INFORMATION TO USERS

This manuscript has been reproduced from the microfilm master. UMI films the text directly from the original or copy submitted. Thus, some thesis and dissertation copies are in typewriter face, while others may be from any type of computer printer.

The quality of this reproduction is dependent upon the quality of the copy submitted. Broken or indistinct print, colored or poor quality illustrations and photographs, print bleedthrough, substandard margins, and improper alignment can adversely affect reproduction.

In the unlikely event that the author did not send UMI a complete manuscript and there are missing pages, these will be noted. Also, if unauthorized copyright material had to be removed, a note will indicate the deletion.

Oversize materials (e.g., maps, drawings, charts) are reproduced by sectioning the original, beginning at the upper left-hand corner and continuing from left to right in equal sections with small overlaps. Each original is also photographed in one exposure and is included in reduced form at the back of the book.

Photographs included in the original manuscript have been reproduced xerographically in this copy. Higher quality 6" x 9" black and white photographic prints are available for any photographs or illustrations appearing in this copy for an additional charge. Contact UMI directly to order.

UMI

A Bell & Howell Information Company
300 North Zeeb Road, Ann Arbor MI 48106-1346 USA
313/761-4700 800/521-0600

UNIVERSITY OF OKLAHOMA
GRADUATE COLLEGE

THE DILEMMA OF ADDICTION AND RECOVERY DURING ADOLESCENCE

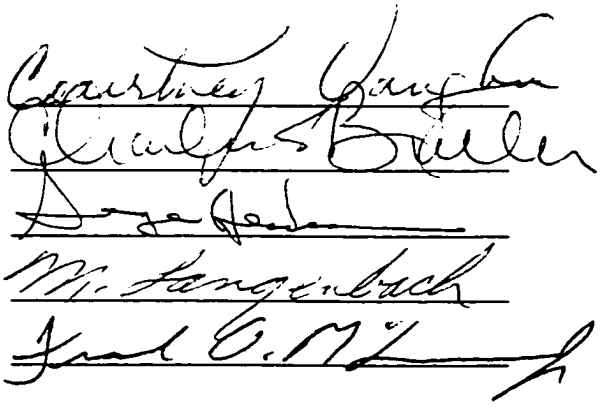
A Dissertation
SUBMITTED TO THE GRADUATE FACULTY
in partial fulfillment of the requirement for the
degree of
Doctor of Philosophy

By
Wesley Long
Norman, Oklahoma
1998

THE DILEMMA OF ADDICTION AND RECOVERY
DURING ADOLESCENCE

A Dissertation APPROVED FOR THE
DEPARTMENT OF EDUCATIONAL LEADERSHIP
AND POLICY STUDIES

BY



Acknowledgments

I first want to thank God for blessing me with the spirit of patience and perseverance because without Him there is no way I would have finished. I want to dedicate the dissertation to my late grandmother Mrs. Leota Long, whom I love and miss, and who was the first to encourage me to continue with school and not to be satisfied with "just one degree." I want to especially thank my loving wife, Monica Yvette, who would not let me quit, and who pushed and prodded when I stalled or procrastinated. Without her love and help I am certain that I would not have finished. Maybe now we can find something else that causes us stress.

To my dear and sweet mother Bobbie Long, I thank you for the words of encouragement and support and for believing that I was capable of earning a doctorate. To my father Elmerece Long, thanks for the never ending financial support and maintaining an interest in my studies and future. To my sisters Latricia Long and Roshawn Jackson, thanks for typing and editing my term papers during my undergraduate years and for giving the support and encouragement during my graduate degree years. To my brothers Michael and Randell Long, thank you for working for me when I had papers due or had to study for an exam. Your assistance and support was greatly appreciated. To the greatest in-laws one could imagine, I want to thank Henry and Thelma Stout for their support and their willingness to help whenever I asked. Your support and love was very important to me.

I also want to thank the following people who were instrumental in my completion of the dissertation with their words of encouragement and their insistence that I stay focused: Freda and Reginald Hall; Tonnie Gatling; Rosalind Burris; Reginald Littlejohn; Donald Shrewsberry; Don Simpson; St. John C.M.E., Church; the long family; and the Terry family. I want to thank the following people who are too young to understand how their presence played a significant role in my completion of the dissertation: Jeffrey Jackson; Tony Stout; Derek "Tiger" Stout; Kacie Burris; Rena Hall; Reggie Hall; Derick Hall; Charles Gatling; and Alexandra "Alex" Jackson. Thanks for the movies, birthday parties, skating, bowling, and sporting events. You called and visited at times when I really needed a break and time away from the dissertation.

I want to thank my dissertation committee: Charles Butler; Frank McQuarrie; George Henderson; Michael Langenbach; and, especially, Courtney Vaughn, my chair. I want to thank you for allowing me to get to know you and your family, and I hope we established a friendship that will last a lifetime.

TABLE OF CONTENTS

TABLE OF CONTENTS (cont.)

ABSTRACT

The study probes how the process of substance use, abuse, and addiction affects the lives of users during their adolescence. Using qualitative research methods, it investigated the lives of seven adolescent substance users who began using licit and illicit drugs during their early teenage years and eventually became addicts. The research focused on the participants' personal history, investigated their relationships with families, peers, schools, and communities in an attempt to trace their involvement with alcohol and drugs. Due to their substance abuse issues, all seven were forced out of the traditional public school setting. During the initial phase of the study, the participants were enrolled in a long-term residential drug treatment program and within nine months of the study, all had graduated from the treatment program and returned home. All seven promised to attend Alcoholics Anonymous (A.A.) and Narcotics Anonymous (N.A.) meetings, work the Twelve Steps and refraining from the return of drugs and alcohol. The researcher interviewed the participants at the treatment center, while they were on weekend passes and in their homes after graduation. Three of the four participants relapsed shortly after graduation, and the four who remained sober had setbacks, but remain committed to recovery. The research findings indicate that the surrender process, and resiliency and social stress theories provide the conceptual understanding of these participants' recoveries and relapses.

CHAPTER ONE

Introduction

Throughout the history of the United States there has been a problem with drug and alcohol use and abuse. In recent years there has been an increase in the use and addiction of youngsters. As a result, government, churches, employers, and eventually educational institutions became involved in the efforts to curb drug and alcohol use and abuse. Public schools have also been involved with addressing social concerns since their inception - assimilating immigrants, desegregating schools, teaching sex education when parents found it too difficult, and educating students about the harms and dangers of drugs and alcohol.

In recent decades schools have attempted to prevent drug and alcohol abuse without much success. Research has deemed prevention programs mostly ineffective. Thus, funding for prevention programs has been on the decline with Drug Abuse Resistance Education (DARE) programs being the exception.

American youth have continued to use alcohol and illicit drugs, and addiction among this age group has increased. Therefore, the recovery process must be studied. A body of research does exist on this topic, but most of this work is methodologically quantitative. In-depth qualitative studies need to be conducted to further investigate the complex nature of recovery and how more and more addicted adolescents can engage in it.

Problem and Research Question

Due to the general failure of prevention education and increasing involvement of youngsters in addictive alcohol and drug use, this study asked:

What factors are related to a select number of adolescents' efforts to become and remain sober?

CHAPTER TWO

Literature Review

Historical Background

The use and abuse of alcohol and other drugs have been an issue in the United States since the colonial period. Farmers discovered that it was easier to market their corn for whiskey than for food consumption. In 1785, Dr. Benjamin Rush, a signer of the Declaration of Independence, proposed the elimination of distilled spirits, and opposed fermented alcohol as a method for eliminating alcohol problems. Because of the increase in alcohol consumption and the view that distilled alcohol was becoming a societal problem, the federal government levied a tax on distilled spirits in an effort to control its consumption (Daugherty & O'Bryan, 1987).

From 1810 to 1830 the consumption of pure alcohol was about seven gallons per capita for persons aged 15 and older. At that time adult men comprised 12.5 percent of the population and consumed 67 percent of the distilled spirits. In 1826 the American Temperance Society was formed to address growing alcohol consumption and the need for prohibition. By 1836 this group was declaring all alcohol evil and called for its elimination in all forms. During the 1920' s Prohibition became the Eighteenth Amendment to the United States Constitution but was repealed in the 1930's because of the inability to enforce it (Daugherty & O'Bryan, 1987).

During the late 1880's the Women's Christian Temperance Union (WCTU), had become the primary force behind public school health education programs. It originally focused on the health of working men and their families. However, the movement changed its philosophy, and alcohol was now perceived as the prime hindrance to healthy living. As a result, the WCTU was influential in

having the negative effects of alcohol use incorporated in schools' health education curricula.

From the creation of A.A. in 1935 through 1960, the unitary disease concept of alcoholism mandated research, treatment, and public policies for addictive diseases. During this period alcoholism was deemed a disease, and a medical model of treatment evolved. The medical-disease model determined that the "cure" for alcoholism was total abstinence. From 1960 to 1970 the medical-disease concept of alcoholism was challenged, and the concept of loss of control to alcohol was questioned. Some alcohol researchers now held that alcoholics could learn to become social drinkers, and abstinence was not necessarily the end goal. This view cast doubt on the medical-disease theory established by early alcohol researchers (Denzin, 1993).

During the 1970's the federal Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act was passed and revised. The act mandated government money for the treatment of alcoholism and required that insurance companies be prepared to pay part of the cost of treatment for alcoholism. This act ignored controlled drinking theories and recognized alcoholism as a disease requiring medical treatment. In the next decade the federal Drug Free Work Place Act was passed, giving employers the power to test their workers for drug (including alcohol) use (Denzin, 1993). From 1980 to 1990 a multitude of community-based treatment methods and centers surfaced. Such centers treated alcoholism but also recognized and served drug addicted patients and poly drug and alcohol abusers as well. As a result, by 1990 there were over 5,000 alcoholism or substance abuse treatment centers in the United States, treating over one million individuals a year, at an annual cost of over 20 billion dollars. Currently, the country has shifted from treatment to bolstering prevention programs, especially for adolescents.

However, the epidemiology of alcoholism and drug addiction continues to be studied. For example, according to the National Institute of Drug Abuse (1991), approximately 60% of America's 112 million persons over the age of 15 drink alcohol at least once per month. It is estimated that 17.8 million people in the United States abuse alcohol, and 10.5 million of these individuals are considered to be alcoholics. In the United States, alcohol has traditionally been the drug of choice, but, as suggested earlier, over the past twenty years, illegal drug use has gained in popularity. Teenagers usually start with alcohol, but often they soon become involved with other drugs such as cocaine, heroine, prescription pills, and inhalants. Current trends indicate that substance abuse among underage persons crosses race, gender, and ethnic boundaries (Brinson, 1991; Department of Mental Health and Substance Abuse Services, 1996; Siegel & Ehrlich, 1995; Vanderschmidt et al., 1993; Way, et al., 1994). The age of persons taking their first drink or experimenting with drugs and alcohol also has declined each year during the last eight years. According to the Department of Mental Health and Substance Abuse Services, the current age of first use is 12.2 years, and because of this, professionals in the substance abuse field have become alarmed.

Theories About Prevention Programs

Several researchers have investigated various prevention methods. The 1979 Surgeon General's landmark report on health promotion and disease prevention identified a dramatic increase of drug use for 15 to 24 year olds. Moreover, the main cause of death for adolescents was motor vehicle accidents with alcohol consumption involved in 60 percent of those incidents. The report also concluded that more than half of the teens between 12 and 17 years of age drink alcohol at least once a month; ten percent of the U.S. high school students

smoked marijuana on a daily basis; and the use of other drugs continued to increase (U.S. Department of Health, Education, and Welfare, 1979).

As a result, substance use researchers have generated numerous theories to explain reasons for and /or mechanisms underlying substance use. Theories often incorporate social learning, past substance use, and/or deviancy variables (e.g., Kandel et al., 1986, 1992; Napier et al., 1983). That is, adolescent substance use is often predicted by: 1) substance use by "significant" others, such as, peers and family members, as well as attitudes communicating approval of substance use; 2) a history of substance use behavior; 3) concurrent involvement with other deviant behaviors, such as criminality and aggression; and 4) to a much lessor extent, drug education received.

Even so, Shope et al. (1992) outlined the advantages for incorporating alcohol and other drug abuse education/prevention in schools: 1) most students attend school and are available to participate in education/prevention programs; 2) schools are becoming more interested in teaching life skills as well as academics; 3) health educators believe that if health behaviors are developed at a young age they will provide a basis for lifelong health skills; 4) the social atmosphere can be used to develop positive peer pressure and relationships; and 5) given the school's visibility in the community, educators' efforts can extend beyond the walls of the classroom.

Based on social learning principles, Hansen's (1991) research resulted in "resistance training." Behavioral strategies were also implemented to address various other life skill problems (Schinke & Gilchrist, 1985). Hansen (1992) indicated that social influence and comprehensive programs had the strongest results. Comprehensive programs, by Hansen's definition, are those with a broad range of mediating variables. He claimed prevention programs had to look at the life experiences, family, and socio-economic status when developing effective

training/intervention programs. A U.S. General Accounting Office (GAO) (1992) report entitled Common Features of Promising Community Programs reached a similar conclusion. Those programs that address a broad range of variables show potential for reducing the incidence of AOD (alcohol and other drugs) use within the teenage population.

The GAO report also added that ideal programs must include a community-based approach. Five dimensions of young peoples' lives need to be addressed in a comprehensive prevention program. They include the: 1) individual; 2) family; 3) peer group; 4) school; and 5) community. The three areas of the public health domain to be addressed in comprehensive programs include: 1) the agent (alcohol and other drugs); 2) the host (individual); and 3) the environment. The services component of comprehensive programs outlined by the GAO includes training for providers, education and training of parents, counseling, and the application of mediating variables. The identified mediating variables include: 1) information and awareness enhancement; 2) self-esteem activities; 3) refusal skills training; 4) youth leadership training; 5) general skills (life skills); 6) values clarification; and 7) alternatives or recreational activities.

Felner et al. (1992) suggest that the abuse of alcohol and other drugs and associated problems grow out of the interplay or psychological characteristics of those in the population and the social environment in which they live. They also assert that, to be effective, prevention programs must be guided by developmental models that indicate emotional and behavioral disorders (such as alcohol and other drug abuse) are the result of multiple and complex causal pathways. Comprehensive programs must, therefore, be viewed in terms of the interrelationship among many other emotional, social, and behavioral problems.

As a result Felner (1992) posits three concepts on which comprehensive prevention programs should be based:

1) in order to address the full range of conditions that make up the causal pathways to alcohol and other drug abuse, it is necessary to have a coordinated school-community approach;
2) a comprehensive prevention program must address not only the child and his/her school experience, but also conditions in the family and community contexts that lend themselves to the development of alcohol and other drug abuse and related problems; and
3) comprehensive programs must be multisystem and multilevel in nature. (p. 6)

Prevention Programs

The Center for Substance Abuse Prevention (CSAP) was the federal government's means of allocating monies to states after the Drug Free School and Communities Act of 1986 passed. The state agency that currently allocates funds and monitors prevention programs where the study was conducted explained that each state was allowed to create its own unique drug and alcohol prevention program. Alice Bundage (1997), who monitors prevention programs for the state's Department of Substance Abuse Services stated that school districts were also allowed to create their own unique drug programs. The guidelines established by the act require that each state and school district provide drug and alcohol education and prevention programs to children/students in the elementary and middle school grades and through community programs.

In the late 1980's few states had state mandated drug education and prevention programs already in existence. California, specifically Los Angeles,

had started drug and alcohol education and prevention programs through police departments. Drug Abuse Resistance Education (DARE) was the creation of the Los Angeles Police Department, and, because it was already in existence when the federal law was passed and was viewed as successful, most states adopted that program. The concept of DARE was to have uniformed police go into elementary and middle schools for six weeks and teach students about the dangers of drugs and alcohol. By 1989, the DARE program was being carried out in every state, and exclusive funding for DARE was provided by the federal government to the various states that had adopted it.

Although individual states and school districts had limited requirements for the programs they were to create during the 1980s and 1990s, they did not seem to be related to the theory regarding excellent prevention programs. Generally, the focus was on early school age children, and they were informed about the harm, danger, and effect of drugs and how to reduce and prevent situations that led to drug use. Because states were allowed to form their own programs, the amount, duration, content, context, and curriculum varied drastically from one state and school district to another. There were no uniform drug and alcohol education and prevention programs nor curricula, therefore each state monitored its program's effectiveness.

Even so, federally sponsored programs were to have 12 components. They focused on:

1) providing information: teaching factual data regarding the types of drugs that are available and the risks associated with their use;
2) decision making: teaching decision-making skills;
3) pledges: asking students to make personal public commitment to resist drug use;

4) values clarification: examining the relationship between an individual's values and his or her behavior;
5) goal setting: teaching skills for setting goals;
6) stress management: teaching skills for managing stress;
7) self esteem: focusing on developing feelings of self worth;
8) resistance skills training: teaching assertiveness skills to resist offers of drugs and helping students identify the pro-drug bias in the media;
9) life skills training: teaching communication skills, human relations skills, and skills for resolving interpersonal conflict;
10) norm setting: establishing conservative norms regarding substance abuse;
11) assistance: using peer counseling in preventing drug abuse; and
12) alternatives: providing experiences incompatible with substance abuse, (e.g., athletic activities, drug free social events) (Hansen, 1992).

As the years wore on, drug prevention and education shifted from information about and history of drugs to "resistance" training. Project Adolescent Experiences to Resistance Training (ALERT) and Self Management and Resistance Training (SMART) were examples of the change. Students were to be taught how to resist the temptations of drugs and avoid persons who used drugs (Ellickson & Bell, 1992). The premise of resistance training was to equip non-users with the skills (e.g., decision making, assertiveness training, and selection of positive peers) to avoid drugs. The resistance approach provided drug education and prevention information, but founders felt that due to peer pressure, information and education was not enough.

Students needed to be skilled in avoiding drugs and how to resist the influence of peers and others who were drug involved.

Few drug education and prevention programs have received nation-wide attention. The DARE Program (discussed earlier) has won national reviews and has been touted as effective. DARE is offered in over half the elementary schools in the United States. It reaches 5.5 million students per year and is the most widely used school-based drug-use prevention program in the United States (Ennett et al., 1994). DARE is also an international program and is represented in 20 countries. The "Just Say No" to drugs program, made popular by former First Lady Nancy Reagan during the 1980's, used media and celebrity personalities to warn against the dangers of drug use. Here's Looking At You (HLAY) was another prevention program that got national attention, and its approach was similar to the ones already in existence. However, it involved students and their families in the community and not police and prominent figures. Its intentions were the same as the others, educating children about drugs and their effects.

Program Evaluation

Early outcome studies on many drug and alcohol prevention programs indicated that not only were they largely ineffective in reducing substance abuse or preventing future abuse, but they sometimes increased the use and sale of drugs and alcohol because they gave too much information about drugs and alcohol (Botvin, 1984; Kinder et al., 1980). Scare tactic approaches also failed when attempting to decrease drug and alcohol use among teenagers. Such discouraging results convinced the National Commission on Marijuana Abuse to recommend a ban on prevention programs in 1973 (Newcomb & Bentler, 1988). Kinder et al. (1980) also found that adolescent drug and alcohol prevention programs seemed to

increase substance abuse more than the comparable adult prevention programs. Although programs such as "Here's Looking at You" (HLAY), ALERT, and SMART became models for drug and alcohol prevention, evaluators found very modest effects, either immediate or longitudinal, and the programs had essentially no carry over effects on subsequent drinking or drug using behaviors (Hopkins et al., 1988). "Just say no" was viewed as ineffective and was unsuccessful in its attempts to curb drug and alcohol abuse among youngsters.

Generally, most of the DARE studies identified some desirable outcomes, but mixed results seemed always to appear. Most studies indicated that from the first year, DARE had a positive short-term impact on the student participant. When compared to other students, they displayed a less favorable attitude towards drugs, a greater awareness of their peers' conservative attitudes regarding substance abuse, an increase in skepticism regarding the media's portrayal of drugs, greater self-esteem, increased assertiveness, and more favorable attitudes toward the police (Ringwalt et al., 1990). However, the same researchers conducted a follow-up study one year later, and DARE showed no statistically significant main effects on substance abuse. Only one of 13 intervening variables, a student's ability to accurately perceive media bias toward alcohol, was identified as significant. Essentially, almost all of the first year main effects had been lost (Clayton et al., 1991; DeJong, 1987; Faine & Bohlander, 1989; Harmon, 1993; Ringwalt et al., 1991; Rosenbaum et al., 1994; Wysong et al., 1994).

In a 42 state federally sponsored program study, Hansen (1988) used cluster analysis to group key components of drug curricula. Programs were classified into three dimensions of content: cognitive; affective; and learning/social influence. Cognitive programs consisted of providing

information and clarifying values. Affective programs were composed of self-esteem, goal setting, decision making, and stress management. The learning/social influence programs included resistance training, norm changing, and pledge making. Substance abuse theories focused on the individuals and their environment or causes that led to substance use and abuse. Most drug prevention and education programs focused on the drug(s) and the individual only, seldom incorporating variables that lead to drug and alcohol use. Thus, researchers and program evaluators agree that prevention program studies are replete with many methodological problems. Difficulties include limited follow-up times, confusion about prevention goals, and errors in sampling and statistical analysis (Hansen, 1988). These methodological issues may obscure the true impact of the programs, perhaps leading to Type Two errors, that is, failing to find significant relationships when they may exist (Ellickson & Bell, 1992; Ringwalt et al., 1990).

Theoretical Explanations for Substance Abuse

Genetic-Biological Theories

Goodwin (1979) suggested several genetic or biological predispositions that could lead to the abuse of alcohol and drugs. Generally they relate to the manner in which alcohol affects the brain. Research also indicates that an individual can be born with an inherited biological predisposition to abusing alcohol and drugs (Goodwin & Guze, 1974; Schuckit & Duby, 1983; Vaillant, 1983). However, there has been controversy and debate over the predisposition theory of alcoholism for, if true, the only treatment is prevention and/or complete abstinence (Lewontin et al., 1984).

Behavioral Science Theories

The major behavioral science theories of substance abuse seek to locate anterior and inner psychological states that precede the actual

substance use and abuse. They locate in the abuser's culture and, psychology factors that condition or shape the predisposition to abuse substances (Madsen, 1974).

Social psychological theory provides a partial explanation, especially for adolescent substance use and abuse. From a developmental standpoint, adolescence is a period of storm and stress. An adolescent is at an age that is best characterized by: 1) the search for identity; 2) the desire to fit into society, usually manifested by membership in peer groups; 3) curiosity and experimentation with "taboo" behaviors that seem omnipresent in the adult world, such as substance use and sexual activity; and 4) a feeling or perception of personal invulnerability (Monte, 1991; Newcomb & Bentler, 1988).

Kandel et al. (1986) and Hawkins et al. (1992) have proposed that substance use behavior among adolescents and young adults may be just one of a syndrome of socially "deviant" or problem behaviors, such as dropping out of school, criminality, and poor or non-existent relationships with family and/or peers. That is, if a pre-adolescent, adolescent, or young adult uses substances, s/he will often have school, delinquency, and interpersonal problems as well, when compared to non-using pre-adolescents, adolescents, and young adults. In other words, "problems" predict or are correlated with "problems." In the transition into adulthood, adolescents are often characterized by engaging in "problem" or "deviant" behaviors, such as early sexual involvement and substance use, perhaps because adolescents view these behaviors as omnipresent in the adult world of which they want to be a part.

Jessor et al. (1968) argue that, when deviant behavior is observed, person variables (e.g., "weak" personality) are not solely to blame. Often

there is a failure of both the person and his/her environment to support the substance abuser. Jessor and Jessor (1978) propose that the "deviant" is often identified by a characteristic set of antecedent-background variables. Although Jessor and Jessor (1978) did not make specific predictions about how deviant youths may be characterized in terms of demographic and socialization variables, they did postulate the types of variables which may be important to consider when investigating problem behavior, such as substance use and abuse. In terms of demographic variables, Jessor and Jessor (1978) suggested investigating parental education, occupation, religious group, and family structure to determine correlates with adolescent substance use. Socialization variables include parental ideology (religiosity, tolerance of deviance, and traditional beliefs), home climate, peer influence, and media prevalence. The researchers understood that there were other factors which influenced adolescent drug and alcohol use and abuse. Understanding the users' families, environments, and peers help form strategies that allow abusers to decrease or stop.

Other theories include Bandura's (1977) social learning theory. Behavior may be explained by four processes of observational learning: 1) attention; 2) retention; 3) reproduction; and 4) motivation. Although adolescents may acquire new behaviors from observing people in general, substance use researchers have focused specifically on the effects of persons within the adolescents' immediate social environment: 1) the family; and 2) peers. Researchers have found that if a family member (such as a parent or sibling) uses and/or abuses substances, the probability that the adolescent in that home or family environment will also be using or abusing will be high (Chassin, 1984; Chassin et al., 1991; Dull, 1992; Hawkins et al., 1992; Johnston & O'Malley, 1986; Kandel, 1980; Kandel et al., 1986). Researchers

also found that one of the most robust predictors of self-use of substances, for pre-adolescent, adolescent, and other users, is the use of substances by peers (Chassin, 1984; Kandel, 1980; Kilty, 1990; Napier et al., 1983; Stacy et al., 1992; Urberg et al., 1990). One of the most robust predictors of current substance use is past substance use (Hansell & White, 1991; Newcomb et al., 1986). That is to say, such behavior predicts the continuation of it.

Thus evolves the gateway theory of substance use and abuse: especially youthful substance users usually start with licit substances such as tobacco and alcohol, and, over time, may progress toward more potent, illicit substances, such as marijuana, and cocaine (Single et al., 1992; Kandel et al., 1992). But as substance abuse researchers promoting the gateway theory often note, using licit substances does not automatically destine a person to move on to using "harder" substances, although s/he is at greater risk for using these "harder" substances than the non-user.

Flowing from much of the literature discussed above, social stress model theorists (Rhodes & Jason, 1988) have identified five categories of stressors: 1) major catastrophic life events (e.g., car accident or death of parent); 2) life transitions (e.g., marriage, divorce, or change of job or home); 3) daily hassles (e.g., frequent arguments with spouse or parents); 4) enduring life strains (e.g., lack of privacy, inadequate housing, or school or work conditions); and 5) developmental stresses (e.g., pressures to fit in with peers and adhere to norms, or establishing a mutually satisfying relationship).

Research has been conducted using the social stress model to understand persons engaged in substance use and abuse (Lindenberg et al., 1993; Rhodes & Jason, 1990). The social stress model seeks explicitly to address the broader social variables that influence adolescent behavior. From this perspective, adolescent drug usage is viewed as the long-term outcome

of multiple experiences with significant others and social systems from birth through adolescence (Wills & Shiffman, 1985). According to the social stress model, adolescents initiate substance use as a means of coping with a variety of stressors and influences that may arise from within the family, the school, the peer group, or the community. The ways in which one interprets and copes with stress may influence the ability to access resources and select appropriate models of success.

According to the model, the likelihood of an individual engaging in drug use is seen as a function of the stress level and the extent to which it is offset by stress modifiers such as: social networks, social competencies, and resources (Rhodes & Jason, 1990). The social stress model suggests that social networks made up of family and peer relationships are the interpersonal factors which bear upon one's decision to initiate and/or escalate drug and alcohol use. Social networks provide the channel by which individuals communicate and incorporate values and standards, develop social attachments, and receive support. Social competencies are innate or acquired intra personal factors such as personality characteristics, decision making, communication, or peer-resistant skills hypothesized to influence a person's decision to use or not to use drugs. Possession of a broad repertoire of coping strategies and the ability to use them will lower the risk that an individual will engage in drug use. Social competence enables the individual to generate and utilize effective strategies to avoid or escape high risk situations. Resources or community factors are another stress modifier posited in the social stress model. Community resources such as school, health, and neighborhood service institutions are sources of information that may influence behavior directly or indirectly. Individuals with insufficient

resources are probably at greater risk for alcohol and other drug use than those with adequate resources (Rhodes & Jason, 1988).

The tension reduction or anxiety reduction model assumes that substance use is a learned means of reducing conditioned anxiety. Dependency on alcohol and other drugs is established when the drinker or addict learns to use alcohol or substances to achieve states of euphoria and to reduce feelings of anxiety or tension (Denzin, 1993). The alcohol use or substance abuse yields positive affective or euphoric states. The substance abuser will continue or increase his/her use because there is more pleasure in continued use than the attempts (withdrawal) to stop.

Power and dependency theories develop psychoanalytic themes of sexuality and childhood experiences as central components of alcoholism and drug addiction in adulthood. They seek to locate the motivation for abuse in the personality makeup of the user (Denzin, 1993). McClelland et al's (1972) power theory argues that men who have accentuated needs for personal, not social, power use excessively. Such men have power fantasies while drinking/using that express aggressiveness, thrill-seeking, and antisocial activities. A desire for personal dominance over others, power, glory, and influence is expressed in the fantasies of heavy users. These fantasies reflect a world that is a competitive arena for males who must establish their dominance over one another (Denzin, 1993). MacAndrew and Edgerton (1969) and Lemert (1967) disagree. It is not the effects of substances that fuel the power fantasies or the aggressive actions of the user, but the culture. That is, power fantasies are part of being male in patriarchal cultures (Denzin, 1993).

Dependency theory contends that heightened masculinity is a reaction formation against underlying dependency needs felt by the male (Williams,

1976). This theory assumes that the prealcoholic/addict has a permanently unfulfilled desire or need for dependency, but is ashamed of this need. For example, the male prealcoholic/addict user desires maternal care and attention, yet wants to be free of this care. A facade of self-reliant manhood is developed to mask this dependency need. Because using is a masculine activity it helps the alcoholic/addict maintain an image of independence and self-reliance. Drinking and using satisfies dependency needs by providing feelings of warmth, comfort, and omnipotence. Using recreates the maternal caring situation. Accordingly, the motivation for drinking/using lies in the desire to satisfy dependency needs not to feel powerful (Denzin, 1987).

Females, on the other hand, may drink for entirely different reasons. A number of women begin using for the same reasons as men but some may begin due to their co-dependency relationships. Women who are engaged in relationships where their male companion is an alcoholic/addict sometimes take on the behavior of their mate. They may begin using, continue, or increase their alcohol/drug use to keep the relationship intact (Denzin, 1993).

Bateson's (1972) theory attempts to analyze the user's inner phenomenological dialogues with self, while also locating the abuser in a materialistic society that is seen as promoting the use of substances as a means of dealing with emotionality, failure, success, and competition. Bateson's theory locates the alcoholic/addict not within him/herself, but in his/her relationship to him/herself or to substances, and with others. Ironically, substance abuse, which begins in the biography of the user as a symmetrical, competitive social act with others turns into an antisocial act that promotes separateness from others (Denzin, 1993).

MacAndrew and Edgerton's (1969) anthropological time-out theory, particularly of drunken comportment, states that societies create time-out

periods when their members are not held accountable for their actions. Alcohol and other drugs may be ingested during those time periods. Drunken comportment in particular, is even culturally patterned behavior in certain societies (Denzin, 1993). Madsen (1974) proposes that because alcohol has been given the cultural meanings of being both an anxiety reducer and the producer of euphoria, it is turned to in moments of high anxiety. Thus, the alcoholic/addicted mind is a product of the environmental stresses that reflect generalized American anxiety regarding freedom, control, achievement, success, pleasure, adventure, love, nurturing, warmth, power, and caring. Conflicting values radiate throughout the society, and these conflicts are lived and experienced in most prominent form in the lives of alcoholics/users who withdraw from society in order to find a pleasure of comfort, security, and self worth. Madsen's (1974) thesis attempts to position the understanding of alcoholism/addiction within the U.S. culture and history. The alcoholic/addicted man or woman is a reflection of the society, the history, and the culture of which s/he is a member (Denzin, 1993).

Dealing with alcohol alone and assuming that many people will always feel driven to escape the vicissitudes of life and drink periodically, Mello, (1972, 1983) and Sobell & Sobell, (1978) used B.F. Skinner's operant theory of learning either to determine the alcoholic's preferred pattern of drinking or attempt to modify the alcoholic's "alcoholic" drinking style. Drinking is hypothesized as being learned, acquired, and maintained as a function of life consequences. The consumption of alcohol is preceded by certain events (antecedents), internal and external, followed by various short- and long-term consequences (Sobell & Sobell, 1978). Mellow (1972) used the following basic concepts of operant conditioning in his behavioral formulations for alcohol abusers: 1) discriminating stimuli that are present for any person

at any time; 2) behavioral options (operants), which include appropriate and inappropriate drinking responses in an experimentally controlled environment; 3) reinforcement, which is any event that maintains behavior or increases the probability of the recurrence of that behavior; and 4) punishment, which is any event that decreases the rate of emission of a behavior (Denzin, 1993). Mellow's (1972) research attempted to change drinking patterns of alcoholics and addicts. Through shock treatment, positive and negative reinforcement, and punishment researchers claimed to recondition the thinking of alcoholics and teach them to practice controlled social drinking practices and become normal social drinkers (Mellow, 1983; Sobell & Sobell, 1978).

The lay theory of alcoholism or addiction combines concepts from the above theories and practical experiences working with substance abusers to explain addiction to the user and his/her significant others. Lay theory is organized around the interpretive structures of: 1) self, time, and causality; 2) denial and rationalization; and 3) successful use. According to lay theory, the rationale which permits the user to go on using long after her or his emotional associates feel s/he should, revolves around the following twelve points: 1) s/he may be a heavy user, but not an alcoholic/addict; 2) s/he deserves to use and has to use because he is unique and special; 3) there are problems in his life with which using helps him or her deal; 4) when using s/he escapes life's problems; 5) when s/he has problems using it is due to matters over which s/he has no control; 6) s/he is a social user who uses heavily and does not use any more than others; 7) those people who say s/he has problems with using do not understand him or her; 8) if people make him/her angry, it is natural to use more and to not interact with them; 9) life is still manageable and everything is under control, even if s/he uses too much on occasion; 10) the reasons to quit are not compelling, although

quitting is possible if s/he wants to; 11) no interference or help from others is needed. All that is necessary is to be left alone so that s/he can use and enjoy substances in solitude, or in the company of others who understand him or her; and 12) when using s/he becomes the kind of person s/he wants to be. Alcohol and/or drugs are his or her best friend (Denzin, 1993).

Thus, because alcohol and drugs alters the temporal structure of the user's consciousness, s/he is always located in a temporal world that is either sped up or spread out over a long period of time called the present. Yet, it is not the present that the user lives in; s/he lives in the past or the future, using drugs to avoid the present (Denzin, 1993). A confusion over temporal causality is produced, for while s/he is using the addict/alcoholic loses track of time and events (Berryman, 1973).

The temporal self references those feelings that derive from the altered temporal consciousness that alcohol and drugs produce. As the effects of alcohol or drug's wear off, the user finds that s/he must return to her/himself. When forced to be responsible for actions that s/he has taken only in thought, the user rebels against those who attempt to hold him/her accountable for his/her actions (Denzin, 1993).

The lay theory of denial is a theory of personal power, for the user feels s/he is in control of her or his world. S/he feels that alcohol and drugs are the keys to that control. The user derives power from using. To take drugs and alcohol away would render him/her powerless. S/he understands power to be the control of self and others in the social situation and the lack of power to be the inability to control her/himself or others. Control of self and others involves interaction, the manipulation of knowledge, secrecy, and the control of information-most centrally information about how much she

has had to use. The user must deny to her/himself and to others, the amounts s/he uses and how dependent s/he is on substances (Denzin, 1993).

A user must be able at certain times to "pass" as a normal human being, one who is not under the influence of alcohol or drugs. Passing as normal s/he disavows addiction. In so doing, the user maintains a secret deviance (Denzin, 1993). Knowing s/he is an addict, s/he can nevertheless pretend not to be so. Another facet of denial is when the user blames others for his/her addiction. The user shifts the blame or cause of his/her abuse on others, usually significant others. Another form of denial is when the user blames the substance itself. The user feels that s/he cannot deal with others except through chemical abuse. Self uniqueness is another form of denial which is the user's belief that s/he is unique and hence must drink. S/he feels that only s/he is experiencing stress and anxiety (Denzin, 1993).

The lay theory of successful drinking is therefore, present when the heavy drinker believes that s/he can control drinking and continues to drink. The heavy drinker remembers when s/he could handle and control drinking and the good times associated with past use and longs for their return (Denzin, 1993).

A.A. and its offshoots, NA, and Cocaine Anonymous (CA) which represent practical applications of lay theory, define the alcoholic or addict as a sick person, suffering from a progressive illness that is physically, mentally, spiritually, and emotionally derived (A.A., 1976). According to A.A. this illness is placed in remission only through abstinence or death.

Treatment Programs

For one reason or another some abusers do find their way to treatment centers. Most of these programs are theoretically eclectic, combining approaches from biological/genetic theories, behavioral sciences,

lay theory, and A.A. (Twelve Steps) postulations (discussed in the next section). Few substance abuse treatment programs are designed specifically to serve adolescents. About 20% of all patients in substance abuse treatment programs are under 19 years of age, and only 5% of these programs have adolescents as their main clientele (Beschner, 1985). The treatment care for adolescent substance users that does exist includes: 1) outpatient treatment; 2) partial hospitalization; 3) inpatient treatment; and 4) residential treatment. Most reported adolescent substance abusers (81.5%) are admitted to drug-free outpatient programs (Beschner, 1985). These programs range from unstructured "drop in" centers to clinics with a more structured environment. The actual activities in an adolescent treatment program may include: 1) individual counseling; 2) self help groups for the patient; and caretakers (e.g., AA, NA, Al-Anon, Al-Ateen); 3) substance-abuse education; and 4) random urinalysis for psychoactive substances. Breathalyser testing, family therapy or involvement, relapse-prevention techniques, legal assistance, and medications are also components of drug treatment programs (Kaminer, 1994).

In outpatient treatment the user continues with his/her daily life without much disruption and receives counseling services by scheduled appointment. Partial hospitalization is viewed as day or evening treatment services in which the user comes into the hospital three or four hours per day for counseling and group activities. Inpatient treatment is an intensive drug treatment program in which the user is admitted into the hospital, and the treatment is led by a physician. Residential treatment is when the user has either completed drug/alcohol abuse treatment or counseling services and, instead of going home immediately, enters a half-way house or group home which continues to reinforce or support the user. Effective treatments are

those that help adolescents achieve treatment and aftercare objectives and have a high probability of maintaining accomplishments. Also they require the least total life-style change for the client.

Explanations of and for Recovery

The recovery process can be divided into four phases: 1) denial; 2) compliance; 3) acceptance; and 4) surrender (Merryman, 1984). As suggested, the adolescent in denial has not yet accepted the idea that s/he must abstain from use. The individual in compliance may have publicly acknowledged a problem with substance abuse, but privately s/he entertains notions of "controlled use." Recovery begins with acceptance, on both an intellectual and emotional level, of the need to abstain from substance use. Recovery continues when the individual surrenders, expressing a heartfelt acceptance that s/he must give up his/her drugs and/or alcohol (Nowinski, 1990; Tiebout, 1944, 1949, 1953, 1954).

Surrender occurs when the addict/alcoholic can no longer justify, or blame, others for his/her problem. S/he can no longer bargain with substances through fantasies of controlled use. S/he can no longer avoid taking responsibility for achieving the task of recovery. Thus, authentic recovery involves changes in values, attitudes, and lifestyle. It demands that the addict detach from the mainstream culture, with its emphasis on instrumental substance use and immediate gratification, its detraditionalization, and its alienation. S/he then embraces an alternative culture, that of other recovering addicts/alcoholics, including their values and traditions (Nowinski, 1990).

The most popular and successful recovery programs follow the Twelve Steps process. Originating with A.A., the Twelve Steps, involve surrender (see Appendix A for list of the Twelve Steps). It states that "we admitted we

were powerless over alcohol-that our lives had become unmanageable" (A.A., 1976: 59). This admission of powerlessness is intended to bring the alcoholic face-to-face with his/her inability to control his/her drinking. Tiebout (1944, 1949, 1953, 1954) argues that the alcoholic's feelings of omnipotence and self-centeredness must be punctured and destroyed, if s/he is to admit a higher power into his/her life. Usually some sort of crisis forces the user to his/her "bottom," the only succor from which is to believe that some sort of god can restore him/her to a sane existence, devoid of substance use. As other of the Twelve Steps are worked, the addict/alcoholic struggles with remaining in a state of surrender and personality reconstruction through atonement of past wrongs and helping other alcoholics and addicts. (See Appendix A for a list of the Twelve Steps.)

The recovering adult and adolescent often relapse, defined in several ways, which include the resumption of drug/alcohol use after a period of abstinence, a return to previous levels of use, and/or the resumption of addiction (Wesson et al., 1986). Most treatment specialists distinguish between a lapse, a single incident of substance use, and relapse, a continued usage pattern. A lapse (or "slip") may or may not result in a relapse, depending on how the addict responds (Tims & Lakefield, 1986). A lapse is more productively viewed as a "mistake" and an opportunity for intervention and further learning.

Twelve Step programs such as A.A., N.A., and C.A. conduct meetings and stress working the program according to these groups' literature (Denzin, 1993). For example, A.A. members attend meetings which consist of oral testimonies and personal testimonies to "working" the Twelve Steps. From the group meetings new members are provided with sponsors (members in long term recovery), and all receive continued support and encouragement.

The meetings are viewed as therapeutic, and they reaffirm to participants that if one continues to work the Twelve Steps s/he can maintain abstinence. A.A. and its subsidiary programs are aimed at the person described in the Twelve Step literature as the "real alcoholic" or "addict," someone who may have started as a moderate user but at some stage of using began to lose control (A.A., 1976).

Other explanations of successful recovery may stem from resiliency: the capacity of those who are exposed to identifiable risk factors to overcome those risks and avoid negative outcomes such as delinquency, behavioral problems, psychological maladjustment, academic difficulties, and physical complications (Bolig & Weddle, 1988; Hauser et al., 1985; Rak & Patterson, 1996). It emphasizes strengths and the enhancement of individual and environmental protective factors. The focus on targeting what is wrong with and fixing deviants is, therefore, shifted to looking for what is right about survivors of all kinds (Turner et al., 1995).

More specifically, resiliency studies have focused on the success of adolescents who should have failed to thrive in a number of ways, but for some reason they did not. These resiliency researchers have identified protective factors that enhance adolescents' abilities to resist stressful life events while adapting to the situation and developing competence in dealing with them (Garmezy, 1983; Werner, 1990). Protective factors are sometimes merely the opposite of risk factors, such as a destructive environment, abusive parents, or poverty (Rutter, 1997). The following compilation of protective factors can be found in the research conducted by (Bogenschneider et al., 1992; Dryfoos, 1990; Resnick, 1993; Stinnett, 1994; and Werner, 1990): 1) problem-solving skills, self-esteem and efficacy, social skills, religious commitment, value of sexual restraint, coping skills,

assertiveness skills, decision-making skills, and a positive view of their personal future; 2) family related protective factors including a close relationship with at least one person, family support, parental standards, parental discipline, parental monitoring, parental communication, and parent as social resource; 3) peer related protective factors such as a close friend and long-lasting close friends; 4) school related protective factors like achievement motivation, educational aspirations, school performance, parent involvement, and a positive climate; and 5) community related protective factors such as belonging to a supportive community, bonding to family, engaging in school or other social institutions, having other adult resources, and being involved with community organizations or a church. Resilient adolescents are able to rely on a greater number of sources of social support than vulnerable youth. Adolescents who feel emotional ties to their family, school, or community are more apt to accept societal approved values and expectations for behavior (Bogenschneider et al., 1992). Perhaps a new model similar to that of the Twelve Steps, will evolve from further investigation of resiliency as it may appear in successfully recovering adolescents.

Social stress theory also provides possible explanations for successful recovery. As noted earlier, according to the model, the likelihood of an individual engaging in drug use is seen as a function of the stress level and the extent to which it is offset by stress modifiers. Epstein and Perkins (1988) define psychological stress as an "internal subjective state involving the perception of threat to one's well-being that is triggered by stressors or stimuli that provoke psychological discomfort in susceptible individuals" (p. 347). The stress response may be immediate or delayed and can be both physiological and psychological. Stressors have generally been defined as

undesirable events, negative life events, everyday experiences, and at risk conditions that challenge the individual and family's resources for dealing with the events (Lindenberg et al., 1993; Mercer et al., 1988). It has been further suggested (Kanner et al., 1981) that daily hassles, the irritating, frustrating, distressing demands that to some degree characterize everyday transactions with the environment may be more important stressors than traditional measures of stressful life events. If the user can control or alleviate his/her stress through protective factors or support systems such as: family, peers, church, and community they are able to maintain sobriety.

Conclusions

Several quantitative studies have been conducted employing the various theories discussed in this chapter to explain why certain groups of recovering adolescents became addicts, entered recovery, remained sober, or relapsed. Even theories explaining addiction have been used to predict recovery. For example when factors causing addiction are removed, recovery will follow (DeJong, 1994; Friedman et al., 1986; Johnson & Pandina, 1991; Siegel & Ehrlich, 1995). Yet few qualitative studies exist. One of them (Denzin 1993) did find that recovering adult alcoholics/addicts remained in recovery through "surrendering" and working a Twelve Step program. Another does probe the complexity of recovery for adult participants while they were adolescents, (Vaughn & Long, in press), but much is yet to be known concerning the complexities of recovery and its relationship to theory in the field.

CHAPTER THREE

Design of the Study

Phenomenology and Ethnography

As noted in Chapter Two, although some theories do offer possible answers to the research question, very few have probed addicted youngsters' experiences and perceptions. Supported by Shipman (1981) who maintains, that only one design or method results in "a one-dimensional snapshot of a very wide and deep social scene" (p. 147), this, research combined two qualitative research approaches: phenomenology and ethnography to answer this question; What factors are related to a select number of adolescents' efforts to become and remain sober?

A phenomenological approach was used to conduct initial interviews and interpret the data from seven adolescent participants who participated in a school/treatment center and were determined to have an excellent chance for recovery from drug and alcohol addiction. The information gathered was introspective and reflected the "point of view of the participant" (Barritt, 1985, p. 140) with regard to the research question.

According to Goetz and LeCompte (1984) inductive research, such as phenomenology, starts with the examination of a phenomenon and then proceeds to the development of a theory or the search for theory that corroborates or helps the researcher understand the findings. Glaser and Strauss (1967) suggest that "one canon for judging the usefulness of a theory is how it was generated, and we suggest that it is more likely to be a better theory to the degree that it has been inductively developed from social research" (p. 5). Barritt (1985) described phenomenology as "the understanding of an event from the point of view of the participant" (p. 140).

Because a phenomenological study recognizes that the researcher is the key instrument (Bogden & Biklen, 1982), the expertise of the researcher becomes an important issue. I, the researcher, have worked in alternative schools for five years and own an agency that provides day treatment counseling services to delinquent youth and substance abusing students. I have also have on staff Certified Alcohol and Drug Counselor's (CADC's) and licensed clinical social workers whose background and training are in substance abuse issues. I have taken numerous courses and training in guidance and counseling which provide additional background for intuitively listening and responding to participants in an interview setting. According to Tesch (1988), phenomenology emphasizes individual, in-depth interviews with the analysis remaining open, tentative, and intuitive. My major professor, has extensive background in phenomenological, historical, and other types of qualitative research. She reviewed all tapes and transcriptions and, independently, identified pertinent themes.

Alcoholics and drug addicts are prone to denial and self justification. In order to establish trustworthiness of the interview data, ethnographic triangulation was implemented by interviewing teachers, counselors, parents, and treatment center staff to validate information provided by the participants. Such measures were consistent with Goetz and LeComptes' (1984) views of ethnography as multi modal or eclectic. Ethnographers use a variety of research techniques to amass their data. Ethnography involves extensive fieldwork and may be pursued in a variety of social settings that allow for direct observations of the activities of the group being studied, communications and interactions with the people, and opportunities for informal and formal interviews (Bogdan & Taylor, 1975; Lofland, 1971).

A second feature of the study's design was also ethnographic. The initial interviews of participants and others involved in their recovery were conducted over a six month period at the drug treatment facility. After the initial interviews the participants and those close to them were observed and re-interviewed once a month for another six months. If a participant was not available, a person in the participant's family or his/her counselor from the center was contacted to maintain continuity in the history of the participant's recovery. This longitudinal aspect of the study enhanced the researcher's insights into the research question and verified the believability of the long-term sobriety or lack of commitment to sobriety of various participants (Van Maanen, 1982). The interview questions probed for problems the youngsters were having and sought explanations for how they were coping with their new sober lives.

The Sample Selection Site

The treatment center wherein the participants were identified, espoused the disease theory of alcoholism; and, therefore, the center used a medical model of treatment, tempered with elements from the various behavioral science theories. It was physician driven, and the services were social psychologically therapeutic in nature. Each client had an individual treatment plan, and therapeutic interventions were employed. However all clients were exposed to a basic treatment program guided by the following: 1) a structured environment; 2) individual/family counseling; 3) group counseling; and 4) an emphasis on the Twelve Steps.

To complete the program and graduate from the facility each client had to progress through five phases. The first consisted of learning and accepting facility rules and agreeing to treatment. The second required the participant to admit s/he was powerless over alcohol or drugs and that s/he

was an alcoholic or addict, committed to individual and group counseling, and to the Twelve Steps. The third phase was an extension of two, with the addition of family counseling and required attendance of A.A. and/or N.A. meetings. The fourth phase incorporated making amends to those hurt by the participant, continuing counseling services, attending A.A. and/or N.A. meetings off the facility premises, successfully visiting homes and communities, and giving oral testimonies of life changes related to sobriety. In the fifth stage the youngster publicly acknowledged his/her addiction and remained sober throughout all phases. The phases were self-paced. No patient completed the program in less than six months, but few ever stayed as long as two years. The clinical staff determined when a youngster moved on to the next phase or whether someone was demoted to an earlier one.

The treatment center was residential. Once admitted, youngsters were moved onto the premises and assigned living quarters. The environment was highly controlled. Only residents were allowed anywhere but the waiting area, and visits were limited to immediate family members on assigned days and times. The student/resident was not allowed to leave the premises unless accompanied by a staff member. Visits, phone calls, and contact with others outside the treatment center were limited so that the resident could focus solely and clearly on his/her substance abuse treatment goals and schooling. Individual and family counseling was required of all residents; each was assigned a primary therapist whose responsibility was to provide individual face-to face services with the client and his/her family. Individual therapy or cognitive therapy which was used at this particular treatment center was directed at the correction or modification of self-destructive belief systems, maladaptive or deficient coping skills, and faulty reasoning patterns. Ideally, through cognitive therapy, the resident was

made aware of his/her problems (personal and substance abuse, etc.), which may have been denied or avoided and helped to develop the strategies, skills, and abilities s/he needed to effectively deal with them (Pagliaro & Pagliaro, 1996).

Family therapy was also stressed. It often plays a significant role in the etiology and maintenance of problematic patterns or substance use among children and adolescents. Family members and significant others were vital to the successful treatment and recovery of the adolescent users. From the family, substance abusers gained the support and encouragement of those they may feel have deserted or let them down. Intervention with the substance abusing adolescent that fails to proactively involve the family in treatment is unlikely to yield significant short- or long-term improvements (Bukstein & Van Hasselt, 1993). For adolescent substance abusers family therapy and involvement was thought to have made the difference in whether the participants will complete treatment or relapse after returning home.

The center employed therapeutic groups which were viewed as social microcosms and enabled members to change and grow while relying on the group to serve as their mirrors (Kaminer, 1994). Group counseling allowed the substance abusers to freely express or communicate their feelings with others who shared the same problems, namely their addiction. Theoretically, group therapy enabled the residents to realize they were not alone, and that they could support, encourage, and learn from one another. The stimulation, activity, and self-disclosure provided by the group created the therapeutic climate in which adolescents might come to grips with and work through their problems, angers, and frustrations in an acceptable, meaningful way (Azima & Richmond, 1989).

In addition, facility clients were assigned an A.A. or N.A sponsor, and they attended weekly meetings on and off the premises, depending on the proximity of their discharge date. They each were given a copy of the Big Book, A.A.'s textbook or other Twelve Step programs literature, which assisted them in understanding the Twelve Step concept of recovery, lending support for those trying to understand their addiction.

The Sample

A sample of seven recovering addicts who lived in this residential treatment center/school were selected for this study. The staff selected the students, maintaining that they had the best chance of recovery among the total number of adolescents in residence. Seven was deemed an appropriate number of participants because, according to Tesch (1984), the usual number of participants in a phenomenological study is between five and fifteen. Patterns most usually will begin repeating themselves at this point.

The sample included three females and four males, and their racial make-up was one African American male, one Native American female, one Jordanian male, two Euro-American females, and two Euro-American males. The participants had been at the facility an average of six months before being interviewed. These students were actively pursuing either their high school diplomas or meeting the requirements for the general equivalency degree (GED), which indicated their desire for further education. (School attendance is not a requirement of the program.) They and their parents signed all the appropriate consent forms, and all of their anonymity was guaranteed.

Methodology

Becoming a participant researcher the researcher spent approximately ten hours per week as a volunteer serving as support staff at the facility for

over six months and continued visiting approximately ten hours per month after conducting the interviews for as long as any of the participants remained. Initially, four, one to two hour interviews were conducted with each of the seven participants. The interviews included a life history of the respondent, a chronicling of the participant's involvement with drugs and alcohol, and the various roles of family and schooling in the adolescent's recovery. Participants were allowed to express their own life histories. The interviewer asked questions only as they were needed to ensure that all pertinent information was covered. Participants were also questioned when the meaning of slang words and jargon was unclear. (See Appendix B for a list of questions.)

Interview tapes were transcribed by an experienced transcriber. In order to verify accuracy of the transcribing, the researcher and major professor listened to the audio tapes several times. Following the procedures set by Hycner (1985) for phenomenological analysis of data, the researcher and major professor studied the transcriptions to identify units of relevant meaning which seemed to cluster together or relate to each other. Thus, the researcher also visited participants in their homes after they left the residential facility. Face-to-face meetings with family members and former counselors, as well as telephone conversations with family and former staff members kept the researcher up-to-date on the participants and comprised the longitudinal part of the study. Continuous field notes were taken and notes were taken during and after each follow-up interview. (See Appendix C for a list of sample follow-up questions.) If further clarification was needed, the primary researcher sought additional information from the taped interviews or through contact with the participant directly in a follow-up study.

Summaries of each respondent's interviews and subsequent information gathered in the follow-up study were written, incorporating the themes that emerged from the data. Including direct quotes, these summaries are included in Chapter Four to acquaint the reader with each participant's history and perceptions. Bogdan and Biklen (1982) argue that research of this kind needs to be well-documented with descriptive information in order to enable readers to assess the interpretations that are being made. The authors further state that quoting the subjects "helps the reader get closer to the people being studied. The quotations not only tell what they said, but how they said it and what they are like" (p. 177).

Scope and Limitation of the Study

One limitation of the study is that even the one-year longitudinal study cannot verify that sobriety can indefinitely be obtained for any or all of the participants. Another limitation of the study is that much of the data was self-reported. Thus, trustworthiness of the study can never be perfectly achieved, although triangulation methods help heighten the level of trustworthiness. Moreover, Needle et al. (1990) found that adolescents' self-reports are in most cases reliable and valid and that the setting in which the interviews are completed does not, as a general rule, result in systematic reporting bias. Nevertheless, the researcher and the major professor made certain that the interviews occurred in the least restrictive settings to assure that the participants were comfortable.

Most qualitative researchers acknowledge that generalizing results of qualitative studies to larger populations is speculative, but the shared experiences represented in other studies of persons similar to those being studied makes the themes and patterns discovered during research applicable and extendable to others. Ultimately, however, according to

Langeveld (1983), it is the reader who will determine the plausibility and applicability of the study.

Definition of Terms

Addict: one who is addicted or in the habit of using and abusing drugs or alcohol.

Alcoholic(ism): a primary, chronic disease with genetic, psychosocial and environmental factors influencing its development and manifestations. The disease is often progressive and fatal.

Crack: an inexpensive form of cocaine which is highly addictive.

High: to be under the influence of a licit or illicit drug or alcohol which alters mood and behavior.

Poly drug user: a person who uses various licit or illicit drugs.

Surrender: occurs when a person realizes they are powerless over alcohol or other drugs and humbles him/herself to a power greater than themselves for attaining and maintaining sobriety.

CHAPTER FOUR

The Participants

Jessica

Jessica was 16 at the time of our first encounter. A Euro-American female, she was one of two children born to her mother and father. Her mother worked in a bank, and her biological father, who is now deceased, was an oil field worker. An alcoholic, he had spent time in the penitentiary for numerous drunk driving convictions and eventually died of a heart attack, most probably brought on by excessive drinking. Jessica was only 11 at the time. Probably, financial destitution led Jessica's mother to remarry. That relationship was not successful, and the couple separated when Jessica was 12.

Jessica began to drink when she was ten and believes that she has been an alcoholic since that time. She has experienced blackouts, overdoses, and alcohol poisoning. She has been in drug treatment four times. Jessica's mother has no history of drug abuse, although she drinks occasionally, and Jessica first obtained alcohol from her mother's liquor cabinet. "I wanted to be just like my dad," Jessica affirmed. Jessica's older brother, a college student, also has a drinking and drug problem.

The death of Jessica's father and the introduction of her mother's new husband and his three children into their household had a disastrous effect on Jessica's already fragile state. She fought regularly with her stepbrother who tried to kill her on one occasion. Jessica explained, "He goes into these blind rages, and he doesn't....even remember what he's doing. He doesn't know." One night he reached for a gun which he thought was loaded and pointed it to "my head and pulled the trigger, and there weren't any bullets in it."

Incidences such as these characterized Jessica's fall into oblivion. She added marijuana, crank, cocaine, crack cocaine, acid, ecstasy, PCP, and crystal methane to the list of drugs that she used. More dramatic than her drug and alcohol use was that she "never paid for it. The only thing I've ever bought was a six-pack of beer." Instead, Jessica traded sexual favors for illegal substances. Evidence of Denzin's (1995) divided self, Jessica's moral self was revolted by such behavior. Grieving over the loss of her father, she was drawn to men to protect and approve of her, but, ironically, the type of men to whom she clung were abusive and demeaning. While using, she tried unsuccessfully to break the insidious dependency cycle. "When I was out using, I would get in trouble. Some guy would try to beat me up or something, [or] one of my boyfriends would try to beat me up and rape me, and I would say, 'God please help me'." In effect, she did at least temporarily break the cycle by overdosing. The night Jessica was taken to the hospital, she had been found in a hotel room with eight adult men, who were arrested for drinking and having sex with a minor.

Jessica has been educated in rural, suburban, and urban public and private schools. The type of education she has received has been dependent on her mother's marital status, due to her impoverished state while single, and relatively middle-class socioeconomic status while married. Teachers and administrators were aware of Jessica's drug use, and she believed they did nothing to help her; although students and staff did make derogatory comments about her, oftentimes behind her back. On the other hand, Jessica did not ask her teachers for help, because she believed them to be unapproachable.

At the time of this writing, Jessica has been released from treatment and is living with her mother in a rural town. Jessica has been sober for several months and is currently a high school senior. Jessica has taken the entrance exam for college and intends to pursue a college education. She remains sober

and continues going to A.A. meetings on a regular basis. She has become actively involved in the drug prevention and education programs of her school and community. "I'm ready to fight.... I've had petty fights, and I'm tired of petty fights, and I want a real fight," she recently stated. That, she truly has.

John

Characterized as nobody's child, John, a Euro American, was 18 years old when we first interviewed him. His mother had two children, John and an older sister. Their mother died when John was six, and he was sent to live with a grandfather. His grandfather died shortly thereafter, and John went to live with an aunt. After a short stay at his aunt's home, John was shuffled off to his grandmother's house. She became ill, and a neighbor, Jake, took John in and became his legal guardian.

The instability of John's life and the availability of drugs led him into early delinquent activities. As a preteen, John began using marijuana, and by the time he was 13, John was participating in gang-related felonious acts. At 17, John was arrested for destruction of property, assault and battery, theft, and petty larceny and sentenced to a drug treatment program. During all of this, John attended public school, wherein he is certain that a number of the teachers were aware of his drug use, but none intervened.

John admits that he turned his life around while in drug treatment. But he believes that any positive focus, such as religious convictions or pursuance of a college degree, can ensure sobriety and a productive life. For example, he does not think that regularly attending A.A., as stressed in treatment, is the only means of remaining sober. According to John, young people such as he "involve themselves in gangs [and drugs] because of the sense of security that is involved in it and the sense of love that they feel from other people. They probably

haven't gotten it in any of their life." For John, replacing the emptiness with devout religious convictions has kept him focused and sober.

John progressed toward high school graduation while in treatment and after leaving returned to high school. After high school graduation John enrolled in a nearby community college. His career interests included physical therapy and the ministry. John met a woman, a fellow student to whom he later proposed. After a lengthy engagement the wedding was canceled when John's fiancée became pregnant by another man. With the discovery of her infidelity John dropped out of school, stopped attending church (but still is a devout Christian) and quit his full-time job. He became a door-to-door vacuum cleaner salesman for a while and is now seeking other employment.

Melinda

Melinda was 15 years old when we first met her. Her mother is a full blood Navajo who never knew her own parents. The older women had spent much of her childhood in foster homes and orphanages, and during this time experienced sexual abuse. Eventually, she was adopted by a white family. Melinda's mother was never married to her estranged father, an alcoholic of mixed racial ancestry (Cherokee Indian, German, Filipino, and Guatemalan) who is currently living in Guam with his wife and children.

When Melinda was ten, her mother married a man who became Melinda's adoptive father. The couple had one other child, a boy, but they divorced a few years after his birth. Her adoptive father is a recovering alcoholic and attends numerous A.A. meetings. Her mother drinks only occasionally but is addicted to over-the-counter mini-thins (weight loss pills). Melinda's mother appears to be very depressed; she has not held down a full-time job since her divorce. Melinda's mother is emotionally homebound, remaining in her room as much as possible and relying on Melinda's grandmother for financial support. When at

home Melinda provided all the nurturing needs for her younger brother, as it was not uncommon for her mother to go without speaking for days at a time. "She said she couldn't handle us kids, and her solution was just to go to her room and not to look at it," Melinda observed. "I wanted them [Melinda's mother and step father] back together because it really hurt and everything because I missed my dad, and it wasn't the same."

On the contrary, Melinda's life consisted of feeding her brother in the morning and evening and helping him with his homework at night. [I stayed] "up until 11:00 or so doing my homework and then [got] right up at 5:30." Melinda was a good student until her mother and stepfather's divorce. At 13, she started using drugs and alcohol and soon "gave up" trying to function. Essentially she began drinking and using to be accepted by her peers and to make her problems "go away." Before going to treatment, Melinda experienced blackouts, ran away from home, and was involved in delinquent behavior. Eventually, her mother banished her from the house, and her adoptive father forced her into treatment.

Melinda seemed to be trying hard to accept the discipline imposed upon her, the demands of schoolwork and the effort to sort out what aspects of her life she could change and what she should accept. Her biggest struggle was one of a child who desperately wanted a loving, stable, family. Yet her mother rarely came to see her in treatment, and Melinda suspected that "she wants me back home for cleaning." Appealing to her adoptive father, Melinda begged him to take her after she completed the treatment program. He refused. One family day Melinda's mother and brother did visit her. Counselors observed her brother crying. And the next day Melinda ran away. No one has seen her since and most people who were involved in her recovery suspect that she is dead.

Mick

Mick was 18 years old when we began our study. A Euro-American male, he was the younger of two boys, born to working class parents. Mick grew up in a violent home. His father regularly beat the boys and their mother. Mick sadly remembered:

> We didn't know what he was going to be like when he came in,... if he was going to flip out about what happened at work today, or if he was going to bring candy to us.... So we were always on guard when dad came home, always worried about it. Because he was real physically abusive, verbally abusive, emotionally and all of that.

The couple divorced when Mick was 12.

Mick's family also has a history of alcohol and drug abuse. His maternal aunt and grandfather are alcoholics; while his father was a heavy drinker and smoked marijuana. Mick started experimenting with drugs at the age of twelve, smoking pot with his older brother which they obtained from their father's "stash." Mick recalled:

> sixth grade summer, it just happened....The family just fell apart. I was messing up real bad,....and I did it [smoked marijuana].... And when I started screwing up in school, [I] did it again.... I was on a roll. My dad had a lot of marijuana, so.... I would steal from his stash.... and go to school and sell it and get high and try to be cool, you know.

By the time Mick was 16 he was addicted to crack cocaine. And "being cool" evolved into being a felon, involved with violent gang activity and drug trafficking. From the seventh grade until he dropped out of high school in the tenth grade his grades suffered horribly. A part of Mick always wanted to do well in school. He flunked nearly each semester during his high school year but repeated the tenth grade three times before deciding to quit.

Everyone at Mick's school was aware of his drug problem; he was even labeled as a "dope head" by many of his peers. In the seventh grade he was caught with marijuana, and he and his family went to counseling. Apparently, this was the only time that any school official or teacher confronted him concerning his drug use and delinquent behavior. Not so with the criminal authorities. Mick discussed his final encounter with police:

> Smoking straight shooters. I'm telling you, man, that's when I got on the street. I was just money hungry. Robbing people all the time. I mean, I got a little newspaper clipping in there in my room, if you want to see it. When I got caught with this up here, I got grand larceny. I was pending my second strap in DHS (Department of Humans Services) custody, and I got the grand larceny. 'So we're going to defer this. You fuck up again son, you're locked up. It's the last warning you get it son.' You know I was like, 'okay, I'm through.' Really. I just couldn't kick the crack, man, without being locked up.

Being in treatment taught Mick to organize his life, talk out his problems, and become attached to some form of higher power for support. He attends a minimum of two A.A. meetings per week. Currently out of treatment, Mick has found an A.A. sponsor who gives him unconditional help. Mick also has completed a GED, and is enrolled in a community college majoring in psychology. He works two part-time jobs that assist in paying his tuition and rent. "I'm doing something. I go to work. It makes me feel good to be productive and have an organized lifestyle.... I just got 100 on a test," he told with an almost childlike pride.

Anthony

When we first met him, Anthony, an African American, was 18 years old. His father and mother were no longer together, and he was not certain if they

were ever married. Anthony spoke of having lived in a mansion-type home and his mother driving a Rolls-Royce when he was young. Perhaps his memories were ones of a child whose mother worked for a car dealer and was allowed to drive an expensive car. Apparently, however, his father and mother did provide for his family, but that all ended when his parents severed their relationship. Anthony was ten, and his mother also had four other children living with her. She and her family moved into a low income housing project, and his life changed dramatically when the family became dependent on government assistance, which his mother still receives. Anthony's father moved in with Anthony's grandmother, where he still lives today. His estranged son saw him only occasionally. Anthony's mother became addicted to drugs, to which he was constantly exposed, and he was surrounded by numerous other youngsters who engaged in delinquent behavior. At the age of ten he had begun drinking and using marijuana and other drugs, as did the other children living in his mother's home. Anthony said that he believed that everyone used drugs and alcohol because it was prevalent in his life and in the lives of most of his friends and family members. Anthony also joined a gang.

Amazingly, Anthony did attend public school until he reached the tenth grade. High school administrators were aware of his drug and alcohol use, and one assistant principal continuously confronted him about leaving school due to his delinquent behavior and drug use. Anthony was expelled from school but wanted to quit anyway, because, as he put it, "I wasn't getting anything from school but high." When he was yet 17 he was court-ordered to treatment as a result of drug and alcohol-related felony convictions.

When we talked to him he seemed to accept that he was an addict/alcoholic but said, "I didn't know I had a drug problem until I got into treatment. Everyone I know gets high as much as I do." Living in public

housing projects, getting "high" was seen as a "rite of passage" into adulthood. "You were expected to get high when you were young. The grown people gave you drugs and alcohol. If you didn't get high the older people at the complex wouldn't have anything to do with you." Anthony wanted adult male approval and attention, and it was unfortunate that these older men modeled such self-destructive behavior. He did tell us that when his girl friend told him that she was pregnant, and he knew that he, too, was about to became a father and male role model, he felt he should stop using drugs and alcohol.

Despite his occasional candor with us, even in treatment, Anthony longed to appear more well off than he was. He dreamt about having fancy cars, expensive clothes, and large sums of money. These were the same fantasies that had led to his drug dealing and excessive drug use.

> I always wanted to have nice things even though we couldn't afford them [after my parents split up]. I always dream of having a big house, a high priced car, and money to give to my family. Drug selling was the only way I knew how to make a lot of money.

When verifying some of the information in Anthony's story with his mother, who is now in recovery, we found that his parents were separated more than together; his mother and father never owned a home in California (as Anthony had reported); and they never had a Rolls-Royce. His mother volunteered that Anthony has always made up these stories since his early adolescence. Anthony continually told her that he would make sure that they were going to leave the projects and move into the suburbs. It was true that before Anthony turned 14 he was already helping support his family through drug sales, but he lived only sporadically with his mother, choosing instead to reside with older female friends. "If I didn't make money people didn't eat," Anthony had told us, and this seemed to have been close to the truth. Although

Anthony's mother and the other children lived in a housing project, they were one of the few in the complex who had window air conditioner units in each room. His mother and older sibling drove nearly new cars; they had expensive furniture in the apartment; and they wore expensive clothes and jewelry.

While in treatment Anthony had worked toward completing his high school diploma and his counselors believed that he showed signs of authentic recovery. After leaving the center, the lust for money and the lure of his former addiction drove him back to dealing drugs. He was arrested and fled after being released on bail. Today, he has been recaptured and is serving time in prison.

Lisa

When we first interviewed Lisa, a Euro-American female, she was 16 years old. She is the oldest of three girls. Her two younger sisters had also been involved with drugs. Their mother and father were no longer together. They divorced when Lisa was 11 and received government assistance for years. Both of her parents used heroine intravenously, throughout her childhood. Her father was a violent man, physically abusing her mother. She and the two girls lived in a battered woman's shelter for a time when the beatings became too regular or too severe. Recently, Lisa's father and mother quit using, after being arrested, convicted, and sent to prison for selling drugs.

When Lisa's parents were still married, due to domestic violence and abuse, the state took Lisa and her sister into protective custody and placed them in foster homes. Lisa remembers growing up in poor neighborhoods and attending public schools most of her academic years. She did attend a private, religious school at one time, but even this restrictive environment could not protect her from her own early self-destructive activities. Lisa started using in the fifth grade when she sniffed gasoline while walking home from school. She

believed that teachers and administrators were aware of her drug problems but did not care to assist her. According to Lisa:

> I've been getting high most of my time in school, and no one never said nothing to me. I would be stoned in school, if I went. I remember teachers shaking their heads at me knowing I was high.... I was going to school, doing the DARE thing, writing to senators and going to 'just say no'.... Me and my sister knew about drugs first hand. We didn't need DARE or anyone else telling us about drugs. I don't know how we started using because when we were younger and going from foster home to foster home we swore we weren't going to try drugs. It's funny all of us [siblings] are in recovery or drug addicts. We became what we hated, and we said we would never become addicts because of what it did to our family.

During her short life, Lisa has been raped and involved with gangs; she has also had three abortions. She was first raped by her father's best friend while her father lay comatose in the next room from a near heroine overdose. The sexual promiscuity that is sometimes common with sex abuse victims rapidly followed. Lisa's last of three pregnancies was by a 33-year-old physically abusive man who supplied her with drugs. She had moved in with him with the blessing of her mother. By then, her father was in prison, and her mother's heroine addiction was worsening. Yet Lisa still wanted the approval and love of her parents. "I loved both of them so much. I would take the blame for my mother. If she was caught with drugs I would say they were mine so that she wouldn't get in trouble." Lisa protected her mother as often as she could, but as suggested earlier, the older woman's overdosing and hospitalization convinced courts that she was unfit, and the children entered foster care. Eventually Lisa

traveled the same road as her mother, overdosed, was sent to a hospital and then to state ordered treatment.

Not surprisingly, Lisa had poor self-esteem and lacked self worth. Through counseling, which Lisa received in treatment, she began to understand that her early involvement with drugs had stifled her progress and her attempts at success, but she is still overly self-critical and goes through occasional mood swings.

> I sit back and think what our lives would be like if we didn't use. I become mad and angry when I think of my life.... I've never been successful in life. I've messed up everything in my life. My family, friends, dropped out of school, have drug problems--man, my life's a mess.... I've had too much done to my heart, I have a hole in me.

Despite her pain, she remained sober today. She worked toward her GED while in treatment and continued until she was readmitted to high school after her release. At first she hoped to enter the military, but after achieving academic and athletic success in high school, she has expressed an interest in attending college after graduation. Since her release, Lisa has lived in a half-way house and with her father who, after his release from prison, resides in an apartment complex for recovering addicts. Perhaps Lisa is at long last finding the structure and accomplishments she has so desperately needed.

Ali

When we first met him, Ali was a 17 year old male born in Jordan. He moved to the United States with his family when he was four. His mother and father had four children, three boys and one girl; and Ali is the youngest. Ali's family owned three restaurants and a bakery, and lived in an upper middle class neighborhood. Although Ali's family was Christian, it is traditionally Middle Eastern in some respects, stressing the importance of extended family and

deference to familial male authority figures. Ali comes from a home where parents stay together, and there is very little conflict due to the acceptance of each person's distinct gender-related role.

Ali's parents did send him to public schools where he excelled until his encounter with drugs in the ninth grade. He started with marijuana and nicotine, as do so many youth, but it was not long before he experimented with acid, cocaine, crank, and crystal methane. He did not tell teachers and administrators of his eventual addiction to crack cocaine, but he feels they must have known because his behavior and grades changed dramatically after he began using. Soon after his drug use, he started stealing money and goods to buy drugs. He even robbed his uncle's and parents' homes. Finally, he was caught, tried, and sentenced to drug treatment.

When attempting to explain his profound need to begin using drugs, he recalled that certain students routinely called him ethnic names, such as "camel jockey." At first he responded by trying to excel in sports. He explained,

> No one noticed me. I was a good wrestler and didn't get any attention from that. Our school was big on wrestling, and I thought this would make me more popular. When a guy who was kicked off the wrestling team invited me to his house I thought this was the beginning for me. All they did was get high, and before long I was getting high with them.

As a patient in treatment, Ali's external profile did not conform to that of the typical adolescent addict-alcoholic. He had not been abused, nor were his parents addicts or alcoholics. He claimed that his desire to obtain peer approval drove him to early drug involvement. However, our investigation revealed that when he was a small child "my mother told me that I was almost not born. My father didn't want anymore kids. My mother refused [to abort me], and to this

day my father has tried to make it up to me because he knows I found out." Apparently his father indulged him.

> I always got what I wanted. I was spoiled, and I knew my father would do anything for me. That's how I was able to get so much money. I could go to the restaurant and take money out of the register, and he wouldn't say anything.... When no one else [friends] could get money for drugs, I always could. My father never questioned what I needed the money for.

After leaving treatment it appeared as though Ali was in recovery. He continued attending A.A. meetings and working toward a GED. However, he was refused entrance back into public school. Perhaps to soothe the blow, his parents bought him an expensive new car, and he was soon a noticeable target for the sometimes opportunistic people who attend Twelve Step meetings. With the promise of sex and drugs, two pretty, blond women (whom Ali met at an A.A. meeting) convinced him to be a driver in a cocaine delivery sale. Ali was caught and arrested. He served four months of a two year prison sentence and was released. Ali has since been unable to keep a job, continues to indulge in drugs, and has been banned from his parents' home.

CHAPTER FIVE

Patterns of Response

As suggested in Chapter Four, two major patterns evolved from the study. Three participants (Ali, Melinda, and Anthony) relapsed, and four (John, Mick, Lisa, and Jessica) did not. In this chapter, an explanation for the three users' behavior will be presented; a discussion of the four sober youths will follow; and possible theoretical explanations for the participants' varying behavior will then be offered.

Three Return to Using

Ali

Ali was the first person recommended for the study by the treatment center staff. All of the professionals involved with him believed he would be successful. According to them he was focused and committed to sobriety, worked diligently on the Twelve Steps, and was actively involved with A.A. and N.A. He had earned the maximum amount of facility privileges-- phone usage, weekend passes, and visits from non-family members. His conduct and behavior were exemplary, and he was helpful to others in recovery.

Ali completed the program and was discharged without a blemish. He returned to his parents' home and attended 30 A.A. meetings in 30 days, a goal he set for himself to prove his commitment. Ali did refuse to work in his family's restaurant and, instead, got a job in a bakery. As noted earlier, it was at one of the 30 meetings that he was approached by two white females who asked for a ride home from a meeting. Ali consented, and the rides became more frequent. Before long, Ali was transporting them to and from each meeting.

After his arrest and conviction for parole violation and drug dealing, I visited him before he left for the state's correctional facility. He said that one of

the two women had convinced him that she had romantic feelings for him, and he was so excited that this beautiful woman wanted him, he attempted to spend all of his free time with her. Ali claimed that she convinced him to use again by "talking down" to him when he told her of his desire to remain sober. According to Ali, she said he needed to grow up, and she could not be with anyone who did not use and judged her for doing so. Ali smoked crack two weeks after becoming involved with her and was selling drugs the next week. Because Ali had accessibility to money (via his parents) the woman and her friend convinced him to purchase drugs that they were to sell and put the profits back into buying more drugs. All three were addicted within the first week of dealing; they smoked, snorted, or shot up everything they purchased and had none left for sale. As noted earlier, at the time of this writing Ali's self destructive behavior continues.

Melinda

Melinda is a very emotionally volatile person. When first interviewed, she cried, laughed, and became angry while discussing her relationship with her parents, her brother, and her involvement with drugs. However, Melinda's teacher at the treatment center school boasted about Melinda's capabilities of receiving an academic scholarship to support her college education. Melinda was extremely responsible at home, school, and at the drug treatment facility. Because of her work ethic, she instantly became one of its leaders. Melinda was a model patient/student at the facility, working diligently on her school work to make certain that she would not be behind once leaving the facility, returning to her school, and working a Twelve Step program. Because of her success, she was allowed visits from persons other than her family; she had phone privileges; and she attended A.A. meetings off the premises. However, Melinda seemed

primarily committed to recovery so she could return home and resume the role of caring for her brother.

Program staff and counselors were always concerned when Melinda heard from either her mother or brother because their calls and visits upset her. Once, Melinda received a call from a neighborhood friend that her mother was not allowing her brother to leave the house, and he seemed very unhappy. That night Melinda attempted to leave without permission. Melinda was found by an officer of the county sheriff's office and returned to the facility. Her father was notified, and the next day she met with her primary counselor and her father. She expressed her concern for her brother and felt that due to her mother's condition she was responsible for her brothers' well-being. The counselor and her father felt that she should be focusing on herself, and her father promised to intervene on her brother's behalf. (Melinda said that she did not believe her father because in the past he never intervened regardless of how odd her mother's behavior became.) It was decided that Melinda would spend a minimum of six more months at the facility. She discussed her disappointment with the program's staff, but to no avail.

Melinda no longer had contact with the outside world, so she was unaware of what was happening to her brother. Two weeks later, Melinda left again and was never found. Melinda's father said that she called her brother and promised to phone again. Melinda's father later said that she contacted her brother five more times during the following month and, then, was never heard from again. Melinda's mother, father, and brother have not heard from her for several months. The police, her counselors, and teachers offer three possibilities regarding her whereabouts: she left the state; joined her biological father in Guam; or, perhaps, is dead.

Anthony

Initially, Anthony was eager to take part in the study. He felt that talking about his drug use and abuse would help him. He was very candid and open about his past and his involvement with drugs. Anthony was the only African-American in the 40 bed facility, and he was the only participant charged with a violent felony conviction, although probably not the only one who had committed such an act. Anthony had been a devoted gang member and "high" on PCP when he and fellow gang members came upon a rival gang and decided to start a fight. The fist fight escalated to a gun fight. Anthony shot one of the rival gang members, and, within minutes of the shooting he was captured by police. Anthony feels that he would have been charged as an adult if he had not been caught immediately after the shooting. The officers took him directly to a detoxification center and had him tested for drugs. Anthony's court appointed lawyer convinced the district attorney's office that his client would be served better at a drug treatment center. Anthony's attorney further argued that it was drugs that had caused his violent behavior, and if Anthony were able to get help for his problem, he might be a law abiding citizen.

When first interviewed Anthony said he was glad to be caught because he would have been dead by then if he were still "running the streets." Throughout the interviews and visits Anthony also seemed excited about returning, clean and sober to his community. Anthony bragged that he would be the only person in his family (mother and father included) who would be drug free.

Like Melinda and Ali, while in treatment, Anthony worked the Twelve Step program with zeal. He earned the right to take weekend passes to visit friends and family, and, like the other participants, submitted to a drug test upon his return. Anthony often came back somewhat depressed from his weekend visits, citing that he never noticed how much time his friends and family spent either

selling, using, or attempting to find drugs. He said that he knew he was doing well regarding his drug issues because he could be around alcohol and drugs all weekend and never get the urge to use. Conversely, he also wondered if his refusal could be related to his assurance of being discovered due to drug testing.

Anthony completed the program, and his graduation was viewed as a success by his probation officer, the program staff, and his family. His mother, grandmother, and siblings also seemed proud of him. During the family interviews Anthony's mother confessed that she and his father had been battling drug and alcohol problems for nearly 20 years. At first Anthony appeared successful. He got a job, continued working toward a GED (when denied re-admission into public school), and regularly attended A.A. and N.A. meetings. Yet, three months after his graduation, Anthony was on the state's "most wanted" list in a local newspaper for drug trafficking. His grandmother recounted that he had been using marijuana on a daily basis, and PCP and crack on occasion. She explained that he was tired of minimum wage jobs and was again seduced by the big money available to those who sold drugs. When caught, Anthony was tried, convicted, and sentenced to 25 years in prison.

Patterns of Response

Social stress substance abuse literature (Epstein & Perkins, 1988; Kanner, et al., 1981; Lindenberg et al., 1993; Mercer et al., 1988) suggests that if the stress level of a recovering person's daily life reaches a perceived intolerable level, s/he will return to using. And this is exactly what happened to the above three participants.

Acceptance

The three participants who relapsed experienced situations and shared similar characteristics that made sobriety difficult. All three were non-white, and, the prejudice of others caused them difficulty. For example, Ali had come to the United States during the U.S.-Iran conflicts and experienced extreme prejudice. At his suburban school, Ali was often the brunt of jokes and was routinely referred to as a "sand nigger." He became excited when he realized that people in the drug culture didn't treat you bad because of your race; their interest was in "getting high," and they befriended anyone who identified themselves with drugs and alcohol. Ali lamented, "I wanted to fit in at school and be accepted, and I knew a lot of my peers were involved with drugs, so I started buying drugs and giving them away so that students would like me." Thus, Ali became popular at school and known as a "drug user, drug seller, and someone who would let you have credit or drugs free, if you were short of cash." He always believed that others would abandon him if he lost contact with the drugs.

Like Ali, Melinda wanted the approval and acceptance of her peers. She attended a suburban school with few non-whites students. A small number of American Indians did attend Melinda's school, but they wore long hair, occasionally wore clothes that indicated their culture and heritage, and were involved with their tribes' ceremonies and other activities. Melinda did not identify with them because she was reared "like a Caucasian." Culturally, Melinda had difficulty deciding where she belonged. Her adopted father was white; her mother was a fair skinned Native American; but her biological father had a mixed non-white ancestry. "It was hard making and keeping friends, and I thought and still do that a lot of it had to do with my race." When one of Melinda's few close friends began socializing with other students, Melinda became afraid that she would lose her friendship. The new friend was a year

older than Melinda and was already using alcohol and alcohol, mainly beer and marijuana. Melinda remembered, "At first I was afraid to use, but they started teasing me and calling me names, and I felt I had to.... I thought they would stop being my friends."

Also focusing on race, Anthony attributed being African American and poor to his entry into drug use. He spoke about how difficult it was for blacks to find decent employment and how the school district so easily gave up on him. "I went to school one day and the principal told me in his office that he felt I was causing problems for students and staff." The principal then informed him that Anthony would be going to school half a day three days a week and would not return full time until his office contacted his mother. One month later the call had never come. "If I was white there is no way this would have happened. Because I'm black they treat me any kind of way." Anthony never went back to school until he was forced into the drug treatment school. There, he seemed eager to continue his education. Nevertheless, after his release, Anthony was bitter and frustrated. "When you're not high white people think you are; when you're not stealing white people think you are; when you're looking for work white people thing you ain't." When reflecting on Anthony's words, he may have been saying, "I'll never make it."

Yet, many white people use drugs and do not work. And it was to please one of them that Ali returned to using. "I could not believe this beautiful white lady liked me.... All through junior high and high school I wanted to date white girls, but none liked me because I was foreign. When she picked me from the A.A. meetings I was so happy." For the first time in his life, Ali was able to date a white female. After being arrested the last time Ali lamented, "I feel so stupid. I should have known that a woman in her thirties wouldn't want a man not even

20. She needed someone with a car, access to money, and crazy enough to supply her needs."

Thus, the minorities in the study were unable or perhaps, had no desire to "pass" (Hillyer, 1993) as white middle-class people. Ali and Anthony attempted to return to public school after their release from drug treatment, but they were told they had to attend alternative schools; both later chose to obtain a GED. They were further alienated from their communities. Ali explained, "when I went home all of my friends and their parents knew of my drug problems and treatment and my criminal acts.... It was strange when people I used to get high with [couldn't] associate with me because of the opinions of their parents." Melinda rejoined, that on one occasion, a parent asked her, "aren't you that Indian girl that is on drugs?".... Parents are uptight that their daughter may be associating with a past drug user.... The most upsetting part is that most of the people I visit are still using [drug involved]," she added.

The failure of all three to find community acceptance added to their stress and frustration. For example, Anthony fulfilled the requirements of the courts and, for the first time in years, was clean and sober. Yet, schools, friends, and parents often treated them as if they were still using and involved in criminal activity. Melinda stated it well. "It was difficult walking in the neighborhood because everyone knew me as the Indian girl that stole her mother's car and became a drug addict.... It's now even harder to make friends."

Premature Adult Roles

Another possible explanation for the participants' relapse was the pressure to behave as adults. Melinda's mother and, to some extent, her father's inability or unwillingness to rear her brother, left her in charge. In addition to her caretaking duties (with the help of her grandmother and father for transportation) Melinda shopped for groceries, school clothes, and made certain

her father was aware of any situations or problems associated with her brother's life.

Anthony knew his mother and father could not afford adequately to feed and clothe him, so he took it upon himself to generate money for himself and the family.

> The extra money I made, made it possible for my younger brothers and sisters to dress like their friends at school.... My mother and grandmother can't afford Nike's, Hilfiger's and stuff.... I made sure no one knew they were on welfare.... They dressed like everyone else and kept money in their pockets.

Unlike Melinda's mother or father, Anthony's mother protested, but ultimately took the money.

> I had to hide from my mother when I first started selling because she was going to get mad.... My older brothers were selling, but they had finished high school.... When she found out she asked me to quit. When she realized I couldn't or wouldn't, everything was cool. She stopped hassling me.

During one interview his mother confessed, "drug money sure comes in handy; welfare don't give you enough to live on." Anthony bought her new televisions, VCR's, and furniture, to name only three.

Anthony and Melinda were simultaneously proud of and overwhelmed by their almost parental roles. Melinda revealed, "I'm angry at my mother for making me be responsible for my brother." And Melinda used more drugs and alcohol when she became overwhelmed with her responsibilities. "I get tired of taking care of my mother and brother.... I can't be a kid. When friends are at football games and parties I'm looking after my brother or doing never ending chores." Anthony did "feel bad sometimes about selling this stuff [crack] to

people because I know what its doing to them and their families but I have to take care of my family." While in treatment Anthony worried, "I wonder how they [his siblings] are looking while I'm in here. Are people making fun of them because my momma ain't able to dress them right?" A part of him seemed truly interested in getting legitimate work so he could resume support of his family.

Ali's dilemma was somewhat different. Because he was the youngest of his siblings he had very vague memories of life in Jordan. But that country's customs and traditions enforced a work ethic. Moreover, his parents expected him to make exceptional grades and work in the family business. Their custom was, if the family worked together, all would benefit. As an adolescent in the United States, Ali refused. Instead, he wanted to "hang out" with friends, shop in the mall, and involve himself in sports. This behavior did not please his family.

> My older brother once came to beat me up for disrespecting my father and acting so selfish.... They didn't approve of my being on the wrestling team or focusing so much on wanting to make friends and being popular.... I would be so disappointed when I would have a match [wrestling], and my family wouldn't attend. They refused to close the business early to support me.... It was also because they felt I should be working because it was the labor of my family that was paying for our home, my clothes, my food, and stuff.... All they wanted to do was work... They never took vacations, closed for holidays, or closed early. They made me feel bad because I felt like the ungrateful son because I wanted to be like other kids my age in the neighborhood... I would get so mad at them for not supporting me in anything that they thought was frivolous I would just take off. When I started using drugs I would want to either stay high or get high when they refused to listen to me about my wants. I would use harder drugs when I was really mad.

Once released from treatment Ali's family seemed more accepting of his Euro-American adolescent status. He was allowed to work for someone other than his parents, and yet, they lavished him with symbols of adult success without his achieving them for himself. They bought him an expensive car and otherwise provided him with the money and accouterments that symbolized accomplishments in adult society without having worked for them himself. Ali could not handle the incongruencies in his life. And the lure of acceptance by adult women and the drug that once seemed to ameliorate him, again, became all consuming.

For one reason or another, Melinda, Anthony, and Ali felt they were torn between adolescent and adult roles. Melinda and Anthony felt they had to support their families, either financially, or emotionally. Ali was forced to bypass adolescence and work hard; but some might suspect that he was given too many material goods at too young an age--things he had not earned for himself. Substance use and abuse was a way for all of them, illusively, to resolve the issue.

Other Family Stressors

It has been suggested that if the user's family emotionally supports him/her in recovery the addict has a better chance of remaining sober and drug free. Melinda, Anthony, and Ali had limited support of this nature. Melinda commented, "I wanted her [Mom] to come and visit so bad. I wanted her to know how I was doing, and how I was working on trying to get home.... She came once during my stay and only stayed 30 minutes. Me and my father pleaded with her to stay, and she wouldn't." Melinda's hope was that her mother would see how well she was progressing and look forward to her daughter's return home. Melinda's step-father was supportive but only in limited ways. He did place her in treatment, but, as Melinda put it, "my father is A.A. crazy. He

spends all of his free time in meetings and with people he sponsors.... I wish he would quit coming to meetings because he criticizes my commitment.... He thinks you have to live A.A." Melinda's grandmother and aunts, about whom she also spoke, would not visit her in treatment. "I wonder why my family wouldn't come see me.... How can they go months without seeing me?" Melinda asked out loud. A final blow was struck when her father refused to let her live with him when she had finished her inpatient stint. Living with him would have provided the only opportunity to sustain for her some semblance of family guidance, and it would have allowed Melinda to maintain consistent contact with her brother.

Ali's family appeared to be emotionally supportive when he first arrived in treatment. They attended group meetings in an attempt to understand Ali's drug problem. But during one group therapy session, with Ali present, his father stated, "it is uncommon for persons from Jordan to involve themselves with drugs, and Ali has shamed the family." Ali's face lowered when his father expressed this view, and after they left, the youngster prayed they would never return. Ali's prayer was at least partially answered because his father, two brothers, and sister did not return for some time, claiming their heavy work schedules precluded it. Ali's mother did continue to see him, but she was angry with him, as well. In her opinion, his drug problem had totally disrupted the family. Before Ali's return home, the facility's counselors were able to get Ali's entire family to return.

Nevertheless, Ali's return home was difficult. His parents constantly questioned his actions, and his siblings never trusted him. "It was strange at home. My brothers would lock up their belongings, count their money before going to bed; or if something was missing, they would come to me first demanding I find what they lost." His relationship with his father was permanently strained. The older man was unable to forgive his son for

committing criminal acts and being a drug addict. "I was going to all those A.A. meetings, and they went unnoticed by my family.... I overheard my brothers and sister saying I hadn't changed, and I would be back using within the month. They never forgave me either and never intended to support me during my recovery."

Anthony faced grave financial pressure after his release from treatment and grave financial strain, as well. Anthony was poor, and had been a gang member. At least Melinda and Ali had grown up in middle and upper middle class neighborhoods, respectively, but Anthony went back to a low income apartment. Drug dealers, gang members, numerous prostitutes, alcoholics, and drug addicts were common residents of and visitors to Anthony's neighborhood. "You can see how hard it was as a kid not to get into trouble and use drugs. Everything you want, good and bad, is in this place.... I hope, one day, I can get me and my family out of here. It's so dangerous.... Just about everyone living here is doing something wrong [illegal]."

After leaving treatment, Anthony experienced a general lack of family support. When Anthony graduated from the drug treatment facility, family and friends had a party celebrating his return home. Thoughtlessly, they served alcohol and drugs. His brother stated that it took some doing to get Anthony to take a drink, but his mother convinced him that he could because of the party; but she cautioned him to stop the next day. Unknowingly, his family was subscribing to time out theory (MacAndrew & Edgerton, 1969) which allows for a temporary suspension of accountability for drug use and abuse.

Anthony's mother seemed to make no connection between the dangers of drinking and drug use. She wanted it known that despite her own addiction, she did not approve of his drug use and selling, but what he did was his own decision. "If Anthony begins using and selling again I would ask him if he was

sure, and if he said 'yea' I wouldn't stop him." Anthony knew his mother's and siblings' views. He was free to do what he wanted, and they would not try to convince him to stay sober. Probably they were conflicted about losing Anthony's formerly plentiful income. "I know for a fact my grandmother wants me to stay sober, but everyone else don't care. If I came home high tonight, no one would say a word, even though they know I would be getting in trouble. I could even go to prison if I get a dirty u.a. [urine analysis]."

Materialism

Materialism is also an integral part of U.S. society, marking those who have money as successful and those who do not as failures. Materialism played a role in Ali's relapse. While interviewed in the treatment center, Ali explained:

> It was hard enough making friends being foreign; it didn't help when my parents refused to buy me Nike's, polo shirts, Cole-Haan shoes and stuff. They didn't see the sense in jewelry, so I was one of the few kids at school who didn't wear a necklace.... When I started selling drugs the first thing I started buying was clothes and jewelry. I always wanted to look like the other kids so I tried to buy every pair of Nike's I could. I kinda became known for my clothes.

Anthony himself could not resist the lure of big money brought on by drug sales.

> When I was out on the streets no one knew I lived in the projects. I dressed clean everywhere I went. I kept money in my pockets and wore the latest styles. My closet was full of clothes and shoes.

Both Ali and Anthony wanted to be visually associated with wealth. It was important to their male identities. Anthony was also very ashamed for anyone to know that he was a project dweller. Because of Melinda's disappearance her attitudes on this matter were unknown.

The Divided Self

Finally, all three participants who relapsed were also excellent examples of Denzin's (1993) divided self, users who seemed unable to integrate two major identities that dwelled within them. On the one hand, Melinda, Anthony, and Ali were very active in their treatment and in N.A. and A.A. Twelve Step programs. Yet they were unable to nurture their emergent sober identities into the functional young adults they might have become. Perhaps in search of a family Anthony returned to his gang and eventually was imprisoned. Melinda could not become a functional young mother to her brother, so, probably, she returned to the streets. Ali could not nurture and sustain the gentle man whom we first met; instead, he became the drug dealer who also occupied a place in his soul.

Four Remain Sober

John

At one point in his recovery, John credited his sobriety to the support of his legal guardian, and his strong religious convictions. John's legal guardian had supported him throughout John's legal woes and two stints in treatment centers and even offered to pay for drug counseling.

> I was involved with gangs, guns, and drugs all while I'm staying in his home, and he was patient with me, never pressuring me. He asked me if I wanted help with my drug use. If needed he would get me into treatment or counseling.

John believed that his father figure was sent to him from God. Another spiritual experience occurred while sitting in back of a police car, after being arrested for the last time.

> I could feel God speak to me in the back seat of the police car. I did not deny my drug use. God put the drug treatment facility on my heart, to go

> back [to treatment] and isolate myself from society and start living for him and not for me, John recalled.

John was proud that he graduated from the program in six months, faster than anyone before him. But he was also quick to give most of the credit to God. "He just dealt with me gradually.... I started reading His word and started praying everyday...., two or three times a day and then continuously." Although John was quite religious, he never actively engaged in a Twelve Step program. "I don't go to A.A. meetings or any of that. I asked God to help me, and He did. I am not recovering I am recovered. God took the desire for drugs from me, and I know I will never go back." However, John does what A.A. would call Twelve Step work, counseling youngsters who are involved with drugs and gangs, and he believes this makes a significant social and personal contribution.

At one point in his recovery, John met an extremely religious woman on whom he also relied.

> She is so good for me. She, along with God, won't let me return to my past [drug use]. I don't need A.A. meetings. I got God and nothing is stronger than Him. Once He released me from drugs, I became clean. I credit her a lot for keeping me grounded. She's against cigarettes, so, you know, she's against drugs.

But as mentioned earlier, this relationship ended in disaster. John left the church they had attended together, but maintains a strong belief in God. Badly shaken by their breakup, however, without a formal support group, John's sobriety could be at risk.

Mick

Also following a somewhat non-traditional path, Mick was discharged from the treatment center for not following facility rules. But instead of being placed back onto the streets, the facility allowed him to enroll in their adult inpatient

program. Mick was grateful because he was still on probation for robbery, breaking and entering, and drug possession, and total suspension from the facility would have forced him back into court, where he could have been sentenced as an adult to time in a penitentiary. While in the adult facility Mick diligently worked the Twelve Steps and attempted to find employment.

The more serious older males had a major impact on Mick. "They know the seriousness of quitting. At the other facility the kids were so young, and, like me, they were telling the counselors what they wanted to hear and knew as soon as they were discharged they were going to use again." Mick's new roommates were sincere about quitting.

> They had to for some of the same reasons I had to, problems with the law. They wanted to be successful, and they encouraged you, too. There was no faking the counselors or the other people. They confronted you and called you a liar, if they knew you weren't serious about beating your habit.

Since leaving treatment Mick attributes his success to the fear of going to prison (which was imminent if he continued using) and subsequent dedication to the A.A. program.

> I knew I wouldn't be able to handle the adult prison system. I knew if I did not kick these habits, I would be sent to prison. Man, I started working the program harder than ever before. I know if I had been younger, I would have kept using, like I did in the past. I wasn't a cute little kid anymore. I was viewed as a criminal.

Following a suggestion from his parole officer, Mick enrolled in a local junior college.

> I get pumped about going to school. I love that, man. I love being able to say, 'hey I'm going to college. Going to college, and I'm doing

> something. I go to work.' Makes me feel good to be productive and have an organized lifestyle.... School really helps me. If I had known school was this fun and this easy, I might have stayed and listened before I dropped out, well, got kicked out.... I don't know what I'm going to major in. I like so much I'm going to have to choose something.

For the first time in his life Mick believed he had a future, and success in higher education was a significant contributor. "I pray every day that I won't ever use again. I no longer crave drugs or alcohol. There was a time if I smelled drugs it took all I had to stop from trying to get some. Prayer has taken that away from me. I think I've beat my addiction but I got to keep going to meetings." Accompanying Mick from time to time, is a newfound woman friend. Time will tell whether, as in John's case, the relationship will threaten or strengthen Mick's new, sober life.

Lisa

After Lisa completed the treatment center program she chose to live in a half-way house. It existed for those who felt they still had unresolved issues. Lisa was afraid to return home because her mother had just been released from prison and could easily tempt Lisa into using again. Lisa worked hard to develop a positive self image.

> For the first time in my life I actually love myself. I would never again do anything that would hurt me. I had no self esteem, I let people use me and discard me.... Now, I love me, and no one is ever going to use me again. I won't let them.

Lisa and her new found love for herself began to speak out to people in the facility, and to the family members who had exploited or hurt her. These confrontations seemed to cleanse Lisa. She became more and more sure of herself with every one of them. Her father came to a family group session at her

request, and she told him how his actions and addictions had destroyed their family and almost destroyed her.

> Your drug addiction almost killed you and Momma. You never considered me and Jill [her sister]. We went from foster home to foster home, and you never tried to change and come get us. I forgive you, but I would never do my kids like you done us.

Lisa openly expressed her frustration with other facility members who were not sincere in their treatment.

> Treatment is a life or death thing to me, and I get mad if people are here taking up space and wasting my time. I want to get help and learn how to stay away from drugs. This is my life we are talking about, and anyone not serious is delaying my treatment.

If Lisa overheard or saw someone violating a rule she would go to the director and notify them of all infractions. She was clear in her determination to rid the facility of all who were not serious. Consequently, Lisa became ostracized by fainthearted patients.

After leaving the half-way house Lisa continued attending A.A. and N.A. meetings and "working" a rigorous recovery program. Part of every Twelve Step program, Lisa credits a dependence on God for her continued success.

> My life was unmanageable, some of it no fault of my own. I prayed to God, and I put my life in His hands. I was raised in the church and went to private schools run by churches. I knew how to pray, and I knew God answered prayer.

Lisa believed that with God's help she could refrain from drug use. Her spiritual strength helped her build a new relationship with her mother and father. She even shared a home first with her mother then her father. "I'm not mad at them anymore. They had drug addictions, and, I know, with mine, I was not

responsible. The drugs are all you want, and nothing or no one is more important than feeding your addiction." Lisa was even able to get her mother and father to come to family counseling groups, and both of Lisa's parents began attending A.A. and N.A. meetings with the encouragement of Lisa. At the last interview they were all attending A.A. meetings with her sister as well. "My family is a family again. We have a long way to go, but they are supportive of my wants and needs, and I support them."

Although in treatment, Lisa had taken and passed the GED exam, she re-enrolled in public school and made the girls softball and volleyball teams. "I never attended school, and I wanted to prove to myself that I could be successful and graduate from high school." Also a pep club member, Lisa enjoyed being a student and making friends. For once, she felt like a "normal" girl. "If these people knew of my past they would die. I'm doing so well no one knows I go to A.A. and N.A. meetings, or that I am in recovery.... For the first time I feel so normal. I was so crazy to use drugs. I almost ruined my life."

Near the end of this study Lisa quit school and moved back into a half-way house, because she experienced the urge to use again. Although Lisa enjoyed school immensely, perhaps the pressure of appearing but not feeling normal wore her down. "Passing" as normal may have helped the non-white participants stay sober, but it seemed to have accentuated, not ameliorated, Lisa's divided self (Denzin, 1993).

Jessica

Although Jessica was recommended as a good candidate for remaining sober, in some regards she was a discipline problem while in treatment. She was very vocal concerning her likes and dislikes regarding facility rules and people associated with the facility whether they were patients or staff. Yet, Jessica was

just as critical of herself as she was of others. She blamed herself for many of her mistakes.

> I was beaten and raped by boyfriends and strangers, but it was my fault. If I wasn't so dependent on drugs, I wouldn't have experienced none of that.... I did all kinds of unspeakable stuff to feed my habit. Looking back I see how bad off I was. I can't blame anyone but myself for getting into those positions.

She understood that her abusers were also to blame, but she believed she would have never met them if she had not been addicted.

After graduation from the facility Jessica moved back into her mother's home. She had little difficulty getting back into public school. "The school didn't have an alternative school because the school district is so small. They [school officials] wanted me to be home schooled, but my mother didn't want that, so they agreed to let me back in school." Jessica was surprised how comfortable she felt when she returned. She had not lived in this district since the sixth grade, and she remembered only a few students. But, word quickly spread of her past involvement with drugs and drug treatment. Jessica viewed this notoriety in a positive way explaining that, "People just started coming up to me and speaking. They all knew who I was. It was cool that everyone wanted to know me."

Jessica's mother also continued to give her support as she had during Jessica's three residential treatment stays, twice overdosing, two psychiatric in-patient stints, and three emergency room visits due to drug abuse. Jessica's mother even drives her 50 miles to attend support group meetings.

> I don't know what I would do without my mother. We used to have so many fights and problems. She told me she loved me, and she wanted me to stop using drugs.... My mother works at the bank, and everyone in

town knows her. She told my teacher that I would be glad to talk about drugs and how they almost ruined my life. It's kind of funny that I speak to students every two weeks about staying away from drugs.

Jessica was laughing but she was excited and proud of the fact that she was asked to provide drug education for her school. "I was scared at first but so many of those people didn't know the first thing about drugs. In rural towns people mostly drink. It was amazing to hear myself trying to talk people out of trying drugs. These group meetings were kind of like A.A. for me."

As the months wore on Jessica's popularity increased not only with her peers but with parents in the town, as well. Jessica was singled out at a school assembly by the principal and her home-room teacher for her work with drug education. Jessica was surprised by the recognition and was even more gratified when the principal announced that the school almost refused to re-enroll her. "I think my assisting in the drug groups help me. Even if I wanted to get high,... I don't. I would disappoint so many people. People look up to me, and I couldn't do that to them."

Patterns of Response

Spiritual Recovery

All four participants indicated that either through religion or a Twelve Step program they had identified some sort of "higher power" from which they drew spiritual strength. The entire Twelve Step program leads a participant into a relationship with a "higher power" and involvement with spiritually related activities. Mick prays,

> everyday for the strength not to use again. People who don't use don't know how tough it is to stay clean. People, places, smells, and stuff remind you of the times when you were using, and your mind makes you start thinking of using. Whenever this happens I just start praying.

Lisa reiterates that,

> Everyday you have to fight for your sobriety. Your mind makes you think you can do it one more time and quit again. You have to have something just as powerful as drugs to fight for you, and that is God. If I didn't pray everyday and believe God helps me, I know I would be using.

Jessica rejoins,

> No matter what situation I was in I knew I could pray, and God would help me. When I finally decided to stop I asked God to help me with my drug problem, and He did. I pray because without Him I know I would be using again and back to my old ways.

John concludes,

> I knew if I was to change my life permanently, I had to have a real relationship with God. All addicts tried to do it themselves and failed. When I asked God to help me something came over me, and I just knew He was dealing with me, and He was going to take my drug problem and any other problem away from me.

All four who remain sober not only prayed consistently, but they also began going to church. None of the four attended church regularly before treatment, and they each sought a church home as soon as they left treatment.

Family Support

The families of the four recovering youngsters were involved in the participants' treatment and continued to be so after their children's graduation. (Conversely, Anthony's family seldom participated; Ali's family came rarely; and although Melinda's father participated regularly, her mother never attended a group session and visited only once.) Jessica's mother explained, "I come because I want to continue to learn about addiction and how I can continue to help Jessica. When I think I have all the answers, I might quit coming." And

John's legal guardian still attends family meetings, even though John no longer participates.

With the exception of John, those still sober are attending A.A. and N.A. meetings with their parents. Mick said, "my family [members] challenge each other. Me, my brother and both my parents are recovering. We ride to the meetings together. I'm only able to go twice a week, but the others attend at least three a week." The support and encouragement of his family being involved with A.A. made it easier for him.

> I used to get high with my brother, steal drugs from my fathers' stash, and get drunk with my mother. Now that we're all sober I don't have anybody to get high with plus we would all know if somebody slipped [relapsed].

Lisa even is also encouraged by her mother's, father's, and sister's decision to get sober.

> I told my mother when she got out of prison I couldn't stay with her if she was still using. She promised she would go to N.A. meetings. We both started going, and then my father, and then my sister.

Like Mick her family was working together to get sober. Lisa recalls,

> It was strange, looking in meetings and seeing your whole family. It's almost embarrassing how we must look to people. I think if any of us relapsed it would mess up the whole family. We're all feeding off each other to remain sober. I decided if somebody failed, I'm keeping on.

Lisa is determined to remain sober, but she is somewhat fearful that one of her family members will relapse. "If my mother starts using again, I'm moving out. I can't be around that stuff. If we all stick together and support each other, one day at a time we'll beat this drug stuff."

Searching for Acceptance in Education

While "Passing" for what society viewed as normal seemed to have taken its toll on Lisa, Jessica made no secret about her former addiction. Yet in some respects, anonymously integrating back into public education benefited John and Mick. Although, Lisa eventually left public school, but at first, she observed,

> I thought there would be problems when I returned to school. I thought people would remember me. It had been a year and a half since I went there. Nobody noticed me. I guess it's because I looked like every other girl at school.

Her ability to hide her past addiction and appear normal, white, and middle class, for a time, enabled her to work on her recovery without additional setbacks. Lisa explained:

> A lot of people have relapsed and return to the [treatment center] because of their treatment when they return home. Me and my friends [study participants] didn't have any problems. Getting back into school is [usually] a problems for people like us, but for some reason we didn't have no problems. I'm sure this added to our success and recovery.

On returning to their communities, Mick and John had no problems resuming their lives. Mick's probation officer even helped him enroll.

> It was easier than I thought. I don't think no one remembered me... [maybe] everyone I used to get high with got kicked out, dropped out, or graduated. I picked up where I left off when I used to go there. Hanging in the halls, meeting with babes, and hanging out on weekends.

Public education also welcomed John back.

> They didn't ask any questions. I went with my transcript from the [treatment] facility school, and, in about five minutes, I was in a counselor's office enrolling. I don't think no one at the school [students]

knew of my past. There are so many kids at the school, no one probably noticed me because I wasn't causing any problems.

Community Support

For one reason or another all four participants were well received by their communities. Jessica experienced some difficulty, but it was short lived. John's legal guardian gave him a party after he was released from treatment, but it was not the drug infested Mardi Gras that Anthony had attended. Neighbors were invited to show they had missed John, and that they supported his efforts to get help.

> I was kinda glad for the party. I was wondering how my next door neighbors were going to act when I got out. The party made it easier for me to fit back in. I was able to hang out with people my age without people thinking I'm trying to corrupt their son or daughter.

Mick and Lisa had the same good fortune with their neighbors. People who knew of their past never mentioned it, and this made the two happy. Lisa commented,

> I just didn't want a whole lot of people in my business. When I got home they left me alone. No one asked questions, even though they knew where I had been. It was not long before I was a normal teenager. I didn't have to go through any problems with friends and neighbors as the facility staff said I might.

Mick had the same experience.

> I knew everyone knew of my drug treatment, but no one mentioned it. Friends and neighbors acted as if I didn't have a problem. They accepted me back as if I wasn't the boy who used to steal from them and be high and drunk all the time.

Deferred Gratification and Decreased Materialism

Probably because the sober participants were getting educational, community, familial, and spiritual validation, they were able to delay gratification. They all went back to school, and those who graduated went on to community college. They each got a part time job immediately after his or her return and was beginning to save for college tuition and automobiles. But, in general, these participants were much less materialistic than they had been during their drug using years. Conversely, Anthony and Ali, remained obsessed with having expensive possessions and the appearance of wealth. An admonition, during her treatment, Lisa had stated, "if we go back to our old ways, trying to keep up with the Joneses, and trying to identify with the gang and drug culture, we'll soon be using again." They all agreed that competing with others rather than working on their own lives was the "kiss of death."

CHAPTER SIX

Conclusions and Recommendations

The intent of this study was to investigate whether or not adolescent substance users were capable of remaining sober after experiencing treatment. The results were mixed. It appears that four participants had enough parental and community support, access to traditional school settings, and spirituality to remain clean and sober. The three who failed were not as fortunate. They also had the added burden of being minority, which in their own words, caused them additional stress and may have hindered their sobriety. Theoretical interpretations of these findings will be discussed in this chapter. But first I will discuss serendipitous but additional findings related to material in the literature review.

Prevention

The study reinforced the literature stating that DARE programs and other drug prevention/education programs were unsuccessful at preventing all of the participants' initial drug use. Each had been involved with DARE during his/her elementary and middle school years, and all agreed that during the programs they were already using, or that the drug prevention/education programs made them more interested in or curious about drugs and alcohol. All seven agreed that drug prevention/education programs did not benefit them, and they did not experience any lasting effects from them. This was also their opinion of the resistance training/education they received in high school. By then they were ingrained in the drug culture. Yet all felt that even if the training had come earlier it would not have had any effect on their decisions to use. Moreover, the DARE program taught Lisa and Ali how to use drugs that they were not yet using (Botvin, 1984; Kinder, 1980).

Theoretical Explanations for Substance Abuse

In Chapter Two numerous theories were introduced to explain the reasons for substance use and abuse. The following reviews theories that seem applicable to the findings of the study and assist in explaining why some participants were successful and others failed.

Genetic-Biological Theory

Goodwin (1979) notes that several genetic or biological predispositions could lead to the abuse of alcohol and drugs. These theories indicate that a gene may be passed from parent to child which may cause the offspring to show a propensity for drugs and/or alcohol. Six of the seven participants had at least one family member who had been or was currently involved with substance use and abuse or in recovery. All six of the participants indicated that their parents were using during their conception and birth. Yet, they all felt that it was the environment that led to their addiction. Perhaps no one wants to believe that s/he is determined to experience a tragic fate.

Behavioral Science Theories

All seven participants were adolescents as it is described by social psychological theory: 1) searching for identity; 2) desiring to fit into society, usually manifested by membership in peer groups; 3) experimenting with "taboo" behaviors that seem omnipresent in the adult world; and 4) feeling invulnerable (Monte, 1991; Newcomb & Bentler, 1988). And all seven participants resolved these issues by using drugs and alcohol. They all said that they felt that they did not "belong" until they became acquainted with drugs. They all had trouble making and maintaining friends, and the friends they were able to attract were those who did not have any qualifications for friendship except drug use. All seven chose peers or peer groups that were already involved with drugs and alcohol, and they were expected or required to indulge in this behavior. All

seven agreed that they were initially hesitant to use substances, but due to peer pressure and wanting a sense of belonging it quickly became easy. With the exception of John, the curiosity and experimentation stage was short lived. In hindsight, six of the seven felt they were addicted by the third to fifth time they used, but they once thought they could stop at any time and felt drugs and alcohol were having little effect on them. It was not until they tried to stop that they discovered they were addicts.

Bandura's (1977) social learning theory explains four processes of observational learning which also help explain the participants' substance abuse: 1) attention; 2) retention; 3) reproduction; and 4) motivation. As stated earlier, six of the seven with the exception of John grew up with their parents and extended family members using and abusing drugs and alcohol. They witnessed drug use, saw the effects of drug use, and learned how to use substances and drug paraphernalia at home. John had the same experiences as the other six, but his initiation came at a later date, and instead of learning from parents he learned from his peers. Initially they had resolved not to use drugs and alcohol due to its negative impact on their families. But in times of crisis or when dealing with personal problems they reached for drugs and alcohol to comfort them (Kandel, 1992; Napier, 1983).

Gateway Theory

The gateway theory of substance use and abuse applies to all seven of the participants. They started with licit substances such as tobacco and alcohol, and they quickly progressed to more potent, illicit substances, such as marijuana, cocaine, and heroine. The female participants also used inhalants which were not illegal substances -- gasoline, Freon, and glues. They all believed they would stop at cigarettes and beer, but soon wanted to get "higher," so they thought the

harder drugs would lead them to euphoria (Kandel et al, 1992; Single et al, 1992).

Explanations of and for Recovery

Several theories also explain why certain participants relapsed, and others were able to abstain and maintain their sobriety.

Behavioralism

B.F. Skinner's operant learning theory was used by Mellow (1983) and Sobell (1978) in an attempt to modify the substance abusers' using patterns. Similarly, it seems that the treatment center in this study helped condition the four participants for non-use. At the facility they received positive and negative reinforcements to discourage self destructive and encourage productive behavior. Random drug tests and support from other patients and staff were common. However, the positive reinforcement that were so commonplace at the treatment facility quickly vanished when the participants returned home, especially for the three who relapsed. For them positive reinforcement to use substances overcame any other reinforcement to remain sober. Peers and sometimes family members encouraged or supported their return to drug and alcohol use with little concern about the possible consequences. It was not until they were again overwhelmed by drug and alcohol use that they realized the severity of their actions. On the other hand, positive reinforcement and the threat of punishment was enough to keep four participants sober. Their families and peers were very supportive and encouraged their recovery. The families of the four also started or continued their involvement in A.A. and N.A. groups that employ repetition and continuous positive and negative reinforcement to encourage sobriety.

Surrender

The four who remained sober had hit a personal "bottom," and as a result they surrendered to a higher power, the linchpin of their sobriety. All four

believed and admitted that they were powerless over the use of alcohol and drugs and that their lives were unmanageable. Unlike the three who relapsed, they had very little difficulty admitting they were addicts, and they needed help from God in moving from addiction to recovery. As a result, they changed their values, attitudes, friendships, and lifestyles which they all agreed helped maintain their sobriety (Tiebout, 1949, 1953, 1954; A.A. Literature, 1976).

Social Stress

As suggested by social stress theory, the likelihood of creating positive environmental conditions definitely led to the four participants' recovery. And the inability to do so led to relapse for the other three. According to the model, the likelihood of an individual engaging in substance use is seen as a function of the stress level and the extent to which it is offset by stress modifiers (Epstein & Perkins, 1988; Lindenberg et al., 1993; Mercer et al., 1988). Stressors have been defined as undesirable events, negative life events, everyday experiences, and "at risk" conditions that challenge the individual and family's resources for dealing with the events (Kanner et al., 1981).Stress levels increased for the three who relapsed when they found that they did not have support from their parents, peers, or community. The events in their daily lives also caused continued stress, and they were unable to offset it with positive social support. Once leaving the treatment center they were unable to or did not re-enter public school, maintain employment, or establish positive relationships with non-using peers. Ali and Anthony went back into communities and living environments that were not healthy for them, nor conducive to a sober lifestyle. And it is assumed that Melinda's experiences were equally as unrewarding. The four who maintained their sobriety had decreased and limited their amount of stress which allowed them to prevent or defer their relapses. The same stressors that fell on the three who relapsed were also factors for the four who maintained sobriety,

but such stress was cushioned by their parental and community support. They learned how to adjust and work through their stressful situations and not allow it to escalate toward use.

Resiliency

Resiliency theory can be seen as an extension of the social stress theory. The definition of resiliency is the capacity of those who are exposed to identifiable risk factors to overcome them and avoid negative outcomes. Resiliency literature attempts to discern how some people persevere when all indicators seem to predict doom. This theory attempted to find out how some were able to be successful given the same predicaments and obstacles of others, and they were able to survive and become successful when the majority of others failed (Rutter, 1997; Turner et al., 1995). The theory searched for characteristics and personality traits that would help explain the drive and determination of those who are not expected to succeed. In this study the same approach was taken. The interest was in finding out what the participants who remained sober possessed that can be extracted and applied to other adolescents attempting to remain sober. The four who remained sober had the same opportunity to relapse as their counterparts, but they were able to fend off the lure and temptation of drugs and maintain their sobriety.

Resiliency theory emphasizes strengths and the enhancement of individual and environmental protective factors. These protective factors enhance the adolescent's abilities to resist stressful life events while adapting to the situation and developing competence in dealing with them (Bolig and Weddle, 1988; Garmezy, 1983; Hauser et al., 1985; Werner, 1990;). These protective factors are, in fact, counters to life's stressful events. They could be support from family, school, peers, and community, augmented by internal personal strength.

Although John and Lisa suffered considerable losses of external support as time went on, they made adjustments and survived without using. This suggests that resiliency can be internalized over time. Even when key environmental support wanes, the participants' spiritual convictions were particularly helpful in this process. As participants were also skillful at making changes to increase external support to replace significant loses during recovery, it inspired them to change their friends, attitudes, and behaviors regarding drugs.

Need for Further Study

Much of the research in addiction, recovery, and relapse focuses on the adult population. More extensive research, particularly of a qualitative nature, needs to be done. Because this study followed the participants for 12 months, there is a need for even longer studies that examine how participants learn for themselves to create the ability to eliminate social stress and maintain resiliency. Other studies may need to be conducted focusing on more than seven participants to determine whether the findings could be generalizable to larger populations.

Recommendations

The need for treatment center schools is crucial. In treatment the participants were informed that they needed to change their past behaviors and seek new friends and relationships, specifically healthy ones, with others who were not drug or alcohol involved. If each treatment center school encourages students to change his/her patterns and disassociate from former friends, while finding new ones, there may be hope. But a mere alternative school devoid of any treatment plan may just provide troubled adolescents with more dysfunctional friends.

Finally, the surrender process, reduction of social stress, and resiliency were the factors that determined whether or not the participants in the study

relapsed. Poverty, racism, family dysfunction, lack of family and community support played a major role in the alleviation or presence of stress, while being non-white and unable to find the hope were the death knells (sometimes literally) for those who failed.

APPENDICES

APPENDIX A

Twelve Steps of Alcoholics Anonymous

1. We admitted we were powerless over alcohol--that our lives had become unmanageable;

2. Came to believe that a Power greater than ourselves could restore us to sanity;

3. Made a decision to turn our will and our lives over to the care of God as we understood Him;

4. Made a searching and fearless moral inventory of ourselves;

5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs;

6. We were entirely ready to have God remove all these defects of character;

7. Humbly asked Him to remove our shortcomings;

8. Made a list of all persons we had harmed and became willing to make amends to them all;

9. Made a direct amends to such people wherever possible, except when to do so would injure them or others;

10. Continued to take personal inventory and when we were wrong promptly admitted it;

11. Sought through prayer and meditation to improve our conscious contact with God as we understood Him, praying only for knowledge of His will for us and the power to carry that out; and

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics who still suffer, and to practice these principles in all our affairs.

APPENDIX B

Background Questions:

1. How many people are there in your family?

2. What are the ages, grades, educational attainment, and employment status of your siblings and parents?

3. Discuss your relationship with your family.

4. Do you think you have been successful in your educational endeavors?

5. What kind of relationship do you have with your peers/friends?

Questions related to research interest:

1. How old were you when you first experimented with drugs?

2. What is your drug of choice?

3. When/how did you know you had become addicted to drugs/alcohol?

4. How did your family relationship change during your drug use/abuse?

5. Is anyone else in your immediate or extended family addicted to drugs and/or alcohol.

6. How has substance use/abuse affected your education?

7. Was anyone (teachers or administrators) aware of your drug and/or alcohol use while attending school?

8. Did you volunteer, or were you ordered (courts or parents) to enter treatment?

9. When did you realize that your substance use/abuse was out of control?

10. Did you have a "hitting bottom" experience?

11. Did your drug use/abuse lead to criminal activity?

12. How confident are you that you will not return to drugs/alcohol once leaving treatment? Why or why not?

13. How difficult is it for you to stay sober?

14. What type of support or encouragement are you receiving now that you are in treatment?

APPENDIX C

Sample follow-up questions to participants and/or person(s) who knew of their sobriety.

1. How difficult is it to maintain your sobriety since leaving the treatment facility?

2. Have you received the support and encouragement that you imagined since leaving treatment?

3. What is your relationship with your family now that you have returned home?

4. Have you relapsed or used since leaving the treatment center?

5. Have you been attending A.A. and/or N.A. meetings since your graduation?

6. How are you progressing with your educational endeavors since graduation from treatment?

7. How have you changed since treatment and sobriety?

8. What factors still exist in your present life that caused you to initially use, and how are you dealing with them?

9. What are your plans for the future?

10. Do you intend to become a social drinker or continue to abstain from drug/alcohol use?

11. How has the community received you since your return home?

12. How has peers received you since you have returned home?

13. Is it difficult to make and maintain friends now that you have returned?

REFERENCES

A. A. World Services Inc. (1976). Alcoholics Anonymous. New York City: NY.

Azima, F. J. C., and Richmond, L. H. (1989). Adolescent group psychotherapy. Madison, CT: International Universities Press.

Bandura, A. (1977). Social learning theory. Englewood Cliffs, New Jersey: Prentice Hall.

Barritt, L., Beekman A., and Mulderij, K. (1995). Researching education practice. Grand Forks, ND: University of North Dakota, Center for Teaching and Learning.

Bateson, G. (1972). The cybernetics of self: A theory of alcoholism. In Batesons (eds.) Steps to an Ecology of Mind. New York: Ballantine, pp. 309-337.

Berryman, J. (1973). Recovery: A Novel. New York: Farrar, Straus and Girouz.

Beschner, G. M. (1985). The problem of adolescent drug abuse: An introduction to intervention strategies. In Friedman and Beschner (eds.) Treatment services for adolescent substance abusers. Rockville, MD: National Institute on Drug Abuse.

Bogdan, R. and Biklen, S. (1982). Qualitative research for education. Boston: Allyn and Bacon.

Bogdan, R., and Taylor, S. (1975). Introduction to qualitative research methods. New York: Wiley.

Bogenschneider, K., Small, K., and Riley, D. (1992). An ecological risk-forced approach for addressing youth at-risk issues. Chevy Chase, MD: National 4-H Center.

Bolig, R., and Weddle, K. D. (1988). Resiliency and hospitalization of children. Children's Health Care, 16, pp. 255-260.

Botvin, G. J., Baker, E., Dusenbury, L., Tortu, S., and Botvin, E. M. (1990). Preventing adolescent drug abuse through multimodal cognitive-behavioral approach: Results of a 3-year study. Journal of Consulting and Clinical Psychology, 58(4), pp. 437-446.

Botvin, G. J., Baker, E., Renick, N. L., Filazzola, A. D., and Botvin, E. M. (1984). A cognitive behavioral approach to substance abuse prevention. Addictive Behaviors. 9, pp. 137-147.

Botvin, G. J., Baker, E., Botvin, E. M., Filazzola, A. D., and Millman, R. B. (1984). Prevention of alcohol misuse through the development of personal and social competence: a pilot study. Journal of Studies on Alcohol, 45(6), pp. 550-552.

Botvin, G. J., and Eng, A. (1982). The efficacy of a multicomponent approach to the prevention of cigarette smoking. Preventive Medicine, 11, pp. 199-211.

Botvin, G. J., and Eng, A. (1980). A comprehensive school based smoking prevention program. The Journal of School Health, 50(4), pp. 209-213.

Botvin, G. J., Eng, A., and Williams, C. L. (1980). Preventing the onset of cigarette smoking through life skills training. Preventive Medicine, 9, pp. 135-143.

Botvin, G. J., Renick, N. L., and Baker, E. (1983). The effects of scheduling format and booster sessions on a broad-spectrum psychosocial approach to smoking prevention. Journal of Behavioral Medicine, 6(4), pp. 359-279.

Brinson, J. A. (1991). A comparison of the family environments of black male and female adolescent alcohol users. Adolescence, 26, pp. 877-884.

Burkstein, O. G., and Van Hasselt, V. B. (1993). Alcohol and drug use. In Bellack and Hersen (eds.) Handbook of behavior therapy in the psychiatric setting. New York: Plenum.

Chassin, L., Rogosch, F., and Barrera, M. (1991). Substance use and symptomatology among adolescent children of alcoholics. Journal of Abnormal Psychology, 100(4), pp. 449-463.

Chassin, L. (1984). Adolescent substance use and abuse. Advances in Child Behavioral Analysis and Therapy, 3, pp. 99-152.

Clayton, R. R., Catterello, A., Day, L. E., and Walden, K. P. (1991). Persuasive communications and drug abuse prevention: An evaluation of the DARE program.. In Persuasive communication and drug abuse prevention, Hillsdale, NJ: Lawrence Erlbaum, pp. 295-313

Clayton, R. R., Cattarello, A., and Walden, K. P.(1991). Sensation seeking as a potential mediating variable for school based prevention interventions: A two year follow up to DARE. Journal of Health Communications, 3, pp. 229-39.

Daugherty, R. and O'Bryan, T. (1987). Blueprints for Change: Exploring the Models for Prevention of Alcohol and Drug Problems. Lexington, KY: Prevention Research Institute.

DeJong, W. (1994). Relapse prevention: An emerging technology for promoting long-term drug abstinence. The International Journal of the Addictions, 29, pp. 681-705.

DeJong, W. (1987). A short-term evaluation of Project DARE (Drug Abuse Resistance Education): Preliminary indications of effectiveness. Journal of Drug Education, 17, pp. 279-94.

Denzin, N. K. (1993). The alcoholic society: Addiction and recovery of the self. New Brunswick: Transaction Publishers.

Dryfoos, J. G. (1990). Adolescents at risk. New York: Oxford University Press.

Dull, R. T. (1992). Correlates of alcohol and marijuana use within a college freshman population. Journal of Alcohol and Drug Education, 38(1), pp. 1-10.

Ellickson, P. L., Hays, R. D., and Bell, R. M. (1992). Stepping through the drug use sequence: Longitudinal scalogram analysis of initiation and regular use. Journal of Abnormal Psychology, 101(3), pp. 441-451.

Ennett, S. T., Tobler, N. S., Ringwalt, C. L., and Flewelling, R. (1994). How effective is Drug Abuse Resistance Education? A meta-analysis and Project DARE outcome evaluations. American Journal of Public Health, 84, pp. 1394-401.

Epstein, L. H. and Perkins, K. A. (1988). Smoking, stress, and coronary heart disease. Journal of Consulting and Clinical Psychology, 56, pp. 342-349.

Faine, J. R., and Bohlander, Jr. (1989). DARE in Kentucky schools 1988-89: An evaluation of the drug abuse resistance education program Bowling Green: Western Kentucky University Social Research Laboratory.

Felner, R. D., Mulhall, P., and Adix, R. (1992). Drug-free school and community prevention programming: Toward a "next generation" of developmental-informed comprehensive initiatives. Prevention Forum, 13(1), pp. 1-10.

Friedman, A. S., Glickman, N. W., and Morrissey, M. R. (1986). Prediction to successful treatment outcome by client characteristics and retention in treatment in adolescent drug treatment programs: A large scale cross validation study. Journal of Drug Education, 6, pp. 149-165.

Garmezy, N. (1983). Stressors of childhood. In Garmezy and Rutter (eds.) Stress, coping and development in children. New York, NY: McGraw-Hill.

Glaser, B. And Strauss, A. (1967). The discovery of grounded theory: Strategies for qualitative research. Chicago, IL: Aldine.

Goetz, J. and LeCompte, M. (1984). Ethnography and qualitative design in educational research. Orlando, FL: Academic Press.

Goodwin, D. (1979). Alcoholism and heredity: a review and hypothesis. Archives of General Psychiatry, 36, pp. 57-61.

Goodwin, D., and Guze, S. B. (1974). Heredity and alcoholism, in Kissin and Begleiter (eds.) The Biology of Alcoholism, Vol. 3. Clinical Pathology. New York: Plenum, pp. 37-52.

Hansell, S., and White, H. R. (1991). Adolescent drug use, psychological distress, and physical symptoms. Journal of Health and Social Behavior, 32(3), pp. 288-301.

Hansen, W.B. (1988). Effective school-based approaches to drug abuse prevention. Educational Leadership, 45(6), pp. 9-14.

Hansen, W.B. (1992). School-based substance abuse prevention: A review of the state of the art in curriculum, 1980-1990. Health Education Research, 7(3), pp. 403-430.

Hansen, W.B., and Graham, J. W. (1991). Preventing alcohol, marijuana, and cigarette use among adolescents: Peer pressure resistance training versus establishing conservative norms. Preventive Medicine, 20(3), pp. 414-430.

Hansen, W.B., Johnson, C.A., Flay, B. R., Graham, J. W., and Sobel, J. (1988). Affective and social influences approaches to the prevention of multiple substance abuse among seventh grade students: Results from project SMART. Preventive Medicine, 17, pp. 135-154.

Hansen, W.B., Malotte, C. K., and Fielding, J. E. (1985). The bogus pipeline revisited: The use of the threat of detection as a means of increasing self-reports of tobacco use. Journal of Applied Psychology, 70(4), pp. 782-789.

Hansen, W. B., Malotte, C. K., and Fielding, J. E. (1988). Evaluation of tobacco and Alcohol abuse prevention curriculum for adolescents. Health Education Quarterly, 15(1), pp. 93-114.

Hansen, W.B., Graham, J. W., Wolkenstein, B. H., Lundy, B.Z., Pearson, J., Flay, B. R. and Johnson, C.A. (1988). Differential impact of three alcohol prevention curricula on hypothesized mediating variables. Journal of Drug Education, 18(2), pp. 143-153.

Hansen, W.B., Graham, J. W., Wolkenstein, and Rohrbach, L.A. (1991). Program integrity as a moderator of prevention program effectiveness: Results for fifth-grade students in the adolescent alcohol prevention trial. Journal of Studies onAlcohol, 52(6), pp. 568-579.

Harmon, M. A. (1993). Reducing the risk of drug involvement among early adolescents. Evaluation Review, 17, pp. 221-39.

Hauser, S. T., Vieyra, M. A., Jacobson, A. M., and Wertreib, D. (1985). Vulnerability and resilience in adolescence: Views from the family. Journal of Early Adolescence, 5(1), pp. 81-100.

Hawkins, J. D., Catalano, R. F., and Miller, J. Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implication for substance abuse prevention. Psychological Bulletin, 112(1), pp. 64-105.

Hopkins, R.H., Mauss, A. L., Kearney, K. A., and Weisheit, R.A. (1988). Comprehensive evaluation of a model alcohol education curriculum. Journal of Studies on Alcohol, 49(1), pp. 38-50

Hycner, R.H (1985). Some guidelines for the phenomenological analysis of interview data. Human Studies, 1985, 8, pp. 279-303.

Jessor, R., and Jessor, S. L. (1978). Theory testing and longitudinal research on marihuana use. In D. B. Kandel (Ed.), Longitudinal research on drug use: Empirical findings and methodological issues. New York, NY: John Wiley & Sons, pp. 41-71.

Jessor, R., Graves T.D., Hanson, R. C., and Jessor, S. L. (1968). Society, Personality and Deviant Behavior: A study of a Tri-ethnic Community. Fort Worth TX: Holt, Rinehart, and Winston.

Johnson, V., and Pandina, R. J. (1991). Effects of the family environment on adolescent substance use, delinquency, and coping styles. American Journal of Drug and Alcohol Abuse. 17, pp. 71-88.

Johnston, L. D., and O'Malley. P. M.,(1986). Why do the nation's students use drugs and alcohol? Self reported reasons from nine national surveys. Journal of Drug Issues, 16(1), pp. 29-66.

Kaminer, Y (1994). Adolescent substance use: A comprehensive guide to theory and practice. New York, NY: Plenum Medical Book Publications.

Kandel, D. B. (1980). Drug and drinking behavior among youth. Annual Review of Sociology, 6, pp. 235-285.

Kandel, D., Simcha-Fagan, O., and Davies, M. (1986). Risk factors for delinquency and illicit drug use from adolescence to young adulthood. Journal of Drug Issues, 16(1), pp. 67-90.

Kandel, D. B., Yamaguchi, K., and Chen, K. (1992). Stages of progression in drug involvement from adolescence to adulthood: Further evidence for the gateway theory. Journal of Studies on Alcohol, 53(5), pp. 447-457.

Kanner. A. D., Coyne, J. C., Schaefer, C., and Lazarus, R. S. (1981). Comparison of two modes of stress measurement: Daily hassles and uplifts versus major life events. Journal of Behavioral Medicine, 4, pp. 1-39.

Kilty, K. M. (1990). Drinking styles of adolescents and young adults. Journal of Studies on Alcohol, 51(6), pp. 556-564.

Kinder, B. N., Pape, N. E., and Walfish, S. (1980). Drug and alcohol education programs: A review of outcome studies. The International Journal of the Addictions, 15(7), pp. 1035-1054.

Langeveld, M. (1983). Reflections on phenomenology and pedagogy. Phenomenology + Pedagogy, 1, 1, pp. 5-7.

Lemert. E. M. (1967). Human deviance, social problems and social control. Englewood Cliffs, NJ: prentice-Hall.

Lewontin, R., Rose, S., Kamin, L. J. (1984). Not in our genes: Biology, ideology, and human nature. New York, NY: Pantheon.

Lindenberg, C. S., Gendrop, S. C., and Reiskin, H. K. (1993). Empirical evidence for the social stress model of substance abuse. Research in Nursing and Health, 16, pp. 351-362.

Lofland, J. (1971). Analyzing Social Settings: A Guide to Qualitative Observation and Analysis. Belmont, CA: Wadsworth.

Madsen, W. (1974). The American Alcoholic: the Nature-Nurture Controversy in Alcoholic Research and Therapy. Springfield, IL: Charles C. Thomas.

McAndrew, C., Edgerton, R. (1969). Drunken comportment: A Social Explanation. Chicago, IL: Aldine

McClelland, D. C., Davis, W. N., Kalin, R., and Wanner, E. (1972). The drinking man. New York, NY: The Free Press.

Mellow, N. K. (1983). A behavioral analysis of the reinforcing properties of alcohol and other drugs in man, pp. 133-198 in Kissin and Begleiter (eds.) The Biology of Alcoholism, Vol. 7, Biological Factors. New York, NY: Plenum.

Mellow, N. K. (1972). Behavioral studies of alcoholism, pp. 219-292 in Kissin and Begleiter (eds.) The Biology of Alcoholism, Vol. 2 Physiology and Behavior. New York, NY: Plenum.

Mercer, R. T., Ferketich, S. L., DeJoseph, J., May, K. A., and Sollid, D. (1988). Effect of stress on family functioning during pregnancy. Nursing Research, 37, pp. 268-274.

Merryman, R. (1984). Broken promises, mended dreams. Boston, MA: Little, Brown.

Monte, C. F. (1991). Beneath the mask: An introduction to theories of personality (4th ed.) Fort Worth, Texas: Holt, Rinehart, and Winston.

Napier, T. L., Bachtel, D. C., and Carter, M. V. (1983). Factors associated with illegal drug use in rural Georgia. Journal of Drug Education, 13(2), pp. 119-140.

Needle, R. H., Su, S. S., and Doherty, W. J. (1990). Divorce, remarriage, and adolescent substance use: a prospective longitudinal study. Journal of Marriage and the Family, 152, pp. 157-159.

Newcomb, M. D., and Bentler, P. M. (1988). Consequences of adolescent drug use: Impact on the lives of young adults. Newbury Park, California: Sage Publications.

Newcomb, M. D., Bentler, P. M., and Collins, C. (1986). Alcohol use and dissatisfaction with self and life: A longitudinal analysis of young adults. Journal of Drug Issues, 16(4), pp. 479-494.

Nowinski, J. (1990). Substance abuse in adolescents and young adults: A guide to treatment. New York: Norton and Company.

Pagliaro, A. M. and Pagliaro, L. A. (1996). Substance use among children and adolescents: Its nature, extent, and effects from conception to adulthood. New York: Wiley.

Rak, C. F. And Patterson, L. E. (1996). Promoting resilience in at-risk children. Journal of Counseling & Development, Vol. 74, pp. 368-373.

Resnick, M. D., Harris, J. J. and Blem, R. W. (1993). The impact of caring and connectedness on adolescent health and well-being. Journal of Pediatrics and Child Health, Vol. 29, pp. 83-89.

Rhodes, J. E., and Jason, L. A. (1990). A social stress model of substance abuse. Journal of Consulting and Clinical Psychology, Vol. 58, No. 4., pp. 395-401.

Rhodes, J. E., and Jason, L. A. (1988). Preventing substance abuse among children and adolescents. New York: Pergamon Press.

Ringwalt, C., Curtin, T., and Rosenbaum, D. (1990). A first year evaluation of DARE in Illinois. Unpublished manuscript. Chicago, IL: Center for Research in Law and Justice; University of Illinois at Chicago.

Ringwalt, C., Ennett, S. T., and Holt, K. D. (1991). An outcome evaluation of Project DARE (Drug Abuse Resistance Education). Health Education Research, 6, pp. 327-37.

Rosenbaum, D. P., Flewelling, R. P., Bailey, S. L., Ringwalt, C. L., and Wilkinson, D. L. (1994). Cops in the classroom: A longitudinal evaluation of Drug Abuse Resistance Education (DARE). Journal of Research in Crime and Delinquency, 31, pp. 3-31.

Schinke, S.P., Gilchrist, L. D., and Snow, W. H. (1985). Skills intervention to prevent cigarette smoking among adolescents. American Journal of Public Health, 75(6), pp. 665-667.

Stuccoed, M., and Dub, J. (1983). Alcoholism in women, in Kissin and Begleiter (eds.) The biology of alcoholism, Vol. 6. Psychosocial Factors. New York: Planum.

Shipman, M. (1981). The limitations of social research 2nd ed. New York: Longman.

Shope, J. T., Dolman, T. E., Campanili, P.C., and Kloska, D.D. (1992). An elementary school-based alcohol misuse prevention program: A follow-up evaluation. Journal of Studies on Alcohol, 53(2), pp. 106-121.

Siegel, R. A., and Ehrlich, A. (1995). A comparison of personality characteristics, family relationships, and drug-taking behavior in low and high socioeconomic status adolescents who are drug abusers. Adolescence, 24, pp. 925-936.

Single, E., Kandel, D., and Faust, R. (1974). Patterns of multiple drug use in high school. Journal of Health and Social Behavior, 15(4), pp. 344-357.

Sobell, M. B., and Sobell, L. C. (1978). Behavioral treatment of alcohol problems: Individualized therapy and controlled drinking. New York: Plenum

Stacy, A W., Newcomb, M. D., and Bentler, P.M. (1992). Interactive and higher-order effects of social influences on drug use. Journal of Health and Social Behavior, 33(3), pp. 226-241.

Stinnett, N. (1994). Secrets of strong families. Presentation at the Ohio Home Economics Association Annual Meeting, Columbus, OH.

Tesch, R. (1984). Phenomenological studies: A critical analysis of their nature and procedures. Paper presented at the meeting of the American Educational Research Association, New Orleans, LA.

Tesch, R. (1988). The contribution of a qualitative method: Phenomenological research. Paper presented at the meeting of the American Research Association, New Orleans, LA.

Tiebout, H. M. (1944). Therapeutic mechanisms in Alcoholic Anonymous. American Journal of Psychiatry, 100, pp. 468-473.

Tiebout, H. M. (1949). The act of surrender in the therapeutic process with special reference to alcoholism. Quarterly Journal of Studies on Alcohol, 10, pp. 48-58.

Tiebout, H. M. (1953). Surrender versus compliance in therapy. Quarterly Journal of Studies on Alcohol, 14, pp. 58-68.

Tiebout, H. M. (1954). The ego factors in surrender in alcoholism. Quarterly Journal of Studies on Alcohol, 15, pp. 610-621.

Tims, F. M., and Leukefeld, C. G. (1986). Relapse and recovery in drug abuse: An introduction. In Tims and Leukefeld (eds.), Relapse and recovery in drug abuse, Rockville, MD: National Institute on Drug Abuse, U. S. Department of Health and Human Services.

Turner, S., Norman, E., and Zunz, S. (1995). Enhancing resiliency in girls and boys: A case for gender specific adolescent prevention programming. The Journal of Primary Prevention, Vol. 16, No. 1, pp. 25-38.

United States Department of Health Education and Welfare (1979). Healthy People: The Surgeon General's Report On Health Promotion and Disease Prevention. DHEW Pub. No. (PHS) 79-55071. Washington D.C. Supt. of Docs., U.S. Government Printing Office, pp. 43-47.

United States General Accounting Office (1992). Adolescent drug use prevention: Common features of promising community programs. Report to the Chairman,Subcommittee on Select Education, Committee on Education and Labor, House of Representatives, pp 24-37. United States General Accounting Office, Gaithersburg, MD 20877.

Urberg, K. A., Shyu, S., and Liang, J. (1990). Peer influence in adolescent cigarette smoking. Addictive Behaviors, 15(3), pp. 247-255.

Vaillant, G. E. (1983). The Natural History of Alcoholism: Causes, patterns, and paths to recovery. Cambridge, MA: Harvard University Press.

Van Maanen, J. (1983). Qualitative Methodology. Beverly Hills CA: Sage.

Vanderschmidt, H. F., Knight-Williams, V. And Vanderschmidt, G. F. (1993). Risk among inner city young teens: The prevalence of sexual activity, violence, drugs, and smoking. Journal of Adolescent Health, 14, pp. 282-288.

Vaughn, C.A., and Long, W.C., (1997). Surrender to Win. Adolescence in press.

Way, N., Stauber, H. Y., Nakkula, M. J., and London, P. (1994). Depression and substance use in two divergent high school cultures: A quantitative and qualitative analysis. Journal of Youth and Adolescence, 23, pp. 331-357.

Werner, E. E., and Smith, R. S. (1990). Protective factors and individual resilience. In Meisels and Shonkott (eds.), Handbook of early childhood intervention. Cambridge: Cambridge University Press.

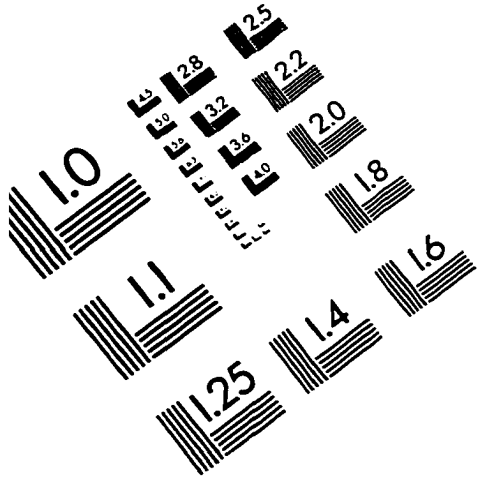
Wesson, D. R., Havassy, B. E., and Smith, D. E. (1986). Theories of relapse and recovery and their implications for drug abuse treatment. In Tims and Leukefeld (ed.), Relapse and Recovery in Drug Abuse. Rockville, MD: National Institute on Drug Abuse, U. S. Department of Health and Human Services.

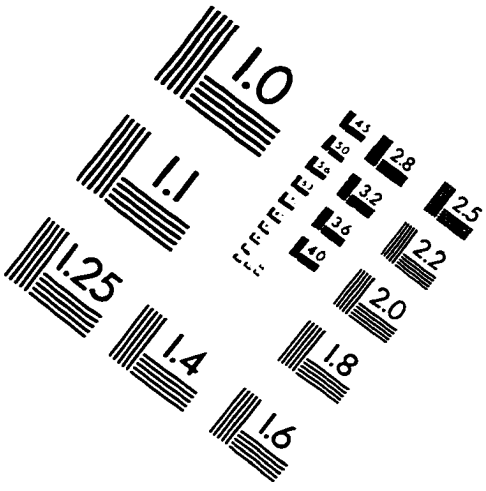
Williams, A. F. (1976). The alcoholic personality, pp. 243-275 in Kissin and Begleiter (eds.) The Biology of Alcoholism, Vol. 4. Social Aspects of Alcoholism. New York: Plenum.

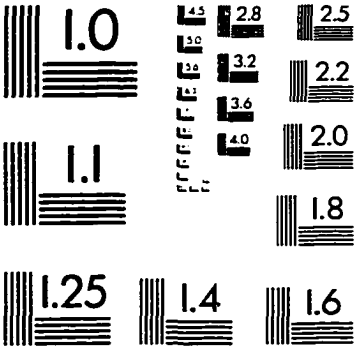
Willis, T. S., and Shiffman, S. (1985). Coping and substance use: A conceptual framework. In S. Shiffman and T. A. Willis (eds.). Coping and substance use. New York: Academic Press.

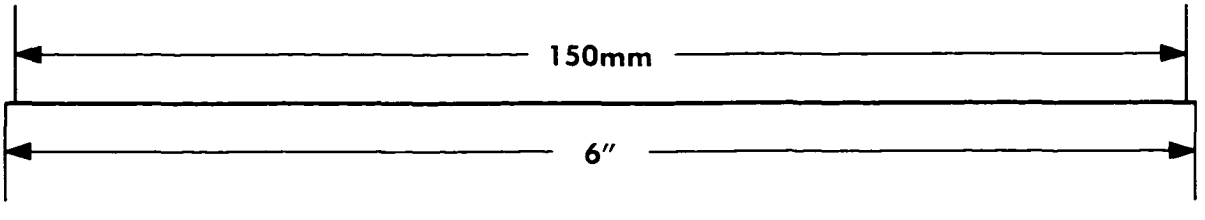
Wysong, E., Aniskiewicz, R., and Wright, D. (1994). Truth and DARE: Tracking drug education to graduation and as symbolic politics. Social Problems, 41, pp. 448-72.

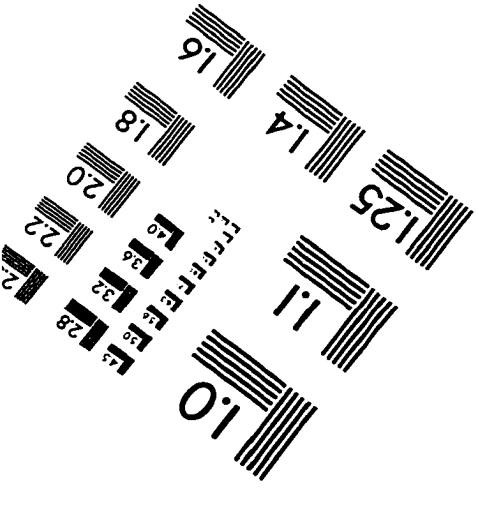
IMAGE EVALUATION TEST TARGET (QA-3)

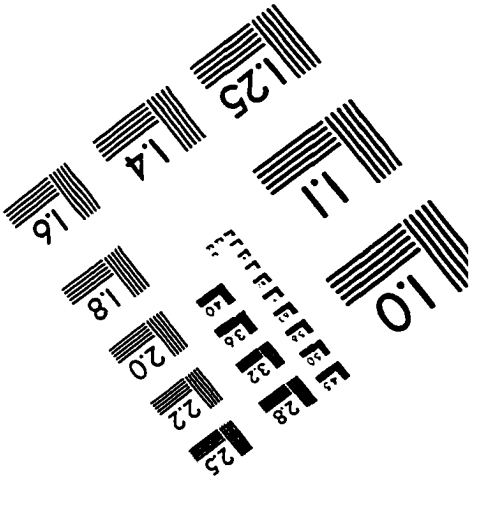












APPLIED IMAGE, Inc
1653 East Main Street
Rochester, NY 14609 USA
Phone: 716/482-0300
Fax: 716/288-5989