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

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Abstract

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

Keywords

African American; adolescents; intervention; monitoring; alcohol use

Background

Previous literature shows that reducing the incidence and prevalence of alcohol use among adolescents is important for several reasons. Early age at initiation has been linked with an increase in other problem behaviors like sexual behavior, early pregnancy, alcohol-related motor vehicle accidents, and crime as well as a rise in alcohol and substance use throughout adulthood (e.g., Anda et al., 1999; DeWit, Adlaf, Offord, & Ogborne, 2000; Dooley, Prause, Ham-Rowbottom, & Emptage, 2005; Odgers et al., 2008). Early alcohol use may increase one's vulnerability to subsequent alcohol problems because it may occur at a time when environmental conditions strongly support regular, continued use (Oxford, Harachi, Catalano, & Abbott, 2000; Spoth, Redmond, Trudeau, & Shin, 2002). Alcohol use in adolescence is also problematic because it has the potential to cascade through other domains such as physical, social, economic, and psychological well-being. Early alcohol use could also negatively affect academic achievement (inclusive of low educational achievement and/or school dropout) and the development of aspirations and normative attitudes concerning marriage (e.g., Blair, 2010; DeWit et al., 2000; Ellickson, Tucker, Klein, & Saner, 2004; Odgers et al., 2008; Oxford et al., 2000; Spoth et al., 2002). In light of existing research, the United States Surgeon General issued a call to action to cease

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underage drinking (U.S. Department of Health and Human Services, 2007); in doing so, particular focus was placed on highlighting specific risks to youth who reported experimenting with alcohol before age 15. Moreover, according to Jones and colleagues, a notable concern relates to the costs for increased alcohol use among African American youth. In particular, these authors point to the following factors as possible negative consequences specifically for African American youth, including dropping out of school, engaging in risky sexual behavior, and becoming involved in the criminal justice system (Jones, Hussong, Manning, & Sterrett, 2008). For this reason, we conduct within-group analyses with a sample of African American youth for this study.

Previous work in this area has also established clear links among ineffective parental monitoring, poor parent-child communication, and increased alcohol use initiation and continuation among adolescents (Brody et al., 2004; Ellickson et al., 2004; Oxford et al., 2000). In a cross-sectional study, Borawski and colleagues (Borawski, Levers-Landis, Lovegreen, & Trapl, 2003) found that negotiated opportunities to spend unsupervised time away from home with peers was positively associated with alcohol use among a sample of 692 adolescents. These authors noted that parents used negotiated unsupervised time with their teens to set limits on youth's whereabouts while offering them independence and freedom. Merely being informed about teens' locations was not enough to protect adolescents from experimenting with alcohol. Rather, negotiated opportunities to be away from parents gave teens chances to experiment, though they did so less irresponsibly. Moreover, because youth 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 Strong African American Families (SAAF) program was designed to discourage risky behavior and encourage competent parenting among African American caregivers and youth 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, Murry, Kim, & Brown, 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 youth. The aims of SAAF, in which a longitudinal, randomized design was used, were to (a) promote the use of parenting practices and active monitoring tactics found to protect youth from substance use and risky behavior; (b) promote 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.

To meet the study's aims, the SAAF project evaluated the effectiveness of a 7-week family-based interactive educational program for African American caregivers and their 11- and 12-year-old children. More than 600 families were divided into two cohorts; families participated in the program beginning in 2001. The families, who were recruited from rural areas and small towns with high levels of poverty and unemployment, are representative of these communities and can be best described as working poor (Brody et al., 2004). Seven waves of data have been collected to date. In between the pretest and 7-month follow-up (posttest) interviews, a weekly intervention program took place. Caregivers and youth who attended all sessions received 14 hours of prevention training. The weekly meetings for the educational program were designed to promote communication between caregivers and their preadolescent children, and the sessions focused extensively on monitoring and parent-child communication (Brody et al., 2004).

In work conducted by Brody and colleagues (2004) relative to the SAAF program, regulated, communicative parenting was characterized by four practices—involved-vigilant parenting, clearly articulated parental expectations for alcohol use, communication about sex, and racial socialization (Brody et al., 2004). Involved-vigilant parenting includes high levels of monitoring and control that co-occur with high levels of emotional and instrumental support (Brody et al., 2004). Disruptions in parental support, parental involvement, nonpunitive parenting practices, and monitoring increase the likelihood of early-onset alcohol use and sexual activity (Brody et al., 2004). Brody and colleagues (2004) cite literature demonstrating that involved-vigilant parenting protects African American youth from dangerous surroundings and involvement in antisocial activity (Brody et al., 2001, 2003), teaches them to anticipate potentially dangerous events in their neighborhoods and schools and to be vigilant (Allen & Majidi-Ahi, 1989; Willis, 1992), promotes self-regulation, and deters externalizing and internalizing behaviors (Brody, Flor, & Gibson, 1999; Brody et al., 2002; Brody, Dorsey, Forehand, & Armistead, 2002; Brody, Murry et al., 2002).

Two additional practices related to regulated, communicative parenting—clearly articulated parental expectations for alcohol use and communication about sex—are focused on in light of existing research concerning parental support and communication (Brody et al., 2004). Emotional support from parents, especially during early adolescence, is a powerful protective factor that is linked negatively with substance use and precocious sexual behavior (Wills, Mariani, & Filer, 1996; Wills, Resko, Ainette, & Mendoza, 2004). Young adolescents who believe their parents will avoid criticizing them and listen to them will be more likely to engage in discussions with their parents about sensitive topics (Brody, Flor, Hollett-Wright, & McCoy, 1998). Parental communication that includes specific discussion of facts, expectations, and skills related to the problems that adolescents face exerts a unique protective effect when parental support is controlled (Wills, Gibbons, Gerrard, Murry, & Brody, 2003). Frequent, harmonious parent-child communication in which African American parents set clear expectations about alcohol use, encourage discussion of adolescent sexuality, and provide information about these issues promotes youth's internalization of their parents' norms for alcohol use and sexual behavior (Brody et al., 1998; Brody, Ge, Katz, & Arias, 2000; Whitaker & Miller, 2000). Such communication also (a) shapes their images of alcohol-drinking peers (Wills et al., 2003); (b) enhances their resistance efficacy, defined as the ability to withstand peer pressure to use substances and to engage in high-risk sexual activity (Bandura, 1997; Sussman & Johnson, 1996; Wills et al., 2003); (c) reduces their tolerance of these behaviors (Wills et al., 2003); and (d) contributes to their development of planful self-regulation (Brody, Murry et al., 2002).

The fourth practice related to regulated, communicative parenting was racial socialization. Racial socialization was included in our conceptualization of effective parenting because racism contributes to substance use (Gibbons, Gerrard, & Lane, 2003) and compromised psychological functioning (Simons et al., 2002) among rural African American youth. Unlike parents in ethnic majority groups, rural African American parents must teach their children how to deal with a society in which both the parents and children are often devalued (McLoyd, 1998; Murry, 2000). Both direct experiences with racial discrimination in social and educational institutions and vicarious experiences mediated through caregivers are hypothesized to induce potentially a sense of futility and helplessness that, in turn, can undermine educational aspirations and induce anger-based responses to life events (Rumbaut, 1994; Williams, Yu, Jackson, & Anderson, 1997). Because African Americans continue to encounter racism on a regular basis (Kessler, Mickelson, & Williams, 1999), some youth may abandon a future orientation and effective strategies for reaching their goals because they come to believe that engaging in planful, goal-directed behavior will not necessarily lead to success in life (Fordham & Ogbu, 1986). Data indicate that African

American children have more positive future orientations, are better able to deal with experiences involving discrimination, evince greater self-esteem and academic success, and are less likely to internalize negative images about race when they are taught about the realities of racial oppression while also advised of the possibility of achieving success in the face of these obstacles (Hughes & Chen, 1999; Murry & Brody, 2002; Smith & Brookins, 1997).

Previous work has reported on the efficacy analyses for this project. SAAF has been demonstrated to be effective in increasing regulated, communicative parenting and reducing rates of substance use among youth participants (Brody et al., 2008, 2004). More specifically, pre-post change in the intervention-targeted parenting behavior has been shown. In Brody et al. (2004) and Brody et al. (2006), evidence was provided that participation in SAAF improved caregivers' abilities in involved-vigilant parenting, racial socialization, and setting expectations for alcohol use. Changes in these parenting behaviors significantly forecasted a delay in the initiation of youth's risk behaviors (i.e., ever use alcohol, ever use marijuana, and ever sexual behavior) at 2-year follow-up (Brody et al., 2008) and a reduction in past 30-day alcohol use at 5-year follow-up (Brody, Chen, Kogan, Murry, & Brown, 2010). Such increases in targeted parenting behaviors relative to alcohol use, specifically, served to influence the children's intentions to drink.

After years of studying this sample, we learned a lot about the caregivers and teens but were yet puzzled by divergent pathways among youth who participated in the treatment condition relative to their alcohol use. Families who participated in the SAAF intervention showed increases in regulated, communicative parenting and low rates of high-risk behavior initiation among youth. In spite of these gains, youth who took part in the intervention proceeded along different pathways relative to alcohol use. Among youth who regularly attended the SAAF program sessions and were exposed to the same prevention curriculum, we wondered, what accounts for the different pathways that the youth took relative to alcohol use 2 years after the program ended? Some youth showed an increase in use while other youth did not. In this investigation, we sought to understand these differential responses to the program. We looked at youth who demonstrated no increase, from pretest to long-term follow-up, in the use of alcohol as well as those whose use did increase across that period of time. Specifically, we desired to learn more about which factors and family processes were important for explaining these pathways. We desired to find out more about why these patterns occurred in the survey data, and in so doing, adopted a method that would permit deeper exploration of these issues.

The current study extends existing research in important ways. First, it illustrates the use of qualitative methods to evaluate intervention programming among African American caregivers and adolescents. Second, it uses in-depth interviews to explore the reasons why youth do or do not respond to prevention programming. Specifically, we desired to learn more about family processes that influenced youth's alcohol use after 2 years in the SAAF program. This will help to provide insight into whether or not the program accomplished its objectives and what changed among youth and caregivers as a result of the program. Third, it builds upon extant work and stands to make a contribution to guide the development of prevention programming in the future.

Therefore, in the current study, we use an in-depth, phenomenological approach to explicate the quantitative findings from the survey, describe the nuanced behaviors for select youth, and understand the meanings of their lived experiences. We focused this investigation on learning about youth who continued to delay alcohol use, as well as youth who began experimenting with alcohol. The specific goal of the current study was to elucidate family processes that influence adolescent participants' responses to the SAAF program relative to

alcohol use after 2 years and to try out 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 employed semistructured interviewing techniques to capture rich detailed data about the caregivers' and adolescents' lived experiences. We expect that the current study's findings will help to refine approaches used to design and build prevention programming for youth and caregivers in the future.

Method

Sample

The data analyzed in 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, youth must have attended four or more educational sessions and scored at the extremes of the responsive continuum on two indicators of SAAF target outcomes—intervention-targeted parenting and alcohol use—2 years after taking part in the program. The intervention-targeted parenting consisted of four indicators: involved-vigilant parenting, adaptive racial socialization, communication about sex, and clear communication of expectations about alcohol use (Brody et al., 2004).

Involved-vigilant parenting is composed of 19 items on Likert-type scales ranging from 1 (*never*) to 5 (*always*) that assess the frequency of parental behaviors with 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 the 19-item involved-vigilant parenting measure is 63.7 at Wave 1 and 65.7 at Wave 4, indicating relatively high parenting practice in the sample.

Racial socialization was assessed using the Racial Socialization Scale (Hughes & Johnson, 2001) that includes 15 items presented on a Likert-type scale ranging from 1 (*never*) to 3 (*three to five times*). The stem for each question starts with, "How often in the past month have you . . . ?" with the stem followed by specific racial socialization behaviors (e.g., ". . . talked to your child about discrimination?" ". . . 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 15-item scale is 22.1 at Wave 1 and 27.3 at Wave 4, indicating relatively infrequent use of the parenting behavior.

Parental Communication About Sex Scale, which was adapted from previous scales measuring parental communication about substance use (see Gerrard, Gibbons, & Gano, 2003; Wills et al., 2003), was used to assess communication about sex. The scale consists of 9 items coded on a Likert-type scale ranging from 0 (*no*) to 2 (*yes, quite a bit*). The stem for each question begins with the following—"Have you ever talked to your child about. . . ?" Examples of the topics include reproduction/having babies, menstruation, sexually transmitted diseases, and HIV/AIDS. The means of the 9-item scale are 4.7 at Wave 1 and 8.5 at Wave 4, indicating relatively infrequent use of the parenting behavior.

Expectations about alcohol and other drugs were assessed using two items written by Spoth et al. (Spoth, Redmond, & Shin, 1998). 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 of this 2-item scale are 3.2 at Waves 1 and 4, indicating a high parenting practice in the sample. (Further description of the four indicators can be found in Brody et al., 2004)

To create the parenting composite, we first standardized the four indicators and then averaged the standardized scores. An assessment of alcohol use was obtained by asking the target child the following question, “During the past month, how many times have you had beer, wine, wine coolers, or other liquor?” The mean past-month alcohol use for the study sample is 0.21 (range 0–4) at pretest compared to 0.15 (range 0–3) for the rest of the intervention sample.

For binge drinking, the target child was asked, “During the past month, how many times have you drunk a lot of alcohol—three or more drinks at one time?” The mean past-month binge drinking for the study sample is 0.07 (range 0–1) at pretest compared to 0.01 (range 0–1) for the rest of the intervention sample. In a relative sense, the study sample is higher in their alcohol consumption than the general intervention sample, a finding arrived at based on a review of their reports of past-month alcohol use and binge drinking at pretest.

Youth who experimented with alcohol at baseline and long-term follow-up without escalation were excluded from these analyses. Using information from the parenting composite and adolescent alcohol use, we calculated the change in the two outcome variables by subtracting Wave 1 measures from the Wave 4 measures in the intervention group. Next, we used the rank procedure in SAS to give ranks to each family based on the two scores. Then, we utilized the total rank score to find families who had the least and the most change in the two outcomes; 41 families were identified. We then removed 13 families who did not attend at least 4 of the 7 educational sessions. The resulting 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, and a 100% response rate was achieved. Caregivers were compensated \$75.00 for their interviews; adolescents were given a \$50.00 gift card.

For comparison purposes, we report on key demographic characteristics for this study 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 (range 29–71). Most caregivers earned 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 (range 14–15); 61% were female and 39% were male. We referred to the adolescents who showed an increase in alcohol use between baseline and long-term follow-up as *experimenters*. Those who did not report experimenting with alcohol during this period were called *nonexperimenters*. At the start of the analysis phase, 6 male and 10 female adolescents were nonexperimenters (57%). Of the adolescents who experimented with alcohol (43%), 5 were male and 7 were female.

Interview Procedures

Interviewers attended two sessions in which they were trained to conduct semistructured interviews; these training sessions included ways to ask questions, strategies for using

probes to obtain full responses from interviewees, and tactics for handling sensitive issues. Interviewers were also familiarized with the SAAF program curriculum, allowing them to probe deeply whether participants mentioned 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.

The main purpose of SAAF was to increase parenting behaviors and monitoring practices that previous research indicated were protective for rural African American children, and the interviewers focused on exploring these behaviors from the caregivers' and adolescents' perspectives (Brody et al., 2004). Consistent with a phenomenological framework, the interviewers also asked participants about their perceptions of SAAF's quality, thoughts and feelings about alcohol, and family and peer contexts and the meanings of these things in their lives. To explore the caregivers' and adolescents' family relationships, daily routines, and alcohol use, the interviewers posed the following questions: (a) "When your caregiver is not able to be with you, how does she monitor your activities?" (If caregiver: "When you are not able to be with your adolescent, how do you monitor his or 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?" To learn more about parenting style, interviewers followed this line of questioning: (a) "Describe your relationship with your parent/child. Are they supportive? Do you usually get along with them? What happens when you don't get along? In your opinion, are the house rules clearly stated and frequently enforced? Does your mother/caregiver provide you with clear expectations for what she wants you to do or not do? Explain. Does your caregiver model the kind of behavior she wants to see in you?" To assess levels of trust between the parent and adolescent, the following questions were asked: (a) "Does your caregiver trust you?" (If caregiver: Do you trust him/her?).

Reliability and internal validity were ensured by using multiple methods and sources of data. The interviews were recorded digitally and later transcribed. For each interview, within 3 days, the interviewer submitted a written account of his or her perceptions of the interview, including respondent honesty and openness, nature of interaction between caregiver and adolescent, an opinion about the veracity of participants' responses, participant's nonverbal cues (e.g., mannerisms), and the overall tone of the interview. The interviewers' written reflections facilitated a better understanding of the interview context. Interviewer comparisons about the discussions with each respondent in the home also helped to confirm the consistency in caregivers' and adolescents' reports or elucidate any contradictions in their accounts. Gathering different perspectives about the interview experience and qualitative data collected from caregiver, adolescent, and interviewers allowed the analysts to confirm that the data were reliable. These different sources of information helped to maximize the likelihood of being attuned to interview bias in responses from youth and caregivers dwelling in the same home (LeCompte & Schensul, 1999).

Reliability was maintained through regular, often daily, communication with interviewers about their comfort with administering the interview protocol and other 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. Transcripts were utilized to record the spoken word and capture respondents' views and attitudes. Also, interviewers were encouraged to evaluate the study method and discuss their interpretations with the first author at meetings. The first author also discussed emergent patterns 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 valuable key informants.

Results

Analysis Procedures

Data were analyzed to detect themes and patterns in a series of steps. First, three data analysts adopted a within-case analysis approach (Huberman & Miles, 1994). 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 analysis approach (Huberman & Miles, 1994). With the goal of uncovering prevalent 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 (i.e., case-oriented approach). As a 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 analysis phase proceeded, we reassigned the adolescents to "experimenters" or "nonexperimenters" categories according to the qualitative interview date rather than that of the long-term follow-up assessment in the larger survey. Some adolescents had experimented with alcohol in between the survey interview at long-term follow-up and the qualitative interview, a period of 6 months or less. By reassigning cases according to the qualitative interview date rather than the follow-up survey assessment date, inconsistencies attributable to the passage of time and participant recall were reduced. After reassignment, 39% of the youth were classified as nonexperimenters and 61% were classified as experimenters. Of the 11 male adolescents in the sample, 2 were nonexperimenters and 9 were experimenters; 4 were reassigned to the experimenter category. One female adolescent was reassigned to the experimenter category, producing final subsamples of 9 nonexperimenting and 8 experimenting female adolescents.

Because 6 months in between the survey interview and qualitative interview proved to be significant, we wondered whether age differences might exist between the two groups. Therefore, to test whether the groups of nonexperimenting and experimenting adolescents were different in their ages, an independent *t* test was performed. The *t* value was 1.83 with $p = .079$, indicating no significant age difference between two groups of adolescents. The mean age of adolescents in the nonexperimenting group was 14.36 ($SD = 0.51$) and the mean age of those in the experimenting group was 14.71 ($SD = 0.47$).

In the next sections, we first outline results pertaining to adolescents' access to alcohol and then we discuss the role of monitoring, trust, and unsupervised opportunities in youth's alcohol use. All names of individuals quoted have been changed to preserve their anonymity.

Access

There were differences in access to alcohol among experimenting and nonexperimenting teens. According to the caregivers, youth who drank alcohol had access to it more than nonexperimenting adolescents did (88% vs. 50%). For example, half of the caregivers of nonexperimenting adolescents 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 experimenters (12%) stated that no alcohol was stored in the home. Seventy-eight percent of the experimenting male youth and 100% of the experimenting female youth indicated that alcohol was kept in the home. In one case, representing an example of interview bias, the caregiver stated that she did not keep alcohol in the home but her daughter contradicted this. The interviewer noted that, according to the teen daughter, the caregiver frequently hosted parties for family members and friends. The teen reported leaving the home to distance herself from the excessive alcohol use and activities to which it gave rise.

According to nonexperimenting female youth, 78% said that they had no access to alcohol. Many female adolescents who experimented with alcohol rationalized it by stating that they drank responsibly, only tried it once, or didn't swallow. Though they admitted trying alcohol, most female adolescents were unwilling to specify who they obtained access from, by either evading the question or saying they were unsure. Yet, for two experimenting female youth (25%), they told the interviewers that in their experiences it was easy to obtain alcohol from adults such as older relatives (e.g., siblings, cousins, aunt) or drug-addicted neighbors who would purchase alcohol for them in exchange for a 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 experiment with alcohol while other youths do not? In the next section, we address the relationships among caregiver-adolescent trust, monitoring, and unsupervised opportunities. We use case examples to point out the significance of caregivers vigilantly monitoring their children, in spite of trusting them, to protect them from risky situations.

Caregiver-Youth Trust, Monitoring, and Unsupervised Opportunities

Nonexperimenting youth—Among families with nonexperimenting youth (sons and daughters), teens reported consistent daily routines and stated that they were at home most of the time (except for school or church) and monitored by their caregiver, grandparent, or older sibling in the home. Teenagers did not report going out on the weekend with their friends but rather communicated with friends by phone. Teens and caregivers shared close and confiding relationships with each other. Caregivers established clear rules for adolescents and disciplined their children, when necessary.

Among the caregivers of nonexperimenting female youth, 63% said that they trust their daughters, and 37% said that they did not. Regardless of their trust level, these caregivers rarely allowed their daughters to be unsupervised. When away from home, these female youth were always monitored by caregivers or trusted adults (i.e., grandparents, aunts, school personnel) in their social networks. A few exceptions to this pattern occurred in families in which the teen was alone after school or the caregiver left the daughter at home when running brief errands, to enhance the youth's confidence and her belief that her parent trusted her. Two caregivers stated that they did not actively monitor their adolescent daughters but trusted God to keep their children "on the straight course" and perceived their daughters' friends, whose parents they had come to know well, as very trustworthy.

Nonexperimenting female youth 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 female youth were expected to call their caregivers if their plans changed or if they would be delayed in returning home.

Here is an example that 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 her how to sit down and discuss the reasons why she 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 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 endure their unfortunate consequences.

The caregivers of the two nonexperimenting male adolescents both said that they trusted their sons, yet did not leave them without continuous adult supervision. One caregiver said that when she is away from home she still monitors things at home saying, "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 nonexperimenting youth to be unsupervised and said that the teens were often with them or another trusted adult in their networks. These adolescents were constantly monitored by other adult family members or by friends' parents whom the caregivers had come to know and trust. One mother, age 37, shared the following:

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 corroborated these reports, stating that they were constantly monitored by their caregivers or other trusted adults.

Experimenting youth—Among families with female and male youth who used alcohol, the youth's daily routines involved spending more time away from home on a regular basis as compared with families with nonexperimenting youth. Not only were youth who used alcohol more likely to travel away from home during the day, but the daily routines in youth's homes were less predictable as compared to nonexperimenting teens. Disruptions in routines were attributable to crisis events that disturbed and taxed the family system like caregiver illness and injury, death of a family member or multiple family members, economic stress, substance use, incarceration, and homelessness.

Moreover, caregivers of experimenting teens were less knowledgeable about their adolescents' activities as compared to caregivers of nonexperimenting teens. Children were allowed to leave the home without stating where they were going or when they would return. This privilege to exit the home without accountability was, in part, reflective of another factor that set the stage for ineffective parental monitoring—low caregiver-adolescent relationship quality. Experimenting adolescents disclosed little about their lives and whereabouts to their caregivers, as compared to nonexperimenting adolescents. While away from home, these youth were more likely to hang out with their friends on the weekend (e.g., teen parties, sleepovers) as compared to their nonexperimenting peers who kept in touch with friends by phone from home. In addition to engaging in different activities with peers, these youth also cited their family members (e.g., older siblings, aunt, cousins) and neighbors as providing alcohol and encouraging its use.

Male youth—Caregivers of experimenting male adolescents did not monitor their children as closely as caregivers of nonexperimenting youth. These caregivers spoke about how the

SAAF curriculum informed them of the signs for which they should watch. Some caregivers reported trusting their sons to be unsupervised, so they gave their sons more freedom and independence than did caregivers of nonexperimenting 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 looser style of monitoring preferred to stay in touch by making phone calls or driving teens to places to see the area where they would be unsupervised and then dropping the teen off at the location. Most noted that they rarely followed up with their teens to determine whether they stayed where they said they would be.

Though caregivers of experimenting male adolescents stated that they loosely monitored their teens, their reports of giving the youth a measure of independence diverged from the youth's perceptions. The youth considered themselves to be very closely monitored. When the interviewers probed further, it became apparent that, although the adolescents' own responses suggested that they were not closely monitored, the youth nevertheless desired more independence than their caregivers were willing to give them.

In one case, though 15-year-old Harry reported alcohol use, his 45-year-old mother, Nina, 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 experimenting with alcohol. She reported a good relationship with her son, and although she reportedly worked long hours, she felt that she was able to monitor her son. 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." In fact, Nina's son revealed that he had drunk alcohol, although he was not currently experimenting with alcohol at time of the interview.

Female youth—Among female adolescents, caregivers of experimenters (29%) tended to monitor their youth more loosely than did the caregivers for nonexperimenters (71%). The former stayed in touch via phone calls and when in the company of a trusted adult, rarely followed up. Youth who experimented with 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 experimenting with alcohol. These caregivers believed that looking for signs of the use of alcohol constituted adequate vigilance. Most adopted this viewpoint based on how they were raised by their own caregivers. This style of loose monitoring was used by the caregiver of Tasha. Tasha was interviewed on the front steps of a public housing complex: "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."

The female experimenters spoke of opportunities that they had to try alcohol for the first time. Faced with a situation in which there was no supervision by an adult who would hold them accountable for underage drinking or where their friends were experimenting with alcohol, many felt overwhelmed with peer pressure to fit in 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 experimented with alcohol. She had been in environments in which teens were experimenting with alcohol. The adolescent granddaughter noted that her friends were trying to avoid using alcohol again: "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 indices 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 include specific behaviors and family resources like vigilant parenting, high-quality parent-child relationships, and healthy parent-child communication that encourage positive outcomes (Brody et al., 2004).

Access is of primary importance in understanding adolescent alcohol use, and findings in the current investigation identified ways in which adolescents acquired alcohol. The neighborhood was one primary route. Neighborhood risk has been noted in the extant literature as a key factor in adolescent alcohol use (Gibbons et al., 2004). Although they held different perspectives on the issue, both caregivers and adolescents noted that adolescents may be exposed to alcohol use in the community.

The current study extends previous work conducted as part of SAAF by identifying specific ways in which youth access alcohol in the community. Adolescents obtained alcohol primarily through neighborhood adults or older relatives, not peers. These individuals were sometimes described by the teens as providing youth with opportunities to learn about alcohol use in a mentored environment as part of their socialization for adulthood or 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 challenges. In addition, some adults in the adolescents' village are not operating as protective factors, as family scientists might hypothesize; rather, they are helping to promote underage alcohol use by playing a key role in offering youth chances to experiment with alcohol. This point supports literature that underscores the importance of examining the role of family members (e.g., cousins, siblings) and acquaintances who give adolescents opportunities for access to alcohol and initiation of use, not just peers (Brook, Kessler, & Cohen, 1999; Catalano et al., 1992; Ellickson et al., 2004; Kosterman, Hawkins, Guo, Catalano, & Abbott, 2000; Rhee et al., 2003).

In addition to variations in access to alcohol, caregivers of experimenting and nonexperimenting youth differed in the monitoring strategies they recalled from the program. Teens whose caregivers responded to the SAAF curriculum by being more vigilant to ensure teens were supervised were likely to be inexperienced with alcohol and to have avoided drinking alcohol. These caregivers ensured that their adolescent children were protected, either in their own care or monitored by a trustworthy adult. Caregivers of nonexperimenting youth also shared good relationships with their youth, set clear rules and expectations, and disciplined youth as needed. Such relationships were protective against alcohol use. Such practices of involved-vigilant parenting and setting expectations for alcohol use have been shown to delay the initiation of alcohol use among youth (Brody,

Kogan, Chen, & Murry, 2008). As such, from the current work, we learned more about how such family processes operate to protect youth from initiating alcohol.

Other caregivers took a more passive approach to monitoring. Among these caregivers, we observed fewer protective factors in play. Caregivers trusted their adolescents to follow their rules in their absence and believed they would know whether their youth were drinking alcohol. Although they were involved in their adolescents' lives, they were not vigilant monitors of youth's whereabouts away from home. These findings extend our understanding about why certain youth used alcohol in the SAAF sample and uncover key family processes that served to provide youth 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 et al., 2000). It appears that, as in previous work by Borawski and colleagues (2003), adolescents took advantage of their caregiver's trust to experiment with alcohol during unsupervised time. It may be that because adolescents assigned to the experimenting group were older, they were able to negotiate more unsupervised time away from home than nonexperimenting youth. In addition, these caregivers thought that their adolescents would surely evince signs of use, which in turn the caregivers would recognize as clues based on information presented in SAAF. This strategy, though useful in combination with other recommendations, cannot be used in isolation to prevent alcohol use because by its very nature it identifies only alcohol use that has already occurred. Consistent with the extant literature, the children of these caregivers were likely to report having increased use of alcohol. 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 et al., 2003).

Among experimenting teens, several factors deemed as being not protective against alcohol use for youth contributed to ineffective monitoring on behalf of their caregivers. Previous work has highlighted how parent's problems can impact monitoring of adolescents (Crouter & Head, 2002). Other factors included less predictable daily routines and low parent-child relationship quality (Crouter & Head, 2002). Experimenting adolescents also reported spending more time away from home than nonexperimenting adolescents. It is also plausible that the teenager's alcohol use may represent a means of coping with stress associated with their parent's life concerns and crisis events. It is also possible that structural features of the family like a single-parent household living arrangement set in motion key family processes that influence the likelihood of an adolescent experimenting with alcohol.

Limitations

Several limitations to the current study must be considered. In keeping with our goal of capturing the depth of the participants' experiences, the sample was small; it was also nonrandom. Thus, the findings may not be externally valid. Conclusions reached in this study are primarily relevant to low-income African Americans who reside in rural northeast Georgia and may not be applicable 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.

Also, data collection across cases was uneven. Although we did not delete any cases from our analyses, some respondents did not offer a full account of their experiences. Therefore, although we were able to determine whether an event occurred, we could not always rely fully on the participants' accounts to determine why it took place. For adults, depth of participants' responses reflected individual differences in talkativeness or fatigue from work and pain associated with injury or disability rather than level of discomfort with the interviewer or interview context. Among adolescents, some were more reticent about those

experiences that did not fall in line with their caregivers' expectations (e.g., drinking alcohol), fearing discipline or disappointing their caregivers despite the stated confidentiality of the interview. Information contained in the interviewer's reflections aided in our understanding of the context of the interview and the respondent's reactions.

Conclusions

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

Although SAAF's targeting of parenting processes supports effective communication and monitoring strategies, it cannot reduce youth's access to alcohol from peers at school, underground liquor stores in the neighborhood, or older family members. These sources of risk are beyond the scope of this family-based prevention program; however, the program did offer resistance strategies (e.g., self-talk to avoid temptation, negative prototypes of substance users) and opportunities for teens to engage in role plays, which have been shown to be effective with offers of alcohol from peers (Brody et al., 2004). The program did not address resisting offers to use alcohol from adults (e.g., family members). Inclusion of such a component in future family-based prevention programs would be a worthy goal.

A multipronged 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. In addition, residents could be supported in the development of neighborhood watch programs that include provision of alcohol to minors along with other crimes on which such programs typically focus. Residents of neighborhoods could serve as watchdogs to look for weaknesses in their communities or underground efforts that support adolescent delinquency related to alcohol.

Previous work has examined specific behaviors and strategies that adults use to look after children and focused on a set of strategies and processes termed *collective socialization* (Simons, Simons, Conger, & Brody, 2004). Collective socialization 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. When community residents band together in this way, the process of monitoring reaches beyond household boundaries and adults cooperatively enforce acceptable conduct for children. Indirectly, SAAF was designed to foster collective socialization by building a network of parents that could rely on each other through the family-based intervention program's group discussion format (Brody et al., 2004).

Future work in this area could follow up with participants who took part in an educational program. The focus of the follow-up would be to review program goals and ensure that participants received correct information on how to apply the information learned. Scholars could also receive information from program participants at this time on how to improve the design of their interventions and identify emergent risk and protective factors. This represents a current need in the field.

Examining differences between experimenting and nonexperimenting youth whose families attended a majority of SAAF sessions provided a perspective on the skills caregivers

incorporated into their parenting and the skills that will require modification or greater emphasis in future implementations. Some caregivers believed that one of the monitoring strategies recommended in the program, observation of youth for signs that they are using alcohol, was sufficient to protect their adolescents to the exclusion of other important monitoring strategies recommended in the program. Findings show that the caregivers' monitoring strategies were affected by their life conditions and parenting styles. The curriculum may need modification to emphasize that monitoring and communication strategies must be used together.

Although caregivers believed they were adopting program recommendations by vigilantly observing youth, 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 give in to immediate pressure rather than honor their caregivers' wishes. Caregivers of adolescents should continue to monitor them closely and vigilantly, enlisting the support of relatives, school personnel, or other trusted adults when they are unable to supervise the teens themselves.

Examining programs from participating families' viewpoints provides an in-depth of understanding that complements findings of randomized, controlled trials (Riger, 2001). The current study demonstrated that, although SAAF was effective in delaying alcohol use, a group of participants who increased alcohol use despite attending four of the seven program sessions. Examination of differences in the family and community contexts of experimenting and nonexperimenting youth demonstrated that access to alcohol and caregivers' selective adoption of monitoring strategies exposed youth to risk opportunities that they were unable to surmount. This is valuable information that can inform modifications to 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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