can assess from a global reading, in what concerns the “state of affairs” of family prevention projects.

About the first ones we may underline:

- The existence of a higher number of Level I projects / activities. This evidence is directly connected to the assumptions we have mentioned in the beginning (occasional activities based on information) and that will correspond to the need of, in a first moment, informing the parents and educators about substances and drug use / abuse.
- The goals focus mainly on information and awareness raising on drug use / abuse. This approach comes from the philosophy of Education and Promotion Health Programs. Countries like France, Portugal and Italy see in their work with the families a way of making those families active agents (partners) in this preventive action. We highlight the creation of specific spaces for families’ support and shelter in Spain and France. There are no significant differences between Level I and Level II projects on what concerns the goals. So, we can state that a more specific theoretical support, as well as a more delaying in time, doesn’t suppose another kind of goals, as one can expected.
- There aren’t projects of national dimension. The majority of them are bound to the town geography or even to the school where they take place. In Spain and France there is a wider level of inclusion.
- We can group most of the projects analysed in what we have previously called Ecologic Model, whose goals are also the development of social and personal skills, with emphasis on the development of self-esteem, assertiveness and avoiding techniques, always considering the individual/group surrounding contexts.
- Evaluation, an important item to assess the success or failure of these activities, is not present in most Level I projects analysed. Except for Spain that mentions both quantitative and qualitative evaluation.

About the second level’s conclusions, we may say that all the prevention activities and projects considered in this study can be classified as specific prevention actions, *e.g.* they are specifically focused on drug use or abuse. So, we know nothing about family prevention activities classified as non-specific actions. In fact, our goal was to study specific programs and actions in five European countries, but this cannot lead us

to forget other prevention activities existing even in these five countries, as well as its eventual worth as means to prevent drug use.

Considering our study's results one cannot claim there is a reality and a specificity of Family Prevention Programs. But one can say that there are prevention programs which also foresee activities that involve parents and educators. These activities are essentially informative and have an occasional character. Some of them may be included in Parental Education area, so they show a strong pedagogic emphasis. Some other ones, following the same emphasis, have as target the young, the peer group and the school context. Few of them are centred in the family – and the missing data on the item General Description of the Project does not allow us to clearly understand how this target-goal is achieved. A supportive and counselling dimension seems to be considered, but we do not know for sure how these activities get the parents, the children and maybe some other members of the family “working together”, in order to prevent drug (ab)use. So, we may conclude that there is a need to find a work base, which allows the creation and development of projects really directed to the family as a whole, that is to say, really focused on the family.

6. CONTRIBUTIONS TO PRIMARY PREVENTION FOCUSED ON THE FAMILY

6.1. INTRODUCTION: THE LOGIC UNDERLYING IREFREA'S INVESTIGATION

IREFREA's goals, as we all know, are: (1) the promotion of an integrated primary prevention; (2) the research in primary prevention area; (3) the study of risk and protective factors associated to drug use/abuse or other ways of juvenile distress; and (4) the creation of a research network in prevention.

IREFREA's research area "Family and Drug Use Prevention", as the name stresses, focuses mainly on family's influence on drug ab(use). In this context, their primary goals articulate themselves with the ones previously mentioned to IREFREA in general. Thus, the research on the relationship between Primary Prevention of substance consumption and Family has guided all our studies.

Always updating goal (4) (broadening of the research network), until now investigation and advance in the science of prevention have imposed has a main referent. Because of that, it is not our perspective to create or implement on the field any prevention program or activity, but rather to give some contribution to a more articulated and supported implementation, development, planification and evaluation of prevention programs, in the set of European countries involved in this network.

In other words, what we have always intended was to follow a logic of understanding and evaluation of what is happening on the field, framed by assumptions of a scientific character, mainly at four levels:

1. A first level based on the investigation of the action's target, *i.e.*, the family, its functioning, perceptions and worries about consumption, besides the analysis of its difficulties and potentialities.

It was on this base that the research carried out in 1996/1997 was planned and implemented. It focused on the study and characterization of the parent-children relationships during adolescence (see. IREFREA, 1997⁶), having as theoretical support the model suggested by Brooks and collaborators (1990⁷). Accordingly we also

⁶ IREFREA (1997) – *Las Relaciones Parento-Filiales en la Prevención del Consumo Adolescente de Drogas*. Comission Européenne, Luxembourg, contract n° Soc 9620126905 FO2 (96 CVV-288-0).

⁷ BROOKS, J. C.; et al. (1990) – *The Psychosocial Aetiology of Adolescent Drug Use: a family interactional approach*. Genetic, Social and General Psychology Monographs, 116, n° 2: 111-267.

evaluated, besides the parent-children relationships themselves, parents and children's behaviours and attitudes towards legal and illegal drug use (their own or the other's), a set of values, as religion and adaptation to social conventions, the perception of the characteristics of the relationship with school and peer group and, plus, some individual factors of youths.

The goal was to know, accepting risk and protective factors defined by Brooks and collaborators (1990), the characteristics of the adolescents' families from the European cities / countries in which the study took place.

Having done this *x-ray*, it seemed important to take another step up in to the complexity of this reality, directly studying how family functioning presents itself as a risk and/or protective factor, namely by identifying the components of functioning that work as such.

In order to operationalize that research (which was conducted in 1998/1999, and therefore specifically connected to IREFREA's goal (3)) we have designed our own conceptual model, of systemic inspiration, which we tested through fieldwork (cf. Mendes & Relvas, 1999⁸; www.irefrea.org). From the results emerged as a conclusion the specific identification of some risk and protective factors of family functioning associated to the beginning of legal and illegal drug use, in the global and differential context of the countries in the network.

2. A second level centred on to the deep knowledge on what has been implemented on the field by technicians and institutions from the countries involved as regards *praxis* of prevention of drug use / abuse focused on family. Following this line, there came up the investigation carried up in 2000/01 and now presented in the previous chapter (Chapter 5) of this book, clearly integrated in IREFREA's goal (1).

3. A third level focusing the comprehensive articulation between the previous two in which, proposes that knowing the families' characteristics in terms of risk and protective factors, as well as the prevention measures targeted to them, we can reflect upon what each one consider to be the role of families in drug use primary prevention. In order to do that, a study will be carried out with this goal in 2001 / 2002, in which *focus group* methodology is used and that we will explain in more detail in the last chapter of this book.

4. Finally a fourth level in the logic of IREFREA's work (although it is not the least important) and which is connected to the necessary reflection and theoretical investigation *on* or *from* the outcomes of the empiric studies conducted in this network. It is in this context that the next three sub-chapters surged up.

The relevance of some aspects, maybe less expected or conceptually less predictable, as well as the challenge of a broader understanding of the reality demanded

⁸ MENDES, F.; RELVAS, A.P., *et al.* (1999) – *Family Relationships and Primary Prevention of Drug Use in Early Adolescence*. Valência, IREFREA & European Commission.

by some data, led to individual reflection made by some members of the researcher team, which are an important contribution to the future development of the IREFREA's work in this research area.

6.2. PREVENTION AND THE SEARCH FOR SPIRITUAL SUPPORT AS A FAMILY COPING DIMENSION: A PSYCHOANALYTIC PERSPECTIVE

By G. Broyer, Professor of Clinical Psychology, Université Lumière – Lyon 2, France

We would like to share the observations of a clinician on a particular point, a curious and somewhat bizarre point, which has come up repeatedly during this study without us being able to make sense of it. To present the circumstances of my encounter with this phenomenon perhaps may intrigue you or, at least, provoke your interest and encourage you to explore this area with us. In any case, it seems to me that this point, which occurs in research on people “at risk”, is part of the question of what it is to “prevent” and what is “effective prevention”. This point, often brought up spontaneously by the subjects themselves, is the reference to the search for spiritual support*, to a religious impulse. After the presentation of my own thoughts about family coping, firstly, we will see how this religious impulse manifests itself in the study secondly considering my encounter with this phenomenon in the prevention of alcoholism and thirdly in the context of the prevention of natural disasters. Finally, we will make some conclusions on the effectiveness of prevention.

6.2.1. The Research Conducted by IREFREA

It concerns a study carried out in 1997-98, after preliminary research in 1996-97, of 500 adolescents between 12 and 16 years old and their families in Coimbra (Portugal), Madrid (Spain), Modena (Italy) and Lyon (France), 2000 adolescents in total. Our aim is to study the statistical correlations, obtained from the answers to a questionnaire, referring to the three evaluation scales already tested in the U.S. and Europe, of family coping in relation to the changes in family relationships and their effect on the prevention of adolescent drug use. [cf. project of the conceptual model of this study, as shown in Mendes & Relvas, 1999: 58 and following]

Concerning the family life cycle, we evaluated:

* Note from this book's coordinator: this findings emerge from the study of family coping since the search for spiritual support is one of the five dimensions in global Family Coping.

- the *the family functioning* through the scale of Olson *et al.* (1995) – FACES III (Family Adaptability and Cohesion Evaluation Scale III);
- family coping* through F-COPES (Family Crisis Oriented Personal Evaluation Scale) of Olson *et al.* (1981);
- the *risk and protective factors* encountered by adolescents within their family environment in the use of legal and illegal substances through Catalano *et al.* scale (1997) (SSRPF – PATO).

The main conclusion is that a cohesive, understanding family without conflicts is not the only solution to the non use of psychoactive substances. Only the use of tobacco and alcohol is associated with this situation. This reinforces the conclusion that the absence of family conflicts as a factor in prevention is a myth and, furthermore, a dangerous myth. This absence can reflect a parental *laissez-faire*, very damaging to the development of an adolescent trying to establish their own identity.

Let's move on to the heart of the subject and look in more detail at these results.

6.2.2. Family Coping in Adolescence: a psychoanalytic approach

“For a start, you're not even my dad!”

What therapist working with adolescent, has not heard a “father” or parents complain of having been dealt the treacherous blow of such comment?... Especially in today's world where of the number of divorces and one-parent families is constantly on the increase even in the cases of families were the new “father” has been successfully accepted after the mother's remarriage.

In fact, this simple comment makes the parents powerless. They do not know how to reply to this deadly little phrase which assigns the bond, the recognition and the authority of parenthood entirely to the other parent.

All this repositions paternal and maternal functions in regard to what psychoanalysis has taught us about the development of the superego, the phenomenon responsible for our “conscience”, for our recognition of authority, traditionally ascribed to the interiorisation of the paternal and maternal images namely at Oedipus phase (cf. Totem & Taboo).

In media and public imagination, a casual relationship is commonly formed between a weakening of the educational role of the family, the loss of family values and the failure of education to transmit these values and the problems of youth, violence, the inner cities, drug addiction ...

During the last conference organised by IREFREA in Palma de Mallorca, I put forward the idea of the “hallucination-perception” complex as another clinical approach to the risk factors of additional behaviour in childhood and adolescence.

This is conform A. Green's (1973) thesis on the role of identification with the dead mother in the development of dependant behaviour and, in my opinion, sheds new light on the addicted subject's return to their body as a rest of libidinal subversion, a concept suggested by E. Dejours (1986). I concluded by considering the kind of mental space offered to people by the essentially "operations" (*in* P. Marty's sense of the term) modern culture and virtual reality culture.

Firstly, I would like to clarify again my thoughts on the relationship to reality within the hallucination – perception complex and, secondly, to study the reality of family relationships in light of the development of psychosexuality as suggested by E. Dejours (1986) and, finally, to approach family coping.

6.2.2.1. The Relation to Reality

Clinicians devoted to the treatment of addictive behaviour have generally shown certain truisms to be false, an observation reinforced by the use of substitution cures. Among these, two die particularly hard:

- the idea that there are gaps in the psyche of the drug addict, gaps filled by the drug or substance;
- the idea that the addict takes the drug to put up a psychological smokescreen, to escape from "reality" into dreams.

Humans are essentially active subjects, creators of their own world through their hallucination-perception complex; the world is hallucinated before being perceived and the issue always remains the same, that one of the "reality of reality" to use an expression of P. Watzlawick (1972) but, more fundamentally, the problem of the world's construction as a person sees it, brought to the fore by the question of traumatic neurosis and psychological traumatism, as recently studied so well by Claude Janin (1996).

Every baby who is discovering the world can be thought of as a scientist at their workbench: they must invent concepts, fantasise, in order to create "reality" while recognising, accepting as true, a certain amount of evidence, of stimuli to which they attribute a definite reality. It is in such a way that we construct, make real, reify our world, reify in the strictest sense of the word, *i.e.*, to give something the status of a thing. For psychologists, the example of Rorschach test effectively demonstrates the nature of the mental processes used to bring stimuli into existence, through the study of the K/C and F + % ratios.

Marty's description of "operative thought" is clearly another example of the nature of mental processes. The relations between the meanings we all create and reality is also a certain indicator of illness, notably in the case of paranoia, for example, where the patient suffers from an excess of a persecuting reality. Obviously, one can create this reality without drugs, "normally", but one can also achieve it with drugs. The use of a substance by a creator is, indeed, a way of creating a reality for one self and not a fantasy or a dream.

The issue raised here is that of the psychological implications regarding the ontogenesis of the links with the world of the image and the virtual world. What is the reality of an image? The image is as real as any reality and in our high technology culture, a six-year-old child will never experience, over the course of his life, everything they have already seen as images.

The example of Kassowitz's film "Assassins" and the controversy it caused at Cannes in 2000 is extremely interesting in this aspect. The director wanted to show the relation between the virtual and real, the collusion, the shock, through the example of children who are used to shooting at "virtual" people all day in video games, that fire in the same way in reality without any more emotion. The critics didn't understand the issue at stake. The response to this problem is to fall back on the "power of the image" but I believe that this is about the problem of ontogenesis, indeed relevant to the issue of (particularly primary) prevention of addictive behaviour and, concerning this, I would once again like to quote Marty's (1994) remark concerning the "operative thought" of the subject who suffers in a way from an excess of reality: "Confronted by the immense therapeutic task presented by such patients and the somatic implications which make it worse, one wishes for the creation of prophylactic measures in the child, which would guarantee fantasy its proper role".

How does this connect to family relationships? The real world of family relationships doesn't escape the primacy of hallucination over perception, as Dejours has shrewdly analysed concerning the ontogenesis of psychosexuality.

6.2.2.2. The Reality of Family Relationships in Relation to Psychosexuality

According to Dejours (1986) a contradiction appears in the birth of sexuality and the erotic body, around which the entire life of man is structured. This contradiction is that which opposes psychosexuality and the physical body. This opposition is obviously not exactly that one of the classical opposition between psyche and soma. Psychosexuality develops at the heart of the parent-child relationship starting from fantasmic communications. These communications play a part in the development of all other relationships; those of care, education, authority etc., and they hamper the latter's coordination or, more simply, they refocus their articulation. Put another way, the child's psychosexuality is constructed in a dialogue or dialectic with his parent's sexuality.

Perhaps it should be emphasized here that this psychosexuality does not develop according to an ontogenesis, or even an ontology, which passes successively through the oral, anal, and genital stages, as carefully described by every psychology text book. Psychosexuality is built on a recognition of loss, a fundamental loss which is expressed in the form of a nostalgia: the loss of a perfectly satisfying primal relationship between child and mother. A lost relationship or, more accurately, a mythical one as it never "really" existed. This recognition of loss is the foundation of psychosexuality, it is a recognition which is opposed to the desire of this primal loss.

The development of this psychosexuality, is none other than the subject's elaborations of suffering caused by the loss, in relation to the fantasy reactions of his parents to this suffering and the disappointment the child shows them. The responses do not just come from the mother, but also the father. The entrance of the father onto the psychological scene does not occur later than the one of mother. If the child complains of not being completely satisfied by the mother, then his mother, for her part, early on experiences the pain of having an unsatisfied child, even a suffering child. It is here that the role of the father immediately starts. The nature of this role depends on the one assigned to the father by the mother during the hardship she experiences. The disappointment can lead to the mother turning to the father for consolation and help. In reality, by this action she is calling not only the father of the child but also on her sexual partner. She cannot avoid this and the child has to become aware of a mother who is not just a mother but also a wife, of a mother who is not completely concerned with her child but who also thinks about her husband. This is Michel Fain's (1981) censure of the lover. Thus, the suffering child can blame its lack of satisfaction on the existence of a third person, who partially receives the mother's attention.

The first experience acquired by the child here is not only the triangulation of relationships (which does not occur until the third or fourth year) but, above all, a fundamental change which puts the child in the position of not being solely in charge of the mental state of the mother. The mother's lack of satisfaction can, from now on, alternate between child and father without ever getting on one or the other.

The result of this conflict ultimately depends on the nature of the mother's mental activity, when she herself was confronted with the challenge of the lost object. This crisis is always important so that the father's involvement in and reaction to the mother's distress can be crucial.

The immediate introduction of the father into the mother-child relationship, or his marginality at this stage of the child's life, is rightly considered as a determining factor in the child's mental future. This has been described in different forms by several authors, among whom J. Lacan occupies a central role. According to these authors, this triangular situation does not, perhaps, become fixed at the birth of the child. It could well date back to even before conception, to the very nature of the meeting between the sexual partners. If the woman only envisages the man as a biological father, then the stages described above are irrelevant - he will be rejected afterwards, as it is often the case, or he may be only considered as a sexual partner and not as a potential father of a child to be bought up. Indeed, in considering him as a male and not as father, she immediately refuses to recognise the child's fantasmic bond which unites him to his father. In some way, by not recognising her sexual partner's bond with the child, she does not recognise his role as a father. Therefore, one could consider the mother's choice of whether to allow her sexual partner a paternal role, as well as that of lover and biological father, as playing a predetermining role in the psychological future of the child to be born. However it would be wrong to consider the mother's choice only, as it is not only her free will that should be taken into account. To get closer to the truth it is

also necessary to consider here the nature of the meeting between the sexual partners, because whatever the terms of the relationship, the man must consent to it, consciously or unconsciously. The non-conscious part of this meeting between two unconscious is therefore crucial. It has a structural value which will become fixed in the development, non-development or distortion of the child's psychosexuality.

The sexual development of the child is, therefore, no more than the sum of the successive representations that the child forms of this triangular relationship. The Oedipus complex is one of these representative formulators, in all its variations, from one child to another and from one family structure to another.

Where do Freud's oral, anal and genital stages fit into this scheme? They are not the stages of an initially binary relationship which later becomes more complex. It is initially more complex or the relationship will not occur. It depends very little on the child and much more on the parents' sexuality. Instead, the stages designate the gradual colonising of the physical body by psychosexuality, to make it a site of sexual pleasure and no longer just a functional instrument concerned with physiological processes. Each stage of the child's neuropsychological development, determined by an innate programme, opens up new possibilities for erotic games. These games progressively free the child from the physiological imperative which he undermines through a mastering of pleasure, that doesn't necessarily come from the reality that regularly calms the excitement derived from need in its most trivial form.

The support of sexuality on these great organic stages is above all the basis of the erotic body on the development of biological functions. The erotic body is, at the same time, a product of the development of psychosexuality and its foundation. It is both the point of departure and of arrival of psychosexuality. It is also the source of sexual urges which have much more to do with the acquired erotic body than with the innate physiological body. The impulse is acquired, not innate, it's psychological not physiological.

This contradiction, between the psychological and the biological, needs to be examined more closely in regard to the continuous and rapid progress in biomedical techniques, which do not only provoke more ethical questions: the structure of family relations are remarkably influenced by modern techniques in medically assisted reproduction. It is in context of such a fantasmic development that family coping is situated.

6.2.2.3. Family Coping

What is coping? It designates the adjustment strategies, the anti-stress processes and mechanisms developed by a person.

Coping comes to the rescue when the weight of a reality is so heavy that it gains a persecution character – stressing. Several types of coping were studied; the main types are coping by assimilation, by accommodation and by evasion. Group coping consists of a dyadic coping, coping as a part of a couple (assisted or delegated coping) and family coping, which attracted the most attention (European Review of Applied Psychology, 1997).

The strategies mobilised by a person to deal with a difficult reality suggest an awareness of a loss of control of the situation, of a recognition of its danger, even of an “illness”. This implies that internal self-control can buckle under the effect of external biological, environmental (group pressure) or intra-psychological (lack of defences against conflict) pressures. The person, therefore, looks for external support, cognitive, familial or other, to compensate the failings of his or her own defence mechanisms. In our study it is of course family coping that is considered.

I won't go into the analysis of the concept of stress, as others have done so sufficiently before me and much better than I could have done.

However, despite everything, the idea of family coping seems to be particularly interesting if we examine it at the second degree, this is, if it is considered not as a passive support but as a support sought out by the individual. This coping, whether possible or not, constitutes an excellent indicator of the type of fantasmic relations with the family and of the way in which psychosexuality is structured, which, as we have seen, leads into the Oedipus complex and social life.

Our entire system for the cure and treatment of addictive behaviour is constructed around the conception of drug-taking as a symptom of suffering, which has its origins in the personal history of the individual and in the early organisation of his relations with the environment.

However, addictive behaviour is not just an individual reaction to this suffering, nor the result of a lack of control by a subject, by nature an active subject, who is the creator of their own world through the hallucination – perception complex. The world is hallucinated before being perceived. This is also true for coping strategies, which do not escape from this construction of the world of relationships; they are an active search for support, individual or social, depending on the different capabilities of each group member (the family, biological or non-related groups, if vertical identification is privileged, or peer groups if lateral identification is privileged) and their interaction. All these strategies only make sense in the context of the familial imagination structured by the fantasmic relationships of the roles of the sexual partners who have a baby. Access to Oedipus and via that even to the superego for the child is, therefore, straight away provided by imaginary triangle and not by a progression from the binary mother-child relationship to the father-mother-child triangle. The modern person, no longer ruled by traditional values, has seen their control of sexual urges by family structures and group morality shaken. They are left more and more alone within their psychological apparatus to experience the conflict between the urge and the ideal, instructive and impulsive anarchy and social constraints, the real and the virtual, between “Eros and culture” and “Eros and civilisation”.

6.2.3. The Search for Spiritual Support

From one study we can conclude that in Coimbra and Lyon we see a statistically significant positive correlation between the reference to spiritual support, the religious

impulse and seeking help from cult members or a divine power (during “stressful” psychological difficulties) and the prevention of psychoactive substances*. Why Coimbra and Lyon and not Madrid and Modena? We are unable to say why! Does it result from anomalies introduced during the translation of the questionnaire or genuine cultural differences? In any case, one detailed research is required to clarify this point because, as mentioned in the introduction, it has previously been encountered by our colleague F. Facy during epidemiological research carried out by INSERM in France. However, he concluded, without any further explanation, that it was a statistical phenomenon.

I consider this a factor worthy of interest, particularly if we compare it with two other situations – the prevention of alcoholism and the prevention of risk from natural catastrophes.

6.2.3.1. “Drink to Seek God”

I have borrowed the title of this section from Anna V. in her book “Jusqu’à plus soif: Renâitre de l’alcool” (Nil Editions Paris, 1999), which could be translated as “Until The Thirst is Quenched: Rebirth from Alcohol”. In this book, remarkable for its clinical insights, the author devotes a whole chapter to the question of God. I quote at length (*idem*: 55 onwards):

“I would, honestly never have had the idea that God – or rather the pursuit of God – could be associated with the torments of alcohol: how could what is divine be hidden behind what was, for me, abjection? Wine = sacred; this was the domain of the symbolic or the history of religion, on the same level as Greek mythology – pure abstraction.

However, certain mystical texts intrigued me with some extremely explicit descriptions, obviously not metaphors. Theresa of Avila, who I would not credit with a great personal experience of drunkenness, depicted with clinical precision in “The Castles of the Soul” the different stages of prayer which permit the soul to ascend to meet God and which exactly coincide with the various degrees of drunkenness. Fascinated, I recognised stage by stage – from the muddled speech and the blissful drowsiness of the prayer of tranquillity to the corpse, like the state of the prayer of rupture – my descent into hell suddenly inverted into an ascent to heaven. There are many similar examples.

On the other hand, I was fully aware of the analogy between what we call “Lifting rock bottom” and certain religious conventions – those which have their roots in disaster, which occur in a beaten, desperate man or woman who has experienced total defeat and accepted it. Who has let go, in other words ... “it is to be cast away to arrive

* Note from this book’s coordinator: See figure 3 (p.123); fig. 4 (p.129) and fig. 7 (p.143); (MENDES & RELVAS, 1999). There, the reader can confirm the data that shows spiritual support as a predictive variable for family attachment in Coimbra and Lyon

in port, to die in order to be reborn into the true life. We must pass through total destruction ... this journey is a crisis. Something has to snap inside us, we must break and melt in the fire of the crisis”

Alcoholism, writes Carlo Coccioli, “is an existential situation, a dimension of the soul – it can be seen as the pathological side of the religious phenomenon”. The unknown authors of the Alcoholics Anonymous program had an intuition (maybe they knew) that at the root of alcoholism – that sacred evil – there is a nebulous but overwhelming feeling of God. It is not impossible that they realised that alcoholism is to religion, or more precisely to mysticism, what cancer cells are to healthy cells. A mystical explosion in a negative direction, alcoholism can perhaps only be treated by very patient work collecting and reassembling the fragments of the personality – of the soul – destroyed by the explosion. Closer to home, Marguerite Duras: “Alcohol does not console, it does not fill the empty psychological spaces of the individual, it only replaces the absence of God. It does not console the man. On the contrary, alcohol comforts man in his madness, it takes him to places where he is master of his destiny. No human being, no woman, no poem, no music, no literature, no painting can replace alcohol in this function it has for man, the illusion of fundamental creation. It is there to replace it. And it does it for a whole section of the population who should have believed in God but don’t any more.” (from *La Vie matérielle*, Paris 1987: 22).

“Alcohol masks mortality. But it is as if God existed. I think people who drink, who are listening, will recognise what I’m saying. Alcohol is God. The world is empty and, all of a sudden, there is God and the world is radiant. I was talking to someone I care about this summer, who drinks, although less than me, who told me this: ‘The absence of God is the cause’ and I was stunned by the obviousness of it.” (Extract from an interview published in the Bulletin de l’Association Freudienne de Belgique, May 1985: 81-82).

Carl Gustav Jung. Unexpected Ancestor?

Jung was one of the first to emphasise this aspect of alcoholism of which most drinkers, drowning in the bottle, are completely unaware, in a way which was decisive for the history of our movement.

Jung, the inventor of Alcoholics Anonymous?

Not completely, but almost. Without him, we wouldn’t have existed. “Did you know that a conversation you had with one of your patients, a certain Rowland H., at the beginning of the thirties, played a crucial role in the birth of our movement?”, wrote Bill W., founder of AA, to Jung in 1961. Rowland H. was a high-profile businessman in the U.S., a tremendous alcoholic who crossed the Atlantic to be treated by Dr. Jung in Zurich. A year of treatment seemed to have worked a miracle and the American left for home overjoyed. But, alas, the inevitable happened. Distraught, he returned to his therapist, but what remained of his hope soon disappeared: you told him at the beginning (I continue to quote Bill’s letter) that this case was hopeless from a medical and psychiatric point of view. This frank and humble declaration on your part is without

a shadow of doubt the foundation stone of our association. (“We admitted we were powerless over alcohol...”, says our first step) – ‘Are there any exceptions?’, asked Rowland H., overwhelmed. “They are very rare”, replied Jung. “Here and there, from time to time, alcoholics have undergone what we call a vital spiritual experience, an experience which seems to consist of violent disturbances and emotional recoveries... in fact, it is this kind of emotional transformation I’ve tried to encourage in you... but I have never been able to succeed faced with an alcoholic of your magnitude.” ‘But’, protested Rowland H., ‘I practise my religion, I’ve still got my faith.’ “An ordinary religious faith is not enough”, replied Jung, “I’m talking about an experience which will transform you, an experience of conversion, if you like. I can only recommend that you plunge yourself into a religious environment of your choice, recognise your personal defeat and devote yourself to the God you believe in, whoever He maybe. Thus, perhaps you will be struck by a flash of this transforming experience of conversion. In my opinion it’s the only way out...” (Anna, V., 1999).

This long quotation allows us to understand the specific nature of this spiritual experience which maybe connected to religion but which more certainly designates an existential crisis in the face of recognition of the mortality of Man, of his weakness, of his defeat – the opposite of the all-powerful. This existential crisis has yet to be described by our clinical concepts.

This is why it seems interesting to bring in the comments of François Le Guern, volcanologist, as recorded by Philippe Vadrot, a student finishing a thesis on “Elements of an Anthropology of Natural Physical Phenomena.”

6.2.3.2. Reflections on the Prevention of Natural Catastrophes

“François Le Guern is part of Haroun Tazieff’s team and asked to define the conditions for tourists to visit the summit of Etna, he replied, in essence, that science can never give univocal solutions concerning security near a crater. Science can never foresee an eruption. The same goes for avalanche corridors and seracs – surveillance zones can be established, but the result of an accumulation of snow can never be predicted. With natural phenomena, there is more intuition than science; an intuitive understanding is required. What I’ve learnt on volcanoes is that you have to use five senses plus a sixth that we call intuition, which in fact isn’t a sense but the combination of the others in a thought process which tries to apprehend rather than comprehend. Talk of foreseeing a volcanic eruption is an anthropomorphic projection! We project our human dimension onto a natural phenomenon; a concrete example: Etna, we want to predict lava flows which destroy houses, but we noticed that over the past ten years the quantity of lava which overflowed from Etna was in fact tiny compared with the quantity of magna involved in the activity in the volcano itself, it is a tiny bit to full. Therefore, to monitor what happens in the volcano in order to find out when the last drop will make the glass overflow is a projection of our human activities for which nature has no concern!

To the question – Is the volcano sacred? – he replied: “Absolutely, there are mythology and beliefs surrounding all volcanoes”. I would say I am as respectful of these beliefs as I am of my mother when she takes communion. Because of what I told you a moment ago, there is an aspect which I can never ignore at the edge of the volcano, and that is metaphysical aspect. I always take it into account. Scientist discount this dimension – an example is Lake Nyos. The witchdoctors around Lake Nyos tell their version of history but it is discounted by the scientist because it isn’t in scientific language. I’ve published scientific work containing their accounts. I’ve analysed them with the help of a linguistic anthropologist. The translation is crucial! For example, the colours are translated into three adjectives: we plotted what the witchdoctors said on the map, in space and time, and it reconstituted exactly the eruption! That is to say that they expressed or related previous catastrophes very well, but in non-scientific language. I’ve just explained that the basis of the natural sciences is observation, then scientific interpretation. Now these people have a way of observing which is just as reliable as ours but they express it in terms of a religious, mythological and traditional language and if we make abstractions from this language (after all our chemistry is more or less of the same type, it is a jargon which isn’t always reliable and contains a certain number of hypotheses) and we go back to the source, for me it has the same scientific quality as what we do. Through their oral traditions, they reconstitute previous catastrophes. Another example – Lake Pavin. When I examined the oral traditions around Pavin, I found women of ill repute who had been punished or killed. I’m convinced that this oral tradition is a vehicle for a catastrophic past event and which people have interpreted in their culture (...) I’ve seen this in Peru, where a plague which decimated the town of Arauqupa was probably a layer of carbonic gas. We’ve done another type of work – we took the account of an African from Lake Nyos who told us inexplicable things – he was cold, he had survived sulphuric acid, he arrived shivering and we said he was mad. But we worked with a doctor who specialises in the physiology of carbonic gas, we looked for information on the slaughter of animals in abattoirs, on modern anaesthetic techniques and on the problems on board submarines in wartime. We had a whole series of experimental evidence and compared it with what the African told us and with what we really experienced it, it is physiologically explainable. He explained it as he experienced it without a physiological explanation but we, the scientists, had to make an effort. We should not reject him as an African witchdoctor, some kind of priest and then, I’d go further and be prepared to shock my scientific colleagues by examining objectively the results of our modern Sciences, with a capital S! after the meeting in Yaoundé, it wasn’t very credible because in comparing the two thesis about what happened at Lake Nyos, my colleagues failed to understand how the inventors of the plane, the bicycle or the car refused to just accept that their inventions worked; but if we went back in time and took an aerial photo of the lakes where there was a potential risk of asphyxia from carbonic gas, we would realise that there was nobody there beforehand! Why? Because they had received the witchdoctor’s message! The witchdoctor’s message wasn’t correct scientifically, but in terms of safety it was better than ours! There is a lesson to learn –

adapt our message to the local population concerning the risk, not in terms of physical chemistry but in economic and social terms”.

6.2.4. Conclusion: Coping as Seeking for Spiritual Support and Prevention

Brought into the field of the prevention to the use of drugs, the words of François Le Guern allow us to consider our way of dealing with the problem of prevention in an overwhelming adolescent population – our language, scientific, overly so, is it not inappropriate?

If we take the dimension of the “spiritual support” seriously, which appears so often in our investigations but that is discounted because it is “non-scientific”, does it not suggest that we are avoiding something important for adolescents? Something of a religious nature or perhaps of a magical nature from the point of view of rational thought. But if this “magical” dimension is a fundamental dimension of the human condition and if it indispensable to the make up of a human (of the rise of religious fundamentalism and cults!), why neglect and distain it? Let’s study it without prejudice and perhaps we could make an ally of it. Let’s learn how to enchant the world once more! And, furthermore, rediscover the necessity of being modern-day witchdoctors.

6.3. PRIMARY PREVENTION INITIATIVES IN FAMILY CONTEXTS: THE CHANGING FAMILY

By S. Pietralunga Spaggiari, University of Modena, Italy

6.3.1. The birth of the family: the significance of “change”

6.3.1.1. Cultural and Structural Changes in Italian Families: the analysis in scientific literature

The family and family life dynamics play an essential role in giving a structure to identity, involving not only those who, in their roles as children, are born and grown within them, but also adults, in a dynamic continuum which links self-perception and perception by others.

This implies clear links to the family’s peculiar features and the genesis and strengthening of conditions of distress, which may lead to situations of full-fledged deviance. These are confirmed, as it is known, by epidemiological findings, while the new items too, mainly speak – above all concerning young people and teenagers, made more vulnerable by a still developing personality structure – of access to drug consumption.

The family is, therefore, the essential reference picture when building up prevention initiatives, especially if addressed to juvenile maladjustment and, in particular, to the consumption of unnecessary substances.

The literature and the results obtained by a research on families, conducted within the context of IREFREA in several progressive steps, confirmed that the variables concerning the family's peculiar features and functioning are good predictive factors for the emergence of such issues (Mendes et al, 1999). Hence, the statement that prevention programs should be addressed to families when the children are not adolescent yet, i.e. at a very early stage.

While the scientific literature has largely analysed and deeply investigated family life's dynamics, systemic psychology has highlighted, in particular, the relevance of psychological and relational dynamics to the progressive strengthening of individual and social identities, first within the partners, then within the family.

Among the many aspects which have been examined in relation to the partners, the themes of the role played by the "marital *quid pro quo*"⁹ or by the expectations induced in today's culture by the "family's myths", in particular that which has been defined as the "romantic love myth"¹⁰, shall be recalled due to their relevance to these considerations. The literature has emphasised that these phenomena powerfully affect individual and relational dynamics between the partners and reflect on the duty which should be performed by the marital relationship – which has been indicated as one of the most important – *i.e.* that of a suitable instrument for the promotion of the couple's progressive detachment from their parental figures¹¹.

Many studies have been conducted also on the different stages of the "family life cycle", each one marked by entirely specific aspects and issues, which vary with the passing of time and depend on the individual characteristics of each family member.

From these contributions, one can argue the importance attached to "change", which seems to be affecting also – and perhaps above all – from a cultural standpoint, each one of these different stages, in which deep changes both in customs and structures, are felt.

6.3.1.2. Current Custom's "Trends" and their Incidence on the Basic Assumptions for Starting a Family

At present, our country is undergoing huge changes in customs which are becoming typical of our culture and which are even affecting the genesis of the family. The time of

⁹ Walsh F., *Coppie sane e coppie disfunzionali: quale differenza?*, Andolfi M. (edited by), *La crisi della coppia. Una prospettiva sistemico-relazionale*, Raffaello Cortina Editore, 1999: 55 and following

¹⁰ Carta S., *La vita familiare. Strutture, processi, conflitti*, ed. Giuffrè, Milan, 1996.

¹¹ Whitaker C. A., *Le funzioni del matrimonio*, Andolfi M. (edited by), *La crisi della coppia. Una prospettiva sistemico-relazionale*, Raffaello Cortina Editore, 1999: 3 and following.

starting a family seems to be particularly interesting in this respect: it is from this moment that the young partners start addressing interpersonal situations and relations which are doomed to become a permanent and entirely new way of living compared to the past, and the changes in progress are so many that they deserve specific consideration.

As far as this process is concerned, the first self-evident change which is being observed in Italy is young adults' staying for longer in their original families¹². This is related to the second change in progress, *i.e.*, the rising age threshold for getting married¹³, though the two phenomena are only partially interrelated, due to the increase of couples living together –not very many, but by now accepted by our culture¹⁴– and the more common decision of staying “single”, that as has been recently observed.

Many factors affect this process: the longer schooling period, so people start working later and reach economic independence later, but also some socio-environmental factors, such as, the low number of houses available.

In addition, it has been observed that the couples choose not to move in together unless they have strong economical stability (a house, possibly owned; stable jobs, generally for both partners, and other).

The statistical findings and the epidemiological studies show, therefore, a “drop” in the number of both civil and concordatory marriages, on one side, and the steady increase in the marrying age¹⁵ on the other side.

The extremely significant phenomenon of new women's conditions, a source of reflections and considerations which often deeply disagree with one another, lays on top of these two phenomena.

One cannot actually underestimate the consequences of some facts which have by now been largely recognised by the Western countries' culture, such as the cultural

¹² This phenomenon is becoming significantly large: the Third United Nations' Report on Women's conditions in the world (*The World Women 2000. Trends and Statistics*) highlights that in Italy only 0.4% of women aged 15 to 19 are married and the rate reaches 10.1% for women aged 20-24. Married women are a minority also in the 25-29 age gap (43.4%), not because there are many single women or unmarried women living with their partners, but because girls, just like boys, stay in their original families for longer.

¹³ Analyses which have been conducted not only in big cities but also in different socio-cultural contexts of smaller centres in Italy – which reflect therefore the most common situations –, highlight that between 1993 and 1996 the bride's average age rose from 28.8 to 29.7, while the groom's age increased from 31.5 to 32.6: Pietralunga S., *Relazioni familiari e prevenzione del consumo giovanile di stupefacenti in Italia*, Report to Irefrea European Seminar, “Vieilles frontiers/Nouveaux horizons”, Coimbra, Portugal, 10-12/12/1998.

¹⁴ In this respect, it may be extremely interesting to look at the information provided by the Third United Nations' Report on women's conditions in the world (*The World Women 2000. Trends and Statistics*): data concerning the situation in Italy for “Women and men in the family” show that unmarried couples are fewer than in other European countries. Only 8% of women aged 20-24, 6% of those aged 25-29 and 4% of those aged 30-34 live with their partners without being married. In the 20-24 age gap, they are 77% in Sweden, 60% in France, Austria, Ireland and Switzerland, 50% in Holland and Norway.

¹⁵ ISTAT, *Famiglie ed aspetti sociali vari, Annuario Statistico Italiano 1998*, Roma; Saraceno C., *Mutamenti della famiglia e politiche sociali in Italia*, Il Mulino, Bologna, 1998.

targets achieved by women and their introduction in the work world (though with the quantitative, but above all qualitative, limitations which still remain), resulting in the woman's new role and new status, which goes beyond the ability to financially contribute to the family's maintenance.

Another factor of change, which is generally affecting the Italians as well as the Western countries in general, is the demographic change resulting from the improved life quality and longer life expectancy.

This results in a new condition, which literature defines as "trans-generational cohabitation"¹⁶, in which a much higher number of family generations, that was imaginable up to a few decades ago are now coexisting and interacting and this for much longer than in the past.

This results in the occurrence and continuance, within the family, of interlaced interpersonal relationships characterised by different roles. These, in their turn, trigger many more and much more complex relational dynamics than in the past, with some family members needing to face up to and take on much heavier running tasks.

At the very special time of starting a family, therefore, its members find themselves challenged by a relational context which is certainly much more complex than it was up to a few decades ago, and such new family structures, due to the longer mean life expectancy, are doomed to continue for much longer.

The analysis of the changes which, in our culture, are affecting the time of the birth of the family, cannot be done without a reference to the so-called "reconstituted" or "extended" families, *i.e.*, those including not only the two partners, but other members as well, coming from previous family arrangements which have then been split up.

Here again, then, the setting up of a new family is challenged by dynamics which are very different from those of the traditional family model, which was the only one handed down by our culture up to a very recent time.

6.3.1.3. The Birth of the Family: new dynamics between the partners

It seems, however, important to underline that a large part of literature does not argue, from this complex and often unclear set of indications, any sign of crisis of the marriage as an institution, also based on some recent surveys on young people's expectations: rather, it believes in a new approach, which attaches more importance to its material components, as if it were a sort of rite of passage to sanction the man's and woman's social stability¹⁷.

¹⁶ Donati P. (edited by), *La famiglia e i rapporti intergenerazionali, Il bambino incompiuto*, n°6, 1995: 55 and following.

¹⁷ Bollea G., *Le madri non sbagliano mai*, Feltrinelli ed., Milano, 1995; Donati P., *Teoria relazionale della società*, Franco Angeli Ed., Milano, 1998.

The literature actually highlights that the above socio-cultural changes result in an increasing lack of “rites of passage”, marking the passage from one life stage to the next (children, adults, then elderly people)¹⁸. In general, one can state that the correlation between age and generational position has got looser: in this context, variability conditions are more and more frequently appearing and go hand in hand with an increased “crisis of the symbolic”, both in family and generational relationships.

The changes stemming from such phenomena mainly affect the roles played by the partners, involving a review of these respective roles and the traditional task-sharing, which is still far from being considered as over, with the uncertainties and crises which unflinchingly go with them.

Even more different from the culturally accepted traditional family model are the dynamics which arise among the members of the above mentioned reconstituted and extended families. These are clearly extremely complex situations, where the problems arising at the time of setting up a new family group are topped up by the issues related to the disappearance of those people who were, traditionally, the emotional and educational points of references, and by the feelings of non-belonging, loneliness and eradication which may take their toll especially on the youngest in the family, whose personality structure is still in development¹⁹.

In this respect, the difficulty has been observed, for those “subjects who are already facing critical and upsetting situations, in dealing with new interpersonal relationships, such as those who come up, for instance, with the parents’ partners and sometimes also with their family groups, towards whom, moreover, positive attitudes or acceptance do not always come easy or natural”²⁰.

6.3.1.4. New Dynamics, not New “Models”: the lack of cultural reference models

Going back to the issues affecting the partners at the time of setting up a family, it must be underlined that, at least in Italy, the cultural change has not yet given rise to any new “reference model”.

In this respect, one could take as an example of the two dynamics which have already been mentioned, which are frequently questioned in the process of setting up and giving stability to a family: the so-called “romantic love myth” and the definition of “marital *quid pro quo*”. They refer to the possible balance between the partners’ mutual expectations with respect to the couple’s and marital relationships.

¹⁸ Donati P. (edited by), *La famiglia e i rapporti intergenerazionali, Il bambino incompiuto*, n°6, 1995: 57.

¹⁹ Pietralunga S., *Relazioni familiari e prevenzione del consumo giovanile di stupefacenti in Italia (Family relationships and prevention of drug consumption in Italy)*, Report to Irefrea European Seminar, “Vieillesse frontiers/Nouveaux horizons”, Coimbra, Portugal, 10-12/12/1998:.5 and following.

²⁰ Pietralunga S., *Relazioni familiari, cambiamento, conflitto e disagio giovanile.*, Report to the National Criminology Conference, S.Martino sul Cimino,1999:4 and following

The former concerns expectations; they are often left unsaid and may – frequently – be partly unconscious, since their construction is largely affected by unconscious models related to “traditional” role-playing, which is also a common feature of literature or films.

The latter refers to the daily role - and task - renegotiating “work”, which is essential to stabilise a new family’s relational and emotional climate; a negotiation which tends, once again, to make use of the traditional models offered by the parental figures, whereas the new family must instead reckon with the new cultural values, for which such models, which were still considered as proper in the recent past, are now useless as guidelines. One realises, then, that at this time of wide and deep cultural transition, the old reference models have not been successfully replaced by any new model to be used as a term of comparison and anxiety-curbing factor.

This results in the partners’ bewilderment, failed expectations and resulting disappointment, and problems in building up and, so to speak, “inventing” a couple-specific relational scenario, often entirely different from that learnt from the family models as experienced during growth.

So new and so deficient in terms of comparison may be the dynamics which come up in the extended family context, both with respect to the needs brought about by the interpersonal relationships coming from the trans-generational cohabitation, and with respect to those dynamics which may arise in the above “reconstituted” and “extended” families.

6.3.1.5. The Influence on Prevention Initiatives

The cultural changing scenario, which we tried to outline and which affects the family, obviously falls in and has to reckon with a larger social context, which sometimes fails to meet the partners’ new requirements and new, increasingly urgent, demands. Despite of the efforts made, certainly more apparent in some Italian regions than in others, the public sector still lacks family-supporting resources and institutional facilities.

One of the stages of the research conducted by IREFREA on the prevention policies for families in Europe²¹ actually highlighted that the Italian service network for day nurseries and nursery schools as well as the following school grades, and also children’s and teenagers’ support and entertaining centres, is still very far from what is required of a real service to be supplied to working families. And the same applies to the whole context of elderly people, especially where they are no longer fully or partly self-sufficient.

The purpose of the huge financial effort which is being made in Italy and in other European countries, for the funding of supporting facilities and prevention initiatives

²¹ Pietralunga S., *Expériences de prévention en Italie et mutation socio-culturelle de la famille, Report to Colloque Irefrea “Ano 2000... Les nouvelles voies de la prévention”*, Lyon, France, 6-8/12/2000.

for families and minors, is to fill such gaps: the objectives pursued are a rationalisation of the existing services (also through a survey of the families' demands), and the setting up of new facilities and new prevention initiatives for an optimal use of the resources which, in some areas, are already at work.

The significance of these aspects is intuitive, for the purpose of giving structure to all preventive action, also based on the results provided by the empirical surveys conducted on these issues during the IREFREA research. This research actually shed light on the significance of the family, both as a protection and a risk factor (Mendes, et al, 1999), on juvenile deviance, and the significance of a systemic approach to the handling of such issues.

This was mainly observed in the Italian social scenario, since in this sample the relationships between the onset of teenagers' distress and family-functioning variables, family attachment and parents-related risk factors (Mendes et al, 1999), have been found to be particularly marked.

6.3.2. Family Life Dynamics: from “change” to “conflict”

6.3.2.1. Family Life Cycle: family dynamics and cultural transition

The conditions in which the family is now set up in Italy and in Western countries in general, even if with different peculiarities and nuances, are certainly new and different, also compared to the very recent past.

Nevertheless, also in their following stages, the family life dynamics develop according to deeply different patterns and procedures from those which, not too long ago, used to mark the “traditional” family model.

The notion of “change” seems, therefore, to become extremely significant, since, in today's social scenario, the cultural changes involving families are often so relevant and numerous that they deeply affect the family's structure and internal dynamics.

As proof of the complexity of such developments, let's just mention the plentiful scientific literature concerning sociology, psychology and criminology, which has been trying to define and investigate the so-called “vital cycle” of the family.

There are many considerations in this respect and all are based on the identification of the family's different “timing”, *i.e.*, as one of the means through which the family's processes deploy, with the objective of achieving the pursued targets. Within this context, a distinction must be made between the short period or “clock time”, and the medium period or “calendar time”, and special attention has been paid by many authors²² to the

²² Among others, see Carta S., *La vita familiare. Strutture, processi, conflitti*, ed. Giuffrè, Milano, 1996; Relvas A.P., *O Ciclo Vital da Familia. Perspectiva Sistémica*, Afrontamento Eds., Porto.

in-depth investigation regarding the “long period”, which marks the family’s life through the years, the so-called “developmental time”²³.

Such marked interest comes from an increasingly common social feeling of bewilderment and distress, due to a peculiar time of cultural transition (as the one we are experiencing right now).

It has actually been observed that the reference models acquired in the original family and handed down almost only by traditional culture up to a few years ago look more and more unsuitable for this progressively changing situation.

This change more and more frequently affects the entire relational structure of the family, both with respect to the partners’ internal dynamics and to the extended family context, but, most importantly, starting with the stage following the decision-making process, which leads to set up a family in one of the forms available in today’s culture, signs of the “shifting” from the area of change to the area of “conflict” are beginning to be more and more clearly felt, along with these symptoms of change.

Such conflict is often the basic assumption for deviance (from pathological to behavioural) and now leaves room, therefore, for considerations which are essential before establishing any prevention plan.

6.3.2.2. The Extent of “Change”.

The cultural factors of change reflect the changes brought about by the new structural and economic features of our country’s society.

They are clear, starting from the older age at which people give birth to their first child²⁴, though they also involve the new demographic context in Italy, which is reflected in the relational dynamics within the family and in each family member’s subjective self-perception and perception of one’s role²⁵.

It has already been highlighted that the objective condition for living together and very often even for at least three – but more and more frequently even four, and

²³ Broderick C.B., *Understanding family process: basic of family system theory*, Sage Production, Newbury Park/London/New Delhi, 1993; Donati P., *Comportamenti a rischio e patologie nella società odierna: il ruolo della famiglia*, *Difesa Sociale*, 4, 1992: 7 and following.

²⁴ In this respect, it has already been mentioned that researches conducted in the first half of the Nineties found an increase from 36.3% to 46.3% in the number of women aged more than 30 when giving birth and a decrease from 26.3% to 15.2% in the number of women aged less than 25 when giving birth: Pietralunga S., *Relazioni familiari e prevenzione del consumo giovanile di stupefacenti in Italia*, Report to Irefrea European Seminar, “Vieilles frontiers/Nouveaux horizons”, Coimbra, Portugal, 10-12/12/1998: 3. Cfr. also Sgritta G.B., *Infanzia, maternità, famiglia: la privatizzazione del problema*, *Il Bambino Incompiuto*, 5, 1995: 29 and following.

²⁵ Donati P., *La famiglia e i rapporti intergenerazionali*, *Il Bambino incompiuto*, 6, 1995: 5 and following; Loriedo C., Strom P., *Processi di trasmissione transgenerazionale nelle coppie e il trattamento delle problematiche connesse alle famiglie di origine*, Andolfi M. (edited by), *La crisi della coppia. Una prospettiva sistemico-relazionale*, Raffaello Cortina Editore, 1999:311 and following.

sometimes five – generations to live together at the same time, and for much longer than in the past, raises role fluctuation and redefinition issues, which are much deeper and more upsetting than it used to be up to a few decades ago²⁶.

This clearly affects the overall family structure, bringing about changes in the family's hierarchical structure, in the relationships among adult members and for minors, for whom clear role-playing and clear relationships with the authoritative figures are essential.

Another source of huge changes are women's new conditions, which brought about substantial and, by now, irreversible changes in women's social conditions and status. Hence, the need to change some of the relational structures which were generally accepted by traditional culture, such as, for instance, task-sharing between the partners, and, also based on women's new financial resources, affects role-building and role-playing among family members (Freeman, 1995; Mancuso, 2000).

The obligation to provide assistance for longer (for instance, to the elderly people) is also strongly affecting the family and its dynamics.

Last but not least, factors of change related to the increased separation and divorce conditions are also emerging.

Meaningful, in this respect, there are also some commercial as well as cultural indications which come straight from the social fabric and which seem to strongly suggest the existence of bewilderment and uncertainty factors at collective level, as well as the emergence of comparatively new issues concerning our social fabric, which are attracting the attention of a larger and larger number of people.

For instance, magazines specifically addressing separation and divorce issues, with a high-quality publishing profile, have come out for the very first time in the Italian press and media worlds as instruments for information and support, related to the need to face such experiences, which unfailingly disrupt anyone's life²⁷.

6.3.2.3. The Shifting from “Change” to “Conflict”: reflections on social policies in primary prevention interventions.

The fact that each one of the factors of change which have been recalled here (and which certainly do not cover all of today's complex situations) contains in itself the

²⁶ Pietralunga S., *Relazioni familiari, cambiamento, conflitto e disagio giovanile, Report to the National Criminology Conference, S.Martino sul Cimino, 1999*: 4 and following.; ISTST, *Indagine sulle strutture e i comportamenti familiari*, Roma, 1985; Sabbadini L. L., *Lavoro familiare, tempo e reti di aiuto, “Tutela”*, 1-2, 1994; Saraceno C., *Mutamenti della famiglia e politiche sociali in Italia*, Il Mulino, Bologna, 1998.

²⁷ In this respect, the problems which may derive from the lack of supervision and real professional training in such magazines, which basically aim at commercial and book-office success, in short, at exploiting the phenomenon, which is all the more strengthened by the deep deficiency of scientific or however quality-controlled publications, has already been mentioned regarding this sector: cfr: Pietralunga S., *Final Report, 1999*, in *Research on “An Evaluative Study on Different European Cultural Conditions in Preventive Programs Directed at Families, 2000*, Project Co-ordinator J.F. Mendes.

basic assumptions for a progressive “shifting” from change to the establishment of a real conflict within families, is quite intuitive.

As far as situations of trans-generational cohabitation are concerned, for instance, the condition of closeness and often of living together comes from and is required by the social conditions and the life style which are now increasingly becoming the hallmark of the Italian family.

Situations in which the choice to set up a new family, which used to mark the two partners’ independence from their original families, strongly clashes with the next step, when the choice to procreate often triggers a process of going back to the original families, are thus becoming more and more common. This thus triggers an evolutionary dynamics, which is somehow “dictated” by external and environmental needs and no longer follows a linear path, but proceeds in a loop.

Though the Italian family structures are now often burdened by a heavier relational responsibility, not to speak of assistance, due to the above phenomena, such as trans-generational cohabitation and reconstituted or extended families, the event of a child’s birth often takes on, however, special significance.

After this, the two partners’ evolutionary and existential progress is challenged, much more urgently than before, by the need to reconstitute and rebuild – on necessarily different bases – a number of interpersonal relationships with the members of their original families, to let the young couple go back to work, a task which adds up to the duty to attend to their children.

Such process is often marked at least by an intensification of relationships, sometimes even by the reconstitution of a new, more complex and larger, family structure. The latter often gathers the previous families in extreme (often also spatial) closeness.

In this respect, situations in which, for the parental figures of the original families, especially if they are still comparatively young and still working, the birth of a grandchild becomes the decisive factor to make existentially crucial choices, such as retirement or early retirement, are becoming more and more frequent.

The statistical findings show that this phenomenon mostly occurs in Central-Northern Italy, where working women are still many more than in the South (ISTAT, 1998).

All this can be strongly disrupting as well: it has been observed that “the same individual actually has to play multiple roles to which social culture often attributes clashing definitions (for instance that of child and parent), sometimes for very long periods, with the crises and uncertainties which they can understandably lead to”²⁸.

²⁸ Pietralunga S., *Relazioni familiari, cambiamento, conflitto e disagio giovanile, Report to the National Criminology Conference*, S.Martino sul Cimino, 1999: 5. See also Baraldi C., Ravenna M., *Fra dipendenza e rifiuto, Una ricerca su percorsi e immagini della droga tra i giovani*, Franco Angeli ed., Milano, 1994; Travaglini R., *Fenomenologia del disagio giovanile*, ed. Goliardiche, Trieste, 1999.

But it is worth underlining that, due to these new structures, the same role is also played, for long periods or sometimes even permanently, by different people (for instance, the parental role may be played by the parents and grandparents at the same time, and the latter often for more hours a day than the parents).

The combination of these factors involves, therefore, substantial changes in the roles played within the family, and the rooting of the conditions for conflicts to crop up.

This is certainly due to the dynamics among the adult members, resulting in an increase in the number of separations and divorces, but this change looks even more significant for the younger members of the family, *i.e.* children and teenagers, for whom the mingling and overlapping of roles may affect the identity structuring process, sometimes with very seriously disrupting consequences (Cavalli, 1984, Cesaro, 1992).

Once again, the above considerations about the unfavourable effects brought about by the lack of institutional family supporting facilities (day nurseries and all schooling grades) in our country apply to this context as well.

With specific reference to conflicts, the consequences induced by the above mentioned increase in the number of separations and divorces in Italy cannot be overlooked either.

Their effects are recognised both in adults' relationships and, in particular, on minors, in whom distress emerges from feelings of solitude and forlornness, on one side, and from the relational problems which may occur in any "reconstituted" or "extended" family on the other side.

The process "sliding" from cultural "change" to conflict takes on, therefore, different features and may lead to the onset of different forms of distress, depending on the position of each family member.

An increase in psychological distress, psychic and/or physical troubles, tensions and violent behaviour inside the family has been observed in adults.

For minors, who are weaker and more vulnerable, the atmosphere of conflict inside the family may lead to situations which lead from distress (psychological crises, relational problems) to maladjustment (maladjustment at school, food disturbances, such as anorexia and bulimia) and deviance ("acting-out" behaviours: flight from home, vandalism, illegal behaviour, including drug consumption), through to suicidal behaviours and the equivalents (which may sometimes include drug consumption).

The indications from the social and cultural contexts look, therefore, extremely complex and many-faceted, as well as increasingly and endlessly changing, in the track of a rapid succession of ideological changes. The prevention initiatives for minors and families, regarding, above all, the approach to unnecessary substances, have, however, to take it all into account.

This area actually showed the specific need to be aware and duly consider all the specific features of the social micro-situation to which the prevention plan is addressed,

since differences among distinct social contexts markedly affect the factors, which specifically bear on them.

In this respect, the research by IREFREA²⁹, in outlining the lines of actions in the field of juvenile distress prevention in Italy, as set forth by the law dated August 28th 1997, n° 285, concerning the “Provisions for the promotion of rights and opportunities for children and adolescents”, showed that the most recent social policy trends emphasise the great importance attached to the family and to a systemic approach.

6.4. THE FAMILY LIFE CYCLE: A FRAMEWORK FOR PRIMARY PREVENTION OF DRUG USE

By A. P. Relvas, University of Coimbra, Portugal

The ideas we intend to present here started being developed in 1996 when we read a “recommendation” from Guy Ausloos. It was in his work about “The Families Competencies”, concluding a chapter that took back a conference presented in 1994 about “Family and Drug-Abuse”, in the sense of identifying pathogenic processes. This “recommendation”, that we will quote next, is framed in a last point entitled “Some Clues of Work”.

“In what matters to prevention: I would like to insist in the importance of giving support to young parents. It is by that moment that crisis, most of the times, is lived hard and painfully and support is rare. It is by that time that couples start disorganising themselves and the mechanisms that lead to dependence are set up. Obviously, this prevention will only succeed on a long-term perspective. However, it seems to me very important to face it because it allows the avoidance of those mechanisms settlement instead of having to correct them later” (Ausloos, 1996: 151).

The days followed and in the years of 1998/1999 we co-ordinated an investigation project, precisely on the extent of IREFREA, about “Family Relationships and Primary Prevention of Drugs use in Early Adolescence” (Mendes & Relvas *et al.*, 1999). The conclusions we could take of it lead us, once again, to Ausloos’ “recommendations”. Meanwhile, we kept our activity as a Systemic Family Therapist and, every now and then, in the encounter with a family who’s problematic, apparently, nothing had to do with drug abuse, we remembered prevention as Ausloos defined it.

Today, the need to specify, concretise and organise those ideas, becomes urgent recollecting and gathering the loose points of that all. From the analysis made, three fundamental topics emerged:

²⁹ Pietralunga S., *Expériences de prévention en Italie et mutation socio-culturelle de la famille, Report to Colloque Irefrea “An 2000... Les nouvelles voies de la prévention”*, Lyon, France, 6-8/12/2000.

1) New directions within primary prevention of drug abuse

- Considering risk and protective factors in prevention

Nowadays, prevention is perceived as a new area of interdisciplinary and interface research: the “prevention science” (Coie *et al.*, 1993). Its goal is to prevent or diminish important human malfunctioning by focusing investigation on the systematic study of potential forerunners of pathology, called, respectively, “risk factors” or “protective factors”. “On the other hand, a particular risk factor is rarely specific to a unique disorder, because disease causes tend to scatter their effects about the different adaptability functions, throughout the development sequence” (*Idem*: 1031). We can, at this stage, talk about “generic risk factors”, commonly preceding various kinds of disorders. These risk factors do not reveal the same predictive capacity throughout the system’s development. The protective factors are defined as some personal or/and social characteristics that perform preventive functions. They can act in two different ways: by interacting with risk factors, minimising their effects, or preventing their appearance. Given the difficulty of complete elimination of risk factors, a good strategy is, probably, the multiplication of protective factors.

- The importance of family factors in prevention:

Merikangas and collaborators (1998) refer to the existence of two types of family factors that, in one way or another, can smooth the progress of (or impede) the risk of substances abuse by children. Those two types are the non-specific and the specific factors. The specific factors are directly related to the family members’ attitudes and behaviours towards drug use. The non-specific factors described are connected with family dynamics – disrupted family structure, unpaired parenting, exposure to high levels of acute and chronic stress, family psychopathology, neglect, emotional or physical and sexual abuse and social deprivation.

Kumpfer (2000), a very good revision article on this subject, is a little more specific: she states that primary family *risk factors* include parent and sibling drug use, poor socialization, ineffective supervision and discipline, negative parent-child relationships, family conflict, family stress, poor parental mental health, differential family acculturation and poverty. Family *protective factors* include one caring adult, emotional support, appropriate developmental expectations, opportunities for meaningful family involvement, setting rules and norms, maintaining strong extended family support networks and other protective processes.

The probability of a child developing problems increases rapidly as the number of risk factors increases relatively to the number of protective factors.

“Children and youths are generally able to withstand the stress of one or two family problems in their lives; however, when they are continually bombed by family problems, their probability of becoming substance users increases” (*Idem*: 5).

So, it is clear to us that parents have an early influence on developmental pathways toward drug use: if one can state that peers’ influence is the major reason to initiate drug use, parental disapproval of drugs is a major reason not to use drugs (Combs *et al.*,

1991). Besides, parental support has been found to be one of the most powerful predictor of reduced substance use in minority youth. As a matter of fact, parent supervision can act as a major mediation of peer influence (Kumpfer, 2000).

So, in prevention one cannot afford to neglect neither specific nor non-specific family factors.

- Changing the prevention targets from the individual to the family:

Prevention programs have typically targeted young people in school-based, universal approaches. Because of increasing frustration of school-based researchers to get long lasting and powerful effects, a number of family-focused research projects were developed. The results obtained helped to strengthen support for family approach (Kumpfer, 2000). In fact, the selective prevention family-focused approaches, that have been rigorously evaluated, have shown positive impact on many risk factors (see Goplerud, 1990; Kumpfer, 1997, Lorion & Ross, 1992, all cited in Kumpfer, 2000).

Achenbach and Howell (1993) sustained that strengthening families could significantly reduce the increased trend in adolescent drug use and other problem behaviours. Nevertheless, anyone can find many types of family prevention approaches and it is important to know something about their differential effectiveness and efficiency. According to the Center for Substance Use Prevention (USA) only behavioural parent training, family therapy and family skills training approaches show strong evidence of effectiveness in reducing risk factors for drug use, increasing protective factors and decreasing drug use. Parent education, family support and family education models didn't have enough research studies with positive results to warrant qualifying them as effective approaches at this time (Kumpfer, 2000).

Actually, one type of approach currently gaining in popularity, namely in the USA, is the structured intervention for high-risk families (a selective prevention type of intervention) as, for instance, the multi-component family skills training programs, supported in the Social Ecology Model (Kumpfer & Turner, 1990-91). These programs generally include behavioural parent training, children's skills training and family therapy.

Another item one should consider in this subject are the principles for best practices in family programs. The authors stress that those principles are the following: the programs should be comprehensive, family-focused, long-term, of sufficient dosage to affect risk or protective factors, developmentally appropriate, beginning as early in the family cycle as possible and delivered by well-trained, effective trainers (*idem*). Let's only underline that empirical data shows that family-focused interventions appear to be more effective than either child-focused or parent-focused approaches. The first ones, if not combined with family approaches can even have a negative effect on family functioning.

So, we may conclude saying that in recent years there has been a shift from focusing therapeutic activities primarily on the child to improving parent's parenting skills and

from there to the recognition of the importance of changing the total family system (Szapocznik, 1997, cit. Kumpfer, 2000).

All these reasons sustained the need to improve family-focused prevention approaches more and more.

2) Conclusions and implications of the survey carried out within IREFREA (research area: Family and Drug Use Prevention):

The survey was conducted in Portugal, Spain, Italy and France and the sample was constituted by 1984 individuals, with a mean age value of 14 years old, distributed by 4 cities. The variables considered in the study were the family functioning type (Olson *et al.*, 1985), the family coping (Olson *et al.*, 1983), the family risk and protective factors (Catalano, Hawkins & Arthur, 1997), as well as some demographics variables and a substances use check-list (alcohol, tobacco, marijuana and other drugs) (conf. Mendes, Relvas *et al.*, 1999).

The development and the results of this survey are described in a book published in 1999 by IREFREA (idem). The most relevant conclusions pointed there are the following:

* The family dynamics variables are important as well as risk as protective factors. The risk factor, clearly identified as a specific one, is associated with parental risk attitudes towards disciplines and anti-social behaviours (namely permissiveness and indulgency). The protective factors, with a more generic and non-specific character, did not always show systematic or constant relations. Nevertheless, it seems that balanced levels of family functioning and family coping, as well as the absence of family conflict, can be considered protective factors. However, the variable family attachment and understanding (absence of conflict) alone does not seem to be a protective factor; it can even become dangerous (risk factor), when it leads to the development of “laissez-faire” parental attitudes. Consequently we may talk of a generic and non-specific factor to take the best of a balanced family functioning.

* We also could establish that family dynamics influence is greater in early stages of substance use. In fact, that influence diminishes gradually as age increases, as well as the range of experienced substances enlarges.

Assuming that family variables are good predictive factors of early substances use (namely alcohol and tobacco), the family-focused programs should be implemented targeting the families whose children have not yet reached adolescence.

Considering the previously pointed out conclusion – family dynamics seen as a generic protective factor – these preventive approaches should aim to support the families in order to help them to promote greater levels of well-being, by reducing the stress related to their own development.

So, we may conclude that these results show a great level of agreement with other international studies pointed out by other researchers on prevention of drug use that we

revised in the previous section. This means that, apparently, there are no significant differences, on this particular subject, on what concerns European and American contexts.

3) Our clinical experience:

As a family therapist, working in a Family Therapy Centre where there is no specific psychopathology indication for therapeutic help, we meet all kinds of families with many diverse problems at many different phases of their lives. Actually, in our clinical practice we generally meet people who believe that their problem can be solved “in family and with the family”. A number of those families seek help because they have some difficulties with their little children – related with sleep, fears, and so on. Some other come to the Centre because their children have problems at school – not only connected with academic performance, but also with discipline, socialization with peers, for example. Other families don’t know how to live with their adolescent children – for instance the mother and the father cannot agree with each other when they need to decide what to do about it. But we also meet families whose problem is parental, marital or fraternal conflict or even their difficulty to manage family life in order to support the older generations. Each one of you can certainly imagine that we could carry on with this list of problems that forces the families to look for the therapist help. Nevertheless we felt the need to clarify this diversity of motives because most of those families have a common and important fear: they are afraid of their children could become drug users/abusers later on.

We can state that this fear is not only independent from the problem, but we can affirm that it is also equally independent from children’s age. Then it is easy for us to think that families “feel” the facts showed by empirical evidence and theoretical assumptions. To be precise, families feel that they perform an important role in view of drug use prevention. This fear can always be explained by means of social influence and the attention given to this subject nowadays (by media, for example). For sure, this can also be true. But, besides that reason we believe that families feel / know that they need to be well so as to take good care of their children, even when children are not the problem.

So, not only the researchers, but the families too, know that they can do something about it, that is to say, they are important agents in preventing drug use. On the other hand, in the end of some well-succeeded therapeutic processes, as a family therapists we felt we had helped those families to active their potentialities in order to prevent drug use, even when the subject drug was never clearly mentioned in the sessions.

Having clarified these three points we may now approach the main subject of this paper: the study of family life cycle may help researchers and other agents involved in prevention family-focused approaches.

There are empirical evidence and theoretical support that point towards the value of family life cycle as a useful framework for the identification of the most difficult phases of family’s development. In fact, we can say that family evolves through time, changing to be able to continue. This requires the use of flexibility and adjustment ability so that

the family structure will alter as family undergoes several stages or transition phases associated with different individual or in-group developmental tasks. Each one of these phases – marriage, families with small children, families with children at school, families with adolescent children and families with adult children (Relvas, 1996) – marks a moment of *crisis* or second order change in the family. In this context, *crisis* is seen as a period where the family feels a need for change and, most of times, it fears it. That fear causes, in turn, an increased stress. Then, we can also say that *crisis* is marked by the necessity of relational and functional system's restructuring.

These *crisis* characteristics create in the family, at those particular stages, a double sense of opportunity to evolve and the risk of sticking in its developmental process leading to pathology. We know that a balanced family functioning depends on the way the family goes through them in order to fulfil its specific global functions: (1) the possibility of development / individualization of each one of its members, linked to (2) an adequate level of socialization within and outside the family. We also know that any other and not expected relevant incident that may occur in family history also shall act like a *crisis* – for example, an accident or any variant of the expected progress of family life cycle as divorce or single-parenthood.

It seems rather difficult to identify specific risk or protective factors of drug use at an early stage of family life, as well as to remove some universal risk factors stressed by researchers (as poverty, for instance). On the other hand it seems easier to identify the greatest risk moments of family disfunctioning, which correspond to the most important family transitions phases previously indicated or to the existence of any significant stressor that may function like a *crisis* in family life (a chronic illness, for example).

So, we can work with families, either in a universal or selected prevention perspective, considering the stages of family life cycle as *risk moments* of development.

Prevention approaches should, then, be designed aiming to improve families' abilities at those particular moments; they should be empowerment approaches. Then, these approaches should aim to help families to fulfil their developmental tasks, either the normative/expected ones, or the new tasks emerging from other stressful events. The most important families' difficulties felt at each phase are well established, so as its most relevant potentialities. We can consider, then, that those difficulties function as developmental risk factors as well as their potentialities function as protective factors.

Thus, prevention must begin at the stage of *couple formation*, helping the couple (whether in general or considering risk groups) to redefine their boundaries, namely affective and organizational, in what family of origin and other significant systems (friends, work, etc.) are concerned, so that they can, effectively, commit to each other as a couple. This, considering that the non-establishment of those boundaries works as the main risk factor at this stage.

At the next stage, *families with small children*, the preventive measures should focus on the support of growing parental needs and, at the same time, on the new re-open of

boundaries to the families of origin and other involving systems, in order to create a support network on the outside for the developing family. Here, the coordination with social institutions may become a relevant aspect. This, considering that one of the major risk factors at this stage is the isolation and the lack of support of the new nuclear family.

At the stage when *children start attending school*, the preventive measures must focus on the task of articulation and adequacy of the school-family relations, framing the demands of school as a social system. It should also be clarified and flexibly defined what is the school and the family's function towards the child at this development stage, as well as the linking points and elements in common that should bring the two systems together. Here, the elements of the school context (teachers, staff) can eventually participate in these actions / measures.

Finally, one should not forget that this stage implies the establishment of new bounds with other families going through that same stage, so the adequacy of these new connections should also be worked upon. Considering as a major risk factor at this stage the mutual non-adaptation between the demands of school and the demands of the family itself, which may put the child in a conflict of loyalty between one and the other.

After this, finally comes the stage of the life cycle which has been more directly considered in this context: *families with adolescent children*. At this stage, besides the work to be developed with the families towards the facilitation of autonomy, both parents and children's autonomy, the establishment of new clear and negotiated rules, the re-establishment of the couple relationship and the support to elder generations, it is important that families adapt themselves to share the struggle for balance between freedom and responsibility with the community, namely the school. Families should also be supported in the establishment of post-parental interests. In the case of specific prevention of drug use the role of the families as preventive agents may be considered. All this in view of the fact that one of the major risk factors at this stage is the incapacity of distinguishing between conceding autonomy and abandonment or a *laissez-faire* attitude (by or towards the children).

This same model can be followed in the mentioned prevention (for example, the families in which the parents, or just one of them, are drug addicts, broadening the items previously mentioned to drug use).

By bringing all these pieces of knowledge together we can define what to do to empower the families. Nevertheless, the practitioner should ever not forget that each family is unique by its history and organization. Besides, it is also fundamental to know every detail of the social microenvironment where the family belongs and where one intends to act.

We can now return to Ausloos idea: in fact, prevention must be initiated when family begins, helping new couples to create their own balanced relational pattern, by avoiding intense conflict or supporting them in their emotional movements of leaving their parents' home, for example. Prevention should also focus on the difficulties felt by

young couples to cope with work and the lack of time to take proper care of their little children, as well as with related school problems, for instance. One can also act preventively when one is supporting parents and families either in their efforts to coordinate autonomy, authority and conflict with adolescent children, or in their efforts to assist the older generation. And we may well multiply the examples.

So, we may conclude that:

- 1) This framework (family life cycle concept) following the new directions of “prevention science”, allows the definition of family-focused prevention in order to reduce generic risk factors of drug use, by increasing protective factors. On the other hand it facilitates that prevention actions can be effectively applied since the earliest phases of development.
- 2) So, this framework may also provide a good “grid” for acting in accordance with our surveys’ results and implications, as well as with other studies’ results.
- 3) Finally, it can give a positive answer to families feelings and worries about drug use by enhancing their own resources – even when no one talks about it...

The last but not the least: the prevention approaches attending these presuppositions do not only intend to prevent drug use, but also intend to promote health and well-being in a more generic way.

7. FAMILY-FOCUSED PRIMARY PREVENTION – WHAT FUTURE? A FINAL REFLECTION LINKING THEORETICAL PERSPECTIVES AND EMPIRICAL DATA

7.1. SOME CONCLUSIONS AND SOME QUESTIONS FOR FUTURE STUDIES

Articulating the results from the research described in Chapter 5 with the reflections and theoretical revisions present throughout this book, the major question one faces is the necessity of, in the European context, starting to plan and implement preventive measures which have as a target-object the *family as a whole, i.e.*, truly focused on the family. All that was said leads to the conclusion that this “new” focus is the great challenge to future activities in a family context. In fact, in the study we carried out, we verified that almost every project works with only one of the family sub-systems, especially parents.

On the other hand, that work has, fundamentally, pedagogic characteristics, which, according to American studies and our own conceptual perspective, does not give any warranties in terms of effectiveness of the developed actions. Thus, in what methodological design of the projects is concerned, we should proceed to another shift towards *approaches more psychosocial characteristics' centred* – as far as we know from the research we have conducted. Finally, it is important to consider *theoretically oriented and supported in the long term interventions*, assuming a *developmental perspective*, that is, beginning as much as possible at the earlier stages of the family life cycle (note that even before children are born). Following this guideline, it makes more and more sense to use what we call *early prevention*. This kind of specific prevention is the first measure with global preventive characteristics, but also with a focus on the specific prevention of drug use.

Its specificity is clear not only through the earliness of the intervention but also through the target-group and the time length of the measure, often narrowed to very specific situations. Some examples of this kind of interventions, programs or projects are those directed at:

- a) young couples when their first child is born;
- b) pregnant adolescents;
- c) pregnant drug addicts;

- d) children of drug addict parents;
- e) children of alcoholic parents.

We can describe two different types of early interventions:

- Pre-natal early prevention
- Early prevention in first childhood

Basically these interventions use the learning and development of:

- personal skills;
- parental skills;
- skills of recognition and expression of feelings and affection;
- communication skills;
- health habits;
- selective and rational use of institutional resources.

However, we believe that this kind of actions are quite few, sometimes even on a experimental basis, and they require a more structured theoretical framework, a better systematisation and follow-up, which will allow us to evaluate and validate these interventions.

Nevertheless, major questions still remain in the research literature on whether to focus on scarce prevention resources: on the child-only, parent-only or total-family approach. Many prevention providers prefer to work only with children in school or community programs (as we can see, for example, in “Youth to Youth” program in Portugal). Others prefer to work only with parents (as we can see in many programs studied in our research, namely in the Program “School for Parents”, in Spain, for instance).

Family intervention researchers strongly believe that to have a lasting positive effect on developmental outcomes of a child, it is essential to improve the family ecology or context by creating more nurturing and supportive parent-child interactions (Szapocznik, 1997, cit. in Kumpfer, 2000). This position leads us, once again, to the approach of the family as a whole as well as to the consideration of its life cycle. So, we can no longer state that if we are working with parents then we are focusing on the whole family. We can design new programs in which parents and children can be put together with preventive purposes. A good example of this program’s model is the family-focused skills training program, with a strong comprehensive characteristic and a mixed approach, including structured parent skills training, children’s social skills training and parent/child activities, sometimes called family therapy or family skills training (Strengthening Families Program [SFP] Kumpfer *et al.*, 1989, cit. in Kumpfer, 2000).

Supported by the social ecology model of adolescent substance abuse, both parents and children attend separate classes for the first hour and then work together in family

session in the second hour. A third hour is spent in logistics, meals, and family fun activities. The underlying concept is to have parents and children separately learning their skills or roles in a family activity and then come together to practice these family skills. These three-hour sessions long last for fourteen weeks, once a week. Some additional family support services (such as transportation or providing meals) are given to increase family's recruitment and retention. The program's content can be summarized as follows:

- The Parents' Training Program sessions included group building, teaching parents how to increase wanted behaviours in children, communication training, alcohol and other drugs education, problem solving, for example.
- The Children's Skills Training Program included a rationale for understanding feelings; social skills of attending, communicating and ignoring; resisting peer pressure; questions and discussion about alcohol and other drugs; handling emotions and sharing feelings, and so on.
- The Family Skills Training Program sessions provided a time for families to practice their skills in: (1) Child's Game (four sessions) focused on training parents in therapeutic parent-child play, with the help of video feed-back, in order to improve parent's play time with the child (Egeland and Erickson, 1990); (2) Family Game meetings (three sessions) where parents and children improved family communication; (3) Parent's Game (four sessions) focused on role-playing during which parents practiced different types of requests and commands with their children.

The thirteenth session was focused on generalization of gains, connecting them with other support services; the fourteenth and last session was a graduation celebration (Kumpfer, 2000).

An innovating project was conducted in Portugal, between 1994 and 1996, under the responsibility of the Federação Regional de Associações de Pais. The need to create in the Family a space where several issues related to drug use could be addressed and discussed in an intra-familial dialogue environment originated the "Convenção das Sete Cidades" and the "Viriato" programs. The originality of these actions was based on three pillars:

- a) They were family-targeted (Parents and Children). An essential condition to participate was that both parents would come with their children;
- b) They supplied and organized similar information for parents and children, so that they could move on to the dialogue with the same knowledge and data;
- c) The creation of the "Space for Dialogue" in the family, where the received information was discussed and every issue that both parents and children found important was addressed and "discovered" on the first day of the program.

Some of the goals were:

- a) to supply information and discuss, in a dynamic and playful way, the problem of drug addiction and deviant behaviour;
- b) to discuss the problem of drug addiction and deviant behaviour in all of their dimensions: social, cultural financial and pathological;
- c) to create an open and trustful environment between the children group and the parents group, for the discussion of that problem;
- d) to create community dynamics which will allow an organized, direct and effective intervention of the preventive messages;
- e) to form community intervention agents;
- f) to bring to reality, through playful activities, the experiences and knowledge of the group.

Nevertheless, this kind of program raises several questions in order to obtain a higher level of efficiency and applicability. Some of them are connected with the best methods for recruiting and retaining high-risk families in the program. Other important questions are: Who benefits most from family interventions? What kind of family should be recruited?; Which members of the family?; In what sense does this benefit work?; Whose methods can we use for best improving program implementation?

Last but not least questions: *How do families understand their role in these prevention activities? How do technicians and researchers in the field understand families' roles in prevention?*

As regards the first question, we know that the younger the children, the least the family worries about the impact of the drug use phenomenon in the family. The perception of the risk that may endanger their children is understood only when the adolescents are confronted with the proximity and danger of the phenomenon. Until then, there might be a social concern, but the lack of interest and carefreeness are evident. To make the parents and educators aware that what happens throughout the growing-up and the development of their children, and also the relationships they establish between them, are risk and protective factors that should be considered.

In what concerns the second question asked, by better understanding the family structure and dynamics, their education styles, the affection relationship, the parents as learning role models, the passing on of values and which values, among many others, we are defining what we call risk factors or protective factors, crucial to design preventive programs.

In order to find some answers to these last questions (since that in order to find some answers to the first ones implies empirical research on programs of that type which have already been implemented and, as far as we know, there is none like that in the countries involved in IREFREA's network) our research team decided to conduct a new project along 2001/2002. We are now developing a study, based on focus-group methodology, in which the families (parents and children) and the prevention practitioners can reflect and discuss the following subjects:

- the parental roles along the different stages of family life cycle;
- the way parents and children deal with emotions, affects and behaviours nowadays;
- the social representation of the Family as a social institution;
- the social representation of prevention;
- the importance and role of social values and demands on families and communities' lives.

We hope that with this study, we can proceed on our contribution to the future challenge in Prevention: an effective work focused on the families, which may lead to a more successful prevention, not only on what regards to substances use but also on what concerns a better Health in its extended concept: a high level of physical, psychological and social well-being. The final result will be that in a not very far future, we will have several preventive instruments that can be used in different moments of the family life cycle and in different stages of human development, creating a network of interventions.

7.2. FINAL CONCLUSIONS

We conclude this work by calling the attention to some of issues we consider to be extremely relevant in what concerns the present and the future of preventive interventions with families, such as:

- 1a) a broader knowledge of the different social, cultural, recreational and educational realities of the communities where the families live in.
- 1b) a deeper knowledge of the risk and protective factors in each community.
- 2a) better information on the structure, organization and functioning of the families.
- 2b) more consistent information on the families' "everyday life" – for example: occupation of the free time, planning of playful, spiritual, religious, cultural and sport activities, among other.
- 3) more precise knowledge of the family risk and protective factors.
- 4) technical and financial support for the family prevention programs, creating selectivity criteria having in mind: a) the moment of the family life cycle, b) the number of family members involved in it, c) the time scope of the program, d) its theoretical framework.
- 5) to give credit for the activities of investigation and of intervention in family context.

- 6) divulgation of the several preventive activities in order to make them known, giving benefit to others.
- 7) to reinforce the integration of activities which involve the entire family *universe* in those programs that do not contemplate them.
- 8) development of program lines of preventive intervention at a national level, but with local *applicability*.
- 9) to promote a first European meeting on the family prevention in its distinct ways.

8. BIBLIOGRAPHY

- Achenbach, T.M.; Howell. C.T., (1993). Are American children's problems getting worse? A 13-year comparison. *Journal American Academy Child Adolescent Psychiatry*, 32: 1145-1154.
- Alarcão, M. (2000). (Des)Equilíbrios Familiares. Una Visão Sistemática. *Psicologia e Saúde*, Coleção Instituto Superior Miguel Torga, ed. Quarteto, Coimbra.
- Ausloos, G. (1996). A competência das Famílias. *Tempo, caos, processo*. Lisboa, Climepsi Ed.
- Becoña, E. (1999). Bases Teóricas que Sustentan los Programas de Prevención de Drogas. Madrid: Plan Nacional sobre Drogas.
- Böhner, J.K.; Bührienger, G.; Konecny, T.J. (1994). Expert report on primary prevention of substance abuse. *IFT Research Report Series*, vol.60.
- Botvin, G.T.; Baker, E.; Dusenbury, L.; Torv, S. and Botvin, E.M. (1990). Preventing adolescent drug abuse through a multimodal cognitive-behavioural approach: results of a three year study. *Journal of Consulting and Clinical Psychology*.
- Bower, E.M. (1969). Slicing the mystique of prevention with Occam's razor. *American Journal of Public Health*, 59: 479-484.
- Brook J.S.; Brook, D.W.; Gordon A.S.; Whiteman M.; Chen, P., (1990). The psychosocial ethiology of adolescence drug use: a family interactional approach. *Genetic, Social and General Psychology Monographs*.116: 111-267.
- Calafat, A. (1995). Los factores de riesgo como fundamento de programas preventivos. In Becoña, E., Rodriguez, A. and Salazar, I. (coord.). *Drogodependencias*. 4: 75-103. Santiago de Compostela: Servicio de Publicaciones e Intercambio Científico de la Universidad de Santiago de Compostela.
- Caplan, G. (1980). *Principios de Psiquiatría Preventiva*. Buenos Aires. Paidós.
- Catalano, R.; Dooley, D. (1982). Economic Change in Primary Prevention. In R.H. Price, B. L. Bader & J. Monohan (Ed.), *Prevention in Mental Health: research, policy and practice*. Beverly Hills: Sage Publications.
- Catalano, R.F., Kosterman, R., Hawkins, J.D., Newcomb, M.D. y Abbott, R.D. (1996). Modeling the etiology of adolescent substance use: A test of a social development model. *Journal of Drug Issues*.

- Cavalli A., Cesareo V., De Lillo A., Ricolfi L., Romagnoli G., *Giovani Oggi*. (1984) *Indagine Iard sulla condizione giovanile in Italia*. Bologna, ed. Il Mulino.
- Center for Substance Abuse Prevention, (1997). *Guidelines and Benchmarks for prevention programming*. CSAP.
- Chamin, A. (1969) Toward an understanding of teenagers: alternatives to drug abuse. *Clinical Pediatrics*, 8: 6-10.
- Cesaro M., Iannaccone A. (1992) *Prevenzione e tossicodipendenze. Il benessere psicologico del bambino*. Salerno, Edisud ed.
- Coie *et al* (1993). The Science of Prevention: conceptual framework and some directions for a national research program. *American Psychologist*, 1013-1022.
- Combs, R. H. *et al*, (1991). Peer vs parental influence in substance use among Hispanic and Anglo children and adolescents. *Journal of Youth Adolescence*, 20: 73-88.
- Comunidad de Madrid (C.M.) (2000). *Catálogo de programas de prevención del abuso de drogas*. Madrid: Consejería de Sanidad Agencia Antidroga.
- Cosnier, J. (1994). *Psychologie des émotions et des Sentiments*, Paris, Retz.
- Cowen, E. L. (1983). Primary Prevention in Mental Health: past, present and future. In R. P. Felner, L. Jason, J. Moritsugn & S. S. Farber (Ed), *Preventive Psychology: theory, research and practice*. New York: Pergamon Press.
- Dejours, C. (1986). Le corps dans l'interprétation. *Revue Française de Psychosomatique* 3/1993, 109-121.
- Dejours, C. (1986). *Le corps entre biologie et psychanalyse* Paris, Payot.
- Dejours, C. (1986). Sens et destructivité dans la névrose de comportement. *Revue Française de Psychosomatique* 10/1996, 17-29.
- Dishion, T.J.; Patterson, G.R.; Stoolmiller, M.; & Skinner, M. (1991). Family, school, and behavioral antecedents to early adolescent involvement with antisocial peers. *Developmental Psychology* 27, 172-180.
- Donalson, S.L., Graham, J.W. y Hansen, W.B.(1994). Testing the generalizability of intervening mechanism theories: Understanding the effects of adolescent drug use prevention interventions. *Journal of Behavioral Medicine*.
- European Monitoring Centre for Drugs and Drug Addiction (E.M.C.D.D.A.) (1998). *Guidelines for the evaluation of drug prevention: a manual for programme-planners and evaluation*.
- European Review of Applied Psychology (1997). *Coping* Paris ECPA 47, 2/1997
- Fain, M. (1981). Vers une conception psychosomatique de l'inconscient, *Revue Française de Psychanalyse*, 45 : 281-292.
- Farate, C. (2001). *O Acto do Consumo e o Gesto que Consome*, ed. Quarteto, Coimbra.

- Fernández-Ríos, L. (1994). *Manual de Psicología Preventiva: teoría y práctica*. Siglo XXI de España Editores, S.A., Madrid.
- Flay, B.R. y Petraitis, J. (1995). Aspectos metodológicos en la investigación de medidas preventivas del consumo de drogas: fundamentos teóricos. En C.G. Leukefeld y W.J. Bukoski (Eds.), *Estudios sobre intervenciones en prevención del abuso de drogas: aspectos metodológicos*. Madrid. Centro de Estudios de Promoción de la Salud (original 1991).
- Freud, S (1907). *Trois essais sur la théorie de la sexualité* 1907.
- Freud, S (1912-13). *Totem et tabou*.
- Freud, S (1923). *Le Moi et le Ça*.
- Freud, S (1930). *Malaise dans la civilisation*.
- Fundación de Ayuda Contra la Drogadicción (F.A.D.), (1997). *Información General para la Prevención de Drogodependencias*. Madrid.
- Goldston, S.E. (1977). An overview of primary prevention programming. In D.C. Kline & S.E. Goldston (Eds). *Primary Prevention: an idea whose time has come*. Washington, D.C.. Government Printing Office. DHEW. No (ADM): 77-447.
- Green, A. (1973). *Le discours vivant* Paris, PUF.
- Hawkins, J. D. *et al.*, (1992). Risk and protective factors for alcohol and other problems in adolescence and early adulthood: implications for substance abuse prevention. *Psychology Bulletin*, 112 (1), 64-105.
- Hundleby, J.D.; Mercer, G.W., (1987). Family and friends as social environments and their relationship to young adolescents' use of alcohol, tobacco and marijuana. *Journal of Clinical Psychology*, 44: 125-134.
- Freeman J. (1995) *La sindrome della bella addormentata*. Totino, Bollati Boringhieri ed.
- Institute For Health Policy (1993). *Substance Abuse: the nation's number one health problem. Key indicators for policy*. Princeton, New York: the Robert Wood Johnson Foundation.
- ISTAT (1998) *Famiglie ed aspetti sociali vari*. Roma, Annuario Statistico Italiano,
- Janin, C. (1996). *Figures et destins du traumatisme*. Paris, PUF.
- Jessor, R. & Jessor, S.L. (1977). *Problem behaviour and psychosocial development: a longitudinal study of youth*. New York: Academic press.
- Jessor, R. & Jessor, S.L. (1980). A Social- psychological framework for studying drug use. En Lettieri, D.J., Sayers, M. y Pearson, H.W. (Eds.), *Theories on drug abuse. Selected contemporary perspectives*. Rockville, MD: NIDA.
- Kantor D., Lehr W. (1985). *Inside the family*. San Francisco, Jossey Bass.
- Kumpfer K. (1995). Access to hard-to-reach women: interventions as confains or strategy, in Jones, C. and De La Rosa, M. Eds National Institute on Drug abuse,

- Technical Review, Methodological Issues: *Ethiology and Consequences of Drug Abuse Among Women*. Silver Spring, M.D. N.I.D.A.
- Kumpfer, K. L. (2000). Effectiveness of a culturally tailored, family-focused substance abuse program: the strengthening families program. *National Conference on Drug Abuse Prevention Research: Presentations, Papers and Recommendations*, (Invited paper) NIDA. <http://165.112.78.61/MeetSum/CODA/Effectiveness.html> .
- Kumpfer, K. L.; Turner, C. (1990/91). The social ecology model of adolescent drug abuse: implications for prevention. *Int. J. Addict*, 25 (4-A), 435-436.
- Kumpfer, K., (1996). Selective preventive interventions: the strengthening families program. *Research Monograph Series. Drug Abuse Prevention Through Family Intervention*, N.I.D.A., 177, 160-207.
- Martín, F. (1999). *Manual para la Elaboración y Evaluación de Programas de Prevención del Abuso de Drogas*. Comunidad de Madrid. Conserjería de Sanidad. Agencia Antidroga.
- Mancuso R., Di Vita A.M. (2000) *Oltre Proserpina. Identità, rappresentazioni sociali e disagio nel ciclo di vita femminile*. Milano, Franco Angeli ed.
- Marty, P. (1976). *Mouvements individuels de vie et de mort* Paris, Payot.
- Marty, P. (1994). La pensée opératoire, *Revue Française de Psychosomatique* 6/1994, 197-209.
- Marty, P. (1995). La dépression essentielle, *Revue Française de Psychosomatique* 8/1995, 209-215.
- Maslow, A. (1968). *Toward a psychology of being*. New Jersey: Van Nostrand, Princeton.
- McDougall, J. (1996). *Eros aux mille et un visage* Paris, Gallimard.
- Melo, R. (2000). Metodologias de Intervenção na Prevenção Primária da Toxicodependência. *Toxicodependências*, (Vol.6), 1, 49-57.
- Mendes, F. (2000). Toxicodependência e Prevenção familiar: uma política para a Europa, in *Revista Toxicodependências*, , (Vol. 6), 3, 61-68, ed. S.P.T.T.
- Mendes, F.; Relvas, A. P. et al., (1999). *Family relationships and primary prevention of drug use in early adolescence*. Valencia, IREFREA & European Commission.
- Merikangas, K. R., et al., (1998). Family factors and substance abuse: implications for prevention. NIDA, Research Monograph, 177, 12-41.
- Mitchell, M. y Jolley, J. (1992). *Research design explained* (2nd ed.). Orlando, Fl: Harcourt Brace Jovanovich.
- Molgaard, V.; Kumpfer, K. (1995). *The Iowa strengthening families program for families with pre and early teens*. Iowa State University, Ames IA.
- Moreira, P. (2000). *Para Uma Prevenção que Previna*. Coleção Psicologia Clínica e Psiquiatria, nº. 10, Coord. Óscar Gonçalves, ed. Quarteto, Coimbra.

- National Institute of Drug Abuse (N.I.D.A.) (1997). *Preventing drug use among children and adolescents: a research based guide*. National Institute of Drug Abuse and National Institutes of Health.
- Negreiros, J. (1990). Programas de Prevenção Sobre Drogas: modelos e resultados. *Cadernos de Consulta Psicológica*, 6.
- Negreiros, J. (1998). *Prevenção do Abuso do Álcool e Drogas nos Jovens*. Porto, Radicário: Instituto do Comportamento Desviante, with the support of the Instituto da Fundação para a Ciência e Tecnologia.
- Perry, C.L. y Kelder, S.H. (1992). Models of effective prevention. *Journal of Adolescent Health*.
- Plan Nacional Sobre Drogas (1997). *Prevención de las drogodependencias: análisis y presupuestos de actuación*. Ministerio del Interior.
- Recio Adrados, J.L. (1999). Familia y Escuela: Agencias Preventivas en Cooperación. *Adicciones*, 11, 3, 201-207.
- Recio Adrados, J.L. (2000). Hacia un programa integrado escolar y familiar para prevenir el consumo de alcohol y drogas. En J.L. Recio Adrados y O. Rodríguez: *Conducta antisocial, violencia y drogas en la escuela*. Universidad Complutense y Agencia Antidroga de la Comunidad de Madrid, 11-125.
- Recio Adrados, J.L.; Calafat, A.; Stocco, P.; Pietralunga, S.; Relvas, P.; Mendes, F.; Broyer, G. (1997). Las relaciones parento-filiales en la prevención del consumo adolescente de drogas. IREFREA y Comisión Europea, Luxemburgo, 1997. 2 vols. Informe final mimeografiado.
- Relvas, A. P. (2000). Estórias de famílias, história familiar e toxicodependência: da compreensão à intervenção. In *Por detrás do espelho. Da teoria à terapia com a família*. Coimbra, Quarteto Ed., 115-130.
- Relvas, A. P. (1996). *O ciclo vital da família. Perspectiva sistémica*. Porto, Afrontamento.
- Ríos, J.A et al (1997). Actuar es posible. *La prevención de las drogodependencias en la familia*. Plan nacional sobre Drogas. Ministerio del Interior. Delegación del Gobierno para el Plan Nacional sobre Drogas.
- Rogers, C. (1961). *On becoming a person*. Boston : Houghton – Mifflin.
- Roussillon, R. (1991). *Paradoxes et situations limites de la psychanalyse*, Paris, Payot.
- Rudner, R.S. (1966). *Philosophy of social science*. Englewood Cliffs, NJ: Prentice-Hall.
- Santacreu, J., Zaccagnini, J.L. & Márquez, M. O. (1992). *El Problema de « la Droga »*. *Un Análisis Desde la Psicología de la Salud*
- Soares, I., (2000). *Psicopatologia do Desenvolvimento: trajetórias (in)adaptativas ao longo da vida*. Coleção Psicologia Clínica e Psiquiatria. Ed. Quarteto, Coimbra.
- Springer, A. & Uhl, A. (1998). *Evaluation Research in Regard to Primary Prevention of Drug Use*: Social Sciences European Commission.
- Watzlawick, P. (1972). *Une logique de la communication*. Paris. Le Seuil.

This work consists of research into the recreational arena the young inhabit during the weekend, particularly at night. It endeavours to achieve a better understanding of youth subcultures and, as part of this, the use of drugs. The study is supported by quantitative data from a wide survey of 2,700 young Europeans (interviewed in Athens, Berlin, Coimbra, Manchester, Modena, Nice, Palma, Utrecht and Vienna) involved in recreational activities. Ethnographical studies were made twice in each city. The qualitative information was analysed in combination and interactively with the quantitative data obtained from the survey. The main subjects analysed in this work are:

- The social division of time, the time for fun
- Subcultures, scenes and tribes
- Drug use and misuse
- Personal control over ecstasy use
- Risk behaviour
- Prevention and the 'club health' dimension

Earlier works by IREFREA as part of the SONAR Survey are:

- Characteristics and social representation of ecstasy in Europe
- Night life in Europe and recreative drug use
- Salir de marcha y consumo de drogas

**This book and other IREFREA books can be downloaded in
www.irefrea.org**

I R E F R E A



IREFREA is a european network interested in the promotion and research of primary prevention of different sorts of juvenile malaise and the study of associated protective and risk factors.