Work in Progress

Prevention Through Connection: A Collaborative Approach to Women's Substance Abuse

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About the Author

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Abstract

This paper conceptualizes substance abuse as a disease of disconnection, which progressively separates and isolates people from relationships that can help them reduce their risk, promote their recovery, and ensure their health and well-being. Examining women's substance abuse in particular, the author explores how women often use drugs or alcohol in two ways: 1) to facilitate and establish connections with others, such as intimate partners, peers, and social groups and/or 2) to cope with serious relational disruptions, violations, or trauma. In response, the author proposes a relational approach to prevention that emphasizes collaboration and the development of growth-fostering interpersonal, professional, and community relationships—prevention through connection. Using an example from a college setting, this paper describes how everyone can participate in a relational approach to prevention, opening the way to new possibilities and opportunities to reduce high-risk substance use and abuse.

This paper will appear as a chapter in an upcoming casebook on Relational-Cultural Theory, edited by Wendy Rosen and Maureen Walker and published by Guilford Press.

Introduction

After graduating as a high school Valedictorian and as a national merit scholar, Alicia was accepted at a prestigious college, a college she believed would ultimately prepare her for a fulfilling career in medicine. With an outstanding academic record and a promising future ahead of her, no one would have predicted that this successful, self-disciplined, conscientious young woman would find herself in a hospital emergency room during her first week of college. No one who knew her would have anticipated that she, like a growing number of college women, would find her life on the line after a single night of heavy drinking. Fortunately, Alicia was connected to a circle of caring friends who recognized the warning signs of serious intoxication. Acting quickly, these friends called 911 and Alicia was taken to the hospital where she was immediately treated for acute alcohol poisoning.

Alicia's story was one of many similar stories I heard while working in college counseling centers. A college education remains a key component of women's efforts to overcome social, political, and economic obstacles, however, more and more women are finding their academic achievements seriously disrupted or derailed by the firsthand effects (e.g., lower academic performance, acquiring a sexually transmitted disease, physical injuries, car crashes, alcohol poisoning, etc.) or the secondhand effects (e.g., being a victim of verbal, physical, or sexual assault, etc.) of high-risk alcohol use and other substance abuse. Recent research suggests that approximately 41% of women at coed institutions are engaging in binge drinking, defined as four or more drinks in a row within the last two weeks (Wechsler et al., 2002). At women's colleges, these researchers determined that the number of women engaging in binge drinking increased 36% since 1993 and the percent of women reporting frequent binge drinking (binge drinking three or more times in the past two weeks) doubled

(Ibid., 2002). Another study, compiling existing data available from Federal sources, suggests that substance abuse in many instances is increasing more rapidly among women than among men (Drug Strategies, 1998).

Historically, the majority of individuals engaging in substance abuse have been men; consequently, most approaches to prevention and treatment have not been designed to respond to the concerns of women. However, a growing number of studies suggest that women are rapidly closing the substance abuse gender gap. More and more girls are trying alcohol, tobacco, and drugs at younger and younger ages, and more women over 60 years old are relying on psychoactive prescription drugs, including tranquilizers, sedatives, and antidepressants (Drug Strategies, 1998). These trends indicate that there is an urgent need to develop approaches to preventing substance abuse that are attuned and responsive to women's experience and psychological development.

This paper will describe an approach to substance abuse prevention that incorporates an understanding of the issues that influence women's substance use and abuse while integrating key concepts of Relational-Cultural Theory (RCT) as it has been developed by the scholars of the Stone Center at Wellesley College (Jordan, Kaplan, Miller, Stiver, & Surrey, 1991; Jordan, 1997; Miller & Stiver, 1997). It will describe how RCT can be utilized as a theoretical foundation for establishing more effective methods to prevent substance abuse among women. However, rather than describing an individual case, I will describe the development of a collaborative community response to prevention, illustrating how multiple forms of connection can be mobilized to reduce substance abuse among women: *prevention through connection*.

Substance Abuse: Moving Toward a Relational Understanding

Most models of prevention are rooted in traditional theories of psychological development that define healthy development as a process of separating from relationships and becoming more independent and self-sufficient. Following these dominant theories, substance abuse is viewed individualistically, suggesting that the problem is located within the individual who is deficient in some way, e.g., ill-informed, weak-willed, immature, or easily influenced by others; or one who has poor decision-making skills, low self-esteem, no self-control, or misperceives social norms (Buckman, 1995; Berkowitz, 1997; Daugherty & O'Bryan, 1993; Perkins & Berkowitz, 1987a). As a result, many approaches to preventing substance abuse emphasize teaching information or skills to increase an individual's ability to stand alone, think independently, be self-sufficient, and resist peer pressure, i.e., prevention through self-sufficiency, disconnection, or separation. Individualistic understandings of substance abuse often spotlight and magnify the *dangers of relationships* through the use of "relational" terms that have grown to have negative connotations, such as "dependency," "enabling," "co-dependency," "peer pressure," etc. Yet recent research suggests that being in relationships—having a connection with others—can be a protective factor that reduces one's risk of developing a substance abuse problem (Resnick et al., 1997; Blum et al., 1997; CASA, 2001a, 2001b). Perhaps the traditional, "separate-self" models of psychological development have constricted our understanding of the complex relational dynamics that influence an individual's involvement with alcohol and other substances, thus preventing us from forming deeper understandings of these problems. Furthermore, traditional models have led us to overlook the important qualities of relationships that help reduce an individual's risk of developing a problem with drugs or alcohol.

RCT challenges us to bring a keen awareness of relationships into the center of our thinking about prevention. It offers us a way to understand the complex relational disruptions and violations—e.g., child abuse, sexual assault, trauma, depression, eating disorders, etc.—that can trigger or exacerbate addictions in women. RCT provides a template for examining alienating and isolating social/cultural conditions of sexism, racism, homophobia, and other forms of marginalization that can increase one's risk of developing a substance abuse problem. Growth-fostering relationships (Miller & Stiver, 1997), on the other hand—relationships characterized by mutual empathy, mutual empowerment, and mutuality—can enhance one's resistance and resilience to the adversities that often precipitate the development of substance abuse-related problems or addictions (Hartling, 2003; Spencer, 2000). Putting relationships at the center of our thinking about substance abuse prevention gives us a new lens through which we can review existing strategies and formulate new, more effective approaches to prevention.

Women and Substance Abuse: A Disease of Disconnection

From an RCT perspective, women's substance abuse can be described as a *disease of disconnection*, a

disease that separates and isolates a woman from essential relationships that can help reduce her risk of developing a substance abuse problem (Covington & Surrey, 1997; Finkelstein, 1996; Gleason, 1993; Markoff & Cawley, 1996; Spiegel & Friedman, 1997) *and* separates her from relationships necessary for well-being and growth (Hartling, 2003; Miller & Stiver, 1997; Spencer, 2000). This disease of disconnection is characterized by a complex interaction of factors that affect an individual's ability to overcome serious relational disruptions or adverse experiences that can trigger or intensify substance use and abuse. These factors also influence a woman's ability to find and maintain relationships that would lead her toward well-being, healing, or recovery.

Taking a relational view of women's substance abuse does not mean overlooking biological factors. Research tells us that all individuals have varying degrees of biological risk of developing a substance abuse problem and that women's physical responses to alcohol and other drugs are different from men's. For example, women become intoxicated after drinking roughly half as much alcohol as men. Women metabolize alcohol differently from men, get drunk faster, become addicted more easily, and develop health-related problems more rapidly (CASA, 1996). RCT leads us to pay special attention to the biological factors associated with a woman's substance abuse because these factors also affect a woman's ability to participate in the relationships that are central to psychological well-being and health (Banks, 2000).

Keeping women's unique biological risks in mind, we can begin to explore the relational-cultural dynamics associated with women's substance use and abuse. Informed by an understanding of women's psychological development and RCT, we can explore two paths through which women become involved with drugs or alcohol: 1) to facilitate connection in response to a natural desire for connection and/or 2) to cope with relational disruptions and violations, including traumatic experiences.

Substance Use and the Desire for Connection

Everyday young women are bombarded with advertising and other media messages suggesting that personal and relational success depend on having a certain appearance or buying the right product. For decades advertisers have marketed idealized images and catchy slogans to capitalize on women's desire for connection. The alcohol industry spends an estimated $6.5 billion annually implying that their products will enhance romance, intimacy, attractiveness, popularity, or sex appeal (Drug Strategies, 1998; Kilbourne, 1999). Advertisers present alcohol as a necessary accompaniment to rewarding interpersonal interactions, including romantic dates, successful social gatherings, festive celebrations, etc. In actuality, advertisers are marketing an *illusion of connection*, the illusion that wearing the right clothes, being the right weight, drinking the right drink, taking the right pill, etc., can lead to satisfying, enduring relationships.

Compounding the pressures inflicted by relentless advertising, the challenge of finding connection in a culture of growing disconnection (Putnam, 2000; Walker, 1999) plays a significant role in women's vulnerability to alcohol or drugs. Women (and likely men) learn quickly that the chemical effects of substances can diminish social inhibitions, reducing their fears of rejection and isolation in social settings. In her poignant book, *Drinking: A Love Story,* Caroline Knapp described the seductive effect of alcohol:

> That may be one of liquor's most profound and universal appeals to the alcoholic: the way it generates a sense of connection to others, the way it numbs social anxiety and dilutes feelings of isolation, gives you a sense of access to the world. (1996, p. 64)

Heterosexual women are frequently introduced to the use of alcohol and drugs through their relationships with boyfriends, husbands, or fathers. Women will match the substance use behaviors of their male partners, perhaps in an attempt to strengthen bonds within these relationships (Williams, 1998). Lesbians face extremely daunting obstacles in their efforts to find connection. Confined by the real dangers of living in a heterosexist, homophobic society, lesbians have few opportunities for developing social and intimate connections beyond bars and other establishments that serve alcohol or where illicit drugs are readily available (Finnegan, 2001). In intimate relationships, the majority of women who drink say that they expect alcohol to facilitate their sexual pleasure. They report that drinking has a positive affect on their sexuality and emotional intimacy, even though heavy drinking results in higher sexual dysfunction, a higher risk of sexual assault and a higher risk of acquiring a sexually transmitted disease (Wilsnack & Wilsnack, 1997; CASA, 1994). In many instances, alcohol or drug use becomes entangled with efforts to find authentic relationships, an attempt to fulfill one's desire for connection.

Substance Abuse as a Source of and a Response to Serious Disconnections

Substance abuse often contributes to many forms of serious disconnection and violations, including interpersonal conflict, interpersonal violence, family disruption or violence, physical and sexual abuse, incest, assault, and more. It is estimated that substance abuse causes or exacerbates 7 out of 10 cases of child abuse or neglect (Reid, Macchetto, & Foster, 1999). Seventy-five percent of sexual assaults reported to authorities involve alcohol consumption by the attacker, the victim, or both (Warshaw, 1988). In 70% of domestic violence cases the assailant or the victim had been drinking (CASA, 1996). In response to these harmful experiences, it is not surprising that some individuals may turn to substances to mitigate their pain and trauma. It has been shown that 90% of all alcoholic women reported being physically or sexually abused as children and that 59% of female adolescent drug users were sexually victimized (CASA, 1994). Victims of trauma or traumatic disconnections may use alcohol or other drugs (self-medication) to manage their bodies' biochemical responses to acute stress, which can persist long after a traumatic event has occurred (Banks, 2000).

In addition, substance use and abuse may provide women with a precarious but readily accessible method for coping with the profound sense of disconnection associated with depression. Miller and Stiver (1988) describe the feelings of chronic disconnection and isolation that women experience when they become depressed. Depression is the most frequent mental health disorder accompanying women's alcoholism, and women more than men develop alcoholism following depression (CASA, 1996). Women may become involved with alcohol or drugs to find relief from the ravages of depression, chronic and profound feelings of disconnection, or the effects of trauma.

Substance Abuse as a Progression of Disconnection

Women's substance abuse can be viewed as a progression of disconnection leading toward greater and greater isolation. While substance use and abuse may begin as an attempt to build relationships and/or an attempt to cope with serious disconnections, these efforts can culminate in the substance becoming a woman's primary relationship, a toxic substitute for connection.

This incipient relational analysis of women's substance use and abuse leads us to consider new possibilities for reducing and preventing women's alcohol/drug-related problems. In the remaining section of this chapter I will explore a community case example, describing efforts to improve and enhance prevention programming at a women's college.

Creating a Connected Community: A Case of Prevention Through Connection

As Alicia's story illustrated at the beginning of this chapter, there is increasing justification for concern about women's substance abuse on college campuses. In response to these concerns, I was hired at a woman's college to develop an alcohol/drug education program for students, faculty, and staff. The administration of the college was supportive of efforts to develop programming based on an understanding of women's psychological development proposed by RCT. After conducting a campus-wide assessment in collaboration with key members of the community (students, staff, administration, and faculty), I began the process of implementing a program integrating the principles and practices of RCT. This approach was designed to facilitate greater community connection and reduce disconnection and isolation, two factors that can increase women's risks of developing a substance abuse problem. This approach involved three key components: 1) making interpersonal connections, 2) strengthening community connections, and 3) building interscholastic connections.

Making Interpersonal Connections

The first priority at this academic institution was to provide a more effective and consistent response to individual students engaged in high-risk substance abuse-related behaviors (e.g., binge drinking, acute intoxication, illegal or abusive drug use, etc.). Rather than directing these students to large group educational experiences, which are commonly used on many campuses, this program began to provide students with free, private, confidential alcohol/drug consultations. In these consultations I offered students specific, personally relevant information for assessing their level of risk and helped them identify a range of choices that would reduce their risk of experiencing an alcohol/drug-related problem (Daugherty & O'Bryan, 1993). While this information often appeared to be helpful, my key goal in these consultations was to establish an interpersonal connection with an individual who recently experienced an alcohol or

drug-related problem. The following stories are examples of my consultations over a two-year period with students exhibiting high-risk drug or alcohol behaviors.

"Yasmine's" Story

Yasmine, a first-year, first-semester international student, was referred to me for consultation after she had been taken to the campus infirmary by other students who became concerned about her intoxication and vomiting following a party. When we met several days after this event, Yasmine appeared to be extremely ashamed, deeply regretting becoming so intoxicated. She said that she had never drunk alcohol because it was prohibited by her Islamic religious beliefs. However, in an effort to meet and "fit in" with American students (a natural desire for connection), she joined some acquaintances at a small, impromptu "party" on campus where drinking was the center of social activity. Reflecting the behaviors of other students at the party, Yasmine quickly consumed "three" shots of vodka. Although she thought she had made a "moderate" drinking choice compared to students who were consuming large quantities of alcohol, after a while she became extremely sick and couldn't stop vomiting. Her friends eventually decided to take her the infirmary.

Sending Yasmine to a large-group alcohol program following her experience would have overwhelmed her with shame, which would then have made her feel publicly disgraced or humiliated (Hartling, Walker, Rosen, & Jordan, 2000; Jordan, 1989). Fortunately, the privacy of a one-on-one consultation appeared to mitigate her intense feelings of shame and facilitated an open conversation about her experience. It allowed her to disclose and examine personal factors that contributed to her severe reaction to drinking, including being exhausted that day, missing dinner prior to the party, feeling highly stressed, and being of a physically petite stature. In addition, Yasmine began to reveal some of the challenges of being an international student and a Muslim.

"I just wanted to be like other students in this country. I wanted to be with them and show that I could do what they do to have fun, which meant drinking," Yasmine declared, "but now I am mortified by what's happened. My family would be so angry and ashamed of me."

"I understand that you feel ashamed of what has happened, especially because it would disappoint your family," I said to her. "At the same time, it seems to me that wanting to meet and get along with others is an important goal when you are in a new community and a new country. In fact, I think it is a smart thing to do. The challenge is to find ways to join with others without losing yourself, without sacrificing what is important to you."

Empathizing with and affirming her desire to create relationships in a new environment, we began to explore some of the challenges of connecting across cultural differences at this particular college. Yasmine acknowledged the dangers of attempting to build relationships with others by matching their high-risk behaviors, such as drinking or drug use. She also recognized that the pressures she felt to assimilate into the American college culture led her to neglect developing connections with other international students with similar religious beliefs and values. In addition, it appeared that her efforts to conform to mythical American standards of independence and self-sufficiency had led her to distance herself from her primary support system, her family. These were some of the relational conditions and dilemmas precipitating Yasmine's high-risk drinking experience.

Naming these dilemmas was the first step in Yasmine's recovery from this experience. By the end of our consultation, Yasmine decided that she would get involved with some of the international student groups on campus and meet with the advisor for Muslim students to begin the process of finding a community of individuals who would support or share her values and religious beliefs. In addition, she identified ways to connect with American and other students without compromising her religious practices or personal values.

"Julie's" Story

Julie was a first-year student who referred herself for an alcohol/drug consultation. She was anxious and upset as a result of an experience she said occurred during the prior weekend. She explained that she had been drinking at a party hosted by a fraternity at a neighboring academic institution. At the party, she drank too much and decided to lie down on a couch in a quiet area of the fraternity. While her memories of what happened after that were foggy and confused, she tearfully described becoming aware that sometime during the night one of the fraternity members had had intercourse with her. In distress, she exclaimed, "I never meant to hookup with anyone at the party! I only had a few drinks. I never intended to get drunk and let someone take advantage of me!" Clearly she held herself completely responsible for drinking too much, yet, I noted that she had no way of estimating the amount of alcohol in the drinks mixed

at the fraternity and she had no way of knowing if the mixed drinks contained other drugs that could have incapacitated her.

Early on, I realized that Julie's state of distress combined with her description of the event suggested that she was trying to cope with a traumatic experience, quite possibly a sexual assault, which would require services beyond a single consultation. Yet Julie's only motivation for scheduling an appointment was to acquire information about how she could to prevent this type of experience from ever happening again, to regain a sense of safety and control. While honoring her desire for information about alcohol, my goal was to create a compassionate connection with Julie that would encourage her to consider additional services for treating her trauma or possible sexual assault, which could trigger future involvement with drugs or alcohol.

To address Julie's concerns, I began our consultation with an examination of factors that influence one's response to alcohol and risk of developing an alcohol-related problem. This allowed Julie to understand some of the complex biological factors that might have contributed to her unintended level of intoxication, e.g., being tired, not eating, consuming mixed drinks with an unknown amount of alcohol content, consuming drinks containing other drugs, etc. (Daugherty & O'Bryan, 1993). This discussion of specific, concrete, personally relevant information appeared to have a calming effect on Julie. Her self-contempt eased as she began to consider the many factors that may have contributed to her being incapacitated, including the possibility that other drugs were mixed into her drink. She also began to realize that no matter how drunk she was, no one had a right to violate her sexually. By the end of the consultation, Julie agreed to arrange a meeting with a staff member in the counseling center to address her experience of trauma. Through consultation empowered by connection, Julie was able to take action and seek the services she needed to fully understand and recover from her alcohol-related traumatic experience.

"Felicia's" Story

Felicia was a sophomore who referred herself for an alcohol/drug consultation after hearing about the start of this free, confidential service on campus. Meeting Felicia in a waiting area, I was surprised to find that she had brought her boyfriend "Terry" to the meeting. Terry was a senior from a neighboring academic institution. He and Felicia had been dating for a number of months. During the meeting, Felicia said she did not drink alcohol or use drugs, but she had a growing concern about Terry's drinking. Although Terry didn't drink regularly, every time he drank he would get extremely drunk. Felicia was worried about what might happen to him whenever he became highly intoxicated. She was particularly concerned because her feelings for Terry were growing stronger. Without any hesitation, Terry responded "I think Felicia is right. I don't drink very often, but when I drink, I can't stop and I know this scares Felicia. I know she thinks I'm going to have an accident or get seriously injured in some way when I'm out drinking with my friends. I also know my drinking is affecting our relationship." He said that Felicia was very important to him and he recognized that his pattern of drinking to get drunk was problematic, even though it hadn't resulted in any other obvious problems (e.g., academic difficulties, disruptive or aggressive behavior, property damage, etc.).

Much of the literature on substance abuse describes the dangers of "enabling" substance abuse behaviors within relationships, yet Felicia's actions reflected the positive side of enabling someone she cared about to seek information before he experienced a major difficulty. Because of my understanding of RCT, rather than presaging the risks of co-dependency in a relationship where one person is drinking, I was able to honor the strength of Felicia's and Terry's relationship that made it possible for them to seek help early. Supported by their love for and connection to each other, both Felicia and Terry were able to explore their individual risks of developing an alcohol-related problem. In particular, Terry was able to examine his family history of alcohol problems and higher than average tolerance for drinking large quantities of alcohol. Without defensiveness or denial, Terry acknowledged the signs of increased risk that could lead to a serious alcohol problem if he continued his current pattern of drinking. Finally, the consultation concluded with a discussion of low-risk choices that would reduce Terry's and Felicia's risk of ever experiencing an alcohol-related problem during their lives (Daugherty & O'Bryan, 1993).

Several weeks after this consultation, I made a follow-up phone call to Felicia to ask about how things were going. "Terry's quit drinking and decided to focus his energy on his academic work and career goals," she said, "This has taken the strain out of our relationship and we enjoy being with each other more than ever."

"Stephanie's" Story

Stephanie was referred after having been taken from campus to a local hospital for observation as a

result of acute alcohol poisoning. When I met with Stephanie, she was initially angry about being required to attend an alcohol/drug consultation; nevertheless, she gradually warmed-up and began to describe some of events that led up to her acute intoxication. Stephanie was a senior studying economics, one semester away from graduating, but she was currently having academic difficulties that were threatening to derail her graduation. She stated that she did not drink alcohol regularly and had never had any other experiences of acute intoxication, yet this wasn't the first time she had tried to get extremely drunk. She also said she didn't have a family history of alcohol problems, a history of trauma, or eating disorders. However, as she began to feel more comfortable with me, she explained that for the past three years she absolutely "hated" her college experience. Unlike other students at this particular college who had many financial advantages that allowed them to attend an expensive private academic institution, Stephanie revealed that she was from a struggling, working-class family and she had had to negotiate enormous financial obstacles to attend college. Despite the success of being accepted at a prestigious academic institution, she described how the class difference between her and the majority of her peers had led her to experience a profound sense of disconnection, alienation, and, ultimately, isolation. Consistent with her lifelong efforts to "pull herself up by the bootstraps," be completely self-supporting and self-sufficient, she explained that she had never talked to anyone about her desperate unhappiness and feelings of isolation. Binge drinking appeared to be one method she used to cope with her feelings when they became intolerable.

"A group of students from my dorm went on a trip to Acapulco together over spring break, staying in a fancy hotel, sitting on the beach, drinking and dancing all night long," said Stephanie, in disgust, "As usual, I had to work during spring break. Even if I wanted to, I couldn't afford to go with them. I just stayed here and got drunk."

If I had focused only on Stephanie's binge drinking, I would have missed the most significant factor contributing to her drinking, class shame (hooks, 2000). Fortunately, RCT promotes attunement to issues of class, race, gender, and sexual orientation that can become sources of intense pain and alienation. Tuning into Stephanie's concerns allowed me to validate the reality of her struggles and work with her to develop a plan of action that would help her move on to finish her degree with out relying on binge drinking. First, Stephanie agreed to schedule an appointment with a therapist in the counseling center to discuss her feelings about her college experience. Then she identified a trusted college staff member with whom she could share her concerns. Finally, by the end of the consultation, she suggested that she might eventually share her experience with a college administrator to help the college administration understand the unique challenges that a student from a working-class family encounters while working and living in a college community where most of students have upper-class privileges.

Strengthening Community Connections

The second priority for implementing prevention through connection at this academic institution was to mobilize and strengthen community relationships as a part of the efforts to address alcohol/drug problems. One specific example of strengthening community connections was the formation of a collaborative committee of campus representatives to examine substance abuse issues. Appointed and supported by the college administration, I was placed in charge of organizing and chairing a collaborative Alcohol/Drug Advisory Committee.

To form the committee, I recruited individuals representing a diverse variety of campus constituencies. This included a member of student government, a student who was a resident assistant in the dorms, the associate director of health services, the campus health educator, a campus police officer, a faculty member, a representative of counseling services, and a head-of-house from the residential system. After the committee was established, the college administration asked the committee to revise the existing alcohol/drug policies to maximize student safety while upholding state and federal laws and avoiding unnecessary intrusive measures. Additionally, the administration assigned the committee the task of developing "understandable *and* enforceable policies" that would hold students accountable while moving them toward constructive changes in behavior.

As the chair of this committee, with a background in RCT and practice, I viewed the formation of this committee as an important opportunity to create a connected, community response to substance abuse. Having participated in past committees which devolved into endless, emotionally charged, adversarial discussions of alcohol policies, I was committed to using relational practices to facilitate constructive discussion of these issues. These relational practices included "listening others into

voice," which involves actively encouraging committee members to openly share their views; promoting mutual empathy by developing a bidirectional sense of understanding among committee members; encouraging mutual empowerment by promoting the sense that each and all members of the committee have an impact on the committee's thinking and work together; and waging good conflict, approaching conflict in a way that leads to positive change (Miller, 1976, 2002).

From the beginning, the members of the committee had diverse and sometimes contentious concerns. Student representatives expressed fear that revising the policies would automatically result in students losing individual privacy and rights. Campus faculty and staff representatives expressed concerns about student safety and legal liability. Campus police and residents staff were particularly concerned with the enforceability and consistency of the proposed revised policies. Fortunately, understanding RCT allowed me to view conflict as a necessary and beneficial part of fostering the growth of the committee's connection and work together rather than as an impediment (Miller, 1976).

As difficult as it was, as a group we took a "bring it on (early)" approach to dealing with conflict, actively encouraging members of the committee to respectfully voice their concerns and objections to proposed revisions of the existing alcohol/drug polices. This, combined with other relational practices, allowed the group to move through arduous disagreements. For example, after a year of work, on the day before the committee planned to deliver their revised alcohol/drug policy to the college administration, a student representative, "Lisa," shocked the other members of the committee by declaring, "We can't give this to the administration. Students will not accept the new policy. They will rebel! It will be a disaster! I won't let this happen!"

"Wow, Lisa, I can tell you are really concerned," I said, focusing on Lisa. "I'm very glad that you have brought this to our attention now before we take the policy to the administration." Rather than discounting, challenging, or denying her eleventh-hour objection, members of the committee joined me in showing empathy toward Lisa, and we began to explore her concerns.

"During our year together we have worked through a number of problems with our proposed alcohol/drug policy," I said. "But, is there something that we missed that has come to your attention?" Relaxing her heightened emotions, Lisa identified one aspect of the policy that the rest of the committee acknowledged might be confusing to some members of the campus community. Lisa pointed out that rushing to finalize the policy too quickly could trigger an unnecessary negative reaction from students, which would completely distract them from seeing the positive aspects of having an improved policy. Acknowledging Lisa's concerns, the committee formulated a new process for implementing their revised alcohol/drug policy that would allow them to make adjustments to the policy, if necessary, during the upcoming year. Specifically, they decided that the revised policy would be used as an interim policy during its/the first year of implementation, which would be considered a transition year. During this transition year, students, faculty, and staff would have the opportunity to give the committee additional feedback about the effectiveness and clarity of the revised policy. After a one-year trial period in which policy could be adjusted, the final version of the policy would be implemented in the second year. Lisa agreed that this extended process of implementing the policy would be a useful way to respond to her concern and still move forward.

Lisa's eleventh-hour concern could have derailed the committee's efforts, but this story illustrates how the committee's collective relational practice led to a more resilient response to a member's sincere concern. Ultimately, acknowledging and validating Lisa's objection enabled the committee to improve the process for implementing the policy. Instead of being broken apart by a last minute conflict, the committee was able to draw upon their relational skills to address Lisa's concern and create an effective solution. Responding to, rather than reacting to, Lisa's concerns facilitated Lisa's reconnection with the group's collaborative work.

Building Interscholastic Connections

A third component of my efforts to practice prevention through connection involved building relationships with professionals working with substance abuse at other academic institutions. After a series of tragic alcohol-poisoning deaths on campuses around the country, many college professionals were motivated to join together in their efforts to prevent these and other alcohol/drug-related problems. With the support of the administration, I represented the college at meetings with representatives from various institutions of higher education to discuss campus alcohol and drug issues.

One example of making an interscholastic connection to prevent and reduce alcohol/drug problems on campus involved joining other

professionals from neighboring college campuses to formulate a shared agreement for improving practices in response to high-risk drinking (Task Force on Underage and Problem Drinking, October 1998). Over the course of many months, this group of representatives developed a list of shared goals in the form of a cooperative agreement to reduce and prevent high-risk drinking behaviors on all campuses in the surrounding metropolitan area. While a few of these goals could not be applied at a women's college (e.g., managing behaviors at fraternities), many of the goals could be readily utilized, including:

- promoting and increasing availability of alcohol-free programming on campus,
- reducing alcohol advertising on or near campus,
- insuring training and support of residential staff,
- encouraging the development of peer support services and programs,
- offering faculty training to help identify problem behavior and provide appropriate intervention,
- establishing methods to regularly communicate and cooperate with local police and municipal authorities,
- increasing partnerships with area campuses, public officials, police services, surrounding neighborhoods, the business community, students, alumni, parents, and secondary schools,
- continuing the planning and evaluation of prevention efforts.

In addition to creating a collaborative agreement, building relationships and working in connection with professionals from other academic institutions allowed all of us to benefit from the collective wisdom that developed through sharing and discussing our individual and community efforts to prevent the growing problem of substance abuse.

Assessing the Impact of Prevention Through Connection

As most people in the field of prevention know, it is difficult to completely or accurately assess the degree to which a program has been effective or ineffective. However, there were indications that the *prevention-through-connection* efforts described in this paper were moving in a positive direction:

1) none of the students referred for an alcohol/drug consultation due to acute intoxication repeated their behavior
2) compared to prior semesters, incidents of acute intoxication were almost cut in half
3) students who attended alcohol/drug consultations encouraged other students to utilize the confidential services and, consequently, voluntary consultations increased
4) members of the Advisory Committee continued to meet to discuss concerns and finalize revisions of alcohol/drug policies that were then successfully implemented, and
5) the development of an interscholastic cooperative agreement provided a national model of colleges to work together on alcohol/drug-related problems.

Prevention Through Connection is for Everyone

This chapter describes some of the new possibilities and opportunities that become evident when we apply a relational-cultural approach to preventing high-risk alcohol/drug-related behaviors on a women's college campus. It highlights components of a connected community response—*the practice of prevention through connection*—to address high-risk alcohol and drug use, which involves creating interpersonal connections, strengthening community connections, and building interscholastic connections. Fortunately, more and more people are recognizing that connections and collaborations are essential for effective, comprehensive prevention efforts. A recent article in the *American Psychologist* (Weissberg, Kumprer, & Seligman, 2003) stresses that:

> Children will benefit most when families, schools, community organizations, health care and human-service systems, and policy-makers work together to strengthen each other's efforts rather than working independently to implement programs... (p. 427)

Still, one of the greatest advantages of prevention through connection has yet to be stated. While many approaches to prevention *must* be implemented, orchestrated, and coordinated by specially trained professionals, *everyone can actively participate in prevention through connection every single day!* RCT suggests that whenever we are promoting, providing, or developing growth-fostering relationships, we are,

in effect, reducing the risk that individuals, women or men, will develop a problem with alcohol or drugs, and everyone can participate in this process. Rather than being the sole province of the "experts," prevention through connection is an inclusive approach. Parents, family members, teachers, professors, peers, administrators, community service providers, supervisors, employers, and others who build growth-fostering relationships are simultaneously practicing behaviors that can reduce the risk that an individual will seek out and/or choose to engage in high-risk alcohol and drug behavior. Furthermore, people who build growth-fostering relationships are providing a key ingredient of resilience that allows individuals to overcome hardships, trauma, and adversities that can trigger substance abuse problems (Hartling, 2003). Ultimately, we may discover that connection is the most powerful component of effective prevention.

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