Elucidating Parenting Processes That Influence Adolescent Alcohol Use:

A Qualitative Inquiry

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Keywords: African American, interventions, parenting, positive youth development, risk behavior, substance use

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Biographical paragraphs:

Tera R. Hurt is an Assistant Professor of Human Development and Family Studies at Iowa State University of Science and Technology. Her research program has two major foci. The focus of her descriptive research is to understand the meanings that individuals attach to their intimate relationship experiences, to examine nuanced behaviors and attitudes in romantic ties, and to understand the diversity in developmental pathways. The focus of her applied research is to translate this understanding into creative, culturally sensitive approaches to enhance intimate relationships. More specifically, she studies the effectiveness of skill-based marital and relationship enrichment curricula, which are designed to strengthen intimate relationships. In both areas of research, she employs samples of African American adults and adolescents and integrates qualitative and survey methodologies to provide complementary perspectives in examining these issues. She draws on developmental, ecological, and life-course theories to guide her work.

Gene H. Brody is Regents' Professor Emeritus of Child and Family Development and Director of the Center for Family Research at the University of Georgia. With funding from NIDA, NIAAA, NICHD, NIMH, and the W. T. Grant Foundation, Dr. Brody focuses on the development, design, and evaluation of family-centered programs to prevent drug use, unsafe sexual activity, and other risk behaviors among African American adolescents and young adults living in rural areas. Through longitudinal, developmental research and randomized prevention trials, he also investigates the role of gene × environment interactions in health and adjustment

among African American youth.

Velma McBride Murry holds a Betts Endowed Chair of Education and Human Development. She is Professor of Human and Organizational Development and Director of the Center for Research on Rural Families and Communities at Vanderbilt University. Dr. Murry is also a Co-Director of the Center for Community Engagement Research Core at Vanderbilt University Medical Center. With funding from NIMH, Dr. Murry has launched a randomized controlled trial of the Pathways for African American Success (PAAS) program to test the efficacy of a computer-interactive family- and community-based preventive intervention program for reducing risk behaviors among rural African American youths. PAAS is a second-generation extension of the Strong African American Families program that Dr. Murry and colleagues developed during her tenure at the University of Georgia.

Cady Berkel is a Post-Doctoral Fellow at the Prevention Research Center at Arizona State University. She received a Ph.D. in Child and Family Development from the University of Georgia in 2006. Her primary research interests concern the impact of discrimination on adolescent health, social disparities, and the protective influence of cultural factors. She is also interested in research on program implementation as a means of improving interventions that may reduce disparities.

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This research was supported by Award Number [5R01AA012768] from the National Institute on Alcohol Abuse and Alcoholism. Cady Berkel's involvement in the preparation of this article was partially supported by Award Number [T32MH18387] from the National Institute of Mental Health. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institute on Alcohol Abuse and Alcoholism, the National Institute of Mental Health, or the National Institutes of Health.

We also gratefully acknowledge the invaluable assistance of Dr. Shannon Miller in supporting the development of this manuscript, as well as assistance from Eileen Neubaum-Carlan, Olive Conyers, Lue Cooper, Tores Cox, Dr. Cassandra Logan, Dr. Patricia Logan, Vannerettee Robertson, and Angie Wilkerson. The first author wishes to thank her colleagues in the Qualitative Faculty Learning Community at the University of Georgia's Faculty Learning Group for helpful comments on an earlier draft. We are indebted to the caregivers and adolescents who shared their experiences with our research team.

Abstract

This study's purpose was to learn why some youths who participated in the Strong African American Families (SAAF) program increased alcohol use after 2 years whereas other youths did not. Using a sample of 28 African American caregiver-youth dyads, we collected qualitative data to explore these issues. Findings underscore the importance of caregivers' practicing vigilant monitoring to keep their adolescents from using alcohol. Recommendations for limiting access to alcohol and encouraging vigilant parenting are discussed.

Elucidating Parenting Processes That Influence Adolescent Alcohol Use: A Qualitative Inquiry

The Strong African American Families (SAAF) program was designed to discourage risky behavior and encourage competence-promoting parenting among African American youths and caregivers who lived in eight rural counties across northeast Georgia (Brody et al., 2004). Using insights and findings from two prior studies, Families In It Together (FIIT; Brody et al., 2002) and the Family and Community Health Study (FACHS; Simons et al., 2002), SAAF was based on an empirically derived model of processes linked to psychological adjustment, alcohol use, and high-risk behavior among rural African American youths. The aims of SAAF were to: (a) promote the use of parenting practices and active monitoring tactics found to protect youths from substance use and risky behavior; (b) promote youth self-regulation, future orientation, resistance efficacy, and negative images of peers who use substances; (c) delay the onset of substance use; and (d) explore the mechanisms through which specific components of SAAF were associated with the onset and escalation of substance use.

A longitudinal, randomized design was used to evaluate the effectiveness of SAAF, which consisted of a 7-week family-based interactive educational program for African American caregivers and their 11- and 12-year old children. Over 600 families were divided into two cohorts and randomly assigned to either SAAF or a control condition; families began taking part in SAAF in 2001. The families, who were recruited from rural areas and small towns with high levels of poverty and unemployment, were representative of their communities and can be described as working poor (Brody et al., 2004).

For data collection, a field researcher visited each family's home to administer a 2-hour interview with a youth and his or her primary caregiver, separately in a private setting. The interview assessments included self-report questionnaires designed to measure intervention-

targeted parenting behaviors and youth protective factors. Parenting behaviors included adaptive socialization, involved-vigilant parenting, clear communications of expectations about alcohol use, and communication about sex. Youth protective factors included resistance efficacy, future-oriented goals, negative images of substance users, acceptance of caregiver influence, and negative attitudes toward sexual activity and alcohol use. Participants received $150 upon completion of each wave of data collection. Seven waves of data have been collected to date, including a pretest and subsequent assessments at 7 months (posttest), 1 year 6 months (follow-up), 2 years 4 months (long-term follow-up), 4 years 4 months, 5 years 4 months, and 7 years 10 months.

Between the pretest and posttest interviews, a weekly intervention program designed to promote communication between caregivers and their preadolescent children took place. At each session, participants were served dinner during the first half hour to facilitate attendance and build rapport between family members and group leaders. During the next hour, caregivers and youths met separately with their assigned facilitators, African American community members trained to teach the SAAF curriculum. During the second hour, caregivers and youths met together as a group. Thus, families who attended all sessions received 14 hours of prevention training.

Previous work has reported on the efficacy analyses for SAAF, which has been demonstrated to be effective in increasing regulated, communicative parenting and reducing rates of substance use among youth (Brody et al., 2004; Brody et al., 2006). Specific intervention-targeted parenting behaviors have been shown to change from pretest to posttest. Brody and associates (2004, 2006) found that participation in SAAF increased caregivers' involved-vigilant parenting, racial socialization, and setting of expectations for alcohol use. Changes in these

parenting behaviors significantly forecast delay in youths' initiation of risk behaviors (i.e., lifetime alcohol use, marijuana use, and sexual activity) at 2 year follow-up (Brody et al., 2006). At 5-year follow-up (Brody et al., 2010), past 30-day alcohol use among SAAF participants was lower than among control participants. Increases in alcohol-related parenting behaviors specifically influenced youths' intentions to drink.

Although we learned much about the caregivers and youths across the course of the SAAF investigation, we were puzzled by the divergence in alcohol use patterns we observed at the 2-year follow-up among youths who took part in SAAF, regularly attending program sessions and being exposed to the same prevention curriculum. In the present study, we sought to understand these differential responses to the program. We looked at youths who demonstrated no increase from pretest to long-term follow-up in their use of alcohol and those whose use increased across that time. Specifically, we wanted to identify the factors and family processes that would explain these pathways. To do so, we employed an explanatory sequential design and adopted a method that would permit deeper exploration of the patterns that emerged from the survey data.

In the current study, we used an in-depth, phenomenological approach to explicate the quantitative findings from the survey, describe the nuanced behaviors of selected youths, and understand the meaning of their lived experiences. Our specific goals were to elucidate family processes that influence adolescent alcohol-related responses to the SAAF program after 2 years and to try a different method of evaluating prevention program outcomes. To delve more deeply into these issues and move beyond the limitations of survey data, we adopted a qualitative research design and used semi-structured interviewing techniques to capture detailed data about the caregivers' and adolescents' lived experiences. We expect the current study's findings to help

refine future approaches to designing prevention programs for youths and caregivers.

Background

The literature shows that reducing the incidence and prevalence of alcohol use among adolescents is important. Early age at initiation has been linked with increases in other problem behaviors, such as early sexual activity, as well as escalation in alcohol use throughout adulthood (e.g., Anda, et al., 1999; DeWit, Adlaf, Offord, & Ogborne, 2000). The effects of alcohol use cascade through domains such as physical, social, economic, and psychological well-being; academic achievement; and the development of aspirations and normative attitudes concerning marriage (e.g., Blair, 2010; DeWit, Adlaf, Offord, & Ogborne, 2000; Ellickson, Tucker, Klein, & Saner, 2004; Oxford, Harachie, Catalano, & Abbott, 2000; Spoth, Redmond, Trudeau, & Shin, 2002). Early alcohol use also increases vulnerability to subsequent alcohol problems if it occurs at a time when environmental conditions strongly support regular, continued use (Oxford, Harachie, Catalano, & Abbott, 2000; Spoth, Redmond, Trudeau, & Shin, 2002). Of particular concern are the costs of alcohol use for African American youth. Jones and colleagues (2008) noted several specific negative consequences for alcohol-using African American youth, including school dropout, sexual risk behavior, and involvement with the criminal justice system. Accordingly, we focused our study on within-group analyses with a sample of African American youths.

Previous work has established clear links among low parental monitoring, poor communication, heightened incidence of alcohol use, and adolescent alcohol use initiation and continuation (Brody et al., 2004; Oxford, et al., 2000; Ellickson, Tucker, Klein, & Saner, 2004). In a cross-sectional study with 692 families on parental monitoring and adolescents' bargaining for time away from home, Borawski and colleagues (2003) found that negotiated opportunities to

spend unsupervised time with peers away from home was positively associated with alcohol use. Information about teens' whereabouts, however, did not prevent adolescents from using alcohol. Rather, negotiated opportunities to be away from parents gave teens chances to experiment, though they did so in a relatively controlled manner. Because youths exposed to unsupervised environments (e.g., teen parties, hangout spots) may encounter opportunities for initiating and experimenting with alcohol, it is crucial for caregivers to be proactive in their expectations, monitoring, and communication with adolescents. The SAAF program focused extensively on monitoring and communication (Brody et al., 2004), recommending strategies such as telephoning or visiting to make sure youths were where they said they would be, observing youth behavior for signs of alcohol use, and getting to know the parents of youths' friends.

The current study extends existing research in several ways. First, it uses in-depth interviews to explore the reasons why youths do or do not respond to prevention programming. Specifically, we wanted to learn more about family processes that influenced youths' alcohol use 2 years after their participation in the SAAF program. This will provide insight into the program's accomplishment of its objectives and the changes among youths and caregivers that resulted from program participation. Second, it illustrates the use of qualitative methods to evaluate intervention programming with African American caregivers and adolescents. Third, it builds upon existing work in ways that contribute to future development of prevention programming.

Method

Sample

The data analyzed for this project were collected in 2005 from participants who were initially recruited into the first cohort of SAAF in 2001. To qualify for the current study, youths

must have attended four or more SAAF sessions and scored at the extremes on an indicator of alcohol use 2 years after taking part in the program. To identify families at the extremes, we used two outcomes targeted in the SAAF intervention, parenting and youth alcohol use. Intervention-targeted parenting consisted of four indicators: involved-vigilant parenting, adaptive racial socialization, communication about sex, and clear communication of expectations about alcohol use. Involved-vigilant parenting is composed of 19 items rated on Likert scales ranging from 1 (*never*) to 5 (*always*) that assess the frequency of parental behaviors concerning involvement (e.g., When you and your child have a problem, how often can the two of you figure out how to deal with it?), inductive reasoning (e.g., When your child doesn't know why you make certain rules, how often do you explain the reason?), consistent discipline (e.g., How often do you discipline this child for something at one time and at other times not discipline him or her for the same thing?), and monitoring (e.g., How often do you know where your child is when he or she is away from home?). The means for parenting behavior were 63.7 at Wave1 and 65.7 at Wave 4 out of a possible score of 95, indicating relatively high involved-vigilant parenting in the sample.

Racial socialization was assessed using the 15-item Racial Socialization Scale (Hughes & Johnson, 2001), which is scored on a Likert scale ranging from 1 (*never*) to 3 (*three to five times*). The items address the frequency with which parents have engaged in specific racial socialization behaviors during the past month (e.g., talked to your child about the possibility that some people might treat him or her badly or unfairly because of his or her race, done or said things to encourage your child to do other things to learn about the history or traditions of your racial group). The means for this scale were 22.1 at Wave 1 and 27.3 at Wave 4 out of a possible score of 45, indicating relatively infrequent racial socialization.

The 9-item Parental Communication About Sex Scale was adapted from previous scales measuring parental communication about substance use (see Gerrard, Gibbons, & Gano, 2003; Wills et al., 2003). The items are rated on a Likert scale ranging from 0 (*no*) to 2 (*yes, quite a bit*). Parents are asked whether they have ever talked with their children about topics such as reproduction/having babies, menstruation, sexually transmitted diseases, and HIV/AIDS. The means for this scale were 4.7 at Wave 1 and 8.5 at Wave 4 out of a possible 18 points, indicating relatively infrequent communication about sex.

Expectations about alcohol and other drugs were assessed using two items written by Spoth et al. (1998). Rated on a scale ranging from 0 (*not true*) to 2 (*very true or often true*), the items were: ‘‘I have told my child exactly what I feel about alcohol and drugs’’ and ‘‘I remind my child that very few children his or her age get involved with alcohol and drugs.’’ The means for this scale were 3.2 at Wave 1 and 3.2 at Wave 4 out of a possible 4 points, indicating relatively frequent expression of parental expectations about substance use. To create the parenting composite, we first standardized the four indicators and then averaged the standardized scores. The four parenting indicators are described in more detail in Brody et al., 2004.

An assessment of alcohol use was obtained by asking the target youth the number of drinks of beer, wine, wine coolers, or other liquor that he or she had consumed during the past month. Mean numbers of drinks were 1.5 at Wave 1 and 0.88 at Wave 4. Youths who used alcohol to comparable extents at baseline and long-term follow-up were excluded from the analyses.

We calculated change in caregiver and youth outcomes by subtracting the Wave 1 measures from the Wave 4 measures for the intervention group. Next, we used the rank procedure in SAS to give ranks to each family based on the two scores. Then, we used the total

rank score to identify the families ($n = 41$) who displayed the least and the greatest change in the two outcomes. We excluded 13 families who did not attend at least four of the seven SAAF intervention sessions. The final sample included 28 caregiver-youth dyads.

Invitations were mailed to these 28 adolescents and their caregivers to request their participation in a small follow-up study. We asked the families to share their experiences with SAAF to help investigators improve the project in the future. Of the targeted sample, all eligible families agreed to participate, a 100% response rate. Caregivers were compensated $75.00 for their interviews; adolescents were given a $50.00 gift card.

Following are the key demographic characteristics of this study's sample; the total sample has been described elsewhere (Brody et al., 2004). All caregivers in the study sample were female; 79% were the adolescents' biological mothers, 18% were grandmothers, and 3% were aunts. Mean caregiver age was 42.9 years. Most caregivers had a high school diploma or GED. Of the caregivers, 46% were not partnered, 25% were dating, 21% were living with a partner to whom they were not married, and 8% were married.

Mean adolescent age was 14.6 years; 61% were female and 39% were male. We refer to the adolescents who increased their alcohol use between baseline and long-term follow-up as *using*. Those who did not report experimenting with alcohol during this period are called *non-using.* At the start of the analysis phase, 6 male and 10 female adolescents were non-using (57%). Among the using adolescents (43%), 5 were male and 7 were female.

Interview Procedures

Interviewers attended two sessions in which they were trained to conduct semi-structured interviews; the sessions covered ways to ask questions, strategies for using probes to obtain comprehensive responses from interviewees, and tactics for handling sensitive issues.

Interviewers were also familiarized with the SAAF program curriculum, enabling them to probe participants' accounts of program activities. Two interviewers visited each home to conduct separate interviews with the caregiver and the adolescent; interviewers were matched with participants on race and gender. All questions were open-ended to maximize the depth and range of information that the respondents could provide. In addition, we did not advance hypotheses about the findings. As mentioned in the Introduction, we sought to explain the differences in outcomes among youths that the survey data revealed. The use of open-ended questions was most conducive to this goal.

The main purpose of SAAF was to increase parenting behaviors and monitoring practices that previous research indicated were protective for rural African American children; thus, the interviewers focused on exploring these behaviors from the caregivers' and adolescents' perspectives (Brody et al., 2004). Consistent with a phenemenlological approach, the interviewers also asked participants about their perceptions of SAAF's quality, their thoughts and feelings about alcohol, and their family and peer contexts, and the meanings of these contexts in their lives. Inteviewers posed the following questions, phrased appropriately for youths and caregivers.

To explore the caregivers' and adolescents' family relationships, daily routines, and alcohol use, the interviewers asked (a) "When your caregiver is not able to be with you, how does she monitor your activities?" (caregiver: "When you are not able to be with your adolescent, how do you monitor his/her activities [e.g., never leave them alone, have someone to check on them often])?", (b) "Do you remember any information in SAAF that addressed alcohol?", (c) "Do you know people who drink alcohol? What kinds of things have you observed?" Interviewer comment: Explore any alcohol use, access, and context of alcohol use.

To learn more about parenting style, interviewers asked: (a) "Describe your relationship with your caregiver/child. Are they supportive?", (b) "Do you usually get along with them? What happens when you don't get along?", (c) "In your opinion, are the house rules clearly stated and frequently enforced?", (d) "Does your caregiver provide you with clear expectations for what she wants you to do or not do? Explain.", and (e) "Does your caregiver model the kind of behavior she wants to see in you?" Trust between the caregiver and adolescent was assessed with the question, "Does your caregiver trust you?" (caregiver: "Do you trust him/her?").

Reliability and internal validity were assessed using multiple methods and sources of data. The interviews were recorded digitally and later transcribed. Within 3 days, each interviewer submitted a written account of his or her perceptions of each interview, including respondent honesty and openness, nature of interaction between caregiver and adolescent, an opinion about the veracity of participants' responses, participant's non-verbal cues (e.g., mannerisms), and the overall tone of the interview. The interviewers' written reflections facilitated understanding of the interview context. Interviewer comparisons about the discussions with each respondent in the home also helped in evaluating the degree of consistency in caregivers' and adolescents' reports. Gathering different perspectives about the interview experience and qualitative data collected from caregivers, adolescents, and interviewers allowed the analysts to evaluate the data's reliability. Using different sources of information helped to maximize the likelihood of detecting interview bias in responses from youths and caregivers in the same family (LeCompte & Schensul, 1999).

Reliability was maintained through regular, often daily, communication with interviewers about their comfort with administering the interview protocol and related field experiences. To ensure reliability across interviewers, interviews were digitally recorded and the first author

conducted intermittent checks of the interviews by listening to the digital recordings to ensure quality control. Interviewers were encouraged to evaluate the study method and discuss their interpretations with the first author at meetings. After data collection ended, the first author discussed patterns in the data with other staff at the research center who had worked with the SAAF participants to obtain their feedback about the information collected. These staff members served as key informants. The recorded interviews were transcribed for analysis.

Results

Analytic Procedures

Data were analyzed in a series of steps to detect themes and patterns. First, three data analysts used a within-case approach (Huberman & Miles, 1994) in which each analyst carefully reviewed the transcripts and then developed case profiles that summarized the interview content for each caregiver-adolescent pair and described the family's experience. Second, information was compared across families using a cross-case approach (Huberman & Miles, 1994). To detect prevailing themes, the analysts examined participants' responses regarding parental monitoring and alcohol use across interviews. Analysts then looked for patterns and attempted to identify clusters of caregivers and adolescents with similar features related to parental monitoring and alcohol use (a case-oriented approach). In the final step, analysts drew conclusions about similarities and differences in the data pertaining to the influence of daily routines, caregiver-adolescent relationship quality, and caregiver monitoring on adolescent alcohol use (Huberman & Miles, 1994).

As the analyses proceeded, some of the adolescents who had been classified as non-using on the basis of the information they provided at the long-term follow-up assessment were reclassified as using because they had initiated alcohol use during the 6 months that elapsed

between the follow-up and the interview. This reassignment on the basis of interview data rather than follow-up assessment data produced more accurate classifications. After reassignment, 39% of the youths were classified as non-using and 61% were classified as using. Of the 11 male adolescents in the sample, 4 were reassigned to the using category, for final subsamples of 2 non-using and 9 using young men. Of the 17 female adolescents in the sample, 1 was reassigned to the using category, for final subsamples of 9 non-using and 8 using young women.

Because the 6 months between the Wave 4 data collection for SAAF and the qualitative interview proved to be a significant window of opportunity for the initiation of alcohol use, we wondered whether age may have contributed to pre-interview initiation. To determine whether non-using and using adolescents differed in age, we performed an independent *t*-test. The *t*-value was -2.73, $p = .012$; this indicated a significant between-group age difference. Non-using youths were slightly younger ($M = 13.18$, $SD = .41$) than users ($M = 13.65$, $SD = .49$).

In the next sections, we first outline results pertaining to adolescents' access to alcohol and then discuss the roles of monitoring, trust, and unsupervised activities in youths' alcohol use. All names of individuals quoted have been changed to conceal their identities.

Access

Access to alcohol differed between using and non-using teens. According to the caregivers, youths who drank alcohol had more access to it than did non-using adolescents (88% vs. 50%). For example, half of the caregivers of non-users of both genders stated that they kept alcohol in their homes. Two caregivers stated that they did not keep alcohol in their homes but still believed that their adolescents had ready access to it at school or in the community. One mother, reflecting on her own childhood experiences, said, "I know there's so much going on in the school system and in the neighborhood....I went in the liquor store and bought [it] before I

was even 16, so they probably go in the stores themselves."

Caregivers of two male users (12%) stated that no alcohol was stored in the home. Among using youths, 78% of the young men and 100% of the young women reported that alcohol was kept in the home. In one family, reports were contradictory; the caregiver stated that she did not keep alcohol in the home but her daughter stated the opposite. According to the daughter, the caregiver frequently hosted parties for family members and friends at which alcohol was used freely. The teen reported leaving the home to distance herself from the alcohol use and the activities that accompanied it. The analysts were alerted to the discrepancy in the respondents' accounts and this source of interview bias with the interviewer's reflections.

According to non-using female youths, 78% said that they had no access to alcohol. Among using female adolescents, many explained their use by stating that they drank responsibly, only tried it once, or didn't swallow it. Though they admitted trying alcohol, most using female adolescents were unwilling to specify the source from which they obtained it, either avoiding the interviewer's attempts to probe and question them or saying they were unsure. Two using female youths (25%), however, told the interviewers that they found it easy to obtain alcohol from adults such as older relatives (e.g., siblings, cousins, aunts) or drug-using neighbors who would purchase alcohol for them in exchange for few extra dollars. Tasha, age 14, reported trying alcohol and said, "A majority of students in high school really work on gettin' alcohol and not drugs because minors can't really get it because the people that sell drugs know you're underage and they know they made mistakes….Alcohol is easier to get."

If adolescents can access alcohol if they desire it, why do some teens use alcohol whereas others do not? In the next section, we address the relationships among caregiver-adolescent trust, monitoring, and unsupervised activities. We use case examples to illustrate the significance of

vigilant caregiver monitoring even of trusted youths to protect them from risky situations.

Caregiver-Youth Trust, Monitoring, and Unsupervised Activities

Non-using youths. Non-using youths of both genders reported consistent daily routines, and they stated that they were at home most of the time when not at school or church and were monitored there by the caregiver, a grandparent, or an older sibling. Non-users reported communicating with friends by phone on the weekend rather than going out with them. These teens and their caregivers had close and confiding relationships with each other. Caregivers established clear rules for adolescents and disciplined them when necessary.

Among the caregivers of non-using female youths, 63% said that they did, and 37% said that they did not, trust their daughters. Regardless of their trust level, these caregivers rarely allowed their daughters to be unsupervised. When away from home, these young women were always monitored by caregivers or trusted adults (e.g., grandparents, aunts, school personnel) in their social networks. A few exceptions to this pattern occurred in families in which teens were alone after school or the caregivers left their daughters at home while running brief errands, to enhance the youths' confidence and perceptions of caregiver trust. Two caregivers stated that they did not actively monitor the adolescents but trusted God to keep their daughters "on the straight course"; they also perceived their daughters' friends, whose parents they had come to know well, as very trustworthy.

Non-using female youths corroborated their caregivers' accounts, with 80% stating that they were constantly monitored by caregivers or other trusted adults. On rare occasions when they were away from home without their caregivers or family members (e.g., school activities), these young women were expected to call their caregivers if their plans changed or if they would be delayed in returning home.

The following example illustrates this pattern. Before taking part in SAAF, 35-year-old Candace told her 14-year-old daughter Shay not to use alcohol; however, SAAF taught Candace how to discuss with Shay the reasons why Shay should not drink alcohol. SAAF participation enhanced Candace's ability to communicate with her daughter on this topic, including her expectations for her daughter's behavior. Candace shared a good relationship with Shay. Although she trusted her daughter, Candace nevertheless felt that it was important to keep a watchful eye on her child. Candace vigilantly monitored her daughter and received support from others in her social network. Shay's teachers, track coaches, and grandfather all participated in the continuous supervision of Shay. Although Shay would have liked greater freedom, she understood that her mom cared for her and did not want her to make mistakes and experience their negative consequences.

The caregivers of the two non-using male adolescents both said that they trusted their sons, but they did not leave them without continuous adult supervision. One caregiver said that she monitored activities in the home even in her absence: "I call and I ask. When I [get] home, I check behind them to make sure they did what I told them to. They know not to tell me a tale." These two caregivers rarely allowed their non-using sons to be unsupervised and said that the teens were often with them or another trusted adult in their networks, such as family members or friends' parents whom the caregivers had come to know and trust. One mother, age 37, shared the following observation:

> I am very particular of my boys. I'm not going to take them to a house and leave them. I'm going to have to get to know that parent first. I'm going to have to see what's going on in your household before I leave my children there….Also, I can trust him because I talk to him.

The sons likewise reported constantly supervision by their caregivers or other trusted adults.

Using youths. Among the families of young women and men who used alcohol, youths' daily routines involved spending more time away from home on a regular basis as compared with families of non-using youths. Not only were using youths more likely than non-users to travel away from the home during the day, but also the daily routines in their homes were less predictable. Disruptions in routines were attributable to crises that upset and taxed the family system, such as caregiver illness and injury, death of one or more family members, economic stress, substance use, incarceration, and homelessness.

Moreover, caregivers of using teens were less knowledgeable about their adolescents' activities than were caregivers of non-users. Using youths were allowed to leave home without stating where they were going or when they would return. This pattern partially reflected another factor associated with low levels of parental monitoring, poor caregiver-adolescent relationship quality. Using adolescents disclosed less about their lives and whereabouts to their caregivers than did non-users. While away from home, using youths were more likely than their non-using peers to spend time with their friends during the weekends at teen parties and sleepovers; non-users kept in touch with friends by phone from home. Using youths also stated that their family members (e.g., older siblings, aunt, cousins) and neighbors provided alcohol and encouraged its use.

Male youths. Caregivers of using male adolescents did not monitor the youths as closely as did caregivers of non-users. These caregivers said that the SAAF curriculum informed them of the signs for which they should watch. Some caregivers reported trusting their sons when unsupervised, so they gave their sons more freedom and independence than did caregivers of non-using adolescents. They were comfortable relying on their knowledge of the signs of alcohol

use to keep their sons safe. Other caregivers stated that they regularly asked older relatives whom they believed to be trustworthy to watch their children. Caregivers who adopted this style of monitoring preferred to stay in touch by making phone calls or personally driving teens to locations where they would be unsupervised. Most noted that they rarely checked with their teens to determine whether they stayed where they said they would be.

Marla, 46, stated that she could only vouch for times that her nephew, Dante, was in her presence, implying that it was possible for Dante to have conducted himself against her wishes in her absence. Indeed, during the qualitative interview Dante reported having drunk alcohol "a little bit. Like it was on New Year's Eve. I wanted to try it," at a party with other teens. Dante did not plan to use alcohol regularly, though, because he feared it would disappoint his aunt. Marla had assumed guardianship for Dante throughout his youth because both of his biological parents had used drugs and alcohol for years, giving this family first-hand experience with the effects of substance abuse. Dante also observed that alcohol is commonly glorified on television and that advertisers link it to sports, women, and other attractive images to promote sales. Nevertheless, Dante noted some negative consequences of alcohol use, such as addiction, vehicle accidents, and other mishaps.

Though caregivers of using male adolescents reported giving the youths a measure of independence, the youths considered themselves to be very closely monitored. Upon further probing it became apparent that, although the adolescents' own responses suggested that they were not closely monitored, the youths nevertheless desired more independence than their caregivers were willing to grant them.

Although 15-year-old Harry reported alcohol use, his mother Nina, 45, felt confident that he had not drunk alcohol. She explained that her son was not at risk because he did not like the

scent of cigarette smoke. In addition, she believed that her knowledge of the signs of alcohol use, such as mood swings or a change in eating habits, was sufficient to alert her if her son began using alcohol. She reported a good relationship with her son and felt able to monitor him despite her report of long working hours. She stated, "He always calls and lets me know where he is. Very rarely does he do something that he doesn't let me know where he's going and who he's going with." Although Harry had drunk alcohol, he was not currently drinking at time of the interview.

Female youths. Among female adolescents, caregivers of users (29%) tended to monitor their youths less closely than did caregivers of non-users (71%). The former stayed in touch via phone calls except when the youths were in the company of trusted adults; in that case, caregivers rarely checked on the adolescents. Youths who used alcohol corroborated these reports. Some caregivers felt that, because they trusted their children, they did not always have to be with them. Other caregivers believed "children will be children" and felt comfortable looking for signs that teens might be using alcohol. These caregivers believed that looking for signs of alcohol use constituted adequate vigilance. Most adopted this viewpoint based on their own rearing by their own caregivers. Tasha's caregiver used this monitoring style. Tasha's interviewer noted, "When asked more about her life, Tasha began to point out many problems in her community, including easy access to alcohol. She pointed to a house just down the street where a woman operated an underground liquor store and sold alcohol to everyone in the neighborhood including minors."

Female users spoke of opportunities they encountered to try alcohol for the first time. Faced with situations in which there was no adult supervision to prevent underage drinking or in which their friends were using alcohol, many felt overwhelmed by peer pressure and complied

by taking a single drink. A grandmother who attempted to monitor her granddaughter's activities and peer associations stated, "I remember you look for the signs of the mood swings of the kids and the kids that they are associated with. I've got firsthand experience with alcohol with their mother and that's why I have to watch closely. Alcohol is the worst thing that can be. That's why I try…when she leaves or goes somewhere I know who she's going with. I'll call their parents and see if she got there even though she calls me. She could call me from anywhere. I have to have a phone number and I have to know who she's leaving with. Because drugs and alcohol have taken over everything, especially drugs. And if I can keep her away from that, then ok." Nevertheless, the granddaughter had used alcohol in environments in which other teens were using it. The granddaughter noted, though, that her friends were trying to avoid further alcohol use: "You can tell they're trying to stop because they'll call you and want to do something and we'll go to like Pizza Hut where you can't get alcohol and we'll stay there."

Discussion

Findings from this investigation support a protective factor perspective. Protective factors are influences that modify the effects of risk in a positive direction (Luthar & Cicchetti, 2000). Such factors are important because they have the potential to alter expected outcomes. Examples of protective factors that encourage positive outcomes include specific behaviors and family resources such as vigilant parenting, high-quality parent-child relationships, and healthy parent-child communication (Brody et al., 2004).

Access to alcohol is of primary importance in adolescents' use, and the current findings identified some of the ways in which adolescents acquired alcohol. The neighborhood was a primary route that both caregivers and adolescents identified, albeit from different perspectives. Neighborhood risk has been noted in the extant literature as a key factor in adolescent alcohol

use (Gibbons, Gerrard, Vande Lune, Wills, Brody, & Conger, 2004).

The current study extends previous work conducted as part of SAAF by identifying specific ways in which youths access alcohol in the community. Adolescents obtained alcohol primarily through neighborhood adults or older relatives, not peers. Teens sometimes described these individuals as providing youths with opportunities to learn about alcohol use in a mentored environment as part of their socialization for adulthood, or as offering teens a way to access alcohol in exchange for a few extra dollars. These findings demonstrate that adolescents' access to alcohol is not just an urban issue, and that African American teens residing in rural towns and small communities face similar circumstances. Clearly, some adults in the village are not serving a protective function in helping to raise the children; rather, they are helping to promote underage alcohol use by providing opportunities for youths to drink. This point is consistent with literature that underscores the importance of examining the roles of family members (e.g., cousins, siblings) and older acquaintances who give adolescents access to alcohol and opportunities to initiate use, rather than concentrating solely on peers (Brook, Kessler, & Cohen, 1999; Catalano, Morrison, Wells, Gillmore, Iritani, & Hawkins, 1992; Ellickson, Tucker, Klein, & Saner, 2004; Kosterman, Hawkins, Guo, Catalano, & Abbott, 2000; Rhee, Hewitt, Young, Corley, Crowley, & Stallings, 2003).

As access to alcohol varied, so did the monitoring strategies that caregivers of using and non-using youths recalled from the program. Teens whose caregivers responded to the SAAF curriculum by becoming more vigilant and ensuring teens were supervised were likely to have avoided drinking alcohol. These caregivers ensured that their adolescent children were protected, either in their own care or that of a trustworthy adult. Caregivers of non-users also had good relationships with their adolescents, set clear rules and expectations, and disciplined youths as

needed. Such involved-vigilant parenting practices have been shown to delay youths' initiation of alcohol use among (Brody et al., 2008). The current study revealed more about the ways in which such family processes operate to protect youths from initiating alcohol use.

Other caregivers took a more passive approach to monitoring, using fewer protective practices. Caregivers trusted adolescents to follow their rules in their absence and believed they would know if youths were drinking alcohol. Although they were involved in their adolescents' lives, they did not vigilantly monitor youths' whereabouts away from home. These findings extend our understanding of the reasons why certain youths in the SAAF sample used alcohol and identify key family processes that provided youths with opportunities to engage in risk behaviors.

As in prior studies, less active parental monitoring was associated with an increase in alcohol use (e.g., Kosterman, Hawkins, Guo, Catalano, & Abbott, 2000). It appears that, as in previous work by Borawski and associates (2003), adolescents took advantage of their caregivers' trust to experiment with alcohol during unsupervised time. Because adolescents assigned to the using group were older, they may have been able to negotiate more unsupervised time away from home than non-using youths. Additionally, their caregivers thought that using adolescents would surely display signs of use, which the caregivers would recognize based on information presented in SAAF. Although it is useful in combination with other recommendations, this strategy cannot be used alone to prevent alcohol use because, by its very nature, it identifies alcohol use only after it has occurred. Consistent with the extant literature, these caregivers' sons and daughters were likely to report having increased their alcohol use. As in previous work, many of these teens noted that they did not plan to drink alcohol but found themselves in environments where the opportunity presented itself (Gibbons, Gerrard, & Lane,

2003).

Among caregivers of using teens, several factors contributed to ineffective monitoring. Previous work has shown that parents' problems can impact their monitoring of adolescents (Crouter & Head, 2002). Other factors included unpredictable daily routines and poor parent-child relationship quality (Crouter & Head, 2002). Using adolescents also reported spending more time away from home than did non-users. Alcohol use also may represent a youth's means of coping with stress associated with a caregiver's life concerns and crises. Family structure, such as the availability of only one caregiver, may set in motion key family processes that influence the likelihood of youth experimentation with alcohol.

Limitations

Several limitations to the current study must be considered. A small sample was used to enable us to capture the depth of the participants' experiences; the sample was also nonrandom. Thus, the findings may not be externally valid. Conclusions reached in this study are primarily relevant to low-income African Americans residing in rural northeast Georgia and may not apply to caregivers and adolescents living in other places. In addition, the data were obtained from retrospective reports and are subject to the participants' recall and interpretation of their experiences.

Data collection also was not consistent across cases. We did not delete any cases from our analyses although some respondents did not offer full accounts of their experiences. Therefore, we were able to determine that an event occurred but could not always determine from the participants' accounts why it occurred. Depth of adult participants' responses reflected individual differences in talkativeness, fatigue from work, and pain associated with injury or disability rather than level of discomfort with the interviewer or interview context. In spite of

the confidential nature of the interview, some adolescent participants were reticent about activities, such as drinking alcohol, that violated their caregivers' expectations because they feared being disciplined or disappointing their caregivers. Information contained in the interviewer's reflections also aided in our understanding of the context of the interview and the respondent's reactions.

Another limitation concerns the measurement of alcohol use. Recall that alcohol use was assessing by asking the target youth the number of drinks of beer, wine, wine coolers, or other liquor that he or she had consumed during the past month. The assessment does not specifically query the adolescent using the word "drink" in the question. However, in the next follow-up question about alcohol use, the assessment inquires about whether the adolescent ever had three or more drinks. This ambiguity represents a limitation.

Conclusions

Despite its limitations, this study is an important facet of the SAAF evaluation. Although quantitative, longitudinal studies from the randomized control trial demonstrated that SAAF was efficacious, qualitative studies can reveal specific changes in family systems as a function of the program and pinpoint external contexts that the program may still need to address (Riger, 2001). On the basis of these analyses, we found that access-related contextual factors and caregiver selective attention to passive monitoring strategies were associated with adolescent risk.

Although SAAF's targeting of parenting processes supports effective communication and monitoring strategies, it does not reduce youths' access to alcohol from peers at school, community members, or older family members. The program, however, included resistance strategies (e.g., self-talk to avoid temptation) that youths rehearsed via role play; this has been shown to be effective for increasing refusal of alcohol offered by peers (Brody et al., 2004). The

program did not address resistance of alcohol use when offered by adults, particularly extended family members. Future family-based prevention programs should cover this situation.

A multifaceted community effort might succeed in reducing this important contributor to adolescent alcohol use. Parents could be encouraged to form partnerships with local and state agencies to increase penalties for selling alcohol to minors or buying alcohol for them. Residents could also be helped to develop neighborhood watch programs that target provision of alcohol to minors along with other illegal activities and to become vigilant in identifying and dealing with situations in their communities that promote underage drinking.

Previous work on child-rearing strategies has examined a process termed collective socialization, which occurs when adults in a community agree upon a common set of standards for child behavior, then monitor their own and other children in the community to reinforce appropriate behavior and address misbehavior (Simons, Simons, Conger, & Brody, 2004). When community residents band together in this way, the process of monitoring reaches beyond the household as adults cooperatively enforce acceptable conduct for children. SAAF was designed to foster collective socialization indirectly, through the program's group discussion format, by building a network of parents who could rely on each other to enforce standards of behavior outside the home (Brody et al., 2004).

Future work in this area could follow participants who took part in an educational program and use assessments to review program goals and ensure that participants know how to apply correctly the information they learned. Program participants could also provide feedback on ways to improve intervention design and identify emergent risk and protective factors, a current need in the field of intervention and prevention.

Examining differences between using and non-using youths whose families attended a

majority of SAAF sessions provided a perspective on the skills that caregivers incorporated into their parenting and those that should receive greater emphasis in future implementations. Some caregivers believed that one monitoring strategy, observation of youths for signs of alcohol use, was sufficient to protect their adolescents without the other important monitoring strategies that the program covered. The curriculum may need to be modified to emphasize that monitoring and communication strategies must be used together.

Although caregivers believed they were adopting program recommendations by vigilantly observing youths, proactive monitoring strategies are also necessary to prevent alcohol use. The current study revealed that adolescents' alcohol initiation or avoidance of initiation largely depended on their caregivers' vigilance in monitoring. When confronted with an opportunity to try alcohol, adolescents were likely to yield to immediate pressure rather than acting in accordance with their caregivers' values. Caregivers of adolescents should monitor youths closely and vigilantly, enlisting the support of relatives, school personnel, or other trusted adults when they are unable to supervise the teens themselves.

The current study demonstrated that, although SAAF was effective in delaying alcohol use, a group of participants increased alcohol use despite attending at least four of the seven program sessions. Examination of differences in the family and community contexts of using and non-using youths demonstrated that access to alcohol and caregivers' selective adoption of monitoring strategies exposed youths to risks that they were unable to surmount. This valuable information can inform modifications of the SAAF program in which the importance of active monitoring can be emphasized and community mobilization to address access to alcohol can be proposed.

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