National Council on Family Relations

Linking family research, education, and practice.

Report

March 2005

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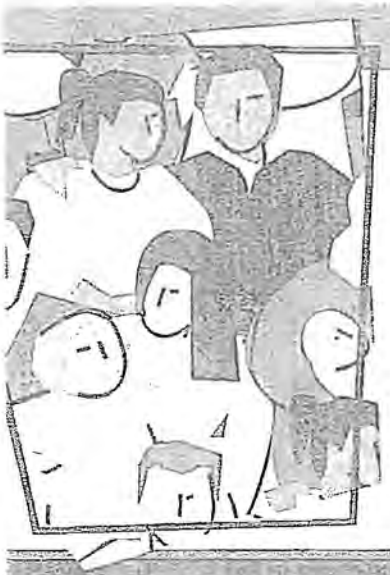

IN THIS ISSUE:

Family Focus on... Substance Abuse Across the Life Span

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"O God! That men and women should put an enemy in their mouths to steal away their brains," wrote Shakespeare in *Othello*.

Today, people still drink to excess, but they also abuse a host of other substances that "steal away their brains."

Articles in this issue of Family Focus explore substance abuse and associated issues, including children born with fetal alcohol syndrome, adolescents who smoke, college students in recovery, older alcoholics, and the need for services tailored to rural residents.

Next Issue: Multiple Meanings of Family

2004 NCFR Fellows Chosen in Orlando

The 2004 Fellowship Committee consisting of Elaine A. Anderson, Estella A. Martinez, Brent C. Miller, Lane H. Powell, CFLE, and Chair, Alan I. Sugawara met at the November NCFR Annual Conference in Orlando, Florida and selected seven NCFR Fellows for 2004.

The NCFR Fellows were nominated by their peers and selected for their history of outstanding contributions to the field of family studies in such areas as published scholarship, innovative and influential teaching presentations, development and implementation of significant intervention of programs designed to promote healthy family relations, development and implementation of innovative curricula for training professionals in family studies, social policy support for family issues, and a consistent record of superior contributions to NCFR over time.

J. Kenneth Davidson, Sr., Ph.D., CFLE, Professor, Sociology, Coordinator of Interdisciplinary Family Studies, Acting Chair of Sociology, University of Wisconsin-Eau Claire, is known for his sustained record of research and scholarly activities in the area of human sexuality and family interaction. Covering almost four decades, his research on human sexuality has covered a wide range of topics including sexual attitudes and behaviors among college students, never-married, married, and divorced women. His latest co-edited book entitled, *Speaking of Sexuality* (2nd Edition, Roxbury, 2005) has been described by colleagues as containing one of the best collection of articles on the topic currently available, which is at the cutting edge of scholarship in the field. NCFR is indebted to Dr. Davidson for his years of leadership in the development and implementation of the CFLE Program, serving as Chair of the Certification Standards as well as Implementation Committees. He was the recipient of the 2003 Ernest G. Osborne Award for Teaching in Family Studies from NCFR.

Michael P. Johnson, Ph.D., Associate Professor, Sociology, Women's Studies, and African and African-American Studies, The Pennsylvania State University, has distinguished himself nationally and internationally in two areas of research, including commitment in relationships, and family violence. As is characteristic of his scholarship, he brought together these two areas and re-conceptualized them in a well-known

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article entitled, "Patriarchal Terrorism and Common Couple Violence" (*Journal of Marriage and the Family, 1995*), changing the way scholars and practitioners understand violence in intimate relationships. Known for his unquenchable thirst for social justice, Dr. Johnson has also committed his efforts toward dealing with issues surrounding gender and ethnicity. Among many other things, he was appointed by the President of his university to serve as Director for the Strategic Study Group on the Status of Women, which made recommendations that improved the policies and practices related to women on campus. His is an outstanding teacher receiving a number of prestigious teaching awards from his university. Some of his valuable contributions to NCFR include leadership in the Research and Theory and Feminism and Family Studies Sections, as well as the Reuben Hill Award Committee.

Leigh A. Leslie, Ph.D., Associate Professor, Family Studies, University of Maryland, is known for her scholarship in the family field related to social support, family stress and coping, family diversity, marriage and family therapy, integrating a feminist perspective. Her co-authored book, *Gender, Families, and Close Relationships: Feminist Research Journeys* (Sage, 1994), was recognized as one of the most influential women's studies books of the decade by the *Women's Studies Review*. Her publications also include the development of innovative curricula for teaching students and professionals about family science, and the design and implementation of significant intervention programs that promote healthy family relations among different socioeconomic and ethnic families. Dr. Leslie is the recipient of her university's outstanding teacher award, and was named as one of Washington Metro Area's outstanding family therapists. NCFR has benefited from her leadership twice on the Board of Directors, and as Chair and Vice-Chair of the Feminism and Family Studies Section.

Walter R. Schumm, Ph.D., CFLE, Professor, Family Studies and Human Services, Kansas State University, is a prolific scholar and family researcher. His publications are numerous and cover a wide range of areas including family theory and research methodology, program evaluation of premarital education and counseling programs, and military families and health. Perhaps best known for his work on the development of the *Kansas Martial Satisfaction Scale,* through a number of validity studies, overcame limitations of earlier instruments. As a co-editor of the *Sourcebook on Family Theories and Methods* (Plenum, 1993), his knowledge of the expertise on the link between theory and methods was noted. A member of NCFR since the 70s, when he served as a Student Representative on the Publications Committee, Dr. Schumm has served twice on the Reuben Hill Award Committee, and as Chair and Treasurer of the Theory Construction and Research Methodology Workshops. Students and colleges have highly valued his collaborative and generous sharing of his skills with them.

Jetse Sprey, Ph.D. Professor Emeritus, Sociology, Case Western University, has been described as a critical family theorist, whose ideas and publications were often enlightening and original, leading to new directions that advanced knowledge or led to shifts in the way people think about selected family issues. He has written on such diverse topics as family disorganization, sexuality, sex roles, family conflict, abuse, power, consequences of divorce, and policy. His writings have been described as going beyond the limits of family sociology, drawing ideas from history, classical philosophy, psychology, and psychoanalysis, as well as traditional sociology. An active member of NCFR since the 60s, Dr. Sprey has served as Chair of the Theory Construction and Research Methodology Workshop, a member of the Publications Committee, a member of the NCFR Executive Board, and as Editor of the *Monograph Series on the Family* (NCFR/Sage, 1975-79). Colleagues also point to his significant contributions to the *Journal of Marriage and the Family (JMF)*, where he served as Book Review Editor, Associate Editor, and Editor. Although retired, Dr. Sprey continues to be active in the field, presently serving on *JMF's* Editorial Board and through his continuing publications.

James M. White, Ph.D., Professor, Family Studies, University of British Columbia, has distinguished himself as a person responsible for the survival and endurance

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Report

of The National Council on Family Relations

Mission Statement for the Report:

REPORT, the quarterly newsletter of the National Council on Family Relations, strives to provide timely, useful information to help members succeed in their roles as researchers, educators, and practitioners. Articles address family field issues, programs and trends, including association news.

President: Gay C. Kitson
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NEWS DEADLINES: April 4 for June issue; July 5 for September issue; October 3 for December issue.

Linda Malone-Colon selected to serve as Director of NCFR's National Healthy Marriage Resource Center

The National Council on Family Relations is pleased to announce the appointment of Linda Malone-Colon, Ph.D., as the Director of the National Healthy Marriage Resource Center. The Center, a grant-funded project within NCFR, was created upon receipt of a 5 year grant from the Administration of Children and Families (ACF) of the Department of Health and Human Services. Dr. Malone-Colon will direct the Center in its mission to establish the nation's first government-funded, Internet-based clearinghouse on information about how to form and sustain healthy marriages.

Dr. Malone-Colon brings a rich background of academic expertise and community marriage initiative experience. She has served as an educator, administrator, and counselor in several institutions of higher education. Outside of her academic endeavors, Dr. Malone-Colon has been actively participating in local and national initiatives to strengthen marriages. She received her MS degree in Clinical Psychology and Ph.D. in Personality Psychology with a minor in Neuropsychology from Howard University. Dr. Malone-Colon will be based out of NCFR's Washington, DC office and can be reached at Linda@ncfr.org or by phone: 202-659-9399.

NCFR Fellows Sought!

Greetings NCFR Members! I am writing to say that I am honored to serve as Chair of the NCFR Fellowship Committee. I am humbled by the many outstanding contributions you have made to the organization and field of family studies. I also want to inform you that the Fellowship Committee is seeking nominations for the 2005 Fellowship Awards. Would you help us identify individuals to join your honored ranks by nominating those who have made significant contributions to the organization and the field and/or who have been overlooked in the past or should be recognized for their accomplishment? The Fellowship Committee would greatly appreciate your assistance. A description of the Fellowship Award, criteria for selection to Fellowship Status, and procedures for submitting nominations follows. I am thanking you in advance.

What Is Fellowship Status in NCFR?

Fellowship status in NCFR is an honor awarded to relatively few members of NCFR who have made outstanding and enduring contributions to the field of the family in the areas of scholarship, teaching, outreach or professional service, including service to NCFR. By definition, outstanding contributions are those that have had a broad impact on the field and are enduring over time. These contributions occur infrequently. No more than 1% of the number of members in NCFR will be awarded fellowship status in any one year.

Examples of outstanding contributions having an enduring impact on the field include, but are not limited to:

A. Published scholarship that has reshaped or shaped the field of family relations.

B. A history of innovation or influential workshop presentation in an area of the family beyond the local level.

C. The development and implementation of innovative, novel or significant interventions or programs designed to promote healthy family relations.

D. The development and implementation of innovative curricula for training professionals in the area of family science.

E. The development of innovative social policy relevant to families.

F. A consistent record of superior contributions to NCFR over time.

What Are the Criteria for Fellowship Status?

A. Fellowship status in NCFR is an honor awarded to relatively few members of NCFR who have made outstanding and enduring contributions to the field of the family in the areas of scholarship, teaching, outreach or professional service, including service to NCFR.

B. Must be nominated by another NCFR member.

C. Must have at least 10 years of professional experience after the receipt of the appropriate graduate or professional degree.

D. Must have been a member of NCFR for at least 5 continuous years at the time of nomination.

E. Must have the endorsement of three individuals (including the nominator), at least two of whom are NCFR members, who describe the outstanding nature of the nominee's contributions.

F. Must have a consistent record of superior contributions to NCFR over time.

Please send your nominations to NCFR at jeanne@ncfr.org. NCFR will reply with further instructions on getting started and the information regarding membership status. **Deadline for nominations is May 1st.** We are trying to build this special recognition to further the legacy of outstanding members of NCFR. Let us hear from you and thank you very much for your consideration.

Estella A. Martinez, Chair
NCFR Fellowship Committee
E-mail: estella@unm.edu

President's Report

Communication in NCFR

In response to the concerns of some members, the NCFR board is re-examining the implications and implementation of the Healthy Marriage Resource Center grant and will be reporting their conclusions within the next month.

Ideal conversation must be an exchange of thought, and not, as many of those who worry about their shortcomings believe, an eloquent exhibition of wit or oratory.

– Emily Post, *Etiquette*,
quoted in *Bartlett's Quotations*

Having the opportunity this past year to see more of what is going on in NCFR, I have been impressed with how many members communicate their concerns, wishes, and interests about the discipline and the organization. They do so through participating in the annual conference, committees, and sections and, recently, higher numbers of submissions to the journals. I have also been impressed with how many read the e-mails that are sent out and the *Report* and then make their opinions known. The staff and the board attempt to address these concerns.

Current Concern

At the moment, some of our members are concerned about the federal grant NCFR has received for the Healthy Marriage Resource Center and, in particular, with some of the restrictions of the grant about the types of relationships and families that are the focus of attention. The grant is a resource center reviewing programs to help families. The board reviewed this issue before NCFR applied for this grant and is examining the issue further now in response to members' concerns and will have more information for you in the coming month.

Members' Communication

As a sign of involvement, over 900 members (or 25 percent of members) replied to the initial member survey last summer and 700 (19 percent) to the follow-up version of the survey after we discovered computer errors.

Communication is not just with others but with oneself. Members are engaged with issues of the discipline. Based on replies to the survey, the top five kinds of communication members value the most are articles in the *Journal of Marriage and Family*, the annual conference, access to research, articles in *Family Relations*, and networking. These are not all activities that immediately lead to interaction with others but reflect members' involvement with the core activities of the organization. NCFR works to keep these activities as priorities of the organization.

How Does the Board Communicate?

The board meets in person three times a year– April, June and November– and by conference telephone calls in other months. Board members go to the meetings of the sections at the annual conference to learn

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of family development theory. Subjected to harsh criticism in the 1970s, this legacy model went into serious decline in academic circles. With the publication of the book *Dynamics of Family Development: A Theoretical Perspective* (Guilford Press, 1991), as well as the chapter on family developmental theory in the *Sourcebook of Family Theories and Methods* (Plenum, 1993), Dr. White successfully overcame some of the limits of such a theory, developing newer concepts in the process. These publications in addition to his co-authored book, *Family Theories* (Sage, 1996, 2002) have been described as classics in the field. His most recent book, *Advancing Family Theories* (Sage, 2004) also seem destined to become another seminal theoretical work. Dr. White has served as President of the Northwest Council on Family Relations and a member of its Board of Directors. He co-chaired NCFR's Life Span Focus Group, served on the Board of Directors of the Theory Construction and Research Methodology Workshops, and was a member of the Reuben Hill Award Committee.

Lynn White, PhD., Professor, Sociology, University of Nebraska-Lincoln, has been described as a quintessential scholar and mentor in the field of family studies. One colleague evaluated her work as "not only prodigious in quality, but exceptional in magnitude and pioneering in its contribution to new knowledge." Instead of focusing on a single topic, Dr. White publishes a few seminal articles on a topic, then moves on to related research topics. These topics are wide ranging, including methodological issues; marriage, marital quality, and marital instability; remarriage and stepfamilies, unpaid family work; sibling and stepsibling relationships, paid work and family life, transition to parenthood, families and the economy, cross-cultural research, and most recently, infertility. Her sustained contribution to NCFR is with the *Journal of Marriage and Family*. She has served as the Book Review Editor and a member of the Editorial Board of the journal. She is presently its Deputy Editor. She has published some 20 articles in the journal since 1978. She has been described as a great mentor of students and faculty in their research endeavors.

Alan I. Sugawara, Chair
NCFR Fellowship Committee

Executive Review

Global Perspectives on Family

As I reviewed the contents for the December 2004 issues of the *Report* and the *Journal of Marriage and Family*, I was struck by the vast amount of information that we know and don't know about what the "understandings of family change and stasis" taking place around the world. I was also struck by important information shared during the 2004 Annual Conference, particularly the session "International Year of the Family, 1994-2004 – Retrospective and Outlook to the Future" wherein the discussion focused on such issues as changes in family structure, demographic aging of family members, rises of migration and the impact of HIV/AIDS – all from a global perspective. In preparing this issue's column, I also considered where does this global perspective on families fit within the context of the strategic plan that the Board of Director's developed in mid-2004. Before moving on, I want to lay out two important facts: one of the strategic objectives is that "over the next three years, increase by 50% the number of people participating in NCFR's various education offerings" and 2008 will be the 70th Anniversary of the founding on NCFR. Taking a page out of *JMF* and in "era of mass globalization," I am proposing that in 2008 NCFR sponsors an international conference on the "International Perspectives on Families and Social Change."

In considering an international conference, and again taking the lead from the guest editors of the *JMF* issue, such a conference would expand the vision of all family scholars and would emphasize the importance of studying broad social change in the context of family research, practice and policy. Such an endeavor comes at a time, for example, when there are shifts from extended to nuclear families as well as rise of one-person households and of cohabitation households worldwide, issues of health concerns to families, such as AIDS/HIV (e.g., China, India and South Africa), strategies for strengthening the family unit (e.g., Singapore, Korea, and Taiwan) and worldwide concerns toward anticipating the aging population of family members.

2008 will be the 70th Anniversary of the founding of NCFR

From my perspective it would be appropriate for NCFR to take on the leadership of such an initiative. But first let me put the 2008 annual conference program chair's mind (whoever that might be) at ease, this would be a special conference taking place in the late spring or early summer of 2008. It would not replace the 2008 annual conference. Going back to the issue of leadership, NCFR is the premier family organization with the vision of "having the field of family scholarship and practice recognized globally for its contribution to the strength and well-being of families." This conference would "connect the dots" between our strategic objective of increasing the number of people participating in NCFR's educational offerings and NCFR's 70th Anniversary.

Here are the particulars for your consideration: in planning the event, I propose to convene the former presidents of NCFR and designated representatives from NCFR Sections to form a stellar plan group. The convening of this august group would be a pre-conference event at the 2005 Annual Conference in Phoenix.

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PRESIDENT'S REPORT *continued from page 4*

the concerns of members, provide the opportunity for a member forum on diversity issues at the annual conference, review reports from the sections, committees, editors, members, and develop initiatives and responses to staff initiatives. When members raise issues with individual board members, these are then shared with the entire board. The board evaluates every policy in the Governance Manual at least yearly. (You can review the Governance Manual on the NCFR website.)

Under the Carver Governance Model which NCFR uses, the board delegates means decisions to the Executive Director, Michael Benjamin, and the staff while the board focuses on the ends on which it wants to see the organization focus its efforts. It discusses these issues in its meetings and reports them to members through the various forums available.

All the indicators of effective communication indicate NCFR members are vitally engaged in the issues of the discipline and the organization and an ongoing dialogue about them. The board and the staff work to facilitate this process. It is our joint efforts at sharing our thoughts and concerns that keep NCFR relevant to the needs of our members. If you have not made your voice heard, I encourage you to do so.

Gay C. Kitson
NCFR President
E-mail: Kitson@uakron.edu

The NCFR Staff now has direct lines. To reach a specific staff person directly, please select from the following list:

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Judy Schutz	763-231-2890
Jeanne Strand	763-231-2881
Amanda Tempel	763-231-2888
Cindy Winter	763-231-2885

The NCFR office can still be reached by the toll free number: 888-781-9331.

International Year of the Family (IYF) - Tsunami of December 2004

In 2004, NCFR participated in the 10th anniversary of the UN's International Year of the Family (IYF). NCFR has chosen to continue to celebrate IYF through 2005. I have agreed to remain chair of the IYF Committee.

In lieu of a traditional column, I wish to focus this column on the South Asian Tsunami of December 2004. It was one of the largest natural disasters, directly impacting families in 11 Asian and African countries. Given the tourist popularity of some locations, families from other regions (e.g., Europe, North America) were affected as well.

On behalf of the IYF Committee, I wish to express my condolences to all families affected by the tsunami. By the time that you read this article, three months will have passed since the tsunami occurred. While the Asian/African survivors' most immediate needs (water, food, shelter) might have been met by this point, we are all aware that the medical, psychological, social and familial needs will be ongoing for years. Although the families and friends of tourists might be physically safe, I recognize that they experience their own pain and challenges in the search for loved ones.

In addition, I wish to express my gratitude to all of you who have made contributions to tsunami relief organizations. Your contributions reflect the generosity, compassion, and empathy of NCFR members. While you all express a commitment to families through your professional work, you demonstrate another layer of dedication when you make a financial contribution to care for others. I also wish to express gratitude to colleagues who are directly providing professional care (e.g., therapy, education) to families affected by the tsunami.

I would respectfully suggest that the tsunami is an important event about which you could teach your students. If you would like your students to be more mindful of the international contexts of family dynamics, then this tragedy presents a "teachable moment." I do not in any way suggest that this tragedy be used in an exploitive manner. Rather, I suggest that you can help students become more compassionate about international families by taking them beyond the headlines. With the ongoing news coverage, you can use this information to teach about such topics as extended family networks, resilience/stress, grief/loss, international adoption, public policy and service provision.

As a final caveat, I would note that it has been argued that there are humanitarian crises in other parts of the world (e.g., Congo) and these crises have not received the attention that they deserve. My attention to the tsunami does not negate my concern for families in other regions of the world. In the coming years, we will try to focus similar attention on other families.

Please feel free to contact me if you have questions/comments about the IYF Committee. Thank you for your attention.

Jacki Fitzpatrick, CFLE
IYF Committee Chair
E-mail: jacki.fitzpatrick@ttu.edu

EXECUTIVE REVIEW

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This group would identify the broad parameters for the conference including establishing a Strategic Steering Committee to serve as the conference's coordinating point and sounding board. This Committee would be relatively small (about six people) who would be representative of the full complexity of NCFR, whose opinions are respected within NCFR and whose final recommendations would be the basis for action. Although we intend to break even or make a slight profit from the conference, the planning cost is estimated at $50,000 over a three year planning period (2005-2007).

In addition, we should not do this event in isolation of other family-related organizations (e.g., International Sociological Association, International Association of Family Sociology, International Federation of Home Economics) that also have a global family perspective including the United Nations.

Let me be clear. This is a proposal that I will be making to NCFR's Board of Director's at its April Board meeting in Washington, DC. As always, I would appreciate your feedback and welcome your suggestions regarding this proposal.

Michael L. Benjamin, M.P.H.
Executive Director
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ON THE NET

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CFLE Directions

CFLEs Recognized at Reception

The Certified Family Life Educator (CFLE) Reception in Orlando, FL provided an excellent opportunity to recognize two CFLEs who made a significant contribution to the CFLE program this past year. In addition, we recognized eight university programs that received NCFR approval in 2004.

Drs. Angeline J. O'Malley, CFLE and Jeannette D. Wilson, CFLE, received the *Special Recognition Award for Outstanding Service to the CFLE Program* for their efforts in creating and editing **Pathways to Practice - A Family Life Education Internship Practicum Handbook**. Angie and Jan saw a need for a comprehensive resource for those working directly with family life education internship and practicum experiences, so they set out to create one! *Pathways to Practice* includes a brief introduction to family life education and internships and practicums, as well as discussion of professional issues in the workplace, enhancement of professional status, potential problems and ethical conduct. Special sections for faculty and site supervisors are included. The Appendix includes a collection of various forms, checklists, agreements/contracts, student assignments, evaluation tools, letters, and more. Materials were submitted by practicing family professionals from throughout the country. *Pathways to Practice* is an excellent addition to the NCFR library of family life education resources. We are grateful to Angie and Jan for their commitment to furthering the profession!

We also recognized eight universities whose programs joined the list of NCFR-Approved Academic Programs in 2004. They include:

Concordia University – St. Paul
Family Life Education

Mississippi University for Women
Family Studies

Towson University
Family Studies

Union University
Family Studies

University of Minnesota
Family Social Science

Western Michigan University
Family Studies

Kansas State University
Family Life Education and Consultation

CERTIFIED FAMILY LIFE EDUCATORS

Following is a list of Certified Family Life Educators designated since October 15, 2004. (* - Provisional)

California
Mary Steele *
Glenda Thompson Bona

Florida
Beatriz Cortes
Eva Nowakowski

Indiana
Julia Erickson *
Scott Hall

Iowa
Staci Kleinhesselink
Jane Njue
Elise Radina

Idaho
Laura Brotherson

Kansas
Janice Adamson
Lisa Flaming
April Lindquist *

Maryland
Jodi Jacobson
Linda Oravecz

Michigan
Heidi Bolster *
Monique Calhoun *
Rebecca Court *
Beverly Darner *
LaVada Dean *
Karna Doyle
Yonnie Fowler *
Denise Johnson
Lewis Johnson
Joshua Kittleman *
Kathleen Klumb *
Donald LaMay *
Grace Nelson-Odinma *
Carol Shetenhelm *
Rebecca Shingledecker *
Nancy Thompson
Nancy Vos-Morin *

Minnesota
Nancy Gonzalez

Mississippi
Mary Bell
Karen Benson
Patsilu Reeves

Missouri
Marjorie Taylor *

North Dakota
Ashley Bossert *

Ohio
Aije Shemo-Booth *
Pamela Smith *
Jeannine Taylor
Carol Werhan

Oregon
Esther Schiedel

Texas
Kenneth Bateman
Marsha Harwell *
Patricia Larson *
Elizabeth Russell
David Sager

Utah
David Jones *
Julie Miller *
Pamela Morrill

Vermont
Talia Glesner *

Virginia
Rebekah Cummings

Washington
Sandra DeAngelo

Wisconsin
Tammy Conrad

Online Courses/Workshops in Family Life Education

One of the goals of the CFLE program for 2005 is to identify online opportunities for courses and continuing education options related to the ten CFLE family life content areas. CFLE applicants are often Tabled in one or more content areas and asked to strengthen their preparation by attending a course or workshop. College credit courses are often too expensive or inaccessible. In many cases an applicant might not need to complete a whole college course but instead just needs to strengthen an area through a shorter workshop or training. We would like to include a section on the NCFR website where people can access a list of workshops, trainings, and college courses etc. related to the ten content areas available online. Ideally at least some of these offerings will be pre-approved for meeting the criteria for the CFLE program.

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Representatives of Approved Programs. Back: Chloe Merrill, APR Chair, Howard Barnes – University of Northern IA, Michael Walcheski - Concordia University, Chantel Lumpkin – Western MI University. Front: Wm. Michael Fleming – UNI, Jan McCulloch – U of MN, Karen Myers-Bowman – Kansas State University

CFLE DIRECTIONS *continued from page 7*

To get started we need help in identifying these programs. If you offer courses or workshops focused on the ten family life content areas, please contact me with information. The main content of the class or workshop should focus on one of the ten family life content areas. We are especially interested in offerings focused on **Family Law and Public Policy** and **Family Resource Management** as CFLE applicants are often weak in these areas. For a more detailed description of the content areas visit the NCFR website at www.ncfr.org. Click on *CFLE Certification* and then *FLE Substance Areas* on the left-hand side bar.

Development of a CFLE Advisory Committee

A number of issues were discussed at the various CFLE meetings held during the NCFR conference. Two of the more important issues included the establishment of a CFLE Advisory Committee and the development of an Emeritus status for CFLEs.

An Advisory Committee would serve as a policy-making and monitoring body for the certification program. They would be responsible for establishing policies related to certification standards, investigate the possibility of developing a CFLE examination, determine the direction of the program and influence marketing efforts. A subcommittee consisting of **Kevin Allemagne, Karen Myers-Bowman, Beckie Adams,** and **Carol Rubino** will work to determine how members of this important committee will be selected as well as clarifying the role of the Committee. Establishment of a CFLE Advisory Committee is an important step in the evolution of the CFLE program!

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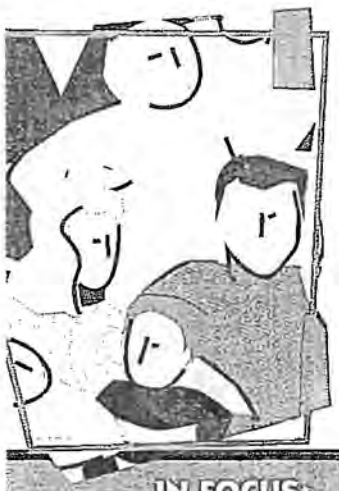

NATIONAL COUNCIL ON FAMILY RELATIONS

Family Focus On...
Substance Abuse Across the Life Span

Issue FF25

IN FOCUS:

From Pub Cultures to Binge Cultures? Social Contexts and Problematic Drinking

by Joanne Cunningham, Ph.D., Adjunct Professor, Women's Studies Program, Quinnipiac University, Hamden, Connecticut

Do binge-drinking cultures exist? While anthropologists might question the use of the term, public health officials, alcohol researchers, and journalists in Australia, England, Ireland, Scotland, and New Zealand have no difficulty in characterizing their countrymen's fondness for drink as a culture of binge drinking. A quick Google search on "binge" and "culture" brings up references for one other former English colony as well—the United States, a country noted for the often problematic alcohol consumption patterns of college students and fraternity pledges.

> The way one drinks is as important as how much one drinks.

Motivation for drinking

"Binge drinking" is defined as the consumption of five or more drinks in a single drinking session for men, and four or more drinks in a single session for women. Of particular concern to many researchers is not just the amount of alcohol consumed, but the motivations behind the drinking. Psychologist M. Lynne Cooper and her colleagues found that positive expectations about drinking, coupled with avoidant emotional coping styles, were associated with problematic patterns of alcohol consumption.

Hazel Blears, a Home Office Minister for the United Kingdom, is stark in her assessment of the motivations of many young drinkers. She asserts they go out "to get as drunk as they can." David Crosbie of Odyssey House, a treatment center in Melbourne, contends, "Not drinking in our culture is almost seen as un-Australian. You are questioned as being abnormal if you don't drink." The director of another Melbourne treatment center, Professor Margaret Hamilton, characterizes Australian culture as "alcohol-sozzled," with drinking to get "pissed" seen as normal behavior.

John Ashton, a public health official in the United Kingdom, describes the case of Manchester, England, as a more extreme variant of British drinking patterns. Faulting cut-price drinking establishments, he notes that the life expectancy of hard-drinking

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Manchester residents is seven years less than that of other Britons.

Café versus pub culture

Contrasting the rowdiness of drinking in Manchester with the more sophisticated continental style, Ashton continues, "If Manchester wants to be the Barcelona of the northwest then we have to change the culture we socialize and eat and drink in."

Blears would concur. She is quoted as saying she would opt for a "continental café-bar culture" over the current alcohol-focused pub culture.

Inherent in such comparisons between pub and café cultures are different understandings of the role of drinking in social life. In the alcohol research literature, a distinction is found between wine-producing and spirit-producing countries. In wine-producing countries, such as Italy and France, alcohol is incorporated into family settings, is taken with meals, and is not associated with gender or rites of passage.

In contrast, in spirit-producing countries such as the United Kingdom and Ireland, the drinking of spirits or beer is the norm, drinking occurs in a non-family context such as the pub, and drinking is associated with gender-role enactment.

Is all pub drinking, therefore, necessarily binge drinking? Of course not. But the social context of the pub does seem to play a role.

Historic roots

Binge drinking patterns may have historical roots as well. One British historian, Angela McShane-Jones of the University of Warwick, traces binge-drinking practices in the United Kingdom to the English Civil War. Based on her research of broadside ballads, McShane-Jones's work shows that "drink and drunkenness went hand in hand with political allegiance as drink and song became linked to politics."

Age of first drinking experience, educational accomplishment, work status, ethnic background, religious participation, and social economic status have been implicated in the propensity to binge drink. Gender plays a paradoxical role. While in years past girls reported fewer binge drinking episodes, girls now are often outpacing their male counterparts. In the United Kingdom, 29 percent of women versus 26 percent of men report binge drinking. In Ireland, 33 percent of women and 31 percent of men do so.

However, the potential for too readily labeling all heavy alcohol consumption as "bingeing" exists. Can the drinking behavior of a group of friends, enjoying a few glasses of wine over dinner and a brandy afterwards really be equated with the drinking behavior of five sports fans competitively drinking beer and whiskey shots?

Meaning, form, and function

The anthropologist Dwight B. Heath, citing differences in the pace and social context of the drinking, would argue not. The author of *Drinking Occasions: Comparative Perspectives on Alcohol and Culture*, Heath argues for consideration of the social meanings, form, and function of alcohol consumption in a given context. To Heath, the way one drinks is as important as how much one drinks.

Drinking to get drunk—rather than to cement social bonds and in the context of family and social settings—is dangerous. Drinking as an illicit activity—or as a performative one such as a symbolic rite of passage or vehicle for gender enactment—is likewise a recipe for trouble.

Joanne Cunningham, Ph.D.

This latter point was highlighted during my anthropological fieldwork in Dublin. While I did not find a pervasive norm of binge drinking, informants, specifically from working class backgrounds, did speak of heavy drinking as a perceived pathway to male status. One informant, now in his 40s, recounted his teen drinking habits:

> *I was forcing it down...I didn't like the taste of it. And I don't think I really got a hit off of it initially, but it was the thing to do, the manly thing to do...the more pints you drink, you become a man. This is the mentality of the youth of the day, anyway.*

What can be done? Some researchers advocate governmental campaigns to publicize the dangers of binge drinking and highlight the potential for negative social, legal, and medical consequences. Changing expectations for an evening's socialization and altering perceptions of the social acceptability of "getting pissed" may derail problematic consumption practices. On an individual level, people should be encouraged to think through their own motivations for drinking, the contexts in which they drink, and their own implicit beliefs and expectations about the nature of having a good time.

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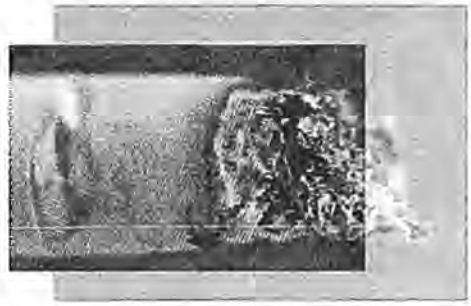
Adolescent Females and Smoking



by Peggy S. Meszaros, Ph.D., and William E. Lavery, Professor of Human Development and Director of the Center for Information Technology Impacts on Children, Youth and Families, Virginia Polytechnic Institute and State University

Smoking is one of the most studied of human behaviors. Thousands of studies document its health consequences, but there remain many gaps in our knowledge about the increased prevalence of smoking among teenage girls and young women.

The percentage of youth who smoke has steadily increased throughout the 1990s. At least 1.5 million adolescent girls in the United States now smoke cigarettes, a rate that almost equals that of adolescent males. The health risks for females who smoke are considerable, especially risks related to reproduction.

An interdisciplinary project

These factors indicate a need to better understand the smoking behavior of teenage girls. To do this, an interdisciplinary group of researchers at Virginia Tech studied the smoking behavior of female adolescents in Virginia during a two-year research project. Participating were researchers in human development, psychology, and chemistry. The project was funded by the Virginia Tobacco Settlement Foundation.

The objectives of the project were to:

- Identify the risk and protective factors influencing the smoking behavior of adolescent girls in Virginia.
- Analyze data from the Virginia Adolescent Resiliency Assessment.
- Catalog effective program interventions focused on adolescent females who smoke.
- Develop a framework of best practices.
- Disseminate information from the project through a number of venues, including a national workshop, a monograph, and a website.

Researchers created a website with resources and research findings. They also published a collection of research papers and articles organized around the major themes of the research projects: prevalence, best practices, risk and protective factors, influences on decision-making, and sensory gating.

In May 2005, researchers from around the country will gather to share insights about smoking prevention among adolescent females and develop new research directions for the future.

Future directions

Among the major findings of this project are these:

- A majority of studies focusing on adolescent smoking still rely heavily on

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Adolescents, Values, and Alcohol

by H. Wallace Goddard, Ph.D., C.F.L.E., Extension Family Life Specialist, University of Arkansas Cooperative Extension; Brent Goff, Ph.D., Assistant Professor, University of Houston-Downtown; and Jason Whitson, B.S., University of Houston-Downtown

Deviant alcohol consumption or high intensity drinking by adolescents is a major problem behavior with serious consequences. Despite a minimum legal drinking age of 21, many young people in the United States consume alcohol. Drinking may be an isolated problem behavior for some youth. But the research suggests that it may also be an expression of general adolescent turmoil that includes other problem behaviors and is linked to unconventionality, impulsiveness, and sensation-seeking.

Numerous studies implicate various personal, family, social, and environmental issues as predictors of excessive alcohol consumption and binge drinking. But there have been few comprehensive studies of the values associated with deviant alcohol consumption by adolescents.

A study of 907 adolescents in three different Southern schools assessed binge drinking, values, and anomie. The values formed five factors that were labeled physical and social well-being, sense of worth, hedonism/materialism, stimulation, and discipline.

> Altruistic values appear to act as a deterrent to binge drinking.

Non-bingers valued physical and social well being, as well as sense of worth more than occasional bingers and heavy bingers did. Occasional bingers and heavy bingers valued hedonism/materialism and stimulation more than non-bingers.

Non-bingers

There were also many significant differences when the groups were compared on 34 individual values. Non-bingers value concern for others, spiritual

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well-being, chastity, self-discipline, rule of law, security, physical well-being, family security, self-insight, pursuit of knowledge, and self-improvement.

Non-bingers also emphasized related values that included a sense of control, sense of accomplishment, being well-respected, warm relationships with others, self-respect, self-fulfillment, freedom, self-determination, meaning in life, wisdom, concern for others, spiritual well-being, privacy, self-discipline, protection of human life, rule of law, security, physical well-being, family security sense of belonging, self-insight, pursuit of knowledge, and self-improvement.

These more traditional and altruistic values revolve around longer-term concern for self, family, others, and society. Such values appear to act as deterrents to binge drinking. It is possible that these values can be used as a basis for appeals and strategies that focus on prevention and intervention. These values seem to represent the security, tradition, benevolence, universalism, and, to some extent, the achievement and power dimensions developed by Shalom H. Schwartz and Wolfgang Bilsky. The wide array of deterrent values gives many options to prevention specialists.

Occasional and heavy bingers

Both occasional and heavy binge drinkers value sexual intimacy, power, and the stimulation of a daring and varied life. But occasional bingers differ from heavy bingers. Occasional bingers place more importance on the following values: sense of control, sense of accomplishment, being well-respected, warm relationships with others, self-respect, self-fulfillment, freedom, meaning in life, wisdom, self-discipline, protection of human life, rule of law, security, physical well-being, family security, sense of belonging, self-insight, pursuit of knowledge, and self-improvement.

H. Wallace Goddard, Ph.D.

The key values of the occasional and heavy bingers tend to focus on hedonism, stimulation, sexual intimacy, and to some extent power and achievement. If binging on alcohol is perceived as a means of fulfilling these values, intervention and change strategies may prove to be difficult.

But prevention strategies that involve changing perceptions about binging and fulfilling these values may have merit. That's because alcohol is a sedative. This means that alcohol is more likely to reduce actual control and power over people, things, and the environment, while failing to enhance stimulation and intimacy.

The differences in values between the occasional and heavy bingers suggest that occasional bingers may respond to the same appeals to values that act as deterrents for the non-bingers. Occasional bingers may also be deterred from binging if binging can be identified as a credible threat to materialistic values.

The use of alcohol by both occasional and heavy bingers to fulfill stimulation values suggests alcoholic tendencies. Prevention or interdiction strategies for heavy bingers should treat these drinkers as an alcoholic in tendency. It is unlikely that information campaigns or even value reconstruction techniques will be sufficient to alter their behavior.

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ADOLESCENT FEMALES *continued from page F3*

self-report and cross-sectional data. We need more studies that use a longitudinal design and employ multiple indicators, including physiological measures.

- Ethnic differences have not been systematically examined. Future research should examine ethnic differences among adolescent females who smoke. Researchers should also take into account socioeconomic status or class.
- Studies show that parents and other family members have a strong influence on adolescent girls who choose not to smoke. For this reason, we need more research on family communication and the effectiveness of educating parents about smoking. The inclusion of parents in smoking prevention and cessation programs should also be considered.
- The literature includes only a few female-specific smoking prevention or cessation programs with effectiveness data. To investigate the need for such gender-specific programs, we need more evidence-based programs to evaluate.
- Researchers involved in this project have proposed an ecological program design framework, with attention to risk and protective factors. Now we must develop prevention and cessation programs using this model and evaluate them empirically using a rigorous evaluation design.

Peggy S. Meszaros, Ph.D.

- We must increase both public and private financial support for research into the smoking behavior of teenage girls. We also need to increase research efforts to routinely explore gender differences in all studies related to youth smoking behavior.

To learn more about the "Adolescent Females and Smoking" project, visit www.femalesmoking.net, or contact meszaros@vt.edu.

Talking with Children about Alcohol and Drugs

by Michelle Miller-Day, Ph.D., Associate Professor, Department of Communication Arts and Sciences, Penn State University

National surveys indicate that alcohol and other drug use continues to decline in the United States among youth in grades eight through 12. Nevertheless, alcohol and other drug use disorders remain among the most common mental disorders in the United States. Approximately one person in seven suffers from alcohol or other drug-use disorder at some time in his or her life.

According to the Monitoring the Future Study, more than half of young people have smoked cigarettes before they reach the 12th grade and nearly a quarter of 12th graders consider themselves to be smokers. More than half of all youth have been drunk on alcohol and have smoked marijuana before they get into the 12th grade. In this study, 73 percent of college students report being drunk during the past month and 7 percent report daily drinking.

Organizations such as the Partnership for a Drug-Free America® encourage parents to converse with their offspring about the risks of drug use. Parents seem to be listening to this advice. According to a study conducted by the Partnership, 98 percent of participating parents reported that they had talked with their children about drugs. But only 27 percent of teens surveyed in the same study reported that they learned any significant information about drug-related issues at home.

Three orientations

Drug talks can be classified into three general parental orientations:

- *My* responsibility.
- *Your* responsibility.
- *Our* responsibility.

In the "my responsibility orientation," the parent assumes most of the responsibility for monitoring and sanctioning a child's choices. This orientation emphasizes the power of the parent to establish standards, seek compliance, and provide rewards or punishments. Parents may threaten punishment, establish a no-tolerance rule, and reward nonuse.

A "your responsibility orientation" encourages children to use their own judgment and requires them to pay for their own substances—if they choose to use them—and to accept the consequences. By relegating the responsibility for drug choices to the child, the parent abdicates his or her responsibility. This approach may be the most developmentally appropriate once a child moves out of the house or is in college.

> Talking with children about drug use is an essential aspect of parenting.

An "our responsibility orientation" is based on mutual responsibility and discourse. Parents and children talk together about the benefits and risks of drug use. This approach also "hints" at expected behavior. Here the basic assumption is that parents can make a contribution to the child's decision-making process.

Framing drug use as a problem

The primary message of many parents is that alcohol and other drug use is a problem. Parents who frame drugs as problematic generally provide warnings about the dangers of drugs and express their disappointment in children who use drugs.

The most common warnings concern the (il)legality of drugs; the effects of drugs on personal control, health, and safety; and the consequences of use. Some consequences may affect parents. These include jail terms or fines for parents who allow their children to drink.

Some parents express outright disapproval of drugs and drug use. Parents who convey disapproval may want to "get it on the record... even though I know you will experiment anyway."

This approach is sometimes effective. As one high school student reported:

> *My dad tried to tell me that marijuana is a gateway drug into the worse drugs. But I told him that I wouldn't do anything else but marijuana. He told me he used to smoke weed, and sometimes he still does. But he told me to watch out for myself and to be a responsible person. He said that even though he's giving me this lecture.... he knows that this talk*

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TALKING WITH CHILDREN *continued from page F5*

isn't going to stop me from smoking weed once in a while. He was absolutely right. But what the talk did do is...that every time I smoke, I think about what drugs this possibly can lead me into and I get grossed out. Hence I rarely ever smoke. Maybe once in a blue moon.

Other parents link disapproval to disappointment and guilt. One student reported: *[My mother] stated that if you ever want to kill me, then you will do drugs. Obviously, I wouldn't want that to happen so, I don't think I will ever try them.*

Using supporting evidence

In addition, when framing drug and alcohol use as a problem, parents often use evidence to support claims.

By far the most common evidence is personal example. Parents often provide accounts of how their own life or the lives of friends and family members were affected by drugs or drug use. Stories of a relative's alcohol-related death, liver failure, or drug abuse and recovery support claims of the harmful effects of drugs.

According to some researchers, listeners expend more cognitive effort to process the message when they are paying attention to a personal story. But developers of parent-training programs are unsure how to design intervention messages for parents who have used drugs and alcohol. Some professionals argue that these parents should integrate their own personal experiences into the conversation rather than ignoring their own history. These professionals believe that the "voice of experience" is sometimes more influential to youth than uninformed dictates.

Parents also use written materials, such as educational books, pamphlets, or Web-based information. One mother reported: *My husband uses tobacco products that I disapprove of, but he is a grown man. He must make his own decisions. More than once I cut articles from the paper to show both my husband and son the dangers of smoking to health.*

Proscriptive and prescriptive information

Parents also may offer proscriptive and prescriptive information to their offspring. Proscriptive information refers to input about what offspring *should not* do or believe, while prescriptive information refers to input about what offspring *should* do or believe. This information can be categorized as tools for healthy living, rules, "using your own judgment," and sanctions for violations.

Tools for healthy living include advice about drinking and driving, how to deal with peer pressure, how to be "smart and safe," or remind a child call if a ride is needed. This is specific and practical advice that can easily be followed. For example, one student reported:

We talked about what I should do in situations where others are using drugs, and what to do if I ever did decide to do drugs, and how to handle friends and peer pressure, and if they were to ever overdose in any other situations.

In addition, parents often outline family rules about drugs and drug use. Some parents articulate a no-tolerance rule in their households. Others provide a framework that weighs the use of drugs and alcohol; often alcohol use is less restricted than other substance use, especially as youth enter college.

Parents may also tell children to use their own judgment when it comes to alcohol and other drug use. Both parents and children tend to believe that this approach empowers the children to make their own decisions. This approach might be most effective with older children who have already received on-going socialization regarding the risks of drug use. As one mother explained:

My attitude as a parent was I started very early conveying attitudes about any drug use, or abuse, about over the counter drugs, prescriptions, etc. They were raised to make the decision and if they make a bad one, they take the consequences.

In families with clear expectations about drug and alcohol use, there are often sanctions associated with violating those expectations. Sanctions tend to include loss of allowance, grounding, and threats that the child will be sent to a foster home. Interestingly, both parents and students report that punishment is often hinted rather directly stated. According to some professionals, this is one area where parents might be clearer with their children.

Michelle Miller-Day, Ph.D.

Targeted and integrated "drug talk"

Parental anti-drug socialization efforts tend to be either *targeted* to specific events or *integrated* into everyday life. Targeted socialization is limited to a particular point or a few points during the child's development. According to some parents and youth, "One talk is better than no talk." Parents may sit down and share their attitudes, expectations, and rules before an event– such as a prom or a party–where the likelihood of drug use is increased.

Parents who practice integrated socialization tend to make a series of ongoing comments about drugs that are integrated into the fabric of everyday life. When this discourse is woven into daily interactions, the topic becomes "no big deal." Integrated approaches cast parents in the role of *ongoing agents* of socialization throughout a child's development.

There is no one right way to conduct parent-child discussions about drugs and drug use. Parents must consider their own experiences, their goals for the drug talk, and the developmental level of the child. But preliminary evidence suggests that the most effective pathway for affecting drug use among late adolescent youth is ongoing discourse by both parents.

More research is needed on short-term and long-term effects of drug talks. Yet one thing is clear–connecting with children about drugs and drug use is an essential aspect of parenting. Parents may or may not be the anti-drug, but they should talk with their children about alcohol, tobacco, and other drug use, and they should combine their talk with a concentrated effort to *listen*.

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Delaware's Juvenile Drug Court

by Jane N. Case, M.S., Doctoral Candidate, School of Urban Affairs and Public Policy, University of Delaware; Policy Analysis and Research Associate, Nemours Health and Prevention Services; and former Mental Health Program Administrator for the Delaware Division of Child Mental Health Services

Senator Joseph Biden first introduced the concept of the drug court in 1994 through the Biden Crime Law. The primary purpose of this law was to offer an option besides incarceration for drug-related offenses. Today, Delaware runs two separate drug court programs, one for adults, administered by the State's Superior Court, and the other for juveniles under 18 years of age, operated out of the Family Court. This article will focus on the juvenile program.

Delaware's small size and its historically stable economy allow for creativity and innovation within state government. The Juvenile Drug Court is one such example of the state's resourcefulness. The court is a joint effort of the State's Family Court system and the Division of Child Mental Health Services, which is housed within the Department of Services for Children, Youth, and Their Families. The Division of Child Mental Health Services provides mental health and substance abuse services to adolescents, children and their families.

Delaware revamped its Juvenile Drug Court program in 2002-2003 to align with national evaluation outcomes and best practice models. The legislation that created state's current program model was passed in July 2002. In January 2003, the program served its first client. Delaware's drug court is no longer a diversion program with psycho-education at the core, but an adjudication program, which emphasizes therapeutically appropriate services for youth in the program. The current model also addresses the needs of repeat offenders, whereas the previous program was for first time offenders only.

The drug court model focuses on family problem-solving and grants Family Court judges the authority to order parents to comply with court decisions. This encourages parent participation and support for youth treatment. Currently, however, there are no defined consequences for parents who do not comply with the court order. Defined consequences exist only for the juveniles in the program.

How it works

Delaware's Juvenile Drug Court Program is a legislatively mandated program that focuses upon youth convicted of misdemeanor drug possession charges or underage alcohol violations. The program is funded by the Division of Child Mental Health Services. The Office of Juvenile Justice and Drug Prevention has endorsed the model that is used for the delivery of this program.

> Drug court is an alternative to incarceration for youths arrested for non-violent drug offenses.

Drug court is offered as an alternative to incarceration for youths arrested for non-violent drug offences. The Deputy Attorney General's office determines eligibility for the program. Juveniles and their families can accept or reject the offer to participate in the program. If they choose to participate, juveniles must plead guilty to the alleged offenses, and the Deputy Attorney General's office notifies representatives from the Family Court and the Child Mental Health drug court team.

This team of four Child Mental Health specialists is responsible for all cases in Delaware's three counties. The team conducts comprehensive, individualized evaluations of each juvenile drug court participant. This evaluation ensures that services are appropriate and will meet the needs of each offender, while also addressing distinctive family dynamics.

A team member interviews family members, school personnel, and other agency representatives with valuable information that can help the team determine the most appropriate treatment modality.

Drug court offers a continuum of behavioral health services that include outpatient therapy sessions, intensive inpatient hospitalization for mental health services, and substance abuse services, depending on individual need.

To complete the program, juveniles must comply fully with their treatment plan and have no further drug charges brought against them for six months following their graduation. If this six-month period passes with no further legal contact, the juveniles' adjudications are vacated. Like other youth with juvenile criminal records, drug court participants may choose to undergo the expungement process at age of 18.

Program evaluation

Perceived barriers to service delivery include the referral rate of alcohol-related offenses, which is inexplicably low. Other challenges include discovering effective ways to serve diverse populations and finding interpreters for non-English-speaking and deaf clients.

There are also programmatic discrepancies between upstate and downstate. Upstate participants have greater legal involvement, and the majority are placed in day- or partial-day-treatment programs. By contrast, the majority of downstate participants are referred to outpatient services with an aide.

In addition, the assignment of only four full-time staff to this challenging population presents an unending challenge to "do more with less."

Despite these obstacles, the single-team approach to juvenile drug court ensures a consistent and effective program, in which community professionals work together to form a cohesive and stable community for care delivery.

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Characteristics of a Collegiate Recovery Community

by Rick Herbert, Graduate Research Assistant; Amanda K. Baker, Assistant Director for Program Replication; H. Harrington Cleveland, Ph.D., Associate Professor, Department of Human Development and Family Studies; and Kitty S. Harris, Ph.D., Director of the Center for Addiction and Recovery, Texas Tech University

Our nation's young adults face a drinking epidemic. As Henry Wechsler and Bernice Weuthrich pointed out in their 2002 study *Dying to Drink*, 30 percent of all high school seniors report binge drinking and nearly one-third of college students qualify for an alcohol abuse diagnosis under psychiatric criteria.

Reflecting this growing epidemic, the number of adolescents admitted to treatment for substance abuse in the United States increased 65 percent between 1992 and 2002, while all admissions increased by only 23 percent, according to a 2004 report of the Substance Abuse and Mental Health Services Administration (SAMHSA). This trend has created a growing population of young adults in recovery from substance abuse, most of whom have not completed their higher education.

Recovery on campus

The pervasiveness of alcohol and other drug use on college campuses makes it very difficult for students in recovery to find peer support and environments that value and reward their recovery. Unfortunately, most college campuses do not provide the instrumental, informational, and social support to help recovering individuals manage the campus environment.

Local 12-step groups are not the answer. Most of these groups are primarily composed of older adults who experienced addiction and recovery later in their lives. As a result, these groups cannot always meet the needs of addicts whose addictions began in their teens and early 20s. Thus, it is imperative that colleges and universities offer peer support and programming to young adults who are simultaneously pursuing their education and maintaining their recovery.

The Texas Tech approach

For nearly 20 years, Texas Tech University has operated a program to support collegiate recovery. Housed in the Department of Applied and Professional Studies, the Center for the Study of Addiction and Recovery has developed a Collegiate Recovery Community that provides a nurturing, affirming environment in which individuals recovering from addictive disorders can find peer support.

The Center provides recovery, academic, financial, psychological and social support to members of the community. Through this holistic approach, the Collegiate Recovery Community is able to address the problems and issues associated with the transitions from high school to college and from active addiction to long-term recovery.

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To date, approximately 100 juveniles have completed drug court. The program reports a success rate of about 60 percent (success is considered program completion or graduation followed by six consecutive months of no further arrests). Promising practices and an enthusiastic team of dedicated professionals bode well for the program's future success.

Policy Implications

Delaware employs a structural approach to children's services. As a result, child protection and welfare, corrections, and mental health and substance abuse services operate within the same department. This reduces the delays in mental health and substance abuse service delivery. Therefore, this amalgamated approach to children's services enables Delaware to identify and establish policy and procedures more practically.

In general, the most effective policy is one that is reality-based and premised on rigorous research. The most useful information available for policy strategy consists of the well-known risk factors that are associated with adolescent substance use and subsequent abuse. For example, parental substance abuse, parental incarcerations, school status, a history of abuse, and sibling substance abuse are all widely agreed upon predictors of youth behavior related to licit and illicit substances.

Jane N. Case, M.S.

Recent research by the Delaware Children's Department suggests that risk factors could be, on average, identified as early as age 7, and are often initially uncovered through the work of child protective services. Clearly, Delaware is well positioned to advance the quality and methods of services delivered to children and adolescents, and to advance the focus of the field of child welfare from late intervention to primary prevention.

Special thanks to Martha Gregor, LCSW, Director of Substance Abuse Services, and Jeanne A. Dunn, M.Ed., M.A., Non-Residential Program Administrator, Division of Child Mental Health Services of the Delaware Department of Services for Children, Youth, and Their Families.

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Persistence of Heavy Substance Use During the Second and Third Decades of Life: A Focus on Family Factors

by Alan Reifman, Ph. D., Associate Professor, Department of Human Development and Family Studies, Texas Tech University

The second and third decades of life (roughly from the early teenage years to age 30) are an important period for the study of substance use and abuse. According to a 2004 National Institute on Drug Abuse newsletter: "Overall rates of drug use peak and begin to subside during [the 18-25] years. Most youths who abuse drugs in their teens or early 20s desist as they mature into full adults, but some do not and some initiate new abuse of additional drugs..."

Researchers often distinguish between *amount* of substance use (that is, the quantity and frequency of consumption) and *problems* associated with heavy use (for example, disruption of major role responsibilities at work, school, or home). This article focuses on persistence in heavy substance use during this interval, addressing two key questions:

- Are teenage heavy substance users also likely to be heavy users and suffer ill consequences as young adults?
- What family factors can affect patterns of substance use during these years?

These questions can be addressed by longitudinal surveys that track the same individuals over time (known technically as *panel* studies). The National Longitudinal Survey of Youth (Survey), an ongoing study begun in 1979 with several thousand participants, has been a rich source for many studies discussed in this article. Other researchers have developed longitudinal studies in their own local areas.

From teen to adult use

As implied above, not all heavy substance-using teens will remain heavy or problematic users in young adulthood. But in terms of *relative* comparisons, heavy substance users during adolescence are clearly *more likely* than their lighter-using teen counterparts to be heavy or problematic users in adulthood.

> Young adults' marital transitions have shown a strong connection to their substance use levels.

Kenneth Sher and colleagues surveyed members of an entering freshman class at the University of Missouri in 1987, with the project now into its 18th year of follow-up. The researchers found that the more frequently students engaged in heavy drinking during their freshman year, the more likely they were to meet clinical criteria for an alcohol use disorder ten years after starting college.

In a recent study using the Survey, Carolyn McCarty and colleagues obtained similar results: respondents who drank heavily during ages 17-20 were more likely to drink heavily during the ages 30-31 than were respondents who drank more lightly during their late teens. More important, McCarty's findings extend those of Sher by using a national database and including both individuals who did and did not attend college.

Finally, 1980s-era studies by Michael Newcomb and Peter Bentler in Los Angeles showed that more extensive substance use (for example, cigarettes, alcohol, marijuana, cocaine) in adolescence carried over into drug-related problems four years later in young adulthood.

Family-related factors

At least three family-related factors appear to be associated with long-term patterns or trajectories of alcohol and other drug use: family history of use, parenting behaviors one experiences as an adolescent, and one's own marital transitions. Although cause and effect cannot be established using survey or other non-experimental methods, the results of these studies suggest the *possibility* of a causal influence of these family factors.

Using the Survey, Bengt Muthén and Linda Muthén analyzed the contribution of family history of problem drinking to adult children's own heavy and problematic use between the ages of 18-37. They found that family history was associated with heightened alcohol problem severity at around age 25 (with the relationship diminishing for older ages). On the other hand, family history was associated with only slight increases in drinking volume.

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PERSISTENCE OF USE *continued from page F9*

Family history may have a relatively small statistical impact on adult children's drinking because the potential chain of causation appears to have several links. Grace Barnes and colleagues studied adolescents in the Buffalo, New York, area for six years. Participants ranged in age from 13-16 at the beginning of the project. The researchers' findings suggested a sequence in which parenting and child-socialization factors had the most direct impact on children's drinking trends from the early-mid teen years to the early 20s.

Parental support and nurturance appeared to facilitate teens' cooperation with parental monitoring (that is, teens were more willing to provide information on their whereabouts after school, in the evenings, and on weekends to their parents). Early monitoring, in turn, appeared to dampen the adolescent children's tendencies to increase their drinking as they reached their late teens and early twenties. Parental alcohol abuse was associated with adolescent drinking in this study only because it appeared to interfere with the protective role of parental support.

Marital transitions

Unlike family history and parenting behaviors, which involve parents, the third factor concerns individuals themselves. Young adults' marital transitions have shown strong connections to their substance use levels. Two sets of investigators—Jerald Bachman and colleagues, who used panel data from their national "Monitoring the Future" study, and Carol Miller-Tutzauer and colleagues, who used the Survey–conducted similar analyses. In both studies, participants ranged in age from roughly 18 to 28 years, and the analyses focused on three consecutive assessments of each respondent, taken one or two years apart.

Using a system where M = married, S = single, E = engaged, and D = divorced, respondents were given three-letter abbreviations to reflect their marital status during each of the three assessments. Bachman and colleagues found that heavy drinking was consistently high in the SSS group and low in the MMM group.

Most fascinating were results for the groups that experienced changes in marital status, as exemplified by the SEM group. These individuals initially (while single) drank heavily (like the SSS group), then reduced their drinking moderately while engaged, and finally, when married, reduced their drinking further to resemble the low level of the MMM group. Miller-Tutzauer and colleagues obtained similar results.

Bachman and colleagues also found generally similar results for cigarette,

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CHARACTERISTICS *continued from page F8*

Since its inception in 1986, the Center has provided community support and relapse prevention services for students from 20 states and three foreign countries. The Center has recently been awarded a U.S. Department of Health and Human Services grant from the Center for Substance Abuse Treatment to develop a model to replicate collegiate community support and relapse prevention programs for implementation on other campuses across the nation.

Characteristics of community members

Currently, there are 70 Texas Tech students within in the Collegiate Recovery Community. The average age of community members is 24 years. Sixty percent are male and 96 percent are non-Hispanic whites. Prior to entering recovery, community members suffered from addictions not only to alcohol and drugs, such as cocaine, heroin, and marijuana, but also to eating disorders.

The severity of their addictions is evinced by their treatment experiences. Nearly all have seen a therapist for their addiction, most went through in-patient treatment, and a third spent three months or more in treatment centers and/or halfway houses.

Compared to samples used by most recovery research, members of the Collegiate Recovery Community have been in recovery for longer periods. Approximately 25 percent have been clean and sober for less than two years; 50 percent have been in recovery for two to five years; and 25 percent report recoveries longer than five years.

> Students in recovery need help maintaining their abstinence.

The change in the lives of community members is reflected in their academics. Twenty-two percent report a grade point average (GPA) higher than 3.75, and 33 percent report a GPA between 3.25 and 3.75. Only 10 percent maintain a GPA of 2.25 or lower.

Research on long-term recovery

In addition to providing a safe haven for young adults in recovery, the Collegiate Recovery Community provides an excellent opportunity to learn about the recovery process. By working with the University's Addictions Discussion and Planning Team, the Center for Study of Addiction and Recovery is building a research program aimed at understanding the processes that lead to long-term recovery. The team includes established substance use researchers Judith Fischer, Miriam Mulsow, and Alan Reifman.

Ongoing research projects use diary methods to examine the day-to-day construction of abstinence through the development and use of social support networks. Although only preliminary data collections and analyses have been completed, early findings confirm that the social support community members receive from each other helps insulate them from the substance use triggers that are endemic to college life.

For more information on Texas Tech's Center for the Study of Addiction and Recovery and the Collegiate Recovery Community, visit www.hs.ttu.edu/csa/default.htm, or contact Amanda.K.Baker@ttu.edu. Contact Bo.Cleveland@ttu.edu for information on addictions and substance use research at TTU or visit the Addictions Discussions and Planning Team website at www.hs.ttu.edu/research/reifman/adapt.htm.

Using Social Comparison Information in Alcohol Abuse Prevention Programs

by Monica K. Miller, J.D., Ph.D., Assistant Professor, Criminal Justice, University of Nevada, Reno

One way that universities try to address alcohol abuse is through the use of advertising that portrays the majority of students as non-binge drinkers. This social comparison information is intended to affect students' attitudes and intentions about drinking, but most programs are untested.

Social comparison theory suggests that people compare themselves with others in order to evaluate themselves. Comparison may be with a real or an imagined "other," and it does not require personal contact. Social comparison predicts that an individual who learns that most students drink less than she does might react in several ways:

- She might form an intention to drink less in the future or adopt more responsible attitudes about alcohol.
- She might distance herself from the comparison "other." She could reason, for example, that the survey respondents were mostly "academic" students who do not drink as much as "social" students like her.
- She might denigrate survey respondents, perhaps by reasoning that respondents were lying about their alcohol intake.

To change attitudes about alcohol, comparison information must be very specific.

Situational relevance

Individuals making social comparisons often consider the relevance of the other's situation to their own. An individual might see her own situation as more like that of a "close other" such as a friend and less like the situation of an ambiguous "survey other." Thus, students might disregard survey comparison information as irrelevant to their own situation.

We asked 221 college students to complete a survey about their drinking behaviors. Later, students were then told that they drank more, less, or about the same amount as either a friend or the average student who completed the survey.

Participants then completed surveys measuring attitudes and intentions about drinking. Other questions determined whether participants distanced themselves from or denigrated the comparison "others."

Shaping positive attitudes

The main finding was that participants had the most positive intentions and attitudes if they were compared to either a friend who drank more than they themselves did or survey respondents who drank about the same amount.

Participants distanced themselves from friends who drank both more and less than they did. But participants did not distance themselves from survey respondents. Finally, participants did not denigrate survey participants. Instead they denigrated friends who drank more than they themselves did.

Comparison to survey respondents

Participants did not denigrate or distance themselves from survey respondents. Perhaps the reason for this is that students have difficulty imagining the characteristics of a group of strangers. It may also be difficult for students to accuse a large number of people of lying on the survey.

If students have difficulty imagining the characteristics of those who took the survey, they may also have difficulty making relevant comparisons. For example, if a student learns that survey respondents drink less than she does, she might assume that respondents are mostly academic students, nonsocial individuals, or athletes who are not supposed to drink. And if a student is told that survey respondents drink more than she does, she might imagine that most respondents are stereotypical college "drunks."

Because it is so difficult to imagine who these respondents are, the student may see the comparison as irrelevant, and she may not be likely to change her intentions or attitudes.

On the other hand, if the student learns that she drinks the same amount as the

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PERSISTENCE OF USE

continued from page F10

marijuana, and cocaine use. They also found that becoming divorced tended to raise substance use, whereas transitions to parenthood appeared to have little effect on substance use.

Alan Reifman, Ph.D.

In conclusion, the combination of conceptual models involving family processes and longitudinal data-analytic techniques has enhanced our knowledge of substance-use trends during the second and third decades of the life span, and should continue to do so.

For more information, contact alan.reifman@TTU.EDU.

Alcohol and the Marital Relationship

by Linda J. Roberts, Ph.D., Associate Professor, Human Development and Family Studies, University of Wisconsin-Madison

Beginning with Durkheim's seminal analysis of suicide, researchers have suggested that marriage offers protection from a host of mental health problems, including alcohol problems. Recent research supports this contention: compared to both the divorced and the never-married, married individuals are likely to drink less and have fewer alcohol-related problems.

Nonetheless, drinking and drinking problems occur with regularity in the context of marriage. More than 90 percent of Americans will marry, and the vast majority of them will drink alcohol to celebrate their new conjugal bond. Drinking by one or both partners will continue to be a characteristic of married life—73 percent of married men and 63 percent of married women in the United States drink alcohol. Many of these couples will experience some type of problem—from mild disagreements to failures in familial responsibility to interpersonal violence and relationship dissolution—due to their alcohol use.

A continuum of alcohol problems

Although "alcoholism" (or alcohol dependence) has been the primary focus of societal concern, it represents only a small fraction of alcohol-related problems. In an influential report, the Institute of Medicine called for a widespread adoption of an *alcohol problems framework* to broaden the base for alcohol-related treatment efforts. Alcohol use and associated problems can be viewed on a continuum ranging from mild negative consequences

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SOCIAL COMPARISON *continued from page F11*

average respondent, she may assume a great variability of respondents, some who drink more and some who drink less than she does. Comparison to what she believes is a diverse student body may be more relevant.

But learning that she is average may also be undesirable, since individuals commonly believe they drink less than most people in their social group. Study results suggest that comparison with a diverse student body, paired with information that a student drinks less than other people leads to more positive attitudes and intentions towards alcohol.

Comparisons to friends

Although it is difficult to imagine the traits of a group of strangers, it is easier to imagine the characteristics of a friend. Individuals distanced themselves both from friends who drink more and those who drink less than they do. Participants wanted to be different than friends who drink a lot and who could be viewed as alcoholics. But they also wanted to be different than friends who drink only a little and who could be viewed as nonsocial or unpopular.

On the other hand, participants denigrated friends who drink more, but did not denigrate friends who drank less. This could be a result of the stigma surrounding alcoholism.

But the most important finding was that comparison with a friend who drinks more increased the student's intentions to drink responsibly. This may be another type of distancing mechanism: participants intend to drink less in the future as a way of distancing themselves from the friend who drinks more than they do.

It is uncertain why comparison with friends who drink less did not affect intentions. Perhaps such comparisons were not seen as relevant.

Using comparison information for prevention

From the standpoint of prevention, it is useful to know what mechanisms individuals adopt (for example, distancing and denigration) when faced with comparison information. Further research could identify how distancing and denigration reactions can be eliminated so that participants would be motivated to change behavior.

Monica K. Miller, J.D., Ph.D.

Perhaps the most encouraging finding is that students expressed more positive attitudes and intentions when the comparison "other" was a friend who drank more than they did or survey respondents who drank about the same amount.

These results indicate that comparison information must be very specific to change attitudes and intentions. In sum, the various responses to comparison information create a complex picture. More research is needed about the use of social comparison information if it is to be a successful tool in alcohol abuse prevention programs.

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MARITAL RELATIONSHIP *continued from page F12*

in a single life domain to the significant medical, vocational, and interpersonal consequences associated with alcohol dependence.

Although societal attention has focused on "alcoholics," the alcohol problems framework casts a much wider net. Practitioners and health care professionals are asked to direct interventions not only to drinkers with alcohol use disorders, but also to drinkers who are experiencing—or could experience—problems due to the pattern and context of their drinking. When considering the marital or family context, it is particularly important to adopt this wider lens of the alcohol problems framework.

> Attention must be paid to the drinker's familial and relational context.

The relational context

The birth and growth of Al-Anon institutionalized the recognition that an individual's drinking behavior influences others, particularly intimate partners and family. In the last 25 years, the "family systems" and "family interaction" perspectives have significantly advanced our understanding of the interface of alcohol and family relationships. An *interaction-systems model* emphasizes both *relational processes* and *bidirectional effects* between marital functioning and drinking. Marital issues are seen as potentially influencing drinking behaviors, and, simultaneously, drinking is seen as influencing marital and family functioning.

Recent research evidence supports this conceptualization: there is evidence for significant relationships between alcohol use and relationship functioning, and more specifically for bi-directional patterns of influence. Heavy or risky drinking is associated with a host of marital difficulties including infidelity, divorce, violence and conflict. Drinking can alter marital and family functioning in a variety of ways including depletion of economic resources, verbal and physical abuse, job problems, communication impairments, social isolation, neglect of household responsibilities, and sexual problems. At the same time, research indicates that drinking and drinking problems can increase as a consequence of marital difficulties or dissolution.

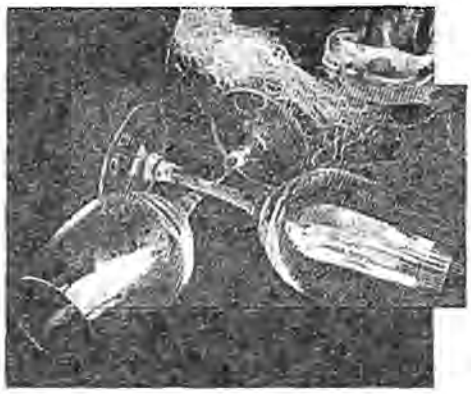
The drinking partnership

Spouses' drinking behaviors are positively associated, that is, they tend to be similar. For example, studies find that alcoholics are more likely to be married to other alcoholics. While this may be attributed in part to heavy drinkers marrying other heavy drinkers, the possibility of one person's drinking influencing the drinking of his or her spouse is also likely. The drinking pattern of a married individual should be seen as existing within a relational context.

The concept of a "drinking partnership" —which includes the typical frequency and amount of drinking, as well as the drinking context and match (or lack of match) between the partners' drinking patterns—highlights the relational aspects of drinking.

Either explicitly or implicitly, partners negotiate norms for their household about alcohol use (for example, whether alcohol is served with meals or offered to guests, whether the refrigerator or liquor cabinet is "stocked"). Further, each partner shapes the other's drinking context, both through direct modeling as well as through the explicit or subtle communication of attitudes and values about drinking—including attempts to control or change the partner's drinking.

The drinking partnership may take varied forms and have different relationships to both alcohol and marital problems. The consumption patterns of each spouse may be less important in predicting marital outcomes than the mutual pattern drinking. For example, more positive marital functioning has been found among couples who drink together rather than apart or who have non-discrepant drinking frequencies. Heavier-drinking spouses married to partners with similar drinking patterns may be especially prone to continue drinking.



Linda J. Roberts, Ph.D.

Implications and future directions

Drinking has the potential to affect the marital functioning of a large number of couples. The evidence suggests individuals or couples identified as having relationship problems should routinely be screened for the presence of alcohol problems. Similarly, issues of couple and family functioning should be routinely assessed in individuals identified as having an alcohol problem. Spouse- or partner-involved alcohol treatment programs should be considered as options when alcohol and marital problems coexist.

The interface of drinking and marriage represents an important arena for future research and intervention efforts. To fully understand the drinking behavior of intimate partners, it is imperative that we consider the relational context of their drinking. Conversely, to fully understand a couple's relationship dynamics, we need to appraise the potential role of drinking in relational dynamics.

For more information, contact ljroberts@wisc.edu. Linda Roberts is the coauthor of Alcohol Problems in Intimate Relationships: Identification and Intervention, *a joint project of the American Association for Marriage and Family Therapy and the National Institute on Alcohol Abuse and Alcoholism. An online version and an order form for a free copy of the guidebook are available at www.niaaa.nih.gov/publications/niaaa-guide.*

The Importance of Family Groups in Substance Abuse Treatment

by James P. Marshall, Ph.D., Family Life Extension Specialist, Department of Family, Consumer, and Human Development, Utah State University

Drug abuse and addiction are among the most serious and costly problems facing society today. The Office of National Drug Control Policy and the Centers for Disease Control and Prevention estimate the economic costs of drug abuse and addiction (including nicotine addiction) in the United States at more than $318 billion annually.

A family systems issue

Although addictive behavior has a clear negative financial and emotional impact on the individual addict, the impact of the addict's behavior on their family system is not as clear-cut. In working with addicts and their families, I often ask the questions, "Do addicts cause problems for their families?" or "Do families cause problems for the addict?" Although seen from different perspectives, both addicts and family members alike answer, "Yes" to these questions, indicating substance abuse and addiction are not only problems of individuals, but of families. Substance abuse treatment, therefore, is a family systems issue.

The primary context for drug abuse prevention programs in the United States has been the public schools. School-based interventions usually focus on academic achievement and training in skills such as decision-making, communication, and refusal of drugs. Despite the prevalence of school-based interventions, and their success, research has also shown that other contexts, such as families, are appropriate and important points of contact and intervention.

Many of the risk and protective factors associated with alcohol and drug abuse are family-related. Family-related risk factors include having parents or family members with substance abuse disorders, positive family attitudes toward and acceptance of substance use, lack of parental attachment, sexual or physical abuse, economic instability, and poor family management. Family-related protective factors include parental warmth, affection, and emotional support; high levels of parental monitoring; and strong parent-child bonds.

> Psycho-education in a family group setting has powerful long-term effects on symptom stabilization.

Judith Brook and colleagues found that protective family factors are particularly important in preventing and treating substance abuse. This is because protective family factors have been shown to moderate the effects of risk factors. Other researchers have noted that the major precursors to drug use and abuse can be decreased by participation in family intervention programs. Family-focused programs have been found to significantly reduce all the major risk domains and increase protective processes.

The importance of context

The substance abuse field has long recognized the need to have the family and other support persons involved in an individual's recovery effort. That was one of the founding premises of Alcoholics Anonymous when it was started by Bill Wilson and Dr. Bob Smith in 1935. Sixty years later, researchers have found compelling support that demonstrates the value of having family members involved in the treatment process. Although many treatment programs have some protocol for including family members, few programs strongly emphasize family-member involvement and family therapy. Most do not provide an opportunity for patients and family members to participate in multi-family groups.

For the families of persons with substance abuse disorders, multi-family psycho-education groups have the potential to improve coping skills, reduce stress, and teach family members how to manage addiction at the individual and family level. William McFarlane's work with patients with severe mental illness, many of whom also suffer from substance abuse disorders, has demonstrated that participation in such groups have positive long-term effects on participants' interpersonal functioning and clinical stability. Participation also leads to a reduction in relapse rates.

Interestingly, McFarlane found that the context in which information is presented and discussed is more important than the content of the information itself. He found that even small amounts of psycho-education and training in a family group setting had powerful long-term effects on symptom stabilization.

It is likely that this stems from the fact that participating families find mutual support and a potential long-term social network. In these groups, families could also exchange resources and coping strategies. McFarlane also found that participation in family groups enhanced

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Substance Abuse Treatment and Child Welfare: Systemic Change is Needed

by Sarah Kaye, M.A., Graduate Research Assistant; and Megan Fitzgerald, B.A., Graduate Research Assistant, Department of Family Studies, University of Maryland

Over the past several years, the number of children removed from the home and placed in foster care because of parental substance abuse issues has steadily increased to a total of over 150,000 in 2002. Because children and families involved in the child welfare system are among the neediest and most vulnerable, they warrant specialized consideration in analysis of substance abuse treatment.

The Adoption and Safe Families Act of 1997 exacerbated the challenges that have historically impeded service provision to parents with substance abuse issues whose children are in foster care. Innovative child welfare agencies and substance abuse treatment programs have begun to use cooperative strategies that may improve services to these specials needs families. However, further research and policy supports are needed for widespread change in this area.

Neglected families

Over 20 percent of children removed from the home are placed in foster care because of parental substance abuse. Parents with substance abuse issues tend to have multiple problems that include mental illness, domestic violence, economic and housing insecurity, and dangerous neighborhoods, among others. Child welfare workers find these parents the most difficult to deal with.

Preliminary research shows that overburdened child welfare workers tend to pay more attention to the least troublesome clients to make best use of their limited amount of time. When this practice is implemented on a large scale, it results in a large subset of families with substantial need that are neglected by the child welfare system.

Institutional gridlock

Child welfare workers require parents to receive substance abuse treatment and

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FAMILY GROUPS *continued from page F14*

problem-solving capacity and the ability to normalize communication, reduce stigma, cross-parent, and be helpful in crisis intervention.

Although McFarlane's research demonstrates the value of including multi-family psycho-education and therapy groups as a part of the treatment process, most mental health facilities still lack family education services of any type. The lack of support for family involvement in substance-abuse treatment may be due, in part, to managed-care providers and federal reimbursement programs that favor individually-based psychotherapy or prescription drug regimens at the expense of family services. The overall lack of funding for family services makes it difficult for any practitioner or agency dependent on third-party payment to include family education and support groups in their programming.

A successful model

The family group at the intensive outpatient treatment program at the Texas Tech University Health Science Center's Southwest Institute for Addictive Diseases involves families in the treatment process. The family group is held weekly and is open to patients, their family members, and support persons. Patients are encouraged to consistently bring at least one family member or support person to the group.

New information (based on the education and family therapy group model developed by Brian Samford and colleagues) pertinent to the family's recovery process is presented and processed each week. Each presentation is followed by a group discussion relating to the topic. The curriculum includes presentations on:

- The family as a system.
- Family change.
- Family boundaries, roles, and structure.
- Family communication.
- Transference of addiction.
- The family recovery process.

In interviews with family group participants, my colleagues and I found that patients and family members valued their joint participation and the opportunity to share in an open group environment more than they valued the specific information presented. This reconfirms McFarlane's findings about the importance of the context or process in which information is presented and discussed. This research also reconfirms the need for agencies, educators, and all who work with individuals suffering from substance abuse disorders to include family members and support persons in the treatment process wherever possible.

For more information, contact jamesm@ext.usu.edu.

SYSTEMIC CHANGE *continued from page F15*

other services before they can be reunified with their children. Unfortunately, even if families receive adequate attention from the child welfare worker, they may find themselves trapped in an *institutional gridlock*. This gridlock is caused by limited service availability, differing perspectives underlying mission and treatment philosophy, and bureaucratic barriers. Each sector uses different indicators to signal success and preparation for reunification. Tension also exists among child welfare workers, court personnel, and substance abuse treatment providers.

Waiting lists prevent parents from entering treatment in a timely manner, but the Adoption and Safe Family Act of 1997 places families on a time clock racing to avoid permanent termination of parental rights. The Act did expand programming for biological parents who meet specified diagnostic categories, but services are limited to 15 months. Even if parents are able to get access to services, substance abuse treatment generally lasts about 18 months. Caseworkers, however, are federally mandated to petition for termination of rights after 15 months. Critics argue that this is insufficient because recovery from addiction is slow and relapse is common.

> Children and families involved in the child welfare system are among the most vulnerable.

Lack of individualized attention

In addition, availability of services does not necessarily promote positive change. Many women with drug and alcohol problems come to treatment with histories of physical and sexual abuse, mental illness, and poor physical health. Child welfare administrators are dismayed by the lack of emphasis on these and other family problems, and they note that this lack of attention may contribute to a high dropout rate.

Parents who complete the full treatment regimen may not demonstrate measurable results. Because caseworkers must rely upon documentation to communicate with judges, services with easily tabulated "progress" are often provided without individualized attention to specific client needs. In practice, service completion is often used as a proxy for client change in the absence of measures of behavioral improvement.

Current policy does not provide adequate funding and infrastructure to effectively support communication and cooperation among the multiple systems that serve families at the federal, state, county, and local levels. As a result, specialized treatment and foster care services may fall under different funding and organizational structures. These systemic differences frequently result in challenges for parents who may be getting mixed or conflicting messages from different treatment providers.

Future directions

Most research on the relationship between substance abuse and child welfare and the influence of public policy relies on qualitative data supplied by caseworkers. Although this is an important perspective, more rigorous research using empirical data and focusing on the experience of children and families in the system is necessary.

Researchers should use available data to conduct quantitative analyses of the impact of the Adoption and Safe Families Act on families with substance abuse issues. Such research could evaluate common critiques of this law by documenting the extent of service gaps for substance-abusing parents. The documentation would show how many families await services and how many are at risk of permanently losing rights to their children due to the unavailibility of service.

While research has indicated that women achieve better outcomes in women-only treatment centers that offer a range of services, there remain questions about the efficacy of individual program components, including cultural and gender competence. Future research could address these unanswered questions through the use of detailed program evaluations.

Sarah Kaye, M.A. and Megan Fitzgerald, B.A.

Policy recommendations

Despite the limitations of available data and scarcity of empirical analysis, the available literature overwhelmingly supports the following policy recommendations:

- Professional cooperative education to increase awareness of the services, goals, objectives, constraints, and need for cooperation between courts, specialized service providers and child welfare workers.
- A computerized referral and performance tracking system to all parties—court personnel, child welfare workers, and substance abuse treatment providers—with pertinent and up-to-date information.
- New funding mechanisms to ease bureaucratic difficulties and improve the quality of services available to families involved in multiple systems.
- More emphasis on continuing care. This has been specifically recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA).
- Specific funding for additional concurrent services. These might include parenting classes and job training. SAMHSA has recommended that parents receive more assistance with housing since Section 8 housing is often not conducive to recovery.

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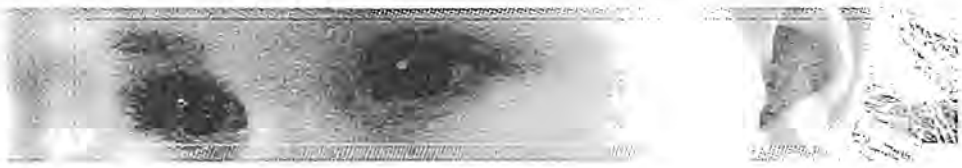

Using Foster Grandparents as Mentors in Family Drug Court: A Case Study

by Elizabeth Donahoe, M.S., M.A., CFLE, Integrated Services Case Manager, Tru Vista, Reno, Nevada

Washoe County Judge McGee started Family Drug Court in Reno, Nevada, in 1994. This specialty court uses Foster Grandparents as mentors to families. Washoe County has the only family drug court in the United States that uses elders and their life experience to supplement traditional social services. The court serves approximately 100 families a year.

The typical client is a 25-year-old white female with no high school education, few job skills, a history of abuse, and an addiction to drugs, alcohol, or both. Clients usually have two or three children.

In most cases, Child Protection has removed the children, and the mother has opted to participate in family drug court as an alternative route to reunification. As part of her reunification plan, the client is expected to participate in addiction treatment, attend parenting and family strengthening classes, work or go to school, and handle any other criminal or civil charges that may be pending.

A dramatic case

Recently, the court accepted a young mother who was addicted to both methamphetamine and alcohol. "Kim" had one 4-year-old son and a newborn daughter who had tested positive for drugs at birth. Child Protection had removed both children shortly after the baby was born.

Their case was more dramatic than usual: the baby girl was born at home on the living room floor. Her identical twin was born dead. Kim had been drinking and had injected herself with methamphetamines.

Kim had no idea that she was pregnant with twins since she had received no prenatal care. At the time of the birth, Kim's husband "Tony" was in the house with the couple's 4-year-old son. After Tony called 911, mother and baby were taken to the hospital. Drugs were detected in the newborn and both children were removed from their parents' custody.

The program

Both of Kim's parents are career criminals. Her first drug use was with her mother at age 13. She has been using drugs for 13 years. Tony is 38 years old and has used drugs off and on for 25 years.

Kim and Tony were referred to family drug court in August 2003. They graduated a year later after working a "perfect program." During that time, they had no relapses. They met and exceeded each expectation and goal of the program.

Kim began her program as an inpatient at a treatment facility sanctioned by the family drug court. She was there about four months. Her newborn daughter was placed with her after 30 days of certified sobriety. Tony remained in the family home and was treated for addiction in an outpatient program. The 4-year-old boy was placed in the care of the maternal great grandmother.

> Washoe County Family Drug Court uses elders to supplement traditional social services.

Each parent worked on their treatment program, which included group therapy, one-on-one therapy, anger management, life skills, organizational skills, self-esteem building, and positive affirmation. Over time, Tony began engaging in parenting classes, family-strengthening classes, and couple's counseling with Kim.

A new lifestyle

Kim and Tony were re-united with each other and their children after what Kim describes as "four long months." They incorporated AA and NA meetings into their program. Kim also started attending an alumni group as well, and Tony has joined in. Tony upgraded his employment and can now spend more quality time with his wife and family.

It appears that Kim and Tony have begun to change their thought processes. They have eliminated old friends and places that could be "triggers " for their drug use. They have engaged their extended families in their recovery process. They have accepted responsibility for past actions and have figured out a recovery plan that works for them both as a couple and as parents.

Help from Grandma

An integral part of the couple's recovery is their relationship with a Foster Grandparent/ Mentor. "Grandma" provided one-on-one support that complemented the traditional social services provided by the court. One of Grandma's main jobs was to help the family envision a better future and work toward that goal in a practical manner. She helped also the family structure activities that promoted family unity, money management, and life skills

With Grandma's guidance and practical help, Kim and the children attended special classes, applied for resources, and engaged in extra activities paid for through the Foster Grandparent connection. Grandma provided support, positive role modeling, and friendship to the family.

Kim has become something of a celebrity in the last year. She has made presentations at the local university and to advocacy groups about her drug use, her involvement

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Addict and Child: A Case Study

by Cheryl A. Dayton-Shotts, M.A., Director of Field Services, Affiliated Systems Corporation, Houston, Texas

Most people do not wake up one morning and decide to become drug addicts. There are usually a series of events in a person's life that leads up to that point. "Melinda" was no exception.

Maternal history

Though Melinda grew up in a family that consisted of a biological mother, father, three sisters and four brothers, her mother was the only one she considered "family." Melinda reports being regularly yelled at, threatened, spanked, and beaten by all family members other than her sisters. She was molested by her brothers between the ages of 3 and 11 years of age. Unable to take it anymore and armed with an eighth grade education, she left home for good.

Melinda has used and injected just about every conceivable drug. At the time of our first meeting she was in a methadone maintenance program, but still injecting cocaine, heroin, and speedballs. She was 36, in extremely poor health, and HIV positive. She continued to have unprotected vaginal, oral, and anal sex with her partners, both her primary partners and those with whom she traded sex for drugs or money.

Though Melinda received a disability check and food stamps, they were not sufficient enough to support her, her child, and her drug habit. Money to pay for her apartment, which she shared with her 5-year old daughter "Lauren," was provided by the man of the moment.

Melinda's current "boyfriend" and one other male, both of whom were drug users, were the only two people that she reported feeling close to. The rest of her social network consisted of acquaintances, mostly drug dealers and users who flow in and out of her life.

A vulnerable child

Lauren, forced to participate in the adult world of drug addiction, had few opportunities to interact with children her own age, much less to form bonding relationships. Lauren's social network consisted of her mother's ever changing circle of contacts.

Like most young children who have not had the opportunity to form real emotional attachments, Lauren desperately clung to anyone who paid her the least bit of attention. For example, Lauren formed an instant and clinging bond with a staff member who only engaged her in child's play (for example, coloring and playing with toys). When it was time for Melinda and Lauren to leave, Lauren had to be physically removed from this staff member's leg.

> Over time, the mother became dependent on her daughter for both emotional support and physical needs.

The scenario repeated itself each time the mother came in to interview. Melinda did little to discourage this behavior; in fact, she encouraged it, suggesting to the staff person that she take Lauren for the weekend, leaving us to wonder how often Lauren was left with or pawned off on perfect strangers.

Lauren's desperate need for attention and her desire for love and affection left her vulnerable to manipulation and abuse. Lauren, like others who have very little, was excited to play with the books and toys we provide the children whose parents we interview. Her eyes lit up when she saw the new Barbie-sized dolls still in their wrapper. She enthusiastically ripped off the packaging. She then proceeded to strip the dolls of all their clothes and engage them in behavior that reflected the experiences of a child who has been exposed to things much too worldly and mature for a 5-year-old.

Role reversal

Over time, mother and child began to reverse roles. Melinda's health had sharply declined over the course of the longitudinal study in which she participated, and she had lost the boyfriend who was her primary support. These life changes caused Melinda to become very needy and dependent on Lauren for both emotional support and physical needs.

A few months after witnessing this change, we learned through Melinda that the school had called Child Protective Services (CPS) in to investigate suspicions that Lauren had been staying home from school to care for her mother. CPS learned that Melinda had been having frequent seizures and blackouts. Lauren, who was now 6 years old, had in fact been functioning as her mother's primary caretaker.

As a result, CPS removed Lauren from her home and began steps to terminate Melinda's parental rights. Melinda, while understandably upset, seemed more concerned with her own needs rather

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GRANDPARENTS

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in family drug court, and its effect on her and her children.

Elizabeth Donahue, M.S., M.A., CFLE

She and Tony are still faced with ongoing challenges. Their 15-month-old daughter has been diagnosed with Fetal Alcohol Syndrome. Their 4-year-old son attends special education classes and takes yoga. The couple is learning to accept the death of their other daughter.

This family's "new" life is just beginning: after their graduation from family drug court, they attended three months of aftercare. They maintain their relationship with their Grandma. Kim believes that Grandma has helped her learn to live a more positive life.

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Rural, Low-Income Families Experience Barriers to Substance Abuse Services

by Elisabeth Fost Maring, Ed.M., Doctoral Candidate, Department of Family Studies; and Bonnie Braun, Ph.D., CFCS, Extension Family Policy Specialist, University of Maryland, College Park

Substance abuse is a health problem that affects most U.S. communities. While substance abuse may once have been concentrated in urban areas, research shows that it is now as common in rural areas as it is in cities. Some researchers attribute this to the economic tragedies of farm failure and a national debt that has changed rural existence. In the late 1990s, a quarter of the U.S. population lived in non-metropolitan or rural areas with high rates of poverty, substandard housing, and lower educational attainment. These factors increase the chances that families will be affected by the negative consequences of risk behaviors, such as problem drinking, drug addiction, and tobacco use.

The rates of drug, alcohol, and nicotine use for adults are about the same in rural towns, mid-size cities, and large urban centers. The rates of use for teens, however, are higher in rural areas than in urban centers.

But rural individuals and families have a harder time accessing services than their urban counterparts. This occurs because rural residents face specific barriers to service provision. The focus on urban drug use has led to service models that may not fit the needs of rural populations. We hope that the findings presented in this article will help researchers and practitioners better understand the unique service needs of low-income rural families.

> Rural populations have different needs than urban dwellers.

Barriers to service

Rural populations face four main barriers when they try to access substance abuse services. These barriers are magnified for those below the poverty line. First, rural families often have to travel long distances to get to prevention and treatment programs. For low-income families, this can pose an insurmountable challenge.

Second, rural communities have a shortage of mental health practitioners. Rural communities have difficulty attracting trained substance abuse professionals, school nurses, and counselors. Those who do practice in rural areas are often trained for work with urban populations. Rural families, therefore, use their primary care physician for mental health care. Physicians in rural areas report that they commonly see patients with substance abuse issues. But physicians say they are apprehensive about treating people experiencing anxiety, depression, and substance abuse because, as family practitioners, they lack adequate training.

Third, the stigma associated with mental health inhibits rural residents from seeking help. Rural values emphasize privacy, self-reliance, conservatism, religiosity, and intolerance for deviance. These values impact attitudes toward health care. Unlike urban dwellers who can more easily remain anonymous, rural residents spend more time in direct contact with acquaintances who may judge their behavior. In addition, rural residents

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than the needs and best interest of her child. It is always sad when a situation escalates to the point where the child has to be removed from the home. But in this case, we felt that, if placed in a stable home, Lauren might actually have a fighting chance at a normal life.

An unpredictable future

Melinda, having completed her time with us, never called us back with an update on her CPS case. It was not until several months later that we learned that Melinda did a stint in rehab and got Lauren back. Unfortunately, we also learned that Melinda was back out using drugs and that she and her daughter were again living place-to-place. Two years later, one of Melinda's social network members told us that Melinda has passed away and that Lauren had been shipped off to live with relatives in another state.

Cheryl A. Dayton-Shotts, M.A.

We will never know the long-term impact of Lauren's childhood experiences on her development. But it is reasonable to assume that her life, like her mother's life, will be affected and perhaps even shaped by these experiences. We can only hope that she will find a counselor or a mentor who will help her obtain the strength to overcome the adversity that life has dealt her.

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RURAL LOW-INCOME *continued from page F19*

tend to rely more heavily on family members for support than on professionals.

Fourth, many rural residents are unaware that they have a mental health problem requiring assistance. As a result, they self-medicate with drugs, alcohol, or tobacco.

Experiences of rural, low-income families

Rural Families Speak is a longitudinal, multi-state study of the well-being of rural, low-income families. This study offers a rich and integrated picture of the lives of rural families from the perspective of mothers. These women face multiple stressors that affect mental and physical health. All of these mothers live just above, at, or below the poverty line. Their mental health and use of drugs and alcohol affects their ability to be employed. As one mother said:

> *And then as I got older, I didn't keep a lot of jobs that I got from 18 to 24 maybe because I became an alcoholic. I was drinking a lot. Actually every day I was drinking a lot. I held jobs, but not for a long time.*

Analyses of substance abuse in these families are just beginning. But our initial findings have implications for researchers, mental health providers, and public policymakers. Among the mothers in Waves 1 and 2 of the study, 36 percent and 23 percent, respectively, reported that they did not know where to find help for a drug or alcohol problem—a finding consistent with the literature on lack of access to mental health care.

When presented with a checklist, mothers seldom selected substance abuse. Fewer than 5 percent indicated that either they or their partner had a drug or alcohol problems. These results are in line with national data on recent illicit drug use among persons 12 and older. But they are much lower than the 21 percent of the population nationally that reports bingeing on alcohol. However, more than one-third of the rural mothers (34 percent in Wave 1 and 37 percent in Wave 2) acknowledged tobacco use. This is significantly higher than the national average of 25 percent. Nearly half of the mothers also reported that their partners (43 percent in Wave 1 and 44 percent in Wave 2) used tobacco.

Interview transcripts, however, show that many mothers mention alcohol or drug use as a family problem, even though they do not indicate this on the checklist. A similar gap is found among participants with regard to identification of depression or anxiety. Many mothers who tested positive for depression on a standardized assessment did not indicate this on the checklist.

Preliminary findings from 414 mothers living in 24 rural counties in 14 states suggest that researchers and practitioners need to explore substance-abuse-related issues in rural families. Simply asking people if they have a mental health problem or use drugs isn't enough.

More research needed

Advocates for families must be aware that different populations have different needs. Advocates must also question assumptions behind programs, policies or research targeting those populations. Historically, substance abuse treatment models were based on male addiction but implemented for both males and females. In addition, most treatment models were urban-oriented.

Over the last 10 years, the distinct needs of rural American families have received greater attention in research, policy, and the media. In 1997, the National Institute of Drug Abuse issued *Rural substance abuse: State of knowledge and issues*, a comprehensive review of prevention and treatment issues. In 2000, the National Center on Addiction and Substance Abuse published another comprehensive review, *No place to hide: Substance abuse in mid-size cities and rural America*. And the Department of Health and Human Services recently produced the *Rural Task Force Report*. The goals of this task force are to:

Elizabeth Fost Maring, Bonnie Braun, Ph.D. Ed.M.

- Improve rural communities' access to quality services.
- Strengthen rural families and communities.
- Support rural policy and decision-making.
- Ensure a rural voice in the consultative process.

The findings that will emerge from the *Rural Families Speak* study should contribute to those goals. Meanwhile, family-focused researchers and practitioners should incorporate the preliminary findings into their research and professional practice. Together, we can find ways to investigate unexplored issues and reduce barriers for rural, low-income families who face mental health and substance abuse challenges.

For more information, contact lisfostmaring@yahoo.com. To learn more about "Rural Families Speak," visit www.ruralfamilies.umn.edu.

Rural Women in Recovery: Treatment and Service Needs, Outcomes, and Strategies

by Cathleen A. Lewandowski, Ph.D., LSCSW, Associate Professor, School of Social Work; and Twyla J. Hill, Ph.D., Associate Professor, Sociology, Wichita State University

Women's treatment needs differ from those of men, since women are more likely to be single parents and impoverished. But the treatment needs of urban and rural women also differ, as indicated by treatment completion rates, services women receive from other agencies, and other factors associated with the addiction and recovery processes. For rural women who are recovering from substance abuse, it is also difficult to get help, since most treatment centers and other supportive services are located in cities.

The women

This study compares the different treatment needs of women who live in urban and rural areas and discusses strategies to translate study findings into more effective drug treatment programs for women. The sample included 79 women receiving services in a women's residential drug treatment program in Kansas in 2003. Of the sample, 46 women were from urban areas, 26 were from rural areas, and seven came from midsize cities.

The 79 women ranged in age from 19 to 54, with a mean age of 31.8. About 90 percent of the women had children, although about only about 60 percent had children at home. About 19 percent were married. In terms of education, 30 percent were not high school graduates, 49 percent had either graduated from high school or had a GED, and 20 percent had some college or a college degree.

Most women (80 percent) had at least one previous drug treatment episode, and 43 percent had two or more previous treatment episodes. Only 20 percent had no previous drug treatment history. Slightly under half (43 percent) were multiple drug users, meaning that they reported a history of using or abusing more than one substance at the time of admission.

The program

The study took place at the Women's Recovery Center, a private not-for-profit residential drug treatment center in Wichita, Kansas. The center is state certified and licensed and has 17 full-time staff, including a nurse, and three part-time staff. The treatment program uses a 12-step model, emphasizing cognitive-behavioral approaches to treatment intervention.

> Some rural women lived over 200 miles from the treatment center.

The Women's Recovery Center provides nursing services, housing, and on-site day care for women's children in addition to drug treatment and education on HIV and other sexually transmitted diseases. It is one of two agencies providing serial, or comprehensive, drug abuse treatment in programs designed specifically for women in the state. Consequently, rural women may travel over 200 miles to obtain treatment. Once in treatment, they often leave their support network behind.

The overall duration of the program is 14 to 15 months, although individual women may not complete the entire program. The three phases of this serial treatment program are inpatient treatment (21 to 30 days), intensive outpatient treatment (4 to 6 weeks), and outpatient treatment for one year. Women can bring their children with them to residential treatment, and the facility can house up to 40 women and children at any given time. The treatment program includes a weekly family night. But women from rural areas rarely participate, since family members often cannot travel the long distance.

Upon completion of inpatient treatment, women are referred to a residential reintegration program that coincides with the outpatient phase of their treatment. This program is also located in an urban area and a woman's participation extends the amount of time she is separated from family, friends, and her own community.

"Voting with their feet"

Of the 79 women in the sample, 48, or 61 percent, had completed residential drug treatment. Six women were still in treatment at the time of interview. Only five women, or 6 percent, had been discharged from residential treatment for inappropriate behavior; 20 women, or 25 percent, had self-discharged and not completed treatment.

Though most of the women received food stamps or medical assistance, only 18 women received cash benefits from Temporary Assistance for Needy Families (TANF). Sixteen women had children in foster care placement, and 15 women were receiving family preservation services while in residential drug treatment.

We compared only urban and rural women who self-discharged or completed treatment. There were no differences by marital status, education, or age. A higher proportion of rural women are white, but this difference is not statistically significant. Of rural women, 39 percent self-discharged

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RURAL WOMEN *continued from page F21*

and 61 percent completed treatment. Of urban women, 24 percent self-discharged and 76 percent completed treatment.

A statistical analysis suggests that the hazard rate for self-discharge for women from rural areas is higher than that of women from urban areas. Younger women, women with less than a high school education, women with children in foster care, and women with higher drug usage, employment problems, or psychological problems are also more likely to self-discharge.

Although urban women tend to have more employment and psychological problems than rural women, urban women are less likely to self-discharge. This suggests that other factors are responsible for the tendency of rural women to "vote with their feet." Such factors may include differences in drug use, treatment history, lifestyle, and distance from home.

Why rural women leave treatment

While most women have used more than one substance, methamphetamine abuse is more prevalent among rural women. Urban women are most likely to abuse crack. Accessibility, rather than actual drug preference may account for these differences. The key ingredients for manufacturing methamphetamine are readily available in rural areas, while urban areas are closer to drug supply routes where crack is distributed.

In terms of lifestyle, rural women may have difficulty in a self-help model of treatment that requires them to interact with urban women who do not share the same experience of small town life. Interviews with women from rural areas suggest that they tend to view urban women as more "street-wise," while urban women tend to view women from rural areas as more naive.

For example, besides selling drugs to support their habit, some women from urban areas had been involved with gangs or employed as exotic dancers or prostitutes. Rural women were more likely to have gotten into the selling and manufacturing of methamphetamine with their boyfriends. They rarely were engaged in other activities. Many rural and small town women could not see past these lifestyle differences to the core concern of their addiction. They believed that they were "not like the other women here."

While urban women's higher rates of service usage may reflect need, it may also reflect increased accessibility and a lifestyle where pursuing social services is acceptable. Social service agencies do not have offices in every county of the state, which means that services are often not available in rural areas. In addition, women from rural areas may be more likely to rely on their support networks than seek social services.

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Distance is another factor. Some women lived over 200 miles from the treatment center, hindering family involvement and their ability to support women during treatment. On the other hand, women whose families and friends are further away may find it easier to establish a new life apart from former negative support systems. But though distance may make it easier for rural women to start a new life, they must adjust to an unfamiliar urban lifestyle, far from any positive support networks they may have at home.

Helping rural women focus on recovery

Responding to the unique treatment needs of women from urban and rural areas poses challenges. The population dispersion in rural areas may make providing residential treatment in a rural setting cost prohibitive. As a result, researchers and the practice community are exploring more creative approaches to addressing the potential unmet service needs of rural women.

At a minimum, practitioners can be more aware of how women from rural areas perceive the treatment center. They can also develop strategies to help women maintain a focus on their recovery. Technology can also be used to facilitate families' participation across geographic distances. For example, Web-based cameras might allow families to participate in family night activities. More research is needed to assess the effectiveness of such strategies for improving drug treatment completion and recovery rates of rural women.

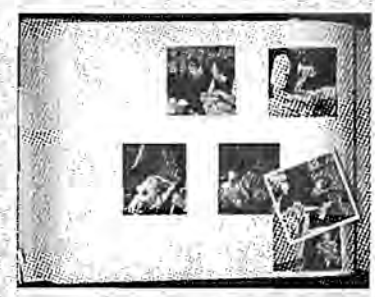
For more information, contact Twyla.Hill@wichita.edu. This research is funded by the National Institute on Drug Abuse and the Office of Research on Women's Health (RO3 DA 143-60-2).

Coming Up in Family Focus

June 2005: Multiple Meanings of Family
Deadline: April 5, 2005

September 2005: Aging
Deadline: July 5, 2005

December 2005: Family Strengths
Deadline: October 4, 2005



For more information or to contribute an article, please contact Nancy Giguere. Phone: 651-642-1378 or gigue001@umn.edu.

We are looking for short articles - 1000 WORDS MAXIMUM - written in journalistic style, that is, no footnotes, endnotes, or bibliographies. We are especially interested in policy-oriented pieces, case studies, and articles that describe researched-based programs.

The Life Course of Alcoholism: Chemical Dependency and Older Adults

by Phyllis A. Greenberg, Ph.D., Associate Professor, Department of Community Studies, St. Cloud State University, St. Cloud, Minnesota

Most of us have been taught that excessive drinking that takes place over a long period of time has detrimental effects on one's health and can even result in death. While we should heed this lesson, it does not account for the hundreds of thousands of adults 65 and older who suffer from alcohol addiction.

Some people, including health care professionals, assume that older alcoholics developed the disease later in life. These professionals see drinking behavior as a coping mechanism to deal with the death of a spouse, retirement, or other significant changes or losses. But this is a myth. In reality, about two-thirds of older alcoholics are early onset alcoholics who have been alcoholic for years.

An unrecognized condition

Alcoholism is seldom identified, diagnosed, or treated in older adults. One study estimated that as many as 60 percent of older adults admitted to acute medical wards are active alcoholics. Yet among these elders, alcoholism is rarely listed as the presenting condition, which decreases the likelihood that the addiction will be treated. Many alcoholic symptoms are mistaken or confused with symptoms of diseases that can occur with advanced age. Failure to diagnose alcoholism results in the treatment of a symptom (confusion, disorientation, or falling, for example) rather than the disease.

Professionals in traditional treatment programs based on behavior modification may believe that older adults are less capable of change. Until recently, many professionals in the field of alcohol treatment believed that older individuals were not good candidates for treatment, and that, if treated, they could not maintain sobriety. In fact, once when I was looking for a treatment option for a client, a provider told me flatly, "You can't teach an old dog new tricks."

As many as 60 percent of older adults admitted to acute medical wards are active alcoholics.

This is when I also learned one of the first cardinal rules of case management: Never get the client to agree to a service until you know you have a provider. This continued to be an issue until I started to work for an Area Agency on Aging. In collaboration with a local treatment program, our agency developed an age-specific treatment program for older adults. The project was funded for three years. During that time we not only helped a number of older adults and their families, but we also built a bridge between providers of aging and chemical dependency services.

Learning more about elderly alcoholics

Since that time I completed a doctorate and moved to Minnesota. Here I had the good fortune to work with Senior Helping Hands/Recovery Plus at St. Cloud Hospital. This age-specific treatment program provides both outpatient and residential outpatient services.

For the last two and a half years, under a grant from the Minnesota Department of Human Services, we have been collecting data on persons in treatment, with a focus on dual diagnosis, chemical dependency and mental health, relapse, and overall treatment modalities. Participants are interviewed while they are in treatment and then via telephone every six months after they have completed treatment.

Much of what we have learned has reinforced prior findings, but we have also made some new discoveries. As other studies have shown, older adults have a high success rate of completing treatment and maintaining their sobriety if they have a strong support system. This support system can include family, peers, clergy, health care providers, and service professionals. Along with this, attendance at AA or other support groups such as aftercare or Alanon is a key to success.

The importance of dual diagnosis

An important component of this project is dual diagnosis. Rather than arguing whether it is depression that "causes" one to self-medicate with alcohol or that it is the alcohol that is the "cause" of depression, we have sought to address both conditions. Initially those who were diagnosed as clinically depressed and bipolar attended a multi-age dual diagnosis group. In examining data collected from clients and staff, we determined that all participants would benefit by greater attention to depression and other mental

Life Course continued on page F24

Older Adults in Substance Abuse Treatment: 2001

In brief

- In 2001, there were 58,000 admissions aged 55 or older, about 3 percent of all substance abuse treatment admissions.
- Alcohol was reported as the primary substance of abuse more frequently among admissions 55 or older than among younger admissions (74 versus 44 percent).
- Abuse of alcohol alone, with no secondary drug abuse, was reported by nearly two-thirds (64 percent) of older admissions.

This report examines substance abuse treatment admissions aged 55 or older in 2001, and compares them with younger admissions. In 2001, there were 58,000 admissions aged 55 or older among the 1.7 million substance abuse treatment admissions in the Treatment Episode Data Set (TEDS). While the number of admissions aged 55 or older has increased over the years, the proportion of admissions aged 55 or older has remained stable at 3 percent of all admissions.

According to the U.S. Census Bureau, the number of Americans older than 55 is increasing–from 59 million in 2000 to a projected 74 million in 2010. Adults older than 55 will constitute 25 percent of the U.S. population in 2010, up from 21 percent in 2000.

TEDS is an annual compilation of data on the demographic characteristics and substance abuse problems of substance abuse treatment admissions. The information comes primarily from facilities that receive some public funding. TEDS records represent admissions rather than individuals, as a person may be admitted to treatment more than once.

Primary substance of abuse

Alcohol was more frequently reported as the primary substance of abuse among admissions aged 55 or older than among younger admissions (74 versus 44 percent) (Figure 1, page F25). Cocaine (5 versus 13 percent) and marijuana (1 versus 15 percent) were reported as the primary substance of abuse less frequently among older admissions than among younger admissions.

Abuse of alcohol alone, with no secondary drug abuse, was reported by nearly

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LIFE COURSE *continued from page F23*

health diagnoses and the relationship of these conditions to alcoholism.

This is one of the few programs in the country that specifically acknowledges and treats alcoholism and mental health. Participants who are diagnosed with clinical depression, bipolar disorder, and other mental health conditions attend the dual diagnosis group and one-on-one sessions with a therapist, as well as the age-specific chemical dependency treatment program.

An increasing number of participants are in treatment for addictions other than alcohol–primarily to pain medications.

These older drug addicts have not yet found a home within Narcotics Anonymous, but they seem to fare well within the senior treatment setting.

A wide range of ages

The average age of people participating in the senior group is 63. Our oldest client was 87. We have also discovered that many younger persons are appropriate for the senior group because the pace and tone of the program are better suited to their needs. For example, the youngest participant was 39, had been in treatment over 20 times, and suffered from alcohol-related dementia.

During the first 18 months of the project, we served over 125 persons (56 percent males and 46 percent females). While many participants have alienated their relatives, some still have supportive family members, many of whom have gone through treatment themselves. Like many other programs, Senior Helping Hands offers family counseling.

Tips for professionals

Professionals who work with older alcoholics should understand that:

- Alcohol has a particularly toxic effect on older persons due to the dramatically reduced levels of body-water volume that occur with advanced age.
- The brain tissue of elders is extremely sensitive to alcohol. It can cause memory loss, confusion, disorientation, and loss of motor control.
- The effects of alcohol addiction are further complicated when alcohol is combined with medications.
- Elderly alcoholics can respond to treatment.

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ADULTS IN ABUSE *continued from page F24*

two-thirds (64 percent) of older admissions while only one-quarter (23 percent) of admissions younger than 55 years old reported abuse of alcohol alone.

Demographics

Admissions aged 55 or older differed little from younger admissions in racial/ethnic composition. Both age groups were about 60 percent White, 24 percent Black, and 12 percent Hispanic (Table 1).

There was a higher proportion of males among admissions aged 55 or older (80 percent) than among admissions younger than 55 (70 percent).

Table 1. All admissions, by Age Group, Sex, and Race/Ethnicity: 2001

	Age <55	Age 55+
	Percent	
Male	70	80
Female	30	20
White	59	51
Black	24	23
Hispanic	12	11
American Indian /Alaska Native	2	3
Asian / Pacific Islander	1	1
Other	2	1
All	100	100

Source: 2001 SAMHSA Treatment Episode Data Set (TEDS).

Source of Referral

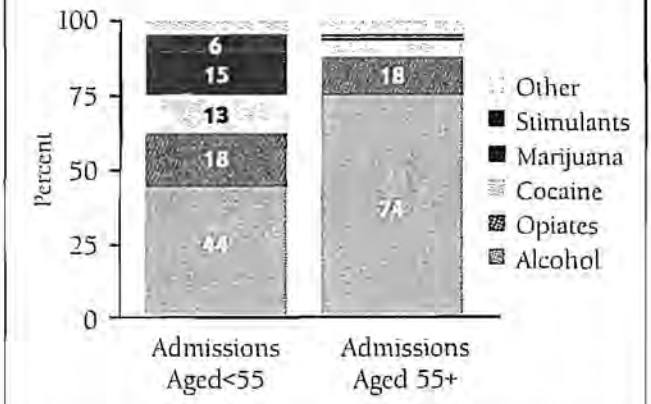
Admissions aged 55 or older were more likely than younger admissions to enter treatment through self-referral (41 versus 36 percent) and less likely to be referred through the criminal justice system (25 versus 35 percent) (Figure 2).

Type of Treatment

Admissions aged 55 or older were more likely to receive detoxification services than younger admissions (36 versus 25 percent) (Figure 3). Older admissions were less likely than younger admissions to receive outpatient treatment, either intensive or non-intensive (50 versus 58 percent).

Reprinted from The DASIS Report, *May, 11.2004*. The DASIS Report, *is prepared by the Office of Applied Studies, SAMHSA; Synectics for Management Decisions, Inc., Arlington, Virginia; and RTI, Research Triangle Park, North Carolina. Retrieved January 31, 2005, from http://oas.samhsa.gov/2k4/olderAdultsTX/olderAdultsTX.htm.*

Figure 1. All Admissions, by Age Group and Primary Substance: 2001

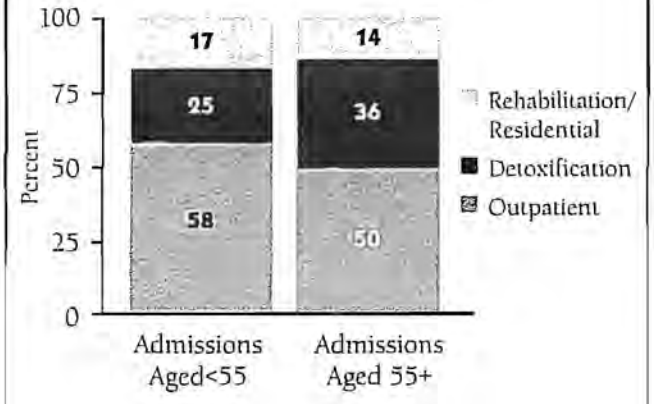


Source: 2001 SAMHSA Treatment Episode Data Set (TEDS).

Figure 2. All admissions, by Age Group and Referral Source: 2001

Source: 2001 SAMHSA Treatment Episode Data Set (TEDS).

Figure 3. All admissions, by Age Group and Type of Treatment: 2001



Source: 2001 SAMHSA Treatment Episode Data Set (TEDS).

The Challenges of Diagnosing a Fetal Alcohol Spectrum Disorder

by Laurie L. Meschke, Ph.D., Assistant Professor, San Francisco State University, San Francisco; and Joyce Holl, MAPA, Executive Director, Minnesota Organization on Fetal Alcohol Syndrome

Fetal alcohol exposure is a common cause of birth defects and developmental disorders. There is an extensive range of diagnoses associated with prenatal alcohol exposure including fetal alcohol effects and fetal alcohol syndrome. Recently many professionals in the field have begun to refer to this range of related diagnoses as Fetal Alcohol Spectrum Disorders (FASD). FASD is not a diagnosis per se but serves as an umbrella term for several diagnoses related to fetal alcohol exposure.

FASD characteristics include abnormal facial features, growth impairment, and difficulties with learning, memory, attention span, problem-solving, speech, and hearing. It is estimated that the daily cost of FASD in the United States is over 16.5 million dollars. FASD is 100 percent preventable. If women choose not to drink alcohol during their pregnancies or if women who drink practice effective contraception or abstinence, they will not have children with FASD.

It is estimated that in the United States, 10 per 1,000 live births have been affected by fetal alcohol exposure. An estimated 2 cases per 1,000 births in the U.S. are children with fetal alcohol syndrome—about 8,000 children each year. These figures are estimates because all persons with FASD characteristics are not screened for diagnosis. In addition, when a person is screened a number of challenges may make a consistently accurate diagnosis difficult or impossible.

Diagnostic criteria

The primary diagnostic criteria focus on four aspects of the patient: (1) face, (2) growth, (3) central nervous system, and (4) alcohol exposure. Screening for facial anomalies includes attention to the absence of skin fold under the nose (smooth philtrum), thin upper lip, and small eye holes (palpebral fissures). Prenatal or postnatal height or weight that is below the 10th percentile draws concern in the area of growth. Central nervous system issues include structural, neurological, and functional abnormalities. Finally prenatal alcohol exposure that is either confirmed or unknown contributes to the diagnosis of a FASD condition.

At a glance, the criteria appear to be straightforward and perhaps simplistic. But in application, practitioners may encounter a number of issues that may complicate an accurate diagnosis.

> The estimated daily cost of FASD in the United States is over 16.5 million dollars.

Facial anomalies and growth

Race can influence the detection of facial anomalies. Folds in the eyelids (epicanthic folds) and short palpebral fissures are two common facial features associated with FAS. However, Native Americans have a genetic trait for the epicanthic folds and Blacks have significantly different palpebral fissures than whites. Age also plays a role. The facial anomalies associated with FASD can dissipate with age.

Age may also affect the growth-screening criteria. Researchers have suggested that some persons with fetal alcohol syndrome catch up in growth. As a result, this criterion may disappear with age. This is not true for all persons with this syndrome. Small sample sizes and lack of longitudinal data may contribute to the inconsistent findings in this area.

Central nervous system

Screening of the central nervous system can also be problematic. Many of the psychological instruments used are not developmentally appropriate for younger children. Assessment difficulties related to the age of the child might affect this assessment.

A number of the cognitive issues related to FASD conditions may also present as independent psychological issues. For example, persons prenatally exposed to alcohol have had higher probability for experiencing delinquent behavior, externalizing, internalizing, and total problem behavior than persons without such exposure. These secondary conditions may be diagnosed prior to the FASD condition, thus delaying appropriate treatment and services. Finally, the presentation of central nervous system issues is likely to change across the lifespan.

Alcohol exposure

Determining alcohol exposure is a considerable challenge. The timing of screening is important. Specifically, retrospective maternal reports of prenatal alcohol use (13 months after pregnancy) have been significantly higher than the levels of use reported during pregnancy. However, antenatal (during pregnancy) reports of alcohol use have been significantly correlated with infant outcomes more frequently than the retrospective measures of prenatal alcohol use. The mother's disclosure about prenatal alcohol use may be affected by shame, guilt, or recall abilities.

Patients oftentimes have very little information about their birth mothers. The

The Challenges continued on page F28

Male Veterans with Co-Occurring Serious Mental Illness and a Substance Use Disorder

In Brief

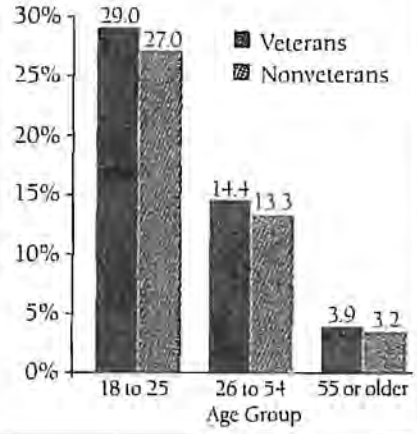
- In 2002 and 2003, an estimated 25.4 million male and 1.6 million female military veterans were living in the United States.
- An estimated 340,000 male veterans had co-occurring serious mental illness and a substance use disorder in 2002 and 2003.
- Younger male veterans were more likely to have co-occurring serious mental illness and a substance use disorder than older male veterans.

The National Survey on Drug Use and Health includes questions for adults aged 18 or older to assess serious mental illness during the year prior to the survey interview. Individuals are classified as having serious mental illness if at some time during the past 12 months they had a diagnosable mental, behavioral, or emotional disorder that met criteria specified in the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV) and that resulted in functional impairment that substantially interfered with or limited one or more major life activities.

The Survey measures serious mental illness using the K-6 distress questions. The Survey also asks persons to report their past year use of alcohol and illicit drugs and includes a series of questions to assess dependence on or abuse of alcohol or illicit drugs based on criteria specified in the DSM-IV. For the purpose of this report, individuals with both serious mental illness and a substance use disorder are said to have co-occurring SMI and a substance use disorder.

Survey respondents also are asked about their military veteran status. A veteran is defined as an individual who has served in any of the U.S. Armed Forces (Army, Navy, Air Force, Marine Corps) but who is not currently serving in the military. This report uses data combined from the 2002 and 2003 Surveys, which estimate that 25.4 million male and 1.6 million female military veterans were living in the United States in 2002 and 2003.

Figure 1. Percentages of male veterans and nonveterans reporting substance dependence or abuse, by age group: 2002 and 2003



Prevalence of substance dependence or abuse

In 2002 and 2003, an estimated 8 percent (2.0 million) of male veterans aged 18 or older were dependent on or abusing alcohol or illicit drugs. Among male nonveterans aged 18 or older, 14.6 percent (11.1 million) were dependent on or abusing alcohol or illicit drugs. Although the rate of dependence or abuse among male veterans is lower than that of male nonveterans, this appears to be due to the older age of veterans. Comparisons controlling for age show that the rates of dependence and abuse among male veterans were greater than that of male nonveterans, although these differences were not statistically significant (Figure 1).

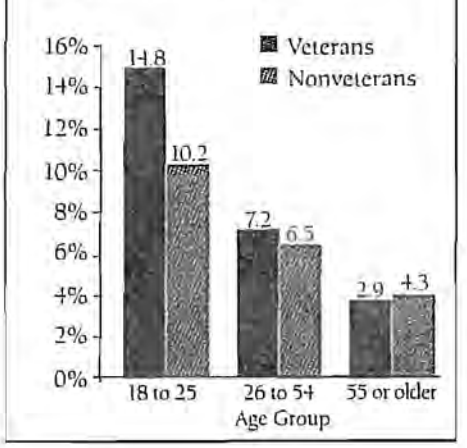
Prevalence of serious mental illness

An estimated 4.6 percent (1.2 million) of male veterans and 7.0 percent (5.3 million) of male nonveterans had serious mental illness in 2002 and 2003. As with substance dependence and abuse, although veterans overall have a lower rate of serious mental illness than nonveterans, a different pattern emerges when the rates are examined by age group (Figure 2).

Younger male veterans aged 18 to 25 were more likely to have had serious mental illness than male nonveterans in the same age group (14.8 versus 10.2 percent, respectively). Among males aged 26 to 54 and 55 or older, the differences in rates of SMI between veterans and nonveterans were not statistically significant. Male veterans aged 18 to 25 were more likely to have had SMI (14.8 percent) than male veterans aged 26 to 54 (7.2 percent) or male veterans aged 55 or older (2.9 percent).

Male Veterans continued on page F28

Figure 2. Percentages of male veterans and nonveterans with a serious mental illness, by age group: 2002 and 2003



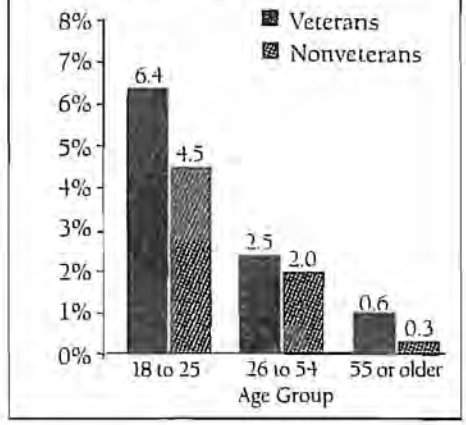
MALE VETERANS *continued from page F27*

Co-occurrence of serious mental illness and a substance use disorder

In 2002 and 2003, approximately 340,000 male veterans had co-occurring serious mental illness and a substance use disorder. The rate of co-occurring serious mental illness and a substance use disorder was lower for male veterans than male nonveterans overall (1.3 percent versus 2.3 percent), in part because of the older age of veterans. Comparisons within age groups indicate higher rates among veterans, although these were not statistically significant differences. However, veterans reported different rates of co-occurring serious mental illness and a substance use disorder within age categories. Younger male veterans aged 18 to 25 (6.4 percent) were more likely than male veterans aged 26 to 54 (2.5 percent) or male veterans aged 55 or older (0.6 percent) to have had co-occurring serious mental illness and a substance use disorder (Figure 3). Similarly, male veterans aged 26 to 54 were more likely than male veterans aged 55 or older to have had co-occurring serious mental illness and a substance use disorder.

Reprinted from The NSDUH Report *(formerly* The NHSDA Report*), November 11, 2004, published by the Office of Applied Studies, Substance Abuse & Mental Health Services Administration (SAMHSA). Retrieved January 31, 2005, from http://oas.samhsa.gov/2k4/vetsDualDX/vetsDualDX.htm*

Figure 3. Percentages of male veterans and nonveterans with a co-occurring serious mental illness and a substance use disorder, by age group: 2002 and 2003



THE CHALLENGES *continued from page F26*

biological mother may be disassociated from the patient through terminated rights, adoption, or death. Maternal alcohol use is often determined secondhand through family members or social service agents.

Finally, according to the data, relatively low prenatal doses of alcohol are associated with developmental deficits and adverse behavioral outcomes. But the definitive level of alcohol exposure necessary for FASD conditions is unknown. Hence, designated dangerous levels of gestational alcohol exposure may vary by the assessment protocol or the practitioner(s) determining the diagnosis.

The Four State FAS Consortium

In 2000 the Center of Substance Abuse Prevention provided Minnesota, Montana, North Dakota, and South Dakota with funds to initiate the Four State FAS Consortium. One of the Consortium's objectives was to examine the diagnosis of FASD conditions. Minnesota collected data on 1,100 persons screened for FASD. The participants were 0 to 46 years old (average of 9.37 years) and 45.3 percent were female. Nearly half of the participants were white. Blacks, Native Americans, and the *other* race category made up the other half of the sample. Fewer than one in 10 were diagnosed with fetal alcohol syndrome and nearly three-quarters received a diagnosis of fetal alcohol effect. One in five did not receive a diagnosis for a FASD condition. The proportion of participants receiving a diagnosis of fetal alcohol syndrome or effect did not differ by race.

We were interested in whether the four specific diagnostic criterion scores differed between those diagnosed with fetal alcohol syndrome or effect and those who did not receive such a diagnosis. No differences in growth emerged between those with or without a diagnosis. But we did find significant differences for the other three criteria by diagnostic outcome.

Persons diagnosed with fetal alcohol syndrome or effect were two times more likely to have severe facial anomalies, a third more likely to have definite central nervous system problems, and eight times more likely to have high risk of prenatal alcohol exposure compared to persons without a diagnosis.

These preliminary analyses reveal the distinct contributions of facial anomalies, definite central nervous system problems, and alcohol exposure to the diagnosis of fetal alcohol syndrome and effect. Further analyses will assist in understanding if growth ever significantly contributes to the FASD screening and if so, for which people.

Laurie L. Meschke, Ph.D.

Joyce Holl, MAPA

For more information, lmeschke@sfsu.edu or jah14@comcast.net.

NATIONAL COUNCIL ON FAMILY RELATIONS

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The NCFR Conference Provides a Top-quality Professional Experience at a Moderate Price

(*or* What Am I Getting When I Pay Out This Much Money?)

Many of you are now in the midst of a cold and snowy winter. Think ahead to November 16-19 in warm Phoenix where the NCFR Conference will be held. Not only will you have a refreshing break physically, but you will receive a great experience that will enrich your professional life.

Check the NCFR website to look for a program that is innovative, and guaranteed to challenge your thinking. In many of the plenary and special sessions there will be diverse viewpoints presented. This will help you grow intellectually.

We know that attending any conference takes a great deal of sacrifice on your part in resources and time. Some have asked why the NCFR conferences cost as much as they do.

We recently conducted a survey on costs of registration fees for various professional conferences. NCFR registration prices are lower than some similar organizations, and higher than others. Organizations that offer lower registration fees are 3-4 times larger than NCFR and can offer lower prices. Some fixed costs are the same regardless of conference size, so it costs NCFR more per person with all the services we offer.

From 1999 – 2003 the NCFR conference registration rate for early bird for members rose from $155 to $210 (an increase of $55 – or a 35% increase for 5 years - an average of 7% per year). In 2004 the fees remained the same as 2003. For 2005 we are increasing the registration fee 7%, but are reducing the registration fees for students. This is a modest increase considering the following services that we have added:

- **Free Cyber Café for all attendees.** Attendees can retrieve their e-mail every day they are at the Conference – free. Most hotels charge a fee of approximately $10 or more per day. With the NCFR Cyber Café, attendees are able to save money and still keep up with their work and stay in touch with family and friends.
- **Complimentary CD of all presentations at the conference given to all attendees.** Other organizations charge an additional fee for printed Proceedings or CDs.
- **Complimentary laptop computers, multi-media projectors, and overhead projectors are offered to presenters for their presentations.** In 1999 NCFR was charging presenters to use any equipment – including $200 for multi-media projectors. Other professional organizations still charge to use equipment. Some charge as much as $490 to use a multi-media projector. The NCFR Board initiated a Quality Control Committee to insure that NCFR conference presentations are of

Annual Conference continued on page 10

CFLE DIRECTIONS

continued from page 8

Emeritus Status

Many certification programs include an Emeritus status that recognizes designees who, while no longer working actively in the field, want to stay connected to the program. NCFR is developing a CFLE Emeritus status to provide recognition to designees who have made a significant contribution to the field over a long period of time. An ad hoc committee has been established to finalize the criteria needed to qualify for Emeritus status. Check the NCFR website or contact me (dawn@ncfr.org) at the NCFR office for details.

Dawn Cassidy, M.Ed., CFLE
Certification Director
E-mail: dawn@ncfr.org

Section News

Family and Health Section

As new section chair, I wanted to take this opportunity to thank all members of the Family and Health Section as well as other members of NCFR who supported our symposia (2), special sessions (3), roundtables (5), paper sessions (6), and posters (22) at the 66th Annual Conference held in Orlando in November of 2004. "Thank yous" are also in order for the session recorders, moderators, and discussants, as well as the outgoing Family and Health Section officers: Teresa Julian (Chair), Barbara Mandleco (Chair elect), Kathleen O'Rourke (Secretary/Treasurer), and M. Elise Radina (Student/New Professional). Our new officers are: Barbara Mandleco (Chair), Sharon Denham (Chair elect), Christine Price (Secretary/Treasurer), and Jennifer Hardesty (Student/New Professional).

This November we awarded our Section's Student/New Professional award ($200) to Jeremy Yorgason for his paper entitled *In Sickness and in Health: Marital Quality, Health, and Medical Co-morbidity.* Jeremy is a post doctoral student at Pennsylvania State University. His faculty advisor is Alan Booth. I also wanted to let you know that Elise Radina, our past section student/new professional officer was responsible for collecting and editing an instructional materials resource packet for the Issues in Aging Focus Group entitled, *Families in Mid and Late Life Syllabi and Instructional Materials.* If you are interested in obtaining a copy ($25) please contact Elise at elise.radina@uni.edu.

Plans for this years' conference are well on their way. The theme is *The Multiple Meaning of Families,* and the Family and Health Section plans on sponsoring/co-sponsoring one and perhaps two special

Family and Health Section continued on page 11

Family Policy Section

The 2004 NCFR Conference in Orlando had a number of wonderful family policy presentations on topics such as military families, foster care, older adults and caregiving, emerging policy research, low income families, and work and family issues. There were also several excellent panel presentations; one dealt with the topic of structural racism and inequalities as well as privileges, and another addressed cutting edge family research and public policy. Our Section meeting began by celebrating the incredible new resource, "Teaching Family Policy: A Handbook of Course Syllabi, Teaching Strategies and Resources, 2nd edition" edited by Elaine Anderson, Denise Skinner and Bethany Letiecq. This publication is available through

Family Policy Section continued on page 11

ANNUAL CONFERENCE

continued from page 9

the highest quality. This was done in response to what the members were asking. At the 2004 Conference approximately 75% of the presenters used Power Point when they gave their presentations.

- **Providing screens and video playback to the plenary and special sessions** make it easier for the attendees to better see the speakers and get more out of the sessions.
- **The President's Welcoming Reception is now offering much more food than it did in previous years.** This is open to all attendees. Beginning last year there were display tables around the room, giving attendees a chance to learn more about how to become involved in NCFR.
- **An additional Reception in the Exhibits area was added in 2004 and will continue every year.**
- **The Work-Life Summit was inaugurated in 2000. This is a way for NCFR to work within the community where we hold the conference.**
- **Beginning in 2004 we offered online submissions for those submitting abstracts.** This has proved to be a much more efficient process for everyone.
- **The Employment Matching Service** is expanding this year. **Nancy Gonzalez,** NCFR staff member with extensive experience in working with graduate students is offering her assistance in helping to write a good resume for those who are seeking jobs.
- NCFR is a known as a friendly organization for everyone – professionals and students. The professionals are eager to mentor bright, promising graduate students into the profession.

These are just a few of the advantages NCFR offers to you at the Conference. Some of the most important reasons to come to the NCFR Conference are that it offers top-quality sessions, and provides great networking opportunities. Some Conference attendees began collaborative work during their graduate school years and have continued working together even though they are in different universities. They use their time at NCFR to meet and continue their work. Some students have stated that they gained as much at the NCFR Conference as they did in a whole semester at school.

I want to challenge you to plan to attend the 2005 Conference in Phoenix. Meet leaders in the field and discover the "Multiple Meanings of Families."

Cindy Winter, CMP
Conference Director
E-mail: cindy@ncfr.org

Affiliate Connection

Texas Council on Family Relations

Over recent years, the Texas Council on Family Relations has developed and implemented several time, energy, and cost-efficient initiatives:

- Monthly board meetings are teleconference calls except for December (conference site visit) and April (annual conference). This initiative saves time, money, and energy and has increased efficiency and communication.
- In 2003, a Long Range Planning committee selected conference locations and general conference themes for the next 7 years. This initiative has resulted in a confirmed 2006 conference site 5 months prior to the 2005 conference.
- The TCFR Newsletter is scheduled to go online in fall of 2005 which is projected to save cost and energy.
- TCFR connects regularly with Louisiana and Oklahoma CFR members. Louisiana has a representative on the TCFR Board. A large group of students from Louisiana attend the annual conference. TCFR and OCFR share proposal and conference announcements.
- TCFR members are involved with the Healthy Marriage Initiatives.
- TCFR's partnership with the Children's Trust Fund of Texas has been critical for the financial strength of TCFR.
- State and city officials, as well as television personalities, have served as guest speakers or town hall leaders at annual conferences which has increased TCFR's exposure to the general public.

TCFR proudly recognizes TCFR members who are NCFR leaders:

- Jacqueline Fitzpatrick – Chair of International Year of the Family
- Maxine Hammonds-Smith – NCFR Presidential Candidate
- Arminta Jacobson – Association of Councils
- Tommie Lawhon – AOC Meritorious Award recipient for her work with students and the state affiliate
- Lane Powell – Past President of AOC; Fellowship Committee member
- Britton Wood – Public Policy Committee Member; past NCFR Presidential Candidate

The TCFR Annual Conference, "Promoting Healthy Families: Caregiving Across the Lifespan," will be March 31-April 1, 2005 at the Green Oaks Hotel in Ft. Worth, TX. Dr. Gay Kitson, NCFR President and Professor Emeritus, Department of Sociology at the University of Akron in Ohio will be the keynote speaker. Dr. Kitson's areas of specialization include sociology of the family, medical sociology, social gerontology, and survey research methods. Students, professionals, and others interested in the well-being of families are invited to attend the conference. For more information, contact Sandy Renick at srenick@coe.unt.edu.

JoAnn Engelbrecht, President
Texas Council on Family Relations

FAMILY POLICY SECTION *continued from page 10*

NCFR and **half** of the proceeds from the sales come to our section!! We also introduced our officers for 2004-2005, some incoming and others continuing on. These include Debra Berke, Section Chair, Denise Donnelly, Secretary/Treasurer, Leigh Ann Simmons, Student/New Professional, and Bonnie Braun, Past Chair. Leigh Ann Simmons, S/NP, presented the Section internship award to Sarah Kaye from the University of Maryland. Sarah received $500 toward her internship with the Child Welfare League in Washington D.C. Leigh Ann is also developing a mentoring program to match S/NPs with experienced policy researchers. A call for volunteers to be mentors/mentees is forthcoming. Finally, we discussed possible programming ideas for the 2005 NCFR Conference. Please contact me with your thoughts about the 2005 NCFR Conference. The programming meeting will take place in April following the Public Policy Conference (see below) so there is time to implement your suggestions.

The Public Policy Conference which will be held in Washington, D.C. on April 14-15, 2005 promises to be an exciting look at the topic of *Families and Security*. Jointly sponsored with the American Association of Family and Consumer Sciences, this conference is a valuable educational opportunity for researchers, educators, and practitioners. Once again, there will be a congressional briefing and poster session linking family research to family policy as well as opportunities to visit your representatives in Congress and make your voices heard related to families and family policy!

Debra L. Berke, Ph.D., CFLE
Chair, Family Policy Section
E-mail: dberke@messiah.edu

FAMILY AND HEALTH SECTION *continued from page 10*

sessions. A topic we are considering for one of the special sessions is on family violence. The other special session topic we are considering concerns a group of nurses who are working with Navajo elders and families in the four corners area (Utah, Arizona, New Mexico, Colorado). I am convinced both sessions we are planning will be excellent and I encourage you to be sure and look for more specific information about our special sessions in the next *NCFR Report*.

Barbara Mandleco
Chair, Family and Health Section
E-mail: Barbara_mandleco@byu.edu

Multiple Meanings of Family

We are currently soliciting articles for the June 2005 issue of *Family Focus*, a special section of *Report*, the quarterly member publication of NCFR.

The topic for this issue is "multiple meanings of family," which is also the theme of the 2005 NCFR Conference in Phoenix.

Possible topics include multi-generation families, single-parent families, same-sex families, adoptive families, foster families, step families, aging families, two-career families, grandparents raising grandchildren, extended families, cross-cultural meanings of family, etc. This is a broad topic, and we welcome all suggestions.

We are especially interested in policy-oriented pieces, case studies, and articles that describe researched-based programs. Please note that the NUMBER OF PAGES PER ISSUE IS LIMITED. The deadline is April 5, 2005. To contribute a piece, please contact the editor, Nancy Giguere, immediately at **gigue001@umn.edu**.

We are looking for short articles - 1000 WORDS MAXIMUM - written in journalistic style, that is, no footnotes, endnotes, or bibliographies (although we will put your email address at the end of the article for those who wish to contact you).

Articles may be written specifically for the *Report*, or Nancy can edit something you've already written (please note that if article has been published elsewhere, you must secure permission to have it adapted and/or reprinted). She can also interview you by telephone and create an article that will carry your byline.

Due to limited space, we will select articles that are not only pertinent but that complement each other and add variety to the issue. Articles not selected will be listed in *Family Focus* and posted on the NCFR website.

All contributors will have an opportunity to review the edited article, but they should be aware that - due to limited space - the editors may make last-minute cuts before *Family Focus* goes to press.

Postdoctoral Fellowship
Northwestern University

One to two-year full-time research position at the Institute for Policy Research, with P. Lindsay Chase-Lansdale. Focus on multidisciplinary, policy-relevant research on children and families, especially "Welfare, Children, & Families: A Three-City Study" (www.jhu.edu/~welfare). Requirements include a Ph.D. in psychology, human development, sociology, or related field, and preferably experience with large data sets and longitudinal analyses. See website for position details. Send a cover letter stating research interests, a curriculum vita, relevant reprints or preprints, and three letters of reference to P. Lindsay Chase-Lansdale, Ph.D., Institute for Policy Research, Northwestern University, 2040 Sheridan Road, Evanston, IL 60208-4100. Review of applications will begin February 15, 2005 until the position is filled. Position to start early summer, 2005. Minority applicants are encouraged to apply.

Helpful Hints for Affiliate Councils

NCFR's meeting for new student affiliate councils was attended by leaders of affiliate councils from across the nation. Attendees of this meeting shared many new and exciting ideas including recommendations for service activities, fundraising, and professional development. Since these recommendations have already proven to be successful, one of them may be helpful for your council.

For many affiliate councils, service is of utmost importance. However, it is sometimes hard to get people to commit to volunteering. Many of the affiliate leaders had suggestions for countering this dilemma. One council held a baby shower for a local crisis nursery, which included traditional shower food, games, and gifts. Another council put on a department-wide talent show with talent provided by students, faculty, and staff as a way to raise donations for local organizations. Yet another council required new members to complete their own member-initiated community service projects.

Another important aspect of running a student affiliate council is fundraising. Leaders of affiliate councils urged new councils to ask the Activities Office at their school if funds are available for their group. Leaders also suggested holding a silent auction at the regional conference, selling candy and other snacks in the department's main office, and developing a seminar on presenting at NCFR as a way to raise funds. One council even held "Pigskin Preschool," a babysitting service during home college football games, to raise money for their group.

The final theme that was discussed at the new student affiliate councils meeting was professional development. Leaders suggested bringing in a professional to speak in a classroom and inviting all others who were interested to join, thus ensuring a large, captive audience. Leaders also recommended constructing a voting guide on family issues, distributing research briefs that were generated via class assignments, inviting a panel of recent family science graduates to present information on their careers, and submitting articles to the *NCFR Report* as ways to enhance professional development.

Leaders of student affiliates across the nation shared many great ideas at the new student affiliate councils meeting; these are just a few and the possibilities are endless. Be creative and remember to bring your ideas to this year's meeting in Phoenix!

Kristine N. Piescher, M.A.
University of Minnesota Student Council
E-mail: kpiesche@che.umn.edu

Northwest Council on Family Relations

I realize that we are just starting a new year however 2006 is not far away! Plan now to attend the Northwest Council's Conference June 21-23, 2006 in Calgary, Alberta, home of the Calgary Stampede and near beautiful Banff National Park. The conference will be hosted by our neighbors to the north at the University of Calgary Main Campus. Conference co-coordinators are Karen Benzies and Don Swenson of the University of Calgary. This regional conference is a great place to share your research and scholarship in a small, friendly setting. Students are encouraged to submit papers. The strengths of this conference are the ability to receive suggestions and constructive feedback on your work from colleagues and to network with others in the Northwest. More details about the conference will be forthcoming during 2005.

Sandy Bailey, President
Northwest Council on Family Relations
President
E-mail: baileys@montana.edu

Michigan Council on Family Relations

Greetings from the Michigan Council on Family Relations. One of our major projects has been exploring ways in which we can make our peer reviewed journal, *Michigan Family Review*, more accessible to researchers and practitioners. Our effort has resulted in a collaboration with the University of Michigan press; that collaboration, under the leadership of our journal editor, Dr. Libby Blume, has resulted in the journal being available online as of February 1, 2005. The upcoming issue will focus on Families and Practice. The website is: http://www.hti.umich.edu/m/mfr

Finally, the availability of the journal online also now means that we will no longer require membership dues or a fee for the journal. Again, what a great opportunity and win-win situation for the Council and family studies scholars and practitioners. We hope that our work will continue to provide you with current research and practice information that supports the well-being of families and communities.

Gloria Warren Ph.D., President
Michigan Council on Family Relations
E-mail: Gloria_warren18@hotmail.com

NCFR wants to know!

If you have moved or plan on moving, please call 1-888-781-9331 or e-mail: info@ncfr.org with your new address. The U.S. Postal Service does not forward publications like the *Report* or journals, and we want to make sure you receive them.

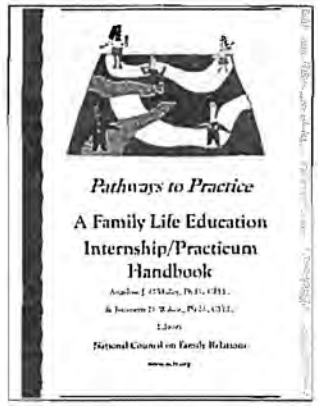
Two Great Resources from the National Council on Family Relations

Vision 2004: What is the Future of Marriage?

A thought-provoking collection of articles summarizing presentations from the 2003 NCFR Annual Conference. Vision 2003 covers topics on ethnically diverse marriages, marriages and TANF, gender roles in marriage, and marriage and public policy. Includes 13 research articles on marriage plus an editorial by leading marriage researcher, Paul Amato, on "The Future of Marriage." Great as supplementary text material for both undergraduates and graduate students.

$8.95 NCFR members;
$12.95 Non-members
plus shipping & handling*
ISBN #0-916174-66-2 OP0604

Family Life Education Internship/Practicum Handbook



NCFR members Angie O'Malley, Ph.D., CFLE and Jan Wilson, Ph.D., CFLE have edited this must-have resource for anyone involved in organizing and/or supervising internship or practicum experiences for family life education students. The book includes a brief introduction to family life education, internships and practicums, as well as discussion of professional issues in the workplace, enhancement of professional status, potential problems and ethical conduct. Special sections for faculty and site supervisors are included. The Appendix includes a collection of various forms, checklists, agreements/contracts, student assignments, evaluation tools and more.

$14.95 NCFR members;
$17.95 Non-members
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Call NCFR today to order either publication (or both!) at 1-888-781-9331 or visit the NCFR website at www.ncfr.org

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Sixth Annual

Public Policy and Education Conference

Families and Security

April 14-15, 2005

on Capitol Hill and at the
Holiday Inn Capitol at Smithsonian
550 C Street Southwest, Washington, DC

Wednesday evening, April 13 - 6:30 - 8 pm

Pre-conference reception with the Groves Conference on Families.
Holiday Inn Smithsonian. Coming in on Wednesday? Please join us! RSVP on your registration form.

Thursday, April 14
Congressional Briefing on Capitol Hill: Family Disaster Preparedness

NCFR members and professors of Family and Consumer Sciences share their expertise with members of Congress and their staffs, conference attendees, press, and the public, on helping families prepare for emergencies and how Public Policies can help. Concurrent Poster Sessions are open for review during the Congressional Briefing. Visit your representatives on the Hill in the afternoon! Attend the evening reception for the Congressional Service to Families Award presentation!

Friday, April 15
Strengthening Family Financial Security

Join your colleagues at three exciting plenaries at the Holiday Inn Smithsonian. Keynote address by Ted Halstead, CEO and founder of the New America Foundation.

For more information go to our website: www.ncfr.org
or contact Nancy Gonzalez, M.Ed., CFLE
NCFR Public Policy Project Director at nancy@ncfr.org

NCFR

Join NCFR, AAFCS and Groves Conference colleagues in Washington DC for intensive educational sessions, concise on-target briefings and face-to-face meetings with national leaders in public policy.

CALENDAR

March 30, 2005

Introduction to Using the Panel Study of Income Dynamics and its Child Development Supplement, Population Association of America Annual Meeting, Philadelphia, PA. More information can be found at http://psidonline.isr.umich.edu

March 31-April 3, 2005

Mobilizing for Change, 2005 Annual Meetings of the Midwest Sociological Society, Marriott City Center, Minneapolis, MN. For further information, visit www.themss.org

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June 23-26, 2005

9th Annual CMFCE/Smart Marriages Conference, Dallas, TX. Find more information at www.smartmarriages.com

November 16-19, 2005

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