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ABSTRACT

This third chapter in "Elementary School Counseling in a Changing World" contains five journal articles which focus on substance abuse prevention. "Perspectives on Substance Abuse Prevention" by John Horan, Andres Kerns, and Christine Olson emphasizes how important it is for children to be able to say "no" to drugs and provides a review of substance abuse prevention programming over the past 20 years. "Putting It All Together: Quest's Skills for Growing Program" by Hank Resnik describes a program developed by Quest International to provide substance abuse prevention to students in kindergarten through fifth grade. "Dilemma Discussion in Drug Education" by Edwin Gerler, Jr. describes a 10-session program to help middle school students progress in their reasoning about using drugs. "Moral Reasoning in Early Adolescence: Implications for Drug Abuse Prevention" by Phyllis Mohr, Norman Sprinthall, and Edwin Gerler, Jr. presents a study examining adolescent thinking as it relates to judgments about abusing drugs. "Helping Children of Alcoholic Parents: An Elementary School Program" by Ruth Davis, Patricia Johnston, Lena DiCicco, and Alan Orenstein describes a therapeutically oriented alcohol education group in elementary schools to help children cope with family alcoholism and prevent them from abusing alcohol themselves. The chapter concludes with a set of issues for elementary school counselors to consider about a world of drug abuse. (NB)

CHAPTER 3

A WORLD OF DRUG ABUSE

Research has shown that students often begin to experiment with drugs in elementary school and that early experimentation frequently leads to abuse and addiction in adolescence. Moreover, research has documented the problems of children from families made dysfunctional by alcoholism and drug addiction. It has been estimated that 6.5 million children under 18 years old and 22 million persons over the age of 18 have been reared by problem drinkers. William Bennett, the coordinator for drug policy under President George Bush, has commented that "the most serious threat to the health and well-being of our children is drug use." This chapter on substance abuse (a) helps elementary school counselors understand the scope and implications of substance abuse and (b) presents drug education programs that are designed to prevent drug abuse and to help children overcome the effects of substance abuse in their families.

The focus of Chapter 3 is on substance abuse prevention. The first article, "Perspectives on Substance Abuse Prevention," presents a clear picture of how important it is for children to be able to say "no" to drugs. However, as the authors of the article point out,

> Focusing on the simple mechanics of saying "no" may be of little value when a more basic choice problem such as "If I say no, I may not be liked by this individual or group" is evident. Thus, training in how to generate alternatives (e.g., learning to say "no" in such a way as to minimize alienating protagonists, discovering how to break into social circles having more compatible values, etc.) may be highly relevant.

With this more basic choice problem in mind, other articles in Chapter 3 provide innovative programs for counselors to implement, including, the broad-based approach of Quest's "Skills for Growing Program" and the cognitive

development approach of "Dilemma Discussion in Drug Education" and "Moral Reasoning in Early Adolescence: Implications for Drug Abuse Prevention." Elementary school counselors will find exciting new ideas in each of the substance abuse prevention programs discussed in this chapter.

Chapter 3 concludes with the article, "Helping Children of Alcoholic Parents: An Elementary School Program." This article recognizes the serious effects of parents' alcoholism on children's development and presents a compassionate approach to helping these young victims receive help whether or not their parents are willing to accept help. The 1990s will undoubtedly bring new problems in the area of substance abuse, but the decade will also witness advances in drug education.

Perspectives on Substance Abuse Prevention

John J. Horan
Andres Kerns
Christine Olson

Some years ago, one of us opined that the drug educator of the 1960s had a lot in common with Christopher Columbus: both were seeking a newer world, but then again, both started out not knowing where they were going; both ended up not knowing where they had been, and both did it all on government money (Horan, 1974). In this article we provide a terse tour of substance abuse prevention programming over the past 2 decades. Showing where we've been is a helpful backdrop for suggesting where we might go in the future. To illustrate that government money can, indeed, be well spent, we describe an empirically promising approach based on teaching assertiveness and decision-making skills and cite the results of a longitudinal evaluation of the assertive training component. We conclude with a description of our current program in the context of our ongoing evaluation efforts.

Prevention Programming

There is an enormous body of literature written in the name of drug education (see Blum, 1976; Evans, D'Augelli, & Branca, 1976; Goodstadt, 1974; Ostman, 1976; Shain, Riddell, & Kelty, 1977). Very little of it, however, is of use to practicing counselors seeking to discover and employ empirically verified prevention programs. Horan and Harrison's (1981) review, for example, indicated that only 26 published references were to intervention endeavors that included drug-related outcome measures. Moreover, only a third of the studies cited met the main requirement of true experimentation, namely, random assignment to experimental conditions. Also, some projects were apparently conducted in the absence of a coherent theoretical base, and most were not replicable because of the undefined or indefinable nature of the independent variable. Furthermore, data-analysis errors seemed to be the norm rather that the exception. Finally, "prevention" by definition, implies a reduced probability of future substance abuse; yet, only 4 of the 26 projects in the Horan and Harrison (1981) review included any sort of the follow-up evaluation effort.

Schaps, DiBartolo, Moskowitz, and Churgin (1981) were able to locate 75 citable projects (of which 69% were unpublished) and expressed similar dismay

about the lack of design quality in the literature. Their exhaustive review categorizes the literature into 10 intervention strategies: information, persuasion, affective-skill, affective-experiential, counseling, tutoring/teaching, peer group, family, program development, and alternatives. Only 10 studies met their minimal criteria for design quality and service delivery intensity, and of these only two showed an impact on drug use. Given that this exhaustive compilation of 75 documents contained 127 evaluated programs, the fact that two should emerge as promising is not surprising and, indeed, might be expected by chance alone.

Information-based programming is the most common prevention modality deployed over the past 2 decades, and thus warrants a closer look. The logic of information-based programming can ultimately be traced to classical decision theory (see Bauman, 1980; Broadhurst, 1976; Bross, 1953; Horan, 1979; and Mausner, 1973); however, such linkage is rarely articulated. Thus, the failure of information-based programming to receive favorable review may well be because of implementation inadequacies rather than to deficiencies in the conceptual basis of the approach.

In any event, according to classical decision theory, our choice between two or more alternatives (e.g., consuming drugs or abstaining from them) depends upon the utilities inherent in each alternative and their probabilities of occurrence. Essentially, we act to maximize subjectively expected utility (SEU); that is, we pick the alternative with the greatest likely payoff.

The purpose of information-based programming thus becomes fairly clear: if we provide our youth with an awareness of the dangerous consequences of drug use (negative utilities) and indicate to them that these consequences are indeed highly probable, the drug avoidance option is virtually assured. No rational human being would select an alternative with a comparable low SEU value.

Unfortunately, drug educators and counselors, however well intentioned, have a long history of distorting the facts about drugs to such an extent that the potential user is apt to find more correct information about drugs in the drug culture than in the classroom. Most accompanying instructional materials (e.g., films, poster, and pamphlets) likewise attempt to miseducate (e.g., see Globetti, 1975; and National Coordinating Council on Drug Education, 1972). Consequently, student skepticism is a highly reactive obstacle to drug education program evaluation.

From an empirical standpoint, Horan and Harrison's (1981) review indicated that compared to no-treatment control groups, information-based drug education curricula can raise drug knowledge levels (as measured by achievement tests keyed to the particular program). Such findings are not particularly noteworthy, given that we might expect parallel outcomes from any curriculum

in math or spelling. Information-based programming is not likely to alter attitudes or drug use behavior meaningfully until its implementation corresponds to the decision-theory framework on which it ought to be based (e.g., the information needs to be perceived as accurate and relevant to the consumption decision). Data confirming that possibility remain to be collected.

Quo Vadis?

Where do we go from here? It might be helpful to step back and view this pessimistic data from a slightly different historical perspective. By the early 1970s, our profession had stumbled to a consensus that drug abuse prevention programs should be directed at fostering one or more of the following objectives: (1) increasing knowledge about drugs, (2) promoting healthy attitudes about drugs, and (3) decreasing potential drug abuse behavior in the general population (Horan, Shute, Swisher, & Westcott, 1973; Warner, Swisher, & Horan, 1973).

To be sure, these objectives were found to be fraught with a number of conceptual and methodological difficulties (see Horan, 1974). It was soon noted, for example, that drug users already knew more about drugs than nonusers, so an invidious misunderstanding of correlation and causality led to widespread fears that drug education may be "pushing rather than preventing."

Moreover, there was considerable disagreement on just what constituted a healthy drug attitude; for example, some professionals advocated stiffer penalties for marijuana consumption, while others argued just as passionately for its legalization. Thus, items on Likert scales used to assess attitude changes had serious shortcomings in content validity.

Finally, behavior changes were difficult to register, given that prior to high school only a small percentage of our nation's youth are actually drug-involved. The problem is one of statistical power; that is, the evaluator must use extremely large sample sizes and wait several years after the program has ended (when the seducing effects of history and maturation have taken their toll), before collecting behavioral data suitable for meaningful analysis.

Rather than confront and attempt to resolve these difficulties, by the late 1970s, many drug educators had abandoned the concept of drugs from drug education! They instead pursued popular humanistic goals; fashionable examples of non-drug drug education included Parent Effectiveness Training (Gordon, 1970), the DUSO Kit (Dinkmeyer, 1973), and the Magic Circle technique (Ball, 1974). If evaluated at all, the outcomes of a typical drug education program in that era were likely to be assessed with measures of self-esteem rather than surveys of substance abuse. (We have no quarrel with the pursuit of

humanistic goals, however, we do believe that such endeavors ought to be supported with their own resources, rather than with redirected funding for the prevention of substance abuse).

As we advance through the 1980s, it is clear that some lessons have not been learned. The tired miseducation strategies of the 1970s, for example, proliferate the professional marketplace along with a plethora of unpromising affect-oriented programs in fancy packages (As Yogi Berra said, "It's like deja vu, all over again").

The wise shopper, however, might take note of the emerging evidence in support of social skills approaches to prevention (see Botvin, 1983; McAlister, 1983; and Pentz, 1983). Nancy Reagan's popular "Just say 'no'" campaign, for example, owes its uncited theoretical base to the assertion training literature. Saying "no," of course, presumes that one has reasons for, as well as the personal-social competence to do so; unfortunately, however, many individuals do not have those resources. Thus, let's take a closer look at the rationale and demonstrated effectiveness of a more fully articulated approach to assertion training.

Assertion Training as a Prevention Program

Assertion training as a drug abuse prevention strategy owes a portion of its theoretical base to classical decision theory. Recall from our discussion of information-based programs, that we select the alternatives with the highest "subjectively expected utility" (i.e., SEU = utility x probability), or in less technical terms, the greatest perceived payoff.

The probable role of peer approval as a utility (or disapproval as a negative utility) accruing from drug abstinence or consumption is virtually self-evident. In the first place, of all the psychosocial correlates of drug use, most conspicuous are the relationships between an individual's use of drugs and the drug-taking behavior of peers (Swisher, Warner, & Herr, 1972); reported correlations are consistent across all drug categories including smoking (Levitt & Edwards, 1970), drinking (Kandel, Kessler, & Margulies, 1978), and the consuming of illegal substances (Kandel, 1974a, 1974b). Second, the power of peer influence has been *experimentally* demonstrated on alcohol consumption (Dericco & Garlington, 1977) and in the formation of expressed drug attitudes (Shute, 1975; Stone & Shute, 1977). Finally, there is some evidence that drug users lack assertiveness skills (Horan, D'Amico, & Williams, 1975); such a deficit could easily increase one's vulnerability to drug-use peer pressure.

Assertion training is an extremely popular and thoroughly documented vehicle for enabling individuals to do "what they really want" in particular

social situations (e.g., Alberti, 1977; Galassi, Galassi, & Litz, 1974; Heimberg, Montgomery, & Madsen, 1977; Holmes & Horan, 1976; Kwiterovich & Horan, 1977; McFall & Marston, 1970). As a drug abuse prevention strategy, assertion training rests on the assumption that many youths, who would otherwise abstain from taking drugs, reluctantly imbibe because they lack the social skills necessary to extricate themselves from social situations in which drug use is imminent. Of course SEUs other than those pertaining to the likelihood of peer approval-disapproval are relevant to drug decisions. For example, the potential user also may estimate (however crudely) the probabilities of euphoric and adverse physiological consequences. Thus, the role of assertion training as a drug abuse prevention strategy is limited to simply shoring up the possibility of free choice. Following such training, youths could still decide to take drugs (on the basis of other SEUs), but in doing so, they would not be capitulating to peer pressure because they would have the competence necessary to finesse themselves away from the drug consumption option without losing face.

To test this theoretical perspective, Horan and Williams (1982) randomly assigned 72 nonassertive junior high students to assertion training (in which one-third of the training stimuli involved drug-use peer pressure), or to placebo discussions focused on similar topics, or to no treatment at all. The experimental assertion training and placebo treatments were delivered in the context of five small-group counseling sessions of 45 minutes duration over a 2-week period. Each treatment group was composed of three same-sex subjects plus the counselor.

The assertion training treatment was based on the intervention model of Galassi, Galassi, and Litz (1974), 10 general assertiveness (non-drug) training stimuli borrowed from McFall and Marston (1970), and five additional training situations involving peer pressure to use drugs. Sessions began with the counselor's instructing about assertiveness and live modeling of an assertive response to a particular training stimulus. Subjects rotated twice in the roles of speaker, listener, and responder for each stimulus. The counselor provided feedback plus additional instruction and modeling when appropriate after each subject's role-played response. Three training stimuli (one involving drugs) were used in each counseling session. Typical examples are as follows:

> *General assertiveness training stimulus:* Picture yourself just getting out of class on any old weekday morning. Hmm. You're a little hungry and some candy or some milk would taste good right about now, so you walk over to the machines and put your money in. You press the button . . . and . . . out it comes. You open it up. Mmm. Whatever it is you just bought, it sure tastes good. It's a good break, right after class. Oh, oh. Here comes your mooching friend again. This person is always borrowing money from you. He's getting closer now, and as he gets

closer your relaxation sort of changes to irritation. Oh, here he comes. Moocher: "Hey, I don't have any money and I'm hungry. How 'bout loaning me 50 cents for a candy bar?"

Drug-specific assertiveness training stimulus: You are out for the day with a group of close friends. While eating some food at a snack shop, you notice a friend you have not seen for a while and you invite him or her over to talk. During the conversation, your friend says: "I just got back from the greatest vacation. I was up in the mountains with some friends of my older brother. We really had a wild time! Hey! You should have been there. I got a chance to try a lot of different drugs that some of the other kids had. I've got some stuff at home. My family isn't home. Come on over and I'll give you some. You all will have the greatest time! Are you coming?"

The results of this study were very promising. At posttest, compared to control subjects, the experimental students showed highly significant gains on behavioral and psychometric measures of assertiveness as well as decreased willingness to use alcohol and marijuana. At 3-year follow-up, these students continued to display higher levels of assertiveness and less actual drug use.

Is That All There Is to It?

The role of assertion training as a drug abuse prevention strategy is limited to that of fostering the competence to say "no" in peer pressure situations focused on drug use. More fully developed social skills programs are currently being designed and evaluated with promising preliminary results (see Botvin, 1983; McAlister, 1983; Pentz, 1983).

Although social skills are critical to adaptive decisions about drugs, other competencies are also relevant. Thus, to maximize benefit in applied settings, we suggest a comprehensive programming approach. At the core of such a program we envision an instructional unit conforming to the implications of classical decision theory. Namely, accurate information regarding the utilities of drug use and abstinence along with their probabilities of occurrence should be readily available (including synopses of dissenting opinions). The misinformation contained in most drug prevention endeavors is educationally and ethically abhorrent.

But classical decision theory is actually inadequate to the task. For example, it assumes that all alternatives are known and that all utilities are rational. Consequently, when developing intervention curricula, drug educators and counselors should pay close attention to the expanding problem-solving and decision-making literatures, which include strategies to help students (a) define their choice problems, (b) enlarge their response repertoires, (c) identify

pertinent information, and (d) implement their desired alternative (Horan, 1979; Moskowitz, 1983).

Current Work at Arizona State

A variety of projects in substance abuse prevention are underway at Arizona State University. For example, due to the generous support of the Sally M. Berridge Foundation, we are in the process of revising the assertive training program described above. Although its effectiveness from an empirical standpoint is clear, the stimuli were developed in the 1970s. They need to reflect the language and "zeitgeist" of the current decade.

The problem of exporting effective programs to the practitioner community continues to vex us as researchers, as does the ever present burden of cost benefit analysis. Professional labor-intensive programs or those requiring high-level expertise to implement will rarely escape a dusty bookshelf destiny. Although, the general strategy of assertion training is within the bailiwick of most practicing counselors, when applied to substance abuse prevention, there are fine nuances that may not be in the professional public domain.

Therefore, we are attempting to commit our program to a videotaped delivery format. We also expect to provide potential assertion trainers with detailed implementation instructions. We envision, for example, a filmed display of various peer pressure situations, that can be stopped and discussed prior to viewing similar vignettes that explicitly model effective assertive responses. The leader's guidebook will call for role-played practice situations, wherein students receive detailed feedback about the proficiency of their rehearsed assertive behavior.

A program of this sort would make no assumptions about the level of practitioner expertise. Counselors already highly proficient in assertion training might use our program as a point of departure; others might follow it verbatim.

We will also be embedding the assertion training component into the larger context of teaching effective decision-making skills. For example, a student may already have a high level of assertive competence (i.e., the ability to say "no" to given peer-exerting pressure). Focusing on the simple mechanics of saying "no" may be of little value when a more basic choice problem such as "If I say no, I may not be liked by this individual or group" is evident. Thus, training in how to generate alternatives (e.g., learning to say "no" in such a way as to minimize alienating protagonists, discovering how to break into social circles having more compatible values, etc.) may be highly relevant. Moreover, frontal assaults on irrational cognitions may be apropos as well. In this case, cognitive restructuring a la Ellis (1962) along the lines of "One's worth as a

person does not depend on being liked by any individual or clique" may be highly productive.

As might be expected, organizing a comprehensive, yet focused, instructional unit for enhancing relevant decision-making skills is a formidable task. Committing it to an interactive videotaped format to aid in exportability increases the burden exponentially. Nevertheless, we feel confident about the ultimate utility of this approach, and are currently in the process of piloting our intervention materials.

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Putting It All Together: Quest's Skills for Growing Program

Hank Resnik

What really works in drug education and prevention? What needs to happen for prevention to be effective? After 2 decades of trial and error, and several generations of funding cycles and drug "crises," some clear answers are beginning to emerge.

Following are several basic premises to consider. All of these are supported by years of research and dozens of books, articles, and reports (Edmonds, 1982; Hawkins, Lishner, Catalano, & Howard, 1986; Johnston, Bachman, & O'Malley, 1985; NIAAA, 1986; Polich, Ellickson, Reuter, & Kahn, 1984; Search Institute, 1984).

1. It is time to put behind us the notion of a "quick fix" to the drug problem. School assemblies, informational pamphlets, and even widely publicized drug awareness and health events are not enough. Although they can be helpful in a more comprehensive prevention effort, there is little evidence that, by themselves and isolated from other prevention activities, they can change young people's behavior.

2. Parent and family involvement is central to effective prevention programming. At one time, it was considered helpful and desirable; increasingly, it is being recognized as a key element.

3. Effective prevention programming takes time. A commitment of as much as 3 to 5 years is not overly ambitious. This does not mean that after 3 to 5 years a prevention program is "over." Rather, by that time, it should have been thoroughly internalized and institutionalized.

4. Good drug education and prevention programs are positive, constructive elements in the life of a school and its community. They lead to a community-wide emphasis on healthy living, positive activities for youth, improved education, and family involvement. A good program does not focus exclusively on the drug and alcohol problem; rather, it promotes a long-lasting, community-wide commitment to the development of human potential, especially the well-being of children and youth.

5. For school-based programs, effective prevention programming is closely associated with better teaching, happier and more successful kids, more involved parents—in a nutshell, better schools.

All of these premises have guided Quest International in the development of its newest program, Skills for Growing, which is targeted at grades K–5. A not-

for-profit educational organization, Quest is already well known for two other programs that have a similar focus. Skills for Living is directed at grades 9–12 and has been adopted by more than 900 school districts throughout the United States and in seven other countries. Skills for Adolescence, developed in close cooperation with Lions Clubs International, is the principal drug education and prevention program of Lions Clubs throughout the world. It is now being used in more than 10,000 middle and junior high schools and has been translated into five languages, in addition to English. Skills for Adolescence is a broad spectrum approach to drug abuse prevention addressing such areas as behavior, cognition, and personal relations. (Gerler, 1986) (See author's note) Skills for Growing has already attracted wide-ranging attention and support. It is being disseminated through a collaborative working relationship with Lions Clubs International and the National Association of Elementary School Principals.

The Quest Conceptual Model

Like all of Quest's programs, Skills for Growing is based on a conceptual model for effective prevention programming that integrates theoretical approaches and research from several related disciplines. The programs of Quest International have two main goals:

1. To help young people develop positive social behaviors such as self discipline, responsibility, good judgment, and the ability to get along with others.
2. To help young people develop positive commitments and bonds in four key areas of their lives: family, school, peers, and community.

Represented graphically in Table 1, the conceptual model can be seen as a simple formula: A + B = C + D. If certain (A) external and (B) internal conditions are met, young people will exhibit (C) positive social behaviors and will develop (D) positive commitments. When these two goals are accomplished, young people will be more likely and better prepared to lead productive, healthy, drug-free lives.

External Conditions

The external conditions envisioned in the Quest Model can be divided into two major categories: environment and skill instruction. Quest has identified seven features of the environment that encourage young people's development of positive social behaviors and commitments. The environment must do the following:

Table 1
Quest International Conceptual Model for K-12 Programming

External Conditions	+	Internal Conditions	=	Positive Social Behaviors	+	Commitment
Environment Opportunity Expectation Caring Predictability Reciprocal interaction Safety Reinforcement		Self-perception Motivation Cognition		Self-discipline Responsibility Good Judgment		Family School Peers
Skill Instruction Thinking skills Social skills				Getting Along with Others		Community

1. Provide opportunities for young people to engage in positive social behavior
2. Clearly communicate expectations that young people will behave in positive ways
3. Be warm and caring
4. Be predictable and consistent (but not rigid)
5. Provide reciprocal interaction with adults and peers so that young people learn mutual respect
6. Be emotionally safe
7. Provide appropriate reinforcement and support for positive social behaviors

In Quest's programs, skill instruction focuses primarily on thinking and social skills. Thinking skills include problem solving, critical thinking, decision making, and goal setting. Social skills include building relationships, enhancing communication, and being able to say "No" to potentially harmful influences.

Another important component of Quest's approach is conveying information—about alcohol and other drugs, for example—through short lectures, independent study, and classroom activities that encourage students to learn in interesting and motivating ways. Nevertheless, the model focuses more on purpose than content, especially at the elementary level.

Internal Conditions

Quest's programs are also designed to affect internal conditions—the child's self-perceptions, motivation, and cognitive development. Self-perception is important because people who are successful in school and in life have a strong sense of being capable. They value themselves and believe that they are worthwhile. They have a sense of control (Glenn & Nelson, 1987). Another key internal condition is motivation, the desire or drive to behave in positive, healthy ways. Especially in a program that emphasizes social skills, students need to be interested and see the relevance of a skill or concept in order to learn it. Three areas of cognition have particularly important implications for skill instruction: memory, understanding, and reasoning. All are combined in Quest's programs in an emphasis on continual information gathering and critical thinking.

Positive Social Behaviors

Positive social behaviors are a principal outcome of Quest's programs. These behaviors can be divided into four categories: self-discipline, responsibility, good judgment, and the ability to get along with others.

Self-discipline consists of respecting oneself, persevering to attain one's goals, and postponing gratification, when necessary. Responsibility involves making and keeping commitments, acting with integrity, being direct and honest, and following through on one's values and beliefs. Good judgment includes considering alternatives and consequences. It involves making wise, informed decisions. Getting along with others is associated with a wide range of social interactions, such as helping, sharing, and cooperating.

Positive Commitments

Another main outcome of the Quest approach is positive commitments and bonding in four critical areas of children's lives: the family, the school, the peer group, and the community. The stronger the positive commitments to these systems, and the more systems to which the child is bonded, the less likely it is that negative and problem behavior will develop.

The Components of Skills for Growing

Given the broad scope of the conceptual model, all of Quest's programs are noteworthy for their comprehensiveness. Each provides a complete set of curricular materials and a variety of components. Each requires that participating

teachers undergo an intensive training workshop before receiving the program materials. Each views the involvement of the total school-community as vital to success.

Skills for Growing was pilot-tested for the first time in the spring of 1988 in ten schools of the United States and Canada. The number of schools expanded to 41 in the fall of 1988, and full implementation of the program will begin in the fall of 1989. The program revolves around five components:

Classroom Curriculum. The curriculum consists of five units, each focusing on a specific theme (for example, "Building a School Community" and "Choosing to be Drug-Free") and offering a series of six lessons. Throughout, the emphasis is on interaction—between the students and the teachers, and the students and each other. The curriculum also provides extensions that relate each lesson objective to various aspects of the standard elementary curriculum.

Positive School Climate. The program establishes a School Climate Committee, made up of teachers, administrators, support staff, students, parents, and community representatives. The basic goal is to involve everyone in the school in the program's positive approaches and activities. A principal task of the committee is to organize and direct efforts to implement the curriculum themes school wide.

Parents as Partners. Parents are encouraged to take an active role in the program through activities they do at home with their children. These activities are outlined in a series of family newsletters for each unit. Parents are also encouraged to become involved in the School Climate Committee. The program provides a series of meetings and booklets for parents that offer practical tips on child rearing in connection with the program's main themes. The emphasis throughout the parent component is on strengthening the family and creating positive links between home and school.

Community Support. Skills for Growing helps to create a team of school and community volunteers whose mission is to increase community involvement in the school and focus community efforts on the needs of children. This component suggests ways to develop cooperative working relationships among community groups and build effective school-community partnerships.

Training. Every classroom teacher in the program must complete an intensive, 3-day workshop led by Quest trainers. The workshop provides both an overview of the program and hands-on experience with the materials. School staff, parents, and community leaders who will play key roles in the program, are strongly encouraged to participate in the training as a team.

The program provides a wide range of materials, including curriculum guides, booklets for students and parents, audiovisual media, and newsletters. After the first year of program implementation, teachers will be kept in touch

and up-to-date through a newsletter called *The Living Curriculum*, which will offer lessons, ideas, and activities to expand the program. Program participants will also be invited to attend regional networking meetings and advanced training workshops sponsored by Quest. In addition, Quest operates a toll-free phone line through which experienced Quest staff members offer practical assistance and answers to questions about the program.

Beyond Drug Education

Skills for Growing was developed by a team of more than 100 educators, psychologists, and curriculum specialists throughout the United States and Canada. It represents a collective lifetime of thinking, experimenting, researching, and innovating in the area of drug abuse prevention and education. One of the main premises of the program is that drug abuse prevention programs must reach far beyond any traditional notion of "drug education" to be effective.

What Skills for Growing is really about is making schools healthier, happier places for children, adults, and the wider school community. Although this is far from being a radically new concept, Skills for Growing provides the tools—the training, the materials, and the organizational support—to make it happen.

Even in the program's early developmental stages, the potential impact was evident. Many teachers and administrators who participated in the pilot project clearly recognized that the program can create important positive changes in elementary schools. Reflecting on the Skills for Growing training, one principal commented, "We are not the same folks today that we were (before training) . . . There is a genuine and gentle warmth, coupled with a sense of caring about who we are and what we do or say to others."

The spirit of cooperation and caring that the program can develop throughout a school is exemplified by one of the pilot school teams that included a bus driver. He became so enthusiastic about the program, the training, and the importance of school-wide cooperation that when he returned to school, he developed a workshop for all the other bus drivers to tell them how they could have a positive impact on children. "I never really thought of it this way before," he told one of the Quest trainers. "A bus driver can set the tone for a child's day. I'm one of the first people the child sees in the morning. I can be an important part of that child's education."

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Dilemma Discussion in Drug Education

Edwin R. Gerler, Jr.

Dilemma Discussion in Drug Education

The current state of drug education is ambiguous at best. Many of the programs offered to counselors for implementation in elementary and middle schools have not been tested empirically and do not have adequate theoretical underpinnings (Horan & Harrison, 1981). Theory-based prevention programs that have been tested or that are currently being tested offer hope that drug education will improve dramatically over the next few years. Horan and Williams's (1982) assertiveness training program, for example, designed to help adolescents resist peer pressure, shows the value of drug education that is grounded in theory and adequately tested. Similarly, the "Skills for Adolescence" curriculum developed by the Quest National Center in Columbus, Ohio, which takes a broader theoretical approach than the Horan and Williams program, seems to be a solid drug education program that is undergoing thorough testing.

It is apparent, however, that even promising approaches to drug abuse prevention do not focus sufficiently on the way young adolescents think when confronted with opportunities to use drugs. The need to correct this deficiency in drug prevention efforts is particularly apparent from recent research (Mohr, Sprinthall, & Gerler, 1987), which showed that middle school students reason at lower levels of maturity when confronted with drug related dilemmas than when faced with other kinds of dilemmas. This finding suggests that drug prevention programming needs to take into consideration theoretical perspectives such as Loevinger's (1977) on ego development, Kohlberg's (1979) on moral development, and Selman's (1981) on interpersonal reasoning.

What follows is a description of a 10-session program, based largely on cognitive-developmental theory that is aimed at helping middle school students progress in their reasoning about using drugs. The program challenges students' current reasoning about using drugs, provides role-taking experiences that allows students to consider the perspectives of peers, and provides students with opportunities to reflect on thoughts and feelings about drug-related issues.

The Dilemma Discussion Program

Participants take part in 10 one-hour, small group sessions that are ideally conducted over a 10-week period. Following each session, students write their

thoughts and feelings in personal journals. Students may discuss their journal entries during any session but are not required to do so.

Phase 1: Getting Acquainted, Group Guidelines, and Drug Information

This phase involves three group sessions incorporating such elements as get-acquainted activities, presentation of guidelines for behavior in group sessions, discussions about the possible side effects of substance abuse, and consideration of social situations in which drug use might be encountered.

Session 1. The group leader involves members in an exercise that asks members to pair off, separate from the group for about 5 minutes, and get acquainted with each other. When members return to the group, they briefly introduce each other to the entire group. Following introductions, the leader discusses the purpose and nature of the dilemma discussion groups, namely, to challenge students' thinking and to prepare students to confront difficult decision-making situations. The leader also identifies guidelines for the group:

1. The group will begin and end on time.
2. Group members should attend every session.
3. Members should keep group discussions of personal matters confidential.
4. Participants should be active in discussions.
5. Members should listen carefully to each other.
6. Members should be considerate in responding to each other.
7. Members should maintain a journal that contains personal reactions to each session.
8. Participants will have opportunities to discuss their journal entries at the beginning of each session.

Session 2. This session provides members with the opportunity to talk about why they want to participate in a dilemma discussion group related to drug use and abuse. Members usually share what they know about drugs, how much peer pressure plays in drug use among students, and how media encourages use of alcohol and other drugs. Discussion of the latter topic usually involves lively conversations about alcohol advertisements associated with television sporting events and about particularly compelling magazine advertisements of alcoholic beverages. Students may also wish to discuss warnings on cigarette advertisements. The leader may challenge students to come up with appropriate warnings for containers of alcoholic beverages.

Session 3. This session begins with students reflecting on their journal entries and, particularly, on discussion in Session 2, about peer and media pressure to use drugs. Next, the leader offers opportunities for members to

discuss not only what they know about drugs, but also how they feel about the use of various types of drugs, including over-the-counter drugs for medical purposes, prescription drugs for medical purposes, legal drugs such as alcohol for recreational purposes, and illegal drugs for recreational purposes. Finally, the leader presents students with the following information about consequences of abusing drugs and encourages students to discuss their feelings about the short- and long-term consequences of drug use:

Alcohol	The effects of alcohol include decreased heart rate, blood pressure, and respiration, as well as impaired coordination, slurred speech, and fatigue. Long-term use of alcohol results in psychological and physical dependence, liver damage, stomach difficulties, and vitamin depletion. Alcohol abuse also results in traffic injuries, and death, as well as Fetal Alcohol Syndrome.
Nicotine	This drug results in increased blood pressure and heart rate, as well as reduced appetite and sensitivity to pain. Long-term effects include cancer and heart disease.
Cannabis	Abuse of marijuana results in red or glassy eyes, increased appetite, impaired coordination, forgetfulness, reduced attention span, animated behavior, and fatigue. Long-term effects include damage to the respiratory system and possible heart damage.
Stimulants	These substances cause loss of appetite, hyperactivity, and paranoia. High doses of certain substances, particularly amphetamines, result in delirium, panic, aggression, hallucinations, psychoses, weight loss, and heart abnormalities.
Inhalants	Use of these substances causes slurred speech, impaired coordination, drowsiness, runny nose, and appetite loss. High doses result in respiratory depression, unconsciousness, and, in some cases, death. Chronic use has adverse physical effects on liver, kidneys, and bone marrow.
Cocaine	This drug causes decreased appetite, weight loss, dilated pupils, periods of tirelessness followed by extreme fatigue, irritated nostrils, anxiety, irritability, and paranoia. Chronic use causes serious health problems, including heart attack, brain hemorrhage, liver and lung damage, seizures, and respiratory arrest.
Psychedelics	These substances alter the senses and often cause panic, nausea, and elevated blood pressure. Large doses of certain psychedelics result in death from brain hemorrhage, heart and lung failure, or repeated convulsions.

Depressants	These drugs cause impaired coordination, slurred speech, fatigue, and decreased respiration, pulse, and blood pressure. When used with alcohol, depressants may be fatal.
Narcotics	Narcotics cause decreased respiration, blood pressure, and pulse rate, as well as fatigue, constricted pupils, watery eyes, and itching. They may also result in nausea and vomiting. Coma, shock, respiratory arrest, and death may result from high doses. When these drugs are injected with unsterile needles, AIDS may be an outcome.
Designer Drugs	The effects of designer drugs are greater than the imitated drug. Designer narcotics may cause drooling, paralysis, tremors, and brain damage. Other designer drugs may create impaired vision, chills, sweating, and faintness.

Phase 2: Beginning Dilemmas

This phase involves three sessions, wherein students discuss and roleplay drug-related situations described by the group leader. These dilemmas stimulate the students to think about social pressures to use drugs. The leader's role during these sessions consists of listening actively, encouraging and supporting roleplay, and asking questions to promote higher levels of reasoning about drug use.

Session 4. This session begins with students reflecting on their journal entries and on previous discussions about consequences of substance abuse and about social pressure to use drugs. Next, the group leader presents students with their first drug-related dilemma for discussion.

> Just before the beginning of the new year, Tony's parents moved into the community and enrolled him in school. He had lived in the same house since birth. Moving was certainly not his idea.
>
> Now, here he was at a new middle school, 400 miles from where he was born and where he wanted to be. Three weeks had passed, and he still didn't know anyone. His new school was an unfriendly place. Kids passed him in the hall as if he didn't exist. Lately, he didn't even feel like getting out of bed in the morning to come to school.
>
> Today, a guy, named Joe, from his English class walked down the hall beside him to the cafeteria and asked him if they could eat together. Things might be looking up for Tony.
>
> Lunch was great. Tony enjoyed telling Joe about his old school, and Joe seemed really interested, asking a lot of questions in between bites of pizza. Tony looked forward to having a new friend.

There was just one hitch. As they walked out of the cafeteria, Joe casually said, "I've noticed you haven't looked too happy about being here, Tony, and I've got something in my pocket that'll fix you right up, make your troubles go away." Joe patted his pants pocket and smiled knowingly.

Tony, feeling embarrassed and uncertain, said nothing.

"No rush, Tony, they'll keep," Joe said. "See you later," and he turned to go down the hall to his locker as the bell rang.

Tony walked on, wondering if Joe wanted him for a friend or what. Tony wanted a friend, but he wasn't sure if he wanted to get involved in drugs. What should Tony do? (Wilkinson, 1988, p. 8)

The leader asks participants to reflect on Tony's situation. During the discussion of the dilemma, the leader challenges students' thinking with questions such as the following:

1. What is Tony's dilemma?
2. What factors enter into Tony's decision? What kinds of statements might Tony be making to himself about his predicament?
3. What alternatives does Tony have? Consider all the choices he has. Which one(s) is he most likely to choose?
4. How do students make friends? Do all new students have problems similar to Tony's? Why or why not?
5. What makes a good friend? Would Joe make a good friend? Why or why not? Would Tony make a good friend? Why or why not?
6. What responsibilities do students already enrolled in school have toward new students?
7. We don't know anything about Tony's race, nationality, or religion. Would these make any difference in Tony's attempts to find new friends? (Wilkinson, 1988, pp. 8–9)

Session 5. Students begin this session by reflecting on journal entries about their first dilemma discussion. Typical student comments include those listed below:

1. I would never be friends with Joe. He's just looking to take advantage of a new kid.
2. Tony is probably a geek. Joe *will* fix him all right.
3. Tony needs to talk with his parents so that Joe will not ruin his life.
4. I would turn Joe in, if he couldn't find out who did it.
5. Joe just wants to help Tony fit in.

Following discussion about journal entries and a review of the dilemma from Session 4, the leader presents another dilemma:

Carrie is walking on air! She has her first, real, live boyfriend. Craig is not just any boyfriend either. He is a grade ahead of her in middle school. She has liked Craig for several months and now he has begun to like her. Craig has asked Carrie to go with him. Everyone at school knows and admires Craig, and now, everyone knows Carrie. She wants to do everything she can to hang on to him.

On Saturday evening Craig invites Carrie to go out with him. She goes with him to see his friends, but she is surprised that it actually turns out that most of his friends are smoking pot. Craig takes his turn and then offers his cigarette to Carrie. Carrie refuses to take part. On the way home, Craig tells Carrie that she really needs to grow up, to make some decisions for herself, and to have some good times in life. He says that she needs to stop ruining fun for everybody else. Craig says that if she is to continue going with him and his friends, she will have to enjoy an occasional smoke.

Carrie is faced with the realization that if she says, "No," she will lose Craig forever, but if she says, "Maybe the next time," she can keep him for the present and avoid embarrassment with her friends. She also thinks that if she can put him off a few weeks, maybe he will like her enough that he will change his mind.

How should Carrie reply to Craig's demands? (Paisley, 1987, p. 113)

After listening to this dilemma, students roleplay the situation, offering several ways for Carrie to reply to Craig's demands. Students also roleplay various alternative responses from Craig and offer subsequent suggestions for Carrie. During and following roleplay, the leader poses questions challenging students to think more maturely about Carrie's situation.

Session 6. Participants begin this session reflecting on their journal entries and on Carrie's dilemma considered in the previous session. Many students find Carrie's dilemma "close to home" and, thus difficult to discuss. The following are sample journal entries in reaction to Carrie: (Students volunteer to share and discuss their journal entries.)

I feel sorry for girls like Carrie. Boys are always trying to get girls to do things that are bad for them. Drugs and sex are all boys think about. If girls give in to pot, the next thing is sex, and maybe with all of the boy's friends. Girls should stick with their own age group and not go with older boys. I am tired of thinking about poor Carrie. I think she will give in. I wouldn't even for the greatest boy. (eighth-grade girl)

Craig has all the luck—good looks, a great body, all kinds of friends, and a nice girl friend. I wish I [were] in his shoes. I would like to have a girl friend especially. I wouldn't force her to smoke pot either. (eighth-grade boy)

> Carrie is too nice to be real. She needs to loosen up and have some real fun. Craig knows how to live. I don't really mean any of this. (eighth-grade boy)
>
> Carrie is too sweet. Her experience with Craig will make her a lot smarter about the way the world is. (eighth-grade girl)

Following participants' voluntary reflections on journal entries, the leader asks students to begin thinking about how to write their own drug-related dilemmas before the next group session. Students express their feelings about the dilemmas already presented and discussed in the group. They also discuss the main components of the dilemmas previously discussed. These components (Galbraith & Jones, 1976) include the following: (a) focus on a genuine problem, (b) action centering about a main character, (c) the presence of choice that has no apparent correct answer, and (d) a question posed about what the main character in the dilemma should do. The leader asks students to prepare a brief dilemma for discussion in the next group session.

Phase 3: Personal Dilemma

This phase includes three sessions in which students write their own drug-related dilemmas and discuss the dilemmas in the group. The leader's role is again to encourage discussion and roleplay and to ask questions that challenge students to reason at higher levels about using drugs.

Session 7. This session begins with only brief reflections on journal entries from the previous session. Next, the students discuss how it felt to write dilemmas on their own. Students who did not write dilemmas, for whatever reason, also participate in this discussion and talk about feelings that led them not to complete the assignment. Some comments during the discussion include the following:

1. Dilemmas are easy to write if they don't come from your own real life.
2. I hate to write these things. This is beginning to be like a class.
3. I don't have any dilemmas in my life and nothing to write about.
4. I just made up something. I don't think anybody will want to talk about it.
5. I have lots of hard choices but none about drugs. I will never use drugs.
6. I like talking about our own dilemmas. They are more realistic than the other dilemmas.

Following this discussion, some students volunteer to read their dilemmas and each is discussed briefly. The leader then forms the participants into small groups of three or four to write dilemmas during the session. The leader circu-

lates among the groups, encouraging participants to stay on task and to complete dilemmas for discussion at the next session.

Session 8. Students briefly discuss their journal entries. The leader asks for a volunteer to read one of the dilemmas created in the previous session. The following is an example from an eighth-grade group:

> Chris is an up-and-coming young basketball player. He shows a lot of academic promise as well. However, Chris has a problem. No matter what he does, he just can't seem to wake up in the morning. He's tried many different things, such as using two alarm clocks, having his parents turn on the overhead light in the bedroom, even just having his parents come in and try to shake him out of bed, but nothing works.
>
> One day, Chris overheard some of his friends talking. It appeared that they were having the same types of problems, but they had found a solution. They were taking amphetamines. Chris asked them about it and they said that it really helped. They said that after using it, they had no trouble waking up in the morning, and it made them more alert in class. Chris began to wonder, "Is this the only way?"
>
> Chris knew that drugs were bad for you, and he had never planned to use them. He also knew that amphetamines would solve his problem, and that they might be the only way to remedy the situation. What would you do if you were in Chris' shoes?

The leader and group members together raise and discuss questions about the dilemma faced by Chris. These questions include the following:

1. What is Chris' dilemma?
2. What might be causing Chris to sleep too much? How will amphetamines affect his problem? Why did Chris think of using amphetamines?
3. What other alternatives does Chris have? Consider all possible choices he has. Which might he choose?
4. Do all kids have trouble waking up? Why or why not?
5. What makes a kid want to keep sleeping in the morning? What makes a kid want to wake up?
6. What responsibilities does Chris have that should make him get up on time?
7. What would you do to help Chris if you were his friend?
8. Where would you go for help if you were Chris?
9. Will Chris try amphetamines to solve his problem? Why or why not?

The leader asks students to write a dilemma for discussion at the next group session. The leader urges everyone to try to complete the assignment this time.

Session 9. Students reflect briefly on their journal entries, particularly thinking about the dilemma of Chris discussed in Session 8. Students then share

and discuss the dilemmas they were assigned to write. At this point in the group process, many of the dilemmas are quite personal and sometimes difficult for students to discuss. The following is an example of a personal dilemma written by an eighth grader.

> Greg's father is an alcoholic, but Greg does not know it. He's seen his father come home drunk a few times and be late for work the next day. Greg's mom always calls his boss when this happens, however, and things turn out all right. To Greg, there is no real problem.
>
> Some of Greg's friends invited him to a party. Everyone seemed to be enjoying him or herself. Then one of Greg's friends walked up to him and offered him a beer. Greg started to say "yes," but he stopped and thought for a moment.
>
> Greg knows he is too young to drink, but he sees his father drink all the time. However, Greg also knows that alcohol is a drug. If you were in Greg's place, what would you do?

As student dilemmas are read and discussed, the group leader and group members ask challenging questions to stimulate thinking about each of the difficult situations presented.

Phase 4: Closing the Group

This phase consists of one meeting that brings closure to the group. During this time, students reflect on how their thinking about drug dilemmas has progressed. The leader's role is to paraphrase and summarize the students' views on their progress.

Session 10. At the beginning of this session, the leader asks the students to read through each of their journal entries from the nine previous sessions. This provides students with the opportunity to observe progress they have made during the group. Students discuss feelings about their progress or lack of it. The leader invites students who have made progress to describe the program for all in the group to hear. The leader then encourages participants who see no movement in their own thinking to discuss their feelings and to consider how their thinking might change in the future.

Does the Dilemma Discussion Approach Work?

Preliminary research (Paisley, Gerler, & Sprinthall, 1988) in drug education involving dilemma discussion has indicated that the approach is effective in helping young adolescents increase their level of reasoning when confronted with drug dilemmas. When compared with control students, students in drug

dilemma discussion groups showed significant increases in principled reasoning about drug-related situations. These increases, of course, do not guarantee that participating students will avoid drugs, but the increases suggest that these students will be better prepared than other adolescents to think maturely about whether or not to use drugs. The ultimate success of such discussion groups in promoting advanced levels of reasoning in students lies in Hunt's (1971) notion about the need for a manageable mis-match between students' present levels of development and educational interventions.

In conclusion, middle school counselors who are planning programs in drug prevention should consider using dilemma discussions. Also, counselors who already coordinate drug education programs should think about including dilemma discussions is existing drug curriculum. Counselors should be aware that the dilemma discussion approach, because it helps students practice language arts skills, is appropriate for use in regular academic courses such as social studies and English classes. In short, counselor and teacher collaboration is a good possibility in drug education efforts that include dilemma discussions. This innovative approach offers the hope that drug education will be perceived as more than an elective or ancillary part of curricula in middle schools.

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Moral Reasoning in Early Adolescence: Implications for Drug Abuse Prevention

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School counselors are concerned about preventing substance abuse among adolescents. This concern is especially justified in light of the national school survey conducted at the University of Michigan's Institute for Social Research (McEneaney & Fishbein, 1983), which showed that, of the nation's high school seniors, (a) 66% reported using illicit drugs at some time in their lives, (b) 43% reported using an illicit drug other than marijuana, (c) 7% reported using marijuana daily, and (d) 31% preported using marijuana before entering high school.

Peer pressure is perhaps the most frequently mentioned reason for the high rate of drug abuse among adolescents. In a research report from the National Institute on Drug Abuse, Carter (1983) concluded:

> In the peer group, attitudes, values, parental behavior, the school, and society are discussed and judged. As participants in these groups, teenagers are influenced by their desire to conform to group expectations. Teenagers most strongly influence each other regarding dress and appearance, choice of leisure-time activities, language, and use of alcohol and drugs. (p. 25)

School counselors have tried various means to help adolescents withstand the peer pressure that often contributes to drug abuse. Counselors in many sections of the United States, for example, are helping teachers to implement the "Skills for Adolescence" curriculum, a new approach to drug abuse prevention developed by the Quest National Center in Columbus, Ohio. This curriculum is an attempt to help adolescents deal effectively with peer pressure and to consider positive alternatives to drug use. Early findings about its effectiveness have been positive (Gerler, 1986).

Some other promising findings about how to reduce the effects of peer pressure among adolescents have come from a study by Horan and Williams (1982), which indicated that junior high school students, when trained to behave more assertively, were significantly less inclined toward drug abuse than were nonassertive youngsters. The researchers concluded that students who are able to act assertively probably "have the competence necessary to finesse themselves away from the drug consumption option without losing face" (p. 342).

If counselors are to be more effective in preventing adolescent drug abuse, however, they need more and better information about how adolescents decide for or against the use of drugs. To supplement the findings of previous studies there is a need for basic research with adolescents—particularly with young adolescents—to determine the thinking processes they use when confronted with the dilemma of whether or not to abuse drugs. It is apparently true that social behavior skills play an important role in adolescents' abilities to resist the peer pressure that contributes to drug abuse; yet, it seems equally plausible that adolescents' reasoning also contributes.

Advances in theory and research about cognitive-developmental functioning, particularly in the area of moral reasoning (Kohlberg, 1979), make investigation of adolescent judgments about drug use especially intriguing. Because previous research (Hedin, 1979) has indicated that educational programs need to be based on the participants' level of reasoning about the issues at hand, both practicing school counselors and researchers might find it useful to know whether adolescents' reasoning about drug use is at the same level as their reasoning about other social dilemmas. Counselors and researchers might also benefit from knowing whether there is a difference between the sexes in their reasoning about the dilemma of drug use. Limited previous research (Gilligan, Kohlberg, Lerner, & Belenky, 1979) has found few, if any sex differences in moral reasoning levels. Nevertheless, if sex differences occur in reasoning about drug use, prevention programs need to be designed accordingly.

The purpose of this study, therefore, was to examine the following questions about adolescent thinking as it relates to judgments about abusing drugs:

1. When confronted with social dilemmas that are "close to home" (e.g., whether or not to use drugs at a weekend party), do young adolescents use the same level of moral reasoning as when dealing with abstract dilemmas that are somewhat removed from daily living?
2. Do male and female adolescents reason at similar levels in resolving drug-related dilemmas?

Understanding how adolescents reason as they make difficult choices about drug use might provide considerable help in building successful prevention programs.

Method

Participants

Students from two eighth-grade classes—a health education class and a physical education class—were selected from a public middle school to participate in

this study. There were 54 participants, 33 boys and 21 girls. They came from a variety of cultural and socioeconomic backgrounds.

Instrument

The measure of students' reasoning used in this study was a modified version of Rest's (1979) Defining Issues Test (DIT). The modified DIT consisted of four dilemmas, two taken directly from the DIT and two drug-related dilemmas modeled after the Rest dilemmas. The two dilemmas taken from the DIT are titled the "escaped prisoner" and the "newspaper" dilemmas. Appendix A is a sample of a drug related dilemma.

Procedures for scoring the modified DIT were the same as those outlined by Rest for scoring the DIT. Responses to the modified DIT yielded scores that were converted to indicate the percentage of student reasoning at Level 1 (preconventional), Level 2 (conventional), or Level 3 (postconventional, principled). Sprinthall and Collins (1984) have noted that (a) preconventional moral reasoning is based in "external, quasi-physical happenings, in bad acts, or in quasi-physical needs rather than in persons and standards," (b) conventional reasoning is based in "performing good or right roles, in maintaining the conventional order, and in meeting others' expectations," and (c) postconventional reasoning is based in "principles that can be applied universally" (p. 179). The modified DIT also yielded scores, which were converted to indicate the percentage of student reasoning devoted to "meaningless" items listed on the instrument. (These items help to determine if a student is reasoning about items or simply responding to their pretentiousness.)

Although there are no reliability and validity data available on the modified DIT used in this study, the DIT itself has been studied thoroughly and has been shown to have high levels of concurrent validity (correlations ranging from .20 to .50 on variables such as achievement, aptitude, and intelligence quotient), construct validity (correlations ranging from .40 to .70 on variables such as cognitive ability and comprehension of moral values), and criterion-group validity (Davidson & Robbins, 1978). Studies of the DIT's reliability have resulted in test-retest correlations in the .80 range (Rest, 1979).

Results

Students responded at all three levels of reasoning measured by the modified DIT. On the four dilemmas combined, the mean percentage of responses at Level 1 = 18.51 (SD = 10.07), at Level 2 = 69.97 (SD = 12.07), and at Level 3 =

20.23 (*SD* = 11.23). As shown in Table 1, there were significant differences between the responses to the DIT dilemmas and the responses to the drug-related dilemmas. (A paired *t* test was used to analyze the differences in group means because the scores from the two DIT dilemmas and the two drug dilemmas were paired for each individual. Therefore, the information for each pair of scores was not independent. Glass and Hopkins [1984] noted, "When each observation in group 1 can be linked to or paired with an observation in group 2, the two sets of observations are dependent or correlated" [p. 240].)

Table 1
A Comparison of 54 Eighth Graders' Moral Reasoning Scores on Two DIT Dilemma and Two Drug-Related Dilemmas

	DIT Dilemmas		Drug Dilemmas		*T*-test results	
Score levels	Group *M*	*SD*	Group *M*	*SD*	Paired *t*	*p*
Level 1	9.54	8.14	28.70	19.11	-6.82	<.0001*
Level 2	61.11	16.18	52.32	20.94	2.37	<.025C
Level 3	26.02	15.97	13.80	13.94	4.14	<.0010*
Meaningless items	3.33	6.73	3.37	5.88	-0.03	>.4000

Note. DIT = Defining Issues Test.
*Statistically significant

The greatest differences in mean percentage of responses to the two types of dilemmas were at Levels 1 and 3. At Level 1 (preconventional) the difference in means was 19.16 percentage points ($t = 6.82, p < .0005$) with the drug dilemmas having the higher percentage. At Level 3 (postconventional) the difference in means was 12.22 percentage points ($t = 4.14, p < .0005$) with the two DIT dilemmas having the higher percentage. At Level 2 (conventional) the difference in means was 8.79 percentage points ($t = 2.37, p < .025$) with the two DIT dilemmas again having the higher percentage. There were no significant differences in percentage of responses to meaningless items.

Table 2 shows the comparisons between the girls' scores and the boys' scores on the DIT and the drug-related dilemmas. Girls and boys did not differ significantly in their responses at any level of the two DIT dilemmas. Girls and boys differed significantly, however, in their responses at Levels 1 and 2 on the drug-related dilemmas. The boys' percentage of responses at Level 1 on the drug dilemmas was 33.33 whereas the girls' percentage was 21.43 ($t = 2.32$,

$p < .025$). At Level 2 on the drug dilemmas, the percentage of female responses was higher, equaling 60.71; the percentage of male responses was 46.97 ($t = 2.46, p < .01$).

Table 2
A Comparison of Moral Reasoning Scores for 21 Eighth-Grade Girls and 33 Boys on Two DIT Dilemmas and Two Drug-Related Dilemmas

Score levels	*M* for girls	*M* for boys	Unpaired *t*	*p*
Level 1				
DIT	7.62	10.79	-1.39	<.10
Drug	21.43	33.33	-2.32	<.03*
Level 2				
DIT	61.19	61.06	0.03	>.40
Drug	60.71	46.97	2.46	<.01*
Level 3				
DIT	28.57	24.39	0.94	<.38
Drug	15.00	14.24	0.19	>.40
Meaningless items				
DIT	2.62	3.79	-0.62	<.38
Drug	2.86	3.70	-0.51	<.38

Note. DIT = Defining Issues Test.
*Statistically significant

Discussion and Implications

This study resulted in two important findings: (a) middle school students seem to reason at higher stages of moral development on abstract social dilemmas than on drug-related dilemmas, and (b) adolescent girls seem to reason at higher stages of moral development on drug-related dilemmas than do adolescent boys. These findings have implications, first, for counselors' work in planning and implementing drug education programs and, second, for extending theory and research on moral reasoning. Both counselors and researchers should note, however, that this study consisted of only a small sample of eighth graders and that the outcomes should be viewed from the perspective of this important limitation.

Implications for School Counselors

Although this was not an intervention study, it has important implications for counselors' efforts in preventing drug abuse. There have been few effective educational methods in drug abuse prevention. Among the exceptions is Horan and Williams's (1982) assertion-training program, which succeeded in preventing drug abuse among junior high students. This program, when viewed in light of the cognitive-developmental findings of our study, may be regarded as having promoted growth in students' reasoning about drug use and as having helped students to be more autonomous, more individuated in their thinking, and therefore less apt to be victimized by the short-term attractiveness of the "forbidden fruit." These results suggest that it may be necessary for school counselors to provide developmental goals for drug programs, particularly goals that are tailored to promote growth in students' levels of reasoning.

One approach counselors can use to promote growth in students' levels of reasoning about drugs is through regular discussions of drug-related dilemmas with groups of students (see Appendix A for an example of a dilemma). The process of such discussion groups consists of these phases:

Phase 1: This phase consists of a few group sessions (2 to 3) incorporating such elements as get-acquainted activities, presentation of guidelines for behavior in group meetings, discussions about the nature and possible causes of drug abuse, and general discussions about dilemmas regarding drug use that adolescents may encounter. The counselor's role in these sessions is to provide information and to encourage active listening among all group participants.

Phase 2: This phase is made up of a few sessions (2 to 3) in which participants discuss and role play situations involving drug-related dilemmas described by the counselor. These dilemmas stimulate adolescent thinking about social pressures to use drugs. The counselors' role in these sessions is to listen actively, to encourage lively interaction and role play among the participants, and to ask open-ended questions that begin to promote higher levels of reasoning about drug use.

Phase 3: This phase consists of a few sessions (2 to 3) in which participants write their own drug-related dilemmas and discuss the dilemmas in the group. The role of the counselor in these sessions is again to encourage both discussion and role play and to ask open-ended questions that promote higher levels of reasoning about drug use. During this phase counselors also try to reinforce participants' motivation to ask questions that stimulate growth in reasoning.

Phase 4: This phase consists of final sessions (1 to 2) that bring closure to the group. Here the participants reflect on how their thinking about drug dilemmas has progressed. The role of the counselor in this phase is to paraphrase and summarize the participants' views on their progress. (We are currently studying

this entire counseling process. Further information and an outline of group sessions may be obtained by writing the third author.)

This kind of counselor-led developmental group seems to have promise for drug abuse prevention. There may be a problem, however, of differing effects of such a developmental program on students (and in the case of this study, male students) who may be reasoning at significantly lower levels than many other members of the group. Hedin (1979) was the first to show that developmental programs may need to be differentiated more clearly according to the present level of the participants' thinking. A meta-analysis of earlier work (Sprinthall, 1981) showed that not all high school or college students, for instance, benefit equally from a general developmental intervention such as peer counseling. Hedin also found that some students (those at more "modest" levels of development) needed substantially more structured learning experiences than do those who are at average or above average stage levels for their age. Thies-Sprinthall (1984) found the same need for structure for adults, namely, in-service teachers. These studies suggest the need to follow Hunt's (1971) notion of a manageable mismatch between students' present levels of development and educational interventions. Too great a discrepancy may invite a developmental version of "ships passing in the night."

Implications for Theory and Research

In addition to having implications for the work of school counselors, this study also has implications for theory and research in moral development. Rest (1979) suggested that one of the major difficulties with early research in moral development was the lack of a complex model to specify the relationship between cognitive structure and content. He noted that the so-called "simple state model," denoting global, unified, qualitative, invariant, and contextual independent elements, was not adequate to encompass theory. Rest's suggestions, of course, were theoretical. Gilligan et al. (1979) proved his point empirically. They found systematic variation in levels of moral reasoning by content. When contemplating sexual dilemmas as opposed to standard dilemmas, the reasoning levels of both boys and girls in the sample fell. In other words, the study demonstrated an interaction between content (standard versus more personal) and the structure of cognition.

Our study demonstrates one outcome similar to that of the Gilligan et al. (1979) study and one that is different. The similarity is that our study showed an interaction between content and structure: The group scores declined overall between the standard and the drug-related dilemmas. This finding is also similar to that of another study (Joyner, 1984), which demonstrated systematic variation by content between standard dilemmas and personal dilemmas at the college

level (i.e., the more personal the dilemmas the lower the scores). Yet, in another study, Tucker and Locke (1986) also found a systematic difference in the level of reasoning, based on how personal the dilemma was, by altering the ethnic identification of the protagonists in dilemmas. It seems possible, therefore, to conclude with some measure of cross validation that content and structure interact and that Rest is correct in calling for a more complex model of developmental growth in moral reasoning.

The second outcome of this study, a finding that differs from that of Gilligan et al. (1979), is the sex interaction. In that study, no sex differences were found. Both boys and girls exhibited a similar decline in reasoning. In our study, on the other hand, sex differences appeared. The boys' level of reasoning declined further than did the girls' level as the content of dilemmas changed from standard to drug related. The boys seemed more adversely affected by the change in content and were much more apt to choose preconventional reasons than were the girls. The boys and girls in the eighth grade may not be starting at the same cognitive level. Whether this is unique to early adolescence, of course, cannot be confirmed without at least some cross-sectional replication, perhaps using students in Grades 8, 11, and college. In any event, further research is needed regarding the content, structure, and sex interaction to elaborate on the basic understanding of stage variation and to determine possible causal explanations.

Conclusion

Advances in understanding cognitive development have important implications for school counselors' work in drug education and for the work of theorists and researchers who are studying moral reasoning. Our findings suggest that adolescents may reason at lower levels about drug use than they do about other issues and thus may be unable to make responsible decisions in drug-related matters. Prevention programs, therefore, should probably focus on drug issues rather than on peripheral, abstract matters of judgment. Our findings also indicate sex differences in reasoning that counselors need to consider in designing drug prevention programs and that researchers need to explore further. As counselors learn more about this important area from additional research, they should be able to design programs for drug abuse prevention that will be more effective than the educational programs currently available.

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Appendix A

A Sample Drug-Related Dilemma Used to Measure Students' Levels of Reasoning

It's Friday night. Don and his friend, Bart, are at their school's football game. They have been friends for many years, are very close, and go to all the football games together. Last week, Bart was elected president of a school club that Don has been trying to get into for the past year. Don now has a good chance of getting into the club with his friend as president. At halftime, some members of the club come up to Don and ask him and Bart to join them behind the stands for a "little partying." Don says, "Sure—great," because this is a chance to get to know these folks better and, perhaps, be asked to join their club. As they leave the stadium to go behind the stands, they pass a policeman. There are always two policemen on duty at the football games in case there is any trouble. When the group finds a quiet spot, everyone sits down and a couple of the kids pull out beers from their coat pockets. One guy rolls a joint and passes it and a beer to Bart, who takes a toke and chases it with beer. Bart then passes the joint to Don. In the past, Don has tried pot and kind of liked it, but he has tried to stay away from it because he does not want to get into any trouble.

Don's parents have made an agreement with him that they will pay all the cost of putting him through college if his grades are pretty good and he does not get into any serious trouble. Don has already picked the college he would like to attend. If he gets caught getting high, he will have broken the agreement with his parents. However, to refuse the joint from his best friend, Bart, in front of this group will hurt Don's chances of getting into the club. Bart asks, "What's wrong, Don? Come on! Relax! We're all friends here." If he does not take the joint and smoke it, his friendship with Bart will be seriously hurt. The club members will ignore Don and not include him in their group anymore.

What should Don do? (circle one): (a) should smoke the joint, (b) can't decide, (c) should not smoke the joint.

The selection of responses includes the following 12 options. (The student is asked to rate the importance of each on a 5-point scale—*great, much, some, little, no*):

1. Whether the policeman catches them
2. Whether Don breaks the agreement he willingly made with his parents
3. Whether Don's father will physically punish him
4. Whether Don recognizes the need for societal values that protect mental and physical health
5. Whether or not Don wants Bart's approval and acceptance
6. The overall factors of Don's mental images and concepts

7. Whether Don loses his new stereo tape deck, which his parents have just given him
8. Don's desire to have a good time
9. Whether the city's laws and the school's rules are going to be upheld
10. Whether or not Don is elected to the club
11. Whether Don likes to watch television
12. Whether it is Don's duty to obey the law to maintain order in the community, even though he would like to smoke marijuana

Helping Children of Alcoholic Parents: An Elementary School Program

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Most alcohol education programs are directed toward junior and senior high school students—adolescents beginning to drink regularly. Younger children, however, also have problems with alcohol. To illustrate, the following are some issues raised by second to sixth graders who kept journals for their alcohol education groups:

- Do you think when kids have a drink at the park that it is okay?
- Why do people drink and get mad?
- Why does my father drink?
- My mother drinks nearly all the time. My father put her in the hospital, but after she came out, she still drinks beer and comes home drunk. Can you tell me what to do?
- Sometimes I think: Am I going to drink when I grow up?
- When my father drinks, he says bad things to me. Then after, he's nice. Why does he do that to me and not to my sister? Is that because I care about him more, or does he dislike me more?
- I am an alcoholic. I drink beer. But I hate to drink. (age 7)
- I have felt I wanted to tell someone something, but I'm always afraid.
- When my father gets drunk, why do I feel responsible for him, and why do I think it's my fault?

These children were part of an experimental program in Somerville, Massachusetts, a predominantly Irish and Italian working-class community of 80,000, adjacent to Boston. School surveys show that the proportion of teenagers who drink heavily (at least once a week and large amounts per occasion) is about 50% higher than comparable national estimates, both for boys and girls. The community's response to these indicators of alcohol abuse must begin by addressing the concerns of its youngest citizens.

Alcohol education conducted by classroom teachers in the early primary grades is an important first step. Teachers can provide information, address fears, and make the entire topic of alcohol use less stigmatizing, so that children

will be more open to discussion and advice in later years when they start to drink and hide their behavior from adults. In addition, teachers in Somerville find that when alcohol is discussed in the classroom, some children display such marked changes in behavior that it is clear that something is wrong. It was these reactions that led us to develop more therapeutically oriented alcohol education groups in elementary schools, which may help children cope with the emotional distress of living with family alcoholism and prevent them from using alcohol abusively in their teenage years or as adults.

Program Structure

The groups meet during school hours for 45-minute periods over 10 weeks. They have 8–12 participants with an age span of not more than 3 years. The sessions are co-led by a staff member at the school, often a guidance counselor, and a psychologist/educator experienced in providing treatment services to children of alcoholics. The meetings include games, movies, puppet shows, coloring books and storybooks, arts and crafts, and other activities adapted from *Decisions About Drinking* (CASPAR, 1978), the alcohol education curriculum used at all grade levels in Somerville.

The program recruits participants in a number of ways. Letters describing the program and seeking parental consent are sent to the families of children receiving special education services. Group leaders visit regular education classrooms, where they talk about the program and distribute permission forms to any child wishing to attend. Teachers, counselors, and parents make referrals, and children encourage their friends to join. Over 4 years, there have been 42 groups at four elementary schools, reaching about 480 children in grades 2 to 6. There currently is a waiting list of students who cannot be served because of limited resources.

About half of the children in the groups come from families in which a parent is alcoholic, although only a small number are in treatment. Of the participants in grades 4–6, 105 responded to a questionnaire at their first group meeting. This sample will be referred to throughout this article. Of this sample, 51% said "yes" to the statement: "Sometimes I think about how much my mother or father drinks." Because this is an unlikely response if the drinking were not disruptive, it can serve as a rough indicator of which children come from alcoholic homes.

In a community with many alcohol problems, when we allow children to volunteer for treatment, encourage parent referrals, and purposely select children with academic and behavior problems, we virtually ensure that many group members will be children of alcoholics, despite the fact that the groups

are open to all. Also, because a wide range of children are attracted by the adult attention as well as by the topic, the groups are not stigmatizing for either the children who attend or, more importantly, their parents, whose permission is required and who might not want their child singled out because of the family's problems.

What Is Taught About Alcohol

Working with younger children highlights the goals of alcohol education. With adolescents, there is a tendency for teachers to emphasize the dangers of alcohol use to prevent misuse, although these scare tactics are rarely effective. The children in our groups are already afraid of alcohol. For example, at their first group meeting, 85% of our group members agree drinking alcohol is "bad"; 90% recognize that "nice people act not nice" when they drink too much; 80% report that most teenagers drink too much; 59% of the children of alcoholics and 42% of other group members believe that most adults drink too much; 36% feel that "people who drink always drink too much"; and under 5% say that drinking helps solve problems but 92% say that people who drink "cause problems for others."

It is not surprising that children of alcoholics hold negative attitudes toward alcohol. More surprising is that the other children in the groups are almost as negative. These feelings seem to reflect the ambivalence of adults. Americans drink "wet" but think "dry" and feel guilty about drinking, so even parents who drink moderately often feel they should teach their children that alcohol is evil. In addition, in a community with considerable alcohol abuse, parents are likely to explain to children that "bad" events—from fights to highway accidents to juvenile delinquency—are due to drinking. In other words, children are socialized to be afraid of alcohol, although this does not stop them from later alcohol abuse. Schools that simply reinforce this socialization are equally ineffective.

An alternative approach is to emphasize an individual's capacity to control alcohol. For example, because of their observations at home, many children equate drinking with drunkenness. They have trouble recognizing as drinking any intake of alcohol that does not have drunkenness as its goal, and they are unaware of the pleasurable feelings and increased sociability many people associate with controlled, moderate social drinking. When we teach these children that alcohol can be a normal and healthy part of family occasions and celebrations, we are showing them that drinking need not be disruptive and that people have a capacity to make decisions about how they drink. We do not want to reinforce the view that alcohol is a scary substance with overwhelming, uncontrollable, and evil effects.

A child who fears alcohol has something to "prove" when he or she enters a drinking situation. A child who has been taught either directly or indirectly by his or her parents that alcohol is an uncontrollable substance may fulfill the prophesy. Rather than scaring children away from misuse by emphasizing abstinence, the groups recognize that most children will eventually drink and try to provide social support for models of moderate drinking behavior. The goal is to make alcohol less emotionally charged—to remove some of the fears and apprehensions that may prevent children from acting responsibly when they enter drinking situations.

What Is Taught About Alcoholism

In addition to learning about alcohol, many of the children in our groups need to learn about alcoholism. Group activities are designed to reinforce a set of messages that are believed to be so basic that they should be communicated by any helping professional who is interacting with the child of an alcoholic.

First, *you are not alone.* Children of alcoholics need to learn that many other young people also live with alcoholism and that their guilt, shame, confusion, and anger at both their alcoholic parent and sober parent (who may ignore the child to attend to the alcoholic) are normal responses, not indications that something is "wrong" with them. Groups in which children can compare experiences are a powerful instrument for making this point.

Second, *your parents' drinking is not your fault.* Children often feel responsible for their parents' behavior. In part, this is because one or both parents may use normal childhood transgressions as an excuse or justification for drinking. In part, the inconsistent pattern of rewards and punishments in an alcoholic home make it difficult for children to know how to act, producing a pervasive sense that they must be doing *something* wrong. Among the group members, one of the most striking findings concerns the following item: "When children do something bad, it makes their parents drink." Although only 13% of other children agree to this statement, 39% of the children of alcoholics agree, suggesting that many understand their parents' drinking in a way that is damaging to their own self-images.

Third, *alcoholism is a disease.* Although adult opinions range from people who view alcoholism as an illness to those who view it as a mechanism for coping with emotional problems, children have a need to know that their alcoholic parent is not a bad person and that drinking is not a sign that their parent does not love them. Treating alcoholism as a disease explains the compulsive quality of their parent's drinking without blaming the parent or the child. It also interprets particular behaviors—for example, the personality changes that alcoholics undergo when drinking lead to an unpredictability that

upsets children; the physical phenomenon of blacking-out leads to broken promises; and withdrawal symptoms are often interpreted by children as a terminal illness, unless they are provided with some basic information.

Fourth, *alcoholics can and do recover.* Children who see a mother or father passing out or being sick the next morning or falling down the stairs are terrified about their parent's safety and need some hope that things can be better. In addition, for children living with alcoholism, their own unhappiness is rarely a sufficient reason to seek help. They go out looking for a way to help their alcoholic, and only then come to recognize their own needs. These youngsters need to believe that recovery is possible, although they must also come to understand that neither their parent's drinking nor their parent's recovery is their responsibility, is under their control, or depends on their behavior.

Finally, *you are a person of worth who needs and deserves help for yourself.* Children must be taught that it is not "selfish" to look after their own needs, that they are as deserving of a good time as their friends, and that they have a right to protect themselves and their siblings in threatening situations. Many children of alcoholics will need continuing support. Hopefully, early contact with helping agents who directly confront rather than ignore the central importance of parental drinking will encourage more children to seek help when they need it.

A Prevention Issue

There is accumulating evidence that during childhood, the offspring of alcoholics exhibit a wide range of problems, including erratic school attendance and poor performance, psychosomatic symptoms, depression, and low measured self-esteem (Deutsch, 1982). When these symptoms, however, lead children to care-givers such as school, mental health, and probation personnel, as they often do, the focus of the intervention is rarely on the child's guilt, shame, and feelings of responsibility for the alcoholic's drinking. The child may deny there are drinking problems at home or may not understand the connection between these drinking problems and his or her feelings.

The counselor may feel that asking about drinking is too great an intrusion into the family or may feel powerless to do anything about the parent's drinking. Therefore, the counselor focuses on the child's current disruptive behavior without addressing the causes of this behavior, since these are seen as irremediable or requiring intervention with the entire family, which is often beyond the counselor's role. The groups attempt to help the child acknowledge and cope with how he or she feels about parental drinking. The group experience has shown that children can learn to feel better about themselves and attend to their own needs, whether or not their parent stops drinking.

There is also convincing evidence that as adults, the offspring of alcoholic parents are more likely (some say twice as likely) to become alcoholic, which raises the issue of what to advise about drinking (Woodside,1982). Some prevention specialists recommend that children of alcoholics be encouraged not to drink at all (O'Gorman, 1981). This runs the risk of increasing fear and apprehension about alcohol among the great majority who eventually will drink, which may increase their susceptibility to drinking problems.

In part, this issue depends on the weight assigned to different causal factors, on which there is little agreement among experts. If genetic inheritance could be shown to be the major factor in the transmission of alcoholism, this might make abstinence the best advice, since even moderate drinking behavior would lead to a high probability of alcoholism. If the key factors in the development of alcoholism, however, are social and cultural and reflect the models of drinking behavior and coping with unhappiness that children learn in their homes, then inculcating new models of moderate drinking behavior and providing information about the warning signs of alcoholism seem to be more crucial tasks.

For older children of alcoholic parents, it is certainly appropriate to suggest that responsible drinking behavior for them should involve greater caution than for others. For the younger children in the groups, who are already afraid of alcohol, it is emphasized that most people can drink moderately and responsibly, that alcohol abuse among teenagers is mostly volitional, and that the illness of alcoholism develops among a relatively small number of (mostly) middle-aged adults, usually after several years of insufficiently controlled drinking. In other words, while we acknowledge that their parents may be unable to control alcohol because they have developed the disease of alcoholism, we simultaneously emphasize the child's potential to control his or her own drinking as teenagers and as adults.

Program Results

Questionnaires given at the first and last group meetings illustrate the kinds of changes we hope to encourage. First, the facts taught about alcohol are retained. For example, although only 37% on the pretest knew that the amount of alcohol in a can of beer, a glass of wine, and a shot of whiskey are the same, 86% understood this equivalency by the posttest, while the percentage for those who believe that coffee can make someone less drunk dropped from 66% to 39%.

Second, alcohol comes to be perceived as more controllable. For example, the percentage for those who say that people who drink always drink too much dropped from 36% to 19%, while those who feel that drinking alcohol is bad dropped by 15%. Some of the ambivalence that children feel about their own

alcohol use is also reduced. One item reads: "Is it okay for a child to have a drink at a family celebration, like a wedding or holiday?" Although 61% said "yes" at the program's start, 89% agreed by the end, with greater changes for children of alcoholic parents who enter more fearful about their own current and future alcohol use. Perhaps because it contradicts an observed reality for children living in families with alcoholism, there were only small changes in the number of those who reported that most adults and most teenagers drink too much.

Finally, there are changes in how children understand alcoholism. Recognition of alcoholism as an illness increased from 73% to 93%. Among children of alcoholics, the percentage for those who say that bad children make their parents drink declined from 39% to 24%. The willingness to admit that children sometimes think that parental drinking is their fault increased from 59% to 81%, with a larger increase among children of alcoholic parents.

Of course, these paper-and-pencil tests hardly begin to describe the growth evident in the groups, at least for some children. For example, a fourth-grade boy from a very disrupted alcoholic family heard us read *Pepper* aloud—a story about a dog who comes to understand that his master has not stopped loving him, although he sometimes forgets to feed him or let him out for walks. This happens because he is alcoholic and sick. When we asked the child to write in his journal about what made Pepper feel better, he wrote: "Knowing what the matter was."

A fourth-grade girl said she was tired because she stayed up every night until her father fell asleep, to keep him from drinking. After a long discussion as to whether this was her responsibility, the next week she said that she was not tired because it was her father's job to keep himself sober, not hers. Later that spring, her teacher stated that she did not know what had happened in the group, but the child was like a new person—more carefree and more able to interact with classmates. This girl has recently registered for her third elementary school group.

After the seventh meeting, during which the group saw a film about alcoholism's effect on families, a fifth-grade girl wrote in her journal that her father is alcoholic, that there is fighting and drinking at home, and that she has never told this to anyone in the world before. She asked us to promise that we would not tell anyone else. Her little sister, who had been in a previous group, had never mentioned her father's drinking, although we had suspected something was wrong because she was so withdrawn when alcoholism was mentioned. Two months later, the fifth grader excitedly approached one of the group leaders in the hallway to say that her father was in detoxification for the first time and was now going to get better. We shared in her happiness but reminded her that recovery was often a bumpy process, as had been discussed in the group. This was a message she seemed to understand and represents a type

of support that could only have taken place because of her group participation. Now, a year later, both she and her sister have enrolled again in a group.

Finally, some teachers have increased their referrals to the groups because they say that children who have attended groups act out less frequently in class. This is being investigated more systematically.

Whatever its immediate impact, a 10-week group is likely to have limited effects. Traditionally, of course, it was felt that children of alcoholic parents could be helped only by "curing" their parent, and if services were provided for children at all, it was as part of the parent's recovery process (Woodside, 1982). Today, more programs are being designed in which the child is the primary client. These programs recognize that children need help, whether or not their parents are willing to accept help. The elementary school groups described in this article are viewed as part of the community's total response to alcoholism.

In Somerville, alcohol education is required in grades 7, 8, and 10 and encouraged at other grades. One-fourth of the teaching staff of 600 has undergone a 20-hour workshop to equip them to teach a five-to-ten-period alcohol education unit. For children in grades 7–12, there is an after-school alcohol education program in which groups are run by trained high-school-aged peer leaders. The mental health center runs groups for children of alcoholic parents who are enrolled in alcohol groups in addition to whatever other therapy they receive. We hope to establish a student assistant program in the high school, and Alateen groups remain an important community resource.

In other words, a network of services is emerging, structured somewhat differently at each age level, but all reiterating the same messages about alcohol use and alcoholism. As these "pieces" are put into place, children who receive support at one age level will be able to connect with similar services later and will know that help is available when they need it.

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Chapter 3
Counseling Issues in a World of Drug Abuse

Issues for elementary school counselors to consider about a world of drug abuse:

1. Why have substance abuse prevention programs often failed?
2. Your school principal has asked you to coordinate the drug prevention program in your school. Describe the steps you would need to follow in developing the program. What resources would you use? How would you enlist the support of teachers, parents, students, and school administrators for your program?
3. What might be harmful about drug education that simply provides students with drug information?
4. You want to develop a support group for children of alcoholic parents. How would you identify the students? What are some of the major concerns you need to address in the group?
5. Write a drug abuse dilemma which children might face at school. How might you use this dilemma to improve children's decision-making about using drugs?
6. Several parents inform you of their concern about the prevalence of drugs in their neighborhood. What can you do to assist these parents?
7. How might elementary school counselors incorporate discussions of values into a drug education program?
8. During a group counseling session a student says that he drinks at home with his parents. How would you handle this situation in the group?
9. How can an elementary school counselor incorporate advertisements for alcoholic beverages into a drug prevention curriculum?
10. What steps should an elementary school counselor take upon learning that parents are using illegal drugs at home in the presence of a child?