Strengthening Family Resilience: Prevention and Treatment for High-Risk Substance-Affected Families

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Abstract

Within the framework of family resilience, the authors summarize research regarding risk factors, risk processes, and risk chains as well as protective factors, protective processes, and protective chains. Then they describe how these components can be applied to therapeutic practice for families with one or more substance-abusing members.

Understanding the nature of risk and resilience in families is recognized as the key to preventing and treating drug and alcohol abuse in substance-affected families (Hawkins, Catalano, & Miller, 1992; Jessor, 1992; Kumpfer, 1997). This need is a crucial concern as substance abuse is one of the leading issues faced by families and society in the United States. "Strengthening the ability of families to raise successful, nonviolent, and non-drug-using children is a critical social goal" (Kumpfer & Alvarado, 1995). Recent estimates indicate that 8.3 million children live in substance-affected families where parents have alcohol or other drug problems (Huang, Cerbone, & Gfroerer, 1998). "Studies show that the overwhelming majority of children affected by parental substance abuse remain in the custody of their parents" (Feig, 1998, p. 234). The costs to society range in the billions annually, and the concern goes well beyond the financial outlay to a realization of the human toll. What impact does being raised by a drug and/or alcohol abuser have on a child? What are the outcomes for such a child and their influence on the next generation?

Parental substance abuse is considered a major factor in child neglect and/or abuse (Famularo, Kinsherff, & Fenton, 1992; Magura, Laudet, Kangy, & Whitney, 1998). Parents that abuse drugs and/or alcohol have children that are three times more likely to be abused and four times more likely to be neglected than children of parents who do not abuse substances (National Center on Addiction and Substance Abuse, 2000). In the extreme, some children die or experience failure-to-thrive syndrome as a result of parents' substance abuse. Many simply go without nutrition and other basic survival needs. In addition, children who are physically and emotionally abused and/or neglected are themselves at risk of developing a substance-abuse disorder,

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thus continuing on what is clearly an intergenerational cycle (U.S. Department of Health and Human Services [DHHS], 1999, 2000a; Felitti, Anda, Nordenberg, Koss, & Marks, 1998). Living in a home where parents abuse substances places children at higher risk of sexual abuse (DHHS, 2000b). The intergenerational cycle continues as two out of three women in drug treatment, who have experienced sexual abuse, report that it contributed to their development of a substance-abuse problem (DHHS; Hayek, 1980). It has been shown that men develop even more severe substance-abuse disorders when they have been sexually abused as children (Simpson, Westerberg, Little, & Trujillo, 1994). They are more likely to overdose and engage in suicidal binges. There is also an increased likelihood that they will attempt suicide again (Krinsley, Brief, Weathers, & Steinberg, 1994; Kroll, Stock, & James, 1985; Linehan, 1993). Children who have experienced neglect and abuse as a result of a substance-affected parent are at risk for higher rates of dual diagnoses of both substance abuse and mental health issues over their lifetimes (Brindis, Berkowitz, & Clayson, 1997; Kumpfer, 1997, 1999; Kumpfer & DeMarsh, 1986; O'Gorman, 1981; Tarter, Blachson, Martin, Loeber, & Moss, 1993).

In addition to the above risks, another effect of parental substance abuse is the genetic vulnerability or "genetic loading" for these children (Goodwin, 1985). Children of alcoholics may have altered brain chemistry that makes them more susceptible to the use and/or abuse of alcohol (Kumpfer & DeMarsh, 1986). They are more likely to begin use at an earlier age, and, when coupled with earlier problematic use, there are more indications of a quicker progression toward developing a substance-abuse problem (Kandel, Simcha-Fagan, & Davies, 1986). Addressing these issues becomes paramount with high figures of 10% of children under the ages of 18 having used illicit drugs in the last 30 days as reported in the National Household Survey on Drug Abuse (DHHS, 1999).

Prenatal substance exposure is yet another by-product of parental substance use. Children exposed to drugs and alcohol in this way are a small portion of those children who are affected by parents' substance abuse, but this can have negative effects on the developing brain of the fetus. While potentially overestimated in the seriousness of the physical and mental deficits reported by the media, the consequences for children prenatally exposed to other drugs does have serious and long-lasting effects (DHHS, 1999). Prenatal exposure to alcohol can cause fetal alcohol syndrome or fetal alcohol effects that have been linked to permanent developmental delays (Brindis et al., 1997). Maternal alcohol abuse is the most frequent cause of mental retardation (Ray & Ksir, 1996). It appears that prenatal alcohol exposure has more severe and long-lasting effects on development, especially intellectual and behavioral consequences. Developmental delays in both cognitive and language deficits or disorders can result from parental substance abuse (Hans,

1995). Prenatally drug-exposed children are reported to have lower birth weight, lower IQ scores, poor feeding abilities and eating issues, higher health care needs, and some display disorganized attachment issues (Hawley & Disney, 1992). Research findings indicate that 10% to 20% of these children receive foster care services at birth, and another 33% receive these services in the subsequent years (DHHS, 2000b).

Children who grow up in substance-affected families have a wide range of unfavorable outcomes. They are reported to have more aggressive behaviors, hyperactivity, sleep disturbances, criminal behavior, and overall poor socioemotional development (O'Gorman, 1981). They have poorer developmental outcomes, while usually more in low-normal ranges rather than severe ranges (DHHS, 1999). They display poor indicators in school performance, peer relationships, self-esteem and impulse control (Kumpfer, 1997; Lawson, Peterson, & Lawson, 1983). They appear to lack attachment to school or family, which can contribute to isolation, depression and suicidal behavior. A 20-year longitudinal study indicated that children raised in alcoholic homes are more likely to have marital failures and be unable to support themselves (DHHS, 2000b). What do these findings mean for these children and their future families?

Rigorous research is necessary to discover effective interventions for substance-abuse prevention and treatment for high-risk children, their families, and their communities. One area of inquiry has been the study of resiliency, including risk and protective factors, risk and protective processes, and risk and protective chains. The study of resilience will work toward developing an understanding of how substance abuse develops and aiding in prevention and treatment approaches. The attractiveness of the protective models is that they are strength-based rather than the previous emphasis on deficit models (Howard, Dryden, & Johnson, 1999).

Risk and Protective Factors, Processes, and Chains for Substance Abuse

The constructs of "risk" and "resilience" have themselves been the subject of much development, examination, and critical review (Hawkins, Catalano, & Miller, 1992; Jessor, 1992; Kumpfer, 1999). While much is yet unknown about how drug and alcohol problems occur, for the last 15 years the epidemiological approach of applying an understanding of the effects of risk and resiliency to the prevention and/or treatment of substance abuse has been emphasized. In this article, we will identify and define the following: (a) concepts currently under consideration, early evidence about individual, family and societal risk, and protective factors which can assist in understanding this very complex subject area; (b) interactive relationships between family risk processes and family protective processes; (c) new avenues to

explore risk and protective chains; and (d) ways to strengthen families and mobilize key processes in family resilience to prevent the development of drug and alcohol problems.

Defining Risk Factors, Risk Process, and Risk Chains

Risk factors. "Risk is an epidemiological concept that states certain agents or conditions increase the probability of outcomes that compromise health, quality of life, or life itself" (Jessor, 1992). These agents or conditions are commonly referred to as risk factors. Most of these factors can be divided into individual, family, and environmental conditions (Kirby & Fraser, 1997). For example, in the area of adolescent alcohol and drug abuse, an example of individual risk factor is low commitment to school; an example of a family risk factor is a family history of alcoholism; and an example of an environmental risk factor is availability of alcohol and drugs (Jenson, 1997).

Risk factors such as these have been also called vulnerability factors (Kirby & Fraser, 1997). They (a) represent the possibility of heightened vulnerability, and (b) appear to be more potent when one is exposed over time (Kirby & Fraser). They can further be categorized as risk traits that predispose one to the development of a problem. These are often characteristics such as genetic markers, gender, the presence of a psychiatric disorder, or some individual trait that may make one more susceptible to a problem such as drug and alcohol issues (Kirby & Fraser, 1997). Some are predisposing factors or preexisting factors that are generally unmodifiable, such as gender. Other risk factors are modifiable, such as social support which can be added to or built on more fully to support an individual or family (Tracy, 1990). The strength of the risk factors also appears to be weighted differently, with some risk factors being more potent than others. One example is the association with friends who use drugs, which appears to be one of the strongest predictors of drug use in adolescents (Barnes & Welte, 1986). Comparing how much a specific risk factor weighs in relation to all other risk factors does develop a framework for yielding the risk ratio or the odds of that risk factor heightening the vulnerability more than other risk factors (Simeonsson, 1994). This knowledge could help direct prevention and treatment interventions.

The research dilemma of exploring risk factors is that it is difficult to attribute the risk factors directly to the outcome of developing a chemical abuse issue. For example, not all children who have a low commitment to school, a family history of alcoholism, and increased availability of alcohol and drugs develop an adolescent substance abuse issue. Wolin and Wolin (1995) predicted that only about one-third of any at-risk population actually develop into a problem. Until more research is conducted, we accept that

while there are no direct causal relationships, risk factors do represent enhanced probability of negative outcomes (Kirby & Fraser, 1997). Another issue with the concept of risk factors is that they may be culture-bound or adaptive to survival. Some risk behaviors may seem unusual to the dominant culture but are promoted within minority cultures. Other risk factors may be acceptable behaviors that are adaptive for the purposes of coping and endurance of a trauma, such as withdrawn behavior in a child who is experiencing abuse (Howard, Dryden, & Johnson, 1999).

What has been proposed in the field is what is described as Additive Models, which suggest that heightened risk factors produce more negative outcomes and that more protective factors produce more positive outcomes (Kirby & Fraser, 1997). In the Additive Model, "risk and protection are thought to balance each other" (p. 18). Jessor (1992) proposed Risk-Protective Factor Theory, suggesting the risk factors would be neutralized by protective factors. Measuring the strength and severity of the risk factors and producing interventions to add protective factors has been proposed (Rondero, 2000). Streissguth, Barr, Kogan, and Bookstein (1996) advanced the Additive framework by assessing children with fetal alcohol syndrome and fetal alcohol effect and were able to predict that higher levels of risk factors, when balanced against protective factors, were associated with secondary disabilities with this group (Rondero, 2000). These findings suggest that reducing risk factors or adding resilience factors outweighs the levels of risk as a prevention and/or intervention strategy. For this reason, it is important to continue to discover and explore the impact of individual, family, and environmental risk factors in the area of substance abuse.

Risk process. One possible method to explore risk factors is conducting research on the interactions between risk factors that can increase or enhance risk (Garmezy, 1985). The risk process describes how a risk factor contributes over time to heightened vulnerability. It is considered to be a mechanism that explains the relationship between the risk factors and exactly how these complex processes work in determining one's risk status (Kirby & Fraser, 1997). A lack of parental monitoring, increased family conflict, and lack of family cohesion are examples of complex risk processes in parent-child transactions. Each in their own right influence the development of a substance-abuse problem (Kumpfer, 1999). The explorations of how each of these processes shape the increased probability of development of a substance-abuse problem or the maintenance of that problem are valuable concepts in understanding the nature of risk and protective factors (Kirby & Fraser).

The interaction of risk factors is yet another level at which to apply these concepts for understanding the risk processes (Kirby & Fraser, 1997). In the second category of models, the Interactive Models, the outcomes are more

strongly influenced by the combination and interaction of risk and protective factors (Kirby & Fraser). For example, factors such as poverty and unemployment place the child and his or her family in strained or stressful situations. Delineating this process is critical to understanding fully the relationship of risk to the development of drug and alcohol problems. Clustering of stressful events or chronic stress is also a construct used frequently to assess risk processes (Kirby & Fraser, 1997).

It has been suggested that the accumulation of stressors or risk factors may cluster together, increasing vulnerability (Pellegrini, 1990). In a study of adolescent drug abusers, Hawkins, Catalano and Miller (1992) found that delinquency, school misbehavior, dropping out of school, and pregnancy were clustered together. Cumulative stressors or risk factors may have more than just an additive effect and in fact may be multiplicative (Kirby & Fraser, 1997; Rutter, 1979; Simeonsson, 1994). These findings make it imperative that the risk process, where risk factors contribute to the development of a substance-abuse problem, be explored. This presents a major challenge to researchers, as any of these risk processes can be mediated by contextual, family and/or individual characteristics or strengths (Kirby & Fraser). These challenges are reinforced by the fact that not all children of substance abusers develop alcohol and drug problems (Simeonsson).

For the purposes of this article, examples of how individual and family risk factors may interact with the environment have been selected to demonstrate the examination of a risk process. There are four ways in which risk factors and the environment may interact: (a) the environment increases the expression of the risk factor; (b) the environment exacerbates the effect of the risk factor; (c) the risk factor exacerbates the effect of the environment, and (d) both the risk factor and the environment are required to raise risk (Simeonsson, 1994). Examples of these interactions are shown in Figure 1.

Risk chains. Risk chains, which assess the sequential linkages of "conceptually distinct risk factors and/or processes" (Kirby & Fraser, 1997), may be more effective in the substance-abuse field (Simeonsson, 1994). These relational concepts of direct risks and absence of opportunities have been considered key to understanding a risk chain (Simeonsson). Growing up in impoverished, chaotic homes, with drug abuse, physical and sexual abuse, poverty, and/or poor family relationships create a risk chain for young mothers to be at risk for using chemicals (Edmondson, 1994). Figure 2 shows a potential explanation of how this chain may work. As in this example, the risk chain is a sequential chain where several risk mechanisms or processes are interacting together to contribute to the development of drug problems. Risk chains reflect the transactional nature of individual, family, and societal risk factors (Simeonsson, 1994). Because it takes into account the strength and multiplicative nature of risk factors that influence the growth of a

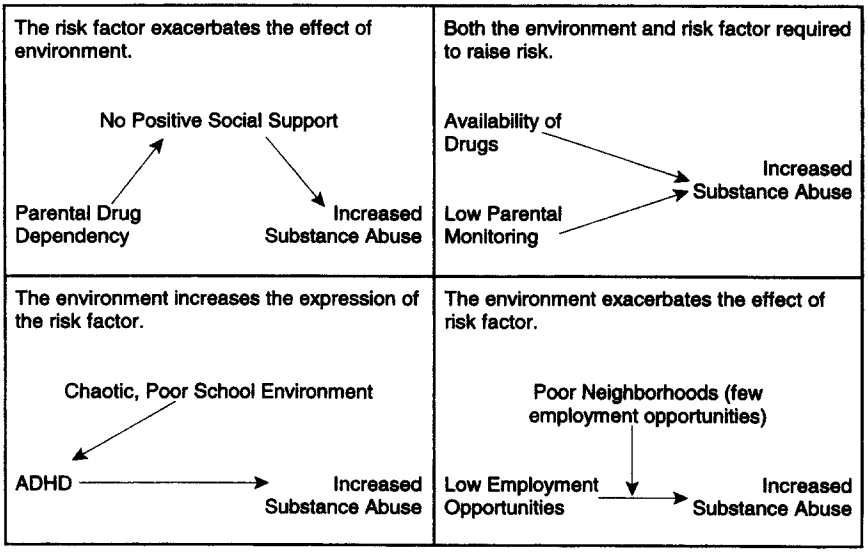

Figure 1. Interactions of environment and risk factor to increase substance abuse.

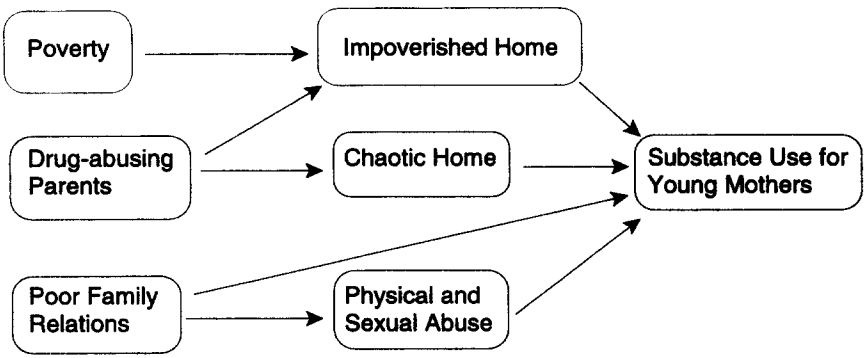

Figure 2. Pathways of substance use for young mothers

substance-abuse problem, it may be of more benefit because these relationships are "complex and usually non-linear" (Simeonsson, p. 21).

The process of identifying risk chains involves assessing the strongest risk factors and risk processes in current research and generating probably sequential and/or interacting clusters of variables that influence the outcomes (Simeonsson, 1994). Critical to this effort is identifying "the most probable manner in which the transactions transpire" (Simeonsson, p. 24).

Defining Resilience, Resilience Process and Resilience Chains

Protective factors. Just like risk factors, there are protective factors that promote resiliency (Kirby & Fraser, 1997). Protective factors are defined as "internal and external forces that help . . . resist or ameliorate risk" (Kirby & Fraser, p. 16). Protective factors are sometimes seen as the polar opposite of risk factors (Rutter, 1987). However, this approach does not always hold true and does not always go both directions. For example, hyperactivity does not have a meaningful polar opposite. Hardiness, a family protective factor, also lacks a meaningful polar opposite risk factor.

Resilience is defined as a positive outcome where protective factors contributed to adaptation in the face of risk factors (Kirby & Fraser, 1997; Werner, 1994; Werner & Smith, 1989, 1992). The capacity to rebound from adversity with more strengths and resourcefulness is also a framework for understanding the concept of resiliency (Walsh, 1998). Masten, Best, and Garmezy (as cited in Kirby & Fraser) described three types of resilience as "overcoming the odds . . . sustaining competence under stress . . . [and] recovery from trauma." For example, for the child of an alcoholic, a protective factor might be successful academic achievement in the face of adversity within the family setting. However, the definition does not state that resilience leaves the individual impermeable to any consequences (Kirby & Fraser). The child of an alcoholic may survive and even excel as a child through the use of external mentors and supports but struggle as an adult, when contemplating marriage, with how to structure family life. Just like risk factors, protective factors are considered cumulative (Howard, Dryden, & Johnson, 1999). Using the Jessor's Protective-Factor model, the greater the balance of protective factors appears to counteract negative risk factors (Howard et al., 1999; Jessor, 1992). An individual can be rendered more or less resilient depending on the accumulation of protective factors, protective processes, and the mobilization of protective chains. Findings suggest that reducing risk factors by adding resilience factors can assist in developing prevention and/or strategy. For this reason, it is important to continue to discover and explore the impact of the individual, family, and environmental protective factors in the area of substance abuse.

Protective process. Just as risk was defined as a process or mechanism, so is the construct of protection applied to a process or mechanism. Protective processes assist in examining the clustering of factors that enhance protection from risk conditions (Kirby & Fraser, 1997). Rutter (1990) indicated that understanding the protective process, including developmental and situational mechanisms, is critical to understanding how the process of resilience occurs. He identified four protective processes: (a) reduction of risk process through altering exposure to risk conditions; (b) reduction of risk chains that contribute to increased vulnerability; (c) protective processes to

enhance self-esteem and self-efficacy; and (d) opening opportunities at the structural level to provide contextual reforms. The key to the protective processes as suggested by Rutter (1987) are the active roles that individuals and families must take in negotiating risk situations. Rutter suggested that the contextual and transactional nature of these protective mechanisms is key to understanding the interplay between risk and protective factors. He further suggested that it is not the factors but how these protective processes develop and contribute to change occurring that are the fundamental research to be accomplished.

Like cumulative factors for risk, there are also studies supporting this approach applied to protective factors (Bradley et al., 1994). The notion that cumulative protective factors can cluster together to provide an additive effect across protective conditions is also under consideration (Kirby & Fraser, 1997). For example, Wolin and Wolin (1995) reported the healthy qualities of children who showed individual resilience in the face of great family adversity, including alcoholism. Protective factors are only mobilized when stress is high (Masten, 1987). They are seen as mediating or moderating variables that assist in buffering against stress, interrupting the risk chain, and preventing a risk factor from occurring (Kirby & Fraser, 1997). While current studies on understanding the nature of these protective mechanisms are focusing on understanding the interaction of the risk and protective factors, much more work needs to be done. For example, family support is a good indicator of resiliency, but how it is enacted in different families within their culture and environmental context needs more examination (Walsh, 1998). When these relationships between risk and resilience can be more fully determined, the combination of reduced vulnerability through removing risk factors, reducing risk factors (intensity, severity, duration) and changing environments will be one part of an extensive process to buffer risk (Simeonsson, 1994). Increasing resiliency through the facilitation and development of resiliency, adding protective factors, and efforts to obtain an improved and/or enhanced environment will comprise a second strategy (Simeonsson). The last strategy will be to modify transactions, introduce catalysts for change, and alter the valence of risk factors to treat the interactive nature of the risk and protective factors, processes and chains (Simeonsson). This is clearly the more complex model from which to conduct research, but it contributes more fully to understanding the relationship between the two concepts.

For the purposes of this article, examples of how individual and family protective factors may interact with the environment have been selected to demonstrate the examination of a protective process. Just like in the risk area, the impact of the environment's role in the reduction of the development of drug problems could be expressed in four ways: (a) the environment increases the expression of the protective factor; (b) the environment energizes the effect of the protective factor; (c) the protective factor energizes the effect of

the environment; and (d) both the protective factor and the environment are required to raise resiliency (Simeonsson, 1994). Examples of these interactions are shown in Figure 3.

Protective chains. Protective chains, while not currently discussed in the literature, also have value in understanding the relationship between several interacting mechanisms. Protective chains operate the same as risk chains. The protective chains that assess the sequential linkages of conceptually distinct protective factors and/or processes can help introduce the relational concepts of resilience in the substance-abuse field. Protective chains combine the concepts of protective factors and the presence of assets that contribute to amelioration of risk and development of hardiness, individual and family strengths, and community/environmental support for positive outcomes. A protective chain is a sequential chain where several protective mechanisms or processes are interacting together to contribute to the reduction of the development of drug problems. Protective chains also reflect the transactional nature of individual, family, and societal protective factors. These chains can take into account the strength and multiplicative nature of protective factors that influence the reduction of a substance-abuse problem. For example, a child with higher intelligence (Garmezy, 1985), even temperament (Tarter et al., 1993), academic achievement, good coping skills, and social responsiveness (Kumpfer & DeMarsh, 1986) will be at less risk because of this interacting protective chain.

The process of identifying protective chains involves assessing the strongest protective factors and protective processes in current research and generating probable sequential and/or interacting clusters of variables that influence the outcomes. Again understanding and identifying "the most probable manner in which the transactions transpire" (Simeonsson, 1994, p. 24) will be important. By looking at the pathways to drug-abuse prevention with adolescents, Kumpfer and colleagues (personal communication, March 12, 2001) found the effect sizes of family influences to be the largest in detouring children from developing a pattern of substance use. The use of a structural equation model helped address the most potent factors. Examples of the factors that could be considered are in Figure 4. One could conclude that efforts to prevent and/or treat young mothers in families would be of great benefit when targeted for services that promote the most powerful outcomes.

Strengthening Families to Prevent and/or Treat Substance Abuse

To further the discussion of risk and resiliency, we now build a more exhaustive review of how the risk processes apply to family resilience and

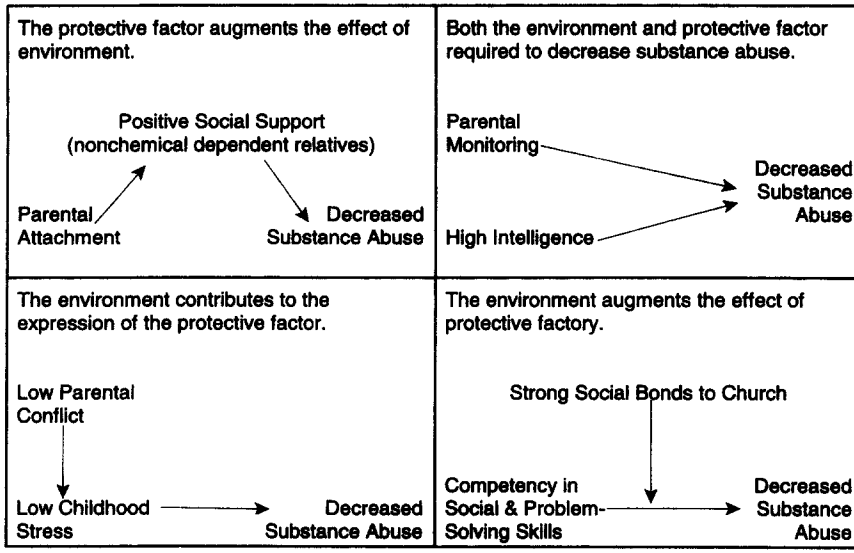

Figure 3. Interactions of environment and protective factor to decrease substance abuse

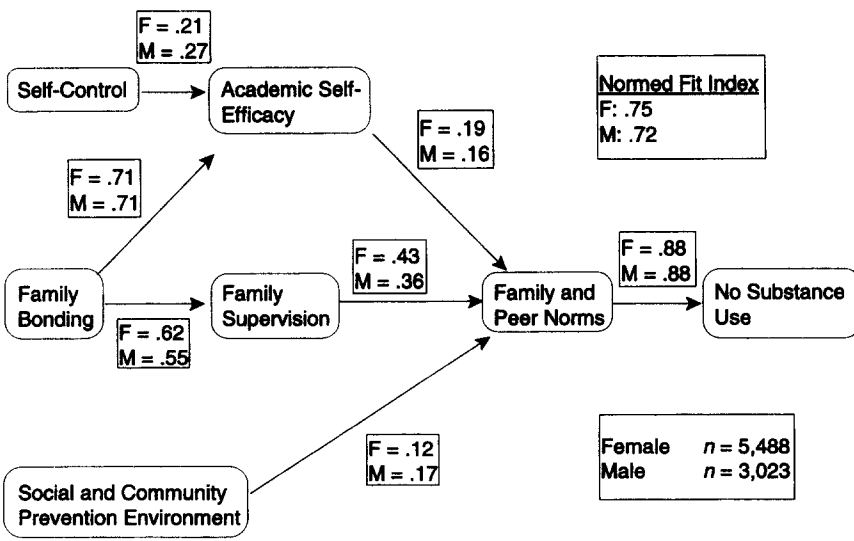

Figure 4. Pathways of protective factors for young mothers

discuss their implications for substance-affected families. Following is a discussion of the key family processes in order to lay the foundation for further research in the area of strengthening families to prevent and/or treat substance abuse.

Walsh (1998) identified three key processes or mechanisms related to family resilience: belief systems, organizational patterns, and communication processes. Each of these processes will be reviewed, and current research related to risk and protective mechanisms will be discussed.

Belief Systems

Family belief systems influence the way in which families perceive and respond to challenges. According to Walsh (1998), key belief systems related to resilience include making meaning of adversity, developing a positive outlook, and fostering a sense of transcendence and spirituality.

Making meaning of adversity. Resilient families make meaning of adversity through valuing affiliation, having a family life cycle orientation, developing a strong sense of family coherence, and appraising crises positively (Walsh, 1998). Families with a collective, rather than individualistic, orientation are able to pull together during times of crisis. They have faith in each other and can turn to each other for support. This foundation of trust allows them to see a crisis as a shared challenge instead of as an individual problem. Researchers who study family functioning indicate that an affiliative value is an important strength (Beavers & Hampson, 1993; Stinnett & DeFrain, 1985). Substance-affected families often develop rigid roles and an individualistic perspective to survive in a chaotic and unsupportive environment. The lack of communication and the "no talk" rule prevent them from seeing substance abuse as a shared challenge (Straussner, 1993).

A family life-cycle orientation allows resilient families to balance stability and change. They accept that families expand and contract over time, and they do not resist the challenges that occur at each individual and family stage of development. Substance-affected families often lack an understanding of the dynamic quality of family life and seem frozen in time (Carter & McGoldrick, 1989). A great deal of time and energy is focused on surviving the immediate challenges presented by the substance user. As a result, there may be a focus on the present without a sense of past connection or future direction. However, some families may react by being preoccupied with past events and traumas related to the substance use or by trying to escape from the past. Children in substance-affected families are often prematurely expected to take on adult roles and are hurried through childhood stages of development.

Resilient families search for order and meaning within disruption and change. They have confidence in their ability to deal with problems. As an individual quality, sense of coherence is a more significant predictor of health and well-being than temperament or intelligence (Cederblad & Hansson, 1996). In families, a strong sense of family coherence predicts better coping and adaptation during a crisis (Antonovsky & Souroni, 1988). In substance-affected families, the discontinuities of life are often perceived as overwhelming. They may lack the energy to search for order and meaning, or they may not believe that order and meaning can be obtained. As a result, substance-affected families tend to select ineffective and unhealthy coping methods and adapt poorly to crises (McCubbin, McCubbin, Thompson, & Thompson, 1998).

Rather than perceiving a crisis as a catastrophe, resilient families view crisis as a challenge. While accepting that no one is either entirely helpless or omnipotent, they believe they can exhibit some control over situations. They look for multiple explanations for problems. In substance-affected families, members often blame and scapegoat each other (Beavers & Hampson, 1993). Their thinking is characterized by self-defeating distortions and exaggerations such as "Nothing can be done," or "It's all your fault."

Developing a positive outlook. Families who are optimistic rather than pessimistic are more likely to achieve positive adaptation during a crisis (McCubbin et al., 1998). According to Walsh (1998), resilient families persevere when faced with difficulty, exhibit courage and provide encouragement to each other, sustain hope and have confidence in their abilities, focus on strengths rather than limitations, and direct their energies toward what can be changed and accept what can not be changed. For substance-affected families, the coping strategies become rigid as survival and guarding from the ramifications of the substance-abusing behaviors become all-consuming. The family may feel fatalistic about its future and minimize opportunities and possibilities. Members may make plans to escape the family. Members fail to see the strengths or even the exceptions to when the substance-abuse behavior occurs (Miller & Berg, 1995). This outlook often increases rumination on the negative aspects of the self and family, leading to depression and feelings of hopelessness and shame (Beattie, 1987).

Fostering transcendence and spirituality. When families believe in larger values and an overarching purpose in life, they find comfort and meaning in trying situations. Spirituality has been identified as a major characteristic of strong families (Stinnett & DeFrain, 1985). Members of resilient families seek inspiration from each other and have the ability to transform adversity into a positive learning experience (Walsh, 1998). For substance-affected families, some feel unworthy of good things in their life, self-blame about being the cause of the problem, or feel that "God" is punishing them to keep them in

these circumstances (Beattie, 1987). They see personal and family values being broken each day so that a coherent set of principles for family life and interactions with outsiders become confused. They experience difficulty transcending the excessive pain and negative experiences in their lives. They lack trust that others or a higher power is there to help or comfort them because they see no immediate evidence (Beattie). Some might be in fact very angry at others or "God" or a higher power that they feel has abandoned them (Beattie).

Organizational Patterns

Adaptability and cohesion have been identified as major dimensions of family functioning (Olson, 1989). Similarly, Walsh (1998) noted that flexibility, connectedness, and use of social and economic resources influence the ability of families to function when faced with difficulties.

Flexibility. Families must balance between two competing needs: the need to change and the need to stay the same. Resilient families are able to reorganize and change when developmental or environmental factors disrupt the family's homeostasis. At the same time, they rely on routines, rituals, and rules to maintain stability and continuity within the family (Olson, 1989). For substance-affected families, the homes can move toward two extremes as a result of reactions to affected family behaviors. They can become more chaotic with few rules and sudden changes in family patterns (Olson). Such families are characterized by sudden and rapid changes with high levels of stress and crisis responses. This places them in a situation where they spend large portions of their time and energies reacting only to the present needs with little long-term planning for meeting life's normal developmental needs (Olson). The other extreme is an excessively rigid family pattern that provides for many rules, little input, and harsh discipline (Kumpfer & Alvarado, 1995; Olson). These families may lack the ability to move forward or to make changes for fear of unbalancing the substance-affected family member(s). Fear of change or fear of retaliation as a result of change best describes the patterns of these families.

Connectedness. The ability to balance separateness and togetherness is key to healthy family functioning (Olson, 1989). In resilient families, members are committed to each other and work together to solve problems while maintaining respect for individual needs and differences. Regardless of family structure, adults exhibit strong leadership to nurture and guide children (Walsh, 1998). A positive relationship between parents and children serves as a protective buffer against involvement with drugs (Wills, 1990).

In substance-affected families, excessive extremes of enmeshed or disengaged boundaries can occur (Olson, 1989). If a family has disengaged

boundaries, the family members do not rely on each other for support, activities, relationships, or comfort. When attachment and bonding are low, youth are more vulnerable to peer and societal influences to use drugs (Stein, Newcomb, & Bentler, 1987). A lack of family bonding also increases the risk that children will engage in risky or antisocial behavior. Franke (2001) analyzed data on almost 19,000 middle and high school students. Youth who did not feel their family understood them, paid attention to them, or spent time with them in fun activities were more likely to trash property or be violent with others than youth who were strongly attached to their families.

Parental control is a strong predictor of problem behavior (Barnes & Farrell, 1992). Families with democratic control and psychological autonomy are most likely to produce youth who are competent and resistant to drug abuse (Baumrind, 1991). Teens with "hands-off" parents are at four times greater risk of smoking, drinking, and using illegal drugs than teens with "hands-on" parents (National Center on Addiction and Substance Abuse, 2000). "Hands-off" parents do not establish household rules and expectations for behavior and do not monitor where their children are or what they're doing. Gottfredson and Hirschi (1990) proposed that inept parenting practices fail to instill self-control and empathy within the child. Children become defiant, impulsive risk-takers. As a result, they are poorly socialized, attracted to antisocial peers, and prone to substance use and other problem behaviors.

Parental monitoring involves both structuring of the child's home, school, and community environments, and tracking the child's behavior in those environments (Dishion & McMahon, 1998). Youth whose parents do not structure their environments or track their location and activities are significantly more likely to use substances and engage in other risky behaviors (Dishion & McMahon; Patterson, 1996).

The other extreme of family connectedness is the enmeshed family dynamics. Family secrets, weak boundaries, parental-child role reversals, poor parental control and familial sexual abuse are often by-products of extreme connectedness (Olson, 1989). The consequences where the children become the functioning person in the family and highly responsible for daily functioning can have long-term effects on emotional well-being (Black, 1981). This can result in behaviors that do not support the growth of family members (Olson, 1989).

Use of social and economic resources. Resilient families are able to mobilize support from extended family and community networks. They also build financial security (Walsh, 1998). Social and economic support is particularly important for single-parent families. Children in single-parent families are at greater risk of smoking, drinking, and using drugs than children in two-parent families. Those living in a household headed by a single mother are at 30% higher risk than youth in two-parent households (National Center on Addiction and Substance Abuse, 2000).

Whether parents are married or single, economic hardship has a negative effect on parenting. Parents who are experiencing financial strain are more likely to be harsh and explosive with their children, and less likely to be nurturing than parents with adequate resources (Conger et al., 1993; Simons, Beaman, Conger, & Chao, 1993). Parents who are under stress tend to exhibit diminished parenting skills.

Communication Processes

Three communication processes help families maintain resilience during daily hassles and major life changes: (a) clarity of communication; (b) open emotional expression; and (c) collaborative problem solving (Walsh, 1998). However, substance-affected families often have rules that forbid expression of certain feelings and constrict communication.

Clarity of verbal and nonverbal communication. Resilient families tend to be clear and consistent in both their words and actions. When ambiguous situations occur, they seek to clarify the problem through truth-seeking and truth-speaking (Walsh, 1998). When talking in a substance-affected family, family members may go to great lengths not to confront directly the behaviors of the dependent family member(s). The "no-talk rule" that keeps members from speaking about issues openly, especially about the substance abuse, makes it difficult to have truth-speaking communication (Beattie, 1987). Mixed messages of "Do as I say and not as I do" may make it difficult to interpret appropriate behavioral and emotional expectations. There is risk in asking for clarification of communication concerning discrepancies in behaviors and spoken language. Black-outs contribute to mixed messages and manipulation of communication.

Open emotional expression. Dealing with the emotions of family life can be challenging for even the healthiest family. Families who are able to express the full range of feelings, take responsibility for their own feelings, display empathy and tolerance for others, and interact in pleasurable ways are more likely to be resilient in the face of adversity (Walsh, 1998). Children's emotional development is fostered by open communication, give-and-take in family discussions, and explanation for rules and consequences (Holmbeck, Paikoff, & Brooks-Gunn, 1995). The risks for substance-affected families are poor communication in large part due to the limits of permission to express feelings during sober and intoxicated states (Straussner, 1993). The expression of true feelings may be relegated to only certain times, such as when a parent is drunk, limiting the flexibility of the give-and-take process (Straussner). The "rules" for communication may not be well-defined or even developed (Straussner). Family members may act out their needs and wishes rather than

talking them out because of limited opportunities to communicate without risk (Straussner). Explosive expression may lead to a lack of trust and constricting of emotions or emotional reactivity and explosive communication with others (Straussner). Both of these extremes limit healthy family communication causing double binds, avoidance, confusion, and negativity that takes over all areas of family life (Straussner).

Collaborative problem solving. There are several ways in which resilient families communicate to solve problems. They brainstorm when problems arise, share in making decisions, resolve conflict in a constructive manner, focus on solutions rather than fault, and take a proactive stance to prevent problems or prepare for future challenges (Walsh, 1998).

For substance-affected families, many conflicts arise that diminish collaborative decision making. Because of the out-of-control nature of daily family life, sometimes members of the family will develop caretaking roles and inappropriately leave out or fix things for the dependent family member (Beattie, 1987; Wegsheider, 1981). This decreases the opportunities for family members to learn the give-and-take of shared decision making or learning the procedure for how to resolve conflicts. At worst, the caretakers become controlling of people and events. This level of domination leaves the other family members with little input and feeling cut off from other family members (Beattie, 1987).

Recommendations for Mobilizing Key Processes in Family Resilience

Based on the four protective mechanisms identified by Rutter (1987) to promote resilience in children, Walsh (1998) proposed four ways in which key processes in family resilience can be mobilized: (a) decreasing risk factors; (b) strengthening protective family processes and reducing vulnerabilities; (c) reducing negative chain reactions that heighten risk; and (d) bolstering family esteem and efficacy through problem mastery. Family counselors and social workers can help families decrease risk factors by providing anticipatory guidance for life changes, teaching ways to reduce and cope with stress, and educating families on strategies that fortify families. Protective family processes can be strengthened by identifying and enhancing family strengths, assisting families with mobilizing their resources, helping families reorganize and reorient after a crisis, and assisting the family to anticipate new challenges that may arise. Negative chain reactions can be reduced by buffering the effects of stress, changing maladaptive coping strategies, and helping the family to rebound from setbacks. Family esteem and efficacy can be bolstered through helping families collaborate and gain confidence in their ability to solve problems, and through raising awareness of their ability to manage challenging circumstances over time.

Conclusion

The current state of knowledge on family risk and resilience is in its beginning stage of development. The foremost recommendations are for the following: (a) more in-depth exploration of the family processes that promote risk and protection so we can understand how change occurs; (b) comprehensive study of the interactions of risk and protective processes to review how they affect each other in the change process; (c) exploration of the pathways that contribute to risk and protective chains so they can be disrupted or enhanced as needed; (d) examination of the most significant elements in the risk and protective chains to assist in focusing our efforts to disrupt damaging chains or enhance protective chains; and (e) development of targeted family strengthening programs that use this knowledge in their development and implementation. The United States spends 13% of its budget on the war on drugs, of which 3% goes to prevention and treatment. We would suggest there are better ways to win the war for and with America's families.

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