What are the effects of Parental Problem Drinking?

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Contents

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Section A

Preface

Preface

Alcohol is one of the most widely misused substances today. The majority of people who drink do so without negative consequences to themselves or others. Nonetheless, there is a group of families and children, whose experiences of someone else's alcohol misuse fall far short of this norm (Alcohol Concern, 2009). Parental alcohol misuse affects up to 1.3 million children in England (Alcohol Harm Reduction Strategy for England, 2004) representing a huge challenge to professionals working in children and family services and those in alcohol support services. Although parental alcohol misuse can have a direct impact on children, there has previously been little support provided to children and family professionals on how to identify alcohol misuse and build children's resilience to it within the family. Furthermore, there has been limited discussion on how alcohol specialists need to provide support to the whole family (Alcohol Concern, 2009).

Living with an alcoholic or problem drinker is a family affair with the potential for each family member to experience stress and be affected to some degree. As a result, it has often been referred to as a *"family illness"* (Ackerman, 1983, pg. 263). Nevertheless, not all alcoholic families are the same, nor are all members of the family affected in the same way. There are many factors that can affect members of alcoholic families differently such as: whether the parent is actively drinking or in recovery (Moos & Billings, 1982); gender of the child as well as gender of the alcoholic parent (Steinhausen, Gobel & Nestler, 1984); race (Ackerman, 1987); and age of the child (Werner, 1986). Ackerman (1983) also argues the degree of alcohol dependence, the type of alcoholic in the home (for example, unavailable or violent), and the individual perception of potential harm in living with an alcoholic parent will influence the extent to which offspring may be affected.

The impact of parental alcohol misuse on children was identified in the late 1960s with an extensive study by Cork. The foreword to her book began:

> *In their concern for the alcoholic, researchers have often overlooked his family. We therefore have little understanding of the sufferings of thousands of children in our communities* (Cork, 1969).

Since this time, the children of alcoholics COAs) and children of problem drinkers (COPDs) have been brought to the attention of researchers and psychologists and their needs are now recognised and attempting to be met. Moreover, it is now recognised that the impact of growing up in an alcoholic home environment often goes beyond the childhood years with some of these children carrying the legacy of social and emotional adjustment problems into adulthood (Menees & Segrin 2000; Hall, Webster & Powell, 2003). While not all Adult Children of Alcoholics (ACOAs) experience problems, studies have shown that ACOAs often do show an increased vulnerability to life stressors and report more symptoms of adjustment difficulties (Hall &Webster, 2002; Hall et al., 2003).

Studies suggest that problematic alcohol use by a parent most significantly affects the quality of their parenting. Problem drinking (PD) can result in a parent being emotionally unavailable, inconsistent and unpredictable (Cleaver, Unell & Aldgate, 1999). This can lead to parenting that is passive, cruel or neglectful; where children are not supervised, nurtured or supported. The impact of alcohol problems on children and families can transcend into every area of life such as: physical and psychological health; finances; employment; social life; and relationships. Velleman (1993) suggested there were seven key aspects of family life that could be adversely affected. These were: roles; rituals; routines; social life; finances; communication; and conflict.

Counselling psychologists work across many settings including drug and alcohol services, schools and generic counselling services. It is therefore important for practitioners to be able to recognise the signs of parental problem drinking (PPD) in children as they can be supported and helped regardless of changes in the drinking behaviour of parents. Additionally, we need to be knowledgeable of the potential long term effects of PPD when these children reach adulthood when many will have families and children of their own. In the following sections I summarise the work contained within this portfolio, each of which attempt to provide an answer to the main question:

"What are the effects of parental problem drinking?".

Section B: Research

The research component consists of a qualitative study exploring the life experiences of adult children of problem drinkers (ACOPDs). Semi-structured interviews were used to explore the participants' experiences which were then analysed using Interpretative Phenomenological Analysis (IPA). Whilst the participants' experiences were extremely varied a number of common themes emerged such as participants' use of numerous 'coping mechanisms'. This master them was particularly prevalent amongst the participants' accounts. A surprise to the research findings was the effect culture played on particular participants' experiences. Whilst all participants were born and raised in the UK, two were of Asian background and had extremely different family values which influenced how they dealt with PPD. A further surprise was the limited discussion in participants' accounts on engaging with services for help with their parents problem drinking both as children and as adults. This raises many questions for practitioners as to why this group of individuals are not considering and seeking available support. Counselling psychologists work across many different contexts and it is invaluable to clinical practice to be knowledgeable about the effects of PPD and the effects particular life experiences may have on potential clients.

Section C: Clinical practice

This clinical piece comes from my own practice as a counselling psychologist in training working in a Primary Care Setting. It is based on a client who was referred for Cognitive Behavioural Therapy (CBT) to reduce anxiety symptoms. Upon assessing the client it became apparent she was experiencing anxiety both at work and in her interpersonal relationships. The piece focuses on a central relationship between mother (Joanna) and son (Andrew) and the difficulties Joanna faced when implementing boundaries with Andrew, her friends, and people in authority.

Joanna was the child of an 'alcoholic' (her words) and had experienced a severe lack of boundaries from a young age, such as witnessing violence towards her mother by her father when he was drunk. This had set in motion a lifetime of relationships with no boundaries, particularly with men, including her uncle (childhood sex abuse), ex-husband (domestic violence) and Andrew (physical abuse). Although Joanna had

engaged in long term therapy for many years focusing on her relationship with her ex-husband in particular, she experienced anxiety symptoms when faced with confrontations with men (primarily) and having to say *"NO"* to those close to her. Joanna feared the consequences such as being harmed physically; rejected by Andrew or her friends; and coming across as a bad mother.

Although Joanna's anxiety could not be solely attributed to her father's alcoholism, it had predisposed her to thoughts that people are unpredictable and violent, leaving her feeling fearful and anxious. This is a common feeling for COAs. COAs and COPDs may not necessarily present to counselling psychologists working purely in addiction or specialist services. This clinical piece reiterates the value of counselling psychologists working in generic services being aware and knowledgeable of the potential impact of PPD on offspring. Clients such as Joanna may not be referred for therapy as a direct result of their parents drinking problem, especially if they have not been involved with the problem drinking parent (PDP) for many years. Joanna was now in her late 60s however her father's alcoholism contributed to the presenting problem and was thus relevant for formulation purposes and treatment plans.

Section D: Critical literature review

The literature review focuses on the effects of PPD with specific reference to 'gender'. It evaluates research on both maternal and paternal problem drinking and addresses the differential impact on children. It illustrates how gender of both the parent and the child can make a difference to the effects experienced by offspring. To illustrate this point, whilst examining same sex patterns Clark, Moss, Kirisci, Mezzich, Miles and Ott (1997) found paternal alcohol problems have been associated with more behavioural problems in boys. Additionally, Coffelt, Forehand, Olson, Hones, Gaffney and Zens (2006) who investigated opposite sex patterns, found that paternal alcohol problems have also been associated with an increased likelihood of alcohol use for girls only. The review considers whether counselling psychologists need to offer treatment to the COPDs and ACOPDs according to their gender.

References

Ackerman (1983). *Alcoholism and the Family*. Retrieved April 2010 from www.nacoa.org/pdfs/Ackerman.pdf.

Ackerman, R. (1987). In Ackerman, R. J. (2002). *Perfect Daughters*. Revised Edition. Adult Daughters of Alcoholics. Health Communications, Inc.

Alcohol Concern: www.alcoholconcern.org.uk/alcohol-concern-in-action/annual-conference-2009.

Alcohol Harm Reduction Strategy for England (2004).

Clark, D. B., Moss, H. B., Kirisci, L., Mezzich, A. C., Miles, R., & Ott, P. (1997). Psychopathology in preadolescent sons of fathers with substance use disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 36(4),* 495-502.

Cleaver, H., Unell, I., & Aldgate, J. (1999). *Children's needs - parenting capacity: The impact of parental mental illness, problem alcohol and drug use, and domestic violence on children's development*, London, The Stationary Office.

Coffelt, N. L., Forehand, R., Olson, A. L., Jones, D. J., Gaffney, C. A., & Zena, M. S. (2006). A longitudinal examination of the link between parent alcohol problems and youth drinking: The moderating roles of parent and child gender. *Addictive Behaviors, 31(4),* 593-605.

Cork, R.M. (1969) . *The Forgotten Children: A study of children of alcoholic parents, Toronto*, Paper Jacks.

Hall, C., & Webster, R. (2002). Traumatic symptomatology characteristics of adult children of alcoholics. *Journal of Drug Education, 32(3),* 195–211.

Hall, C., Webster, R., & Powell, E. (2003). Personal alcohol use in adult children of alcoholics. *Alcohol Research, 8(4),* 157–162.

Menees, M., & Segrin, C. (2000). The specificity of disrupted processes in families of adult children of alcoholics. *Alcohol & Alcoholism, 35(4),* 361–367.

Moos, R., & Billings, A. (1982). Children of alcoholics during the recovery process: Alcoholic and matched control families. *Addictive Behaviors*, *7*, 155-163.

Steinhausen, H., Gobel, D., Nestler, V. (1984). Psychopathology in the offspring of alcoholic parents. *American Academy of Child Psychiatry*, *23*, 465-471.

Velleman, R. (1993). *Alcohol and the family*. London, Institute of Alcohol Studies.

Werner, E. (1986). In Ackerman, R. J. (2002). *Perfect Daughters*. Revised Edition. Adult Daughters of Alcoholics. Health Communications, Inc.

Section B

Parental Problem Drinking
The Life Experiences of the Adult Child

Abstract

The study explores the life experiences of seven adult children of problem drinkers (ACOPDs). Semi-structured interviews were conducted covering four main areas: experiences as a child; experiences as an adult; impact on life; and coping mechanisms. In order to gain an in-depth understanding of the participants' experiences, Interpretative Phenomenological Analysis (IPA) was used. Five master themes were extracted from the data, namely: parent / child relationships; communication problems; coping mechanisms; the road to recovery; and impact on the self. Each master theme also consisted of a number of interrelated subthemes. Of all the master themes, coping mechanisms was by far the most prevalent with participants using numerous ways of dealing with parental problem drinking (PPD) such as avoidance, and trying to keep their parent's drinking problem a secret from other people.

The findings indicated that whilst many within group difference existed in the sample of participants, such as cultural background and status of parental drinking, many common themes still emerged. Moreover, the severity of PPD did not influence the findings to any great extent. A number of the participants' problem drinking parents (PDPs) drank to excess on a daily basis whereas for others consumption was far less, a maximum of three to four units per evening. To conclude, participants' accounts indicated a preference towards informal over professional forms of support. This has important implications for the counselling psychology profession such as a need to improve and increase the services available to both children of problem drinkers (COPDs) and ACOPDs.

Personal Statement

[1]*I would like to commence by sharing my personal and professional motivations for the study. Whilst this study is personally motivated I am not an adult child of an alcoholic or problem drinker. I do however have personal experience of growing up with a parent who suffered from depression and I have often wondered whether this impacted my life over the years. I questioned whether this experience for example had contributed to my being a shy and anxious teenager and whether this had resulted in my continually playing the role of carer with friends and family. Moreover, I questioned whether it has influenced where I am in my life today and some of the life choices I have made, such as embarking on a career in psychology. I therefore have a vested interest in how the family unit especially offspring, may or may not be affected by parental mental health.*

During my first year of the counselling psychology training I commenced a placement in an alcohol counselling service. Although I only worked with the 'addict' or 'problem drinker', the impact their drinking was having on the family as a whole was very much in the room. Some clients felt very guilty and ashamed at the way they behaved towards their loved ones when they were drunk. For some however there was no concept at all that their drinking affected other people. I was often left feeling sad and angry when clients spoke of their children, of various ages, picking up empty bottles and throwing them away, or pouring the alcohol down the sink in the hope their parent would not drink that evening.

Outside of the therapy room, I wondered how these children, some now entering adulthood coped with their parent/s alcohol problem and whether it affected their lives. I had so many questions: Who was supporting them? Did they even know support was available? Moreover, did they know they were entitled to their own support to deal with any short or long term effects of being raised by a problem drinking parent? I was conscious of my own thoughts and experiences influencing

[1] Given the immense involvement of the researcher in qualitative research and in particular when using IPA I have chosen to write in the *"first person"*.

the research process which is why I chose to combine my personal and professional interests to conduct my research on the adult children of parents who drink alcohol problematically as opposed to depression. Given the extent of the drinking problem in the UK this felt an extremely valuable research area to focus on.

Chapter One: Introduction

This chapter will provide the reader with a review of the available literature on the impact of parental problem drinking (PPD). The review will cover research on offspring both as children, and when they reach adulthood. Following an introduction to problem drinking (PD) in the United Kingdom (UK), I will discuss a shift in attention in the research from the 'addict' or 'problem drinker' to the family. The notion of 'Adult Children' will then be introduced and relevant literature will be evaluated. Particular attention will be paid to the many methodological complexities involved when conducting research in this area as a whole. A further transition in the literature from risk of psychological impact to resilience factors in offspring will then be discussed. To conclude the chapter, gaps in the literature will be identified thus leading into the main research aim of the study.

Addiction and counselling psychology

All counselling psychologists engaging in clinical practice will encounter clients who use drugs and alcohol whether or not they choose to work within drug and alcohol focused services. It is therefore desirable for all mental health professionals to receive some form of routine training and education in the social and psychological phenomena that comprise the addiction disorders (Beck, Wright, Newman & Liese, 1993). Moreover, given the substantial impact addiction has on family members, it is becoming increasingly important that practitioners educate themselves on the impact of addiction on the family, and the implications this has for clinical practice. This is of equal importance to counselling psychologists working in both drug and alcohol focused services, and generic services.

Regardless of context, it is therefore extremely valuable to the profession to be able to apply effective treatment to such populations. Additionally, counselling psychologists need to be able to identify family members of problem drinkers especially children or adult children who may not necessarily seek support from a specialist organisation. A child of an alcoholic (COA) or problem drinker (COPD) for example may present to practitioners in services such as Primary Care, Schools or generic counselling services. As practitioners it is important to bear in mind a family member of an addict may not be

aware their parents drinking problem has impacted them negatively. Nonetheless, as psychologists, knowledge of the possible impact of PPD is crucial for case conceptualisation and subsequent treatment plans.

Alcohol: Society's favourite drug

Substance misuse has been described as a *"great and growing evil"* (Royal College of Physicians, 1987) and it is widely acknowledged that the UK has a serious alcohol problem (Alcohol Concern, 2009). Whilst alcohol owns a special status in our society as being the only psychoactive drug that is both socially acceptable and legally available to adults without prescription (Roberts, Fox & McManus, 2001), it is also the cause of huge social and medical problems (Velleman & Templeton, 2005a). This is shown by a heavy toll of public disorder associated with heavy drinking, together with rising morbidity and premature mortality linked to alcohol (Alcohol Concern, 2009). The global consumption of alcohol is clearly growing at a rapid rate, with the health and social costs of PD (i.e. alcohol abuse or dependence) impacting both the drinker and society (World Health Organization; WHO, 2007).

PD in the UK receives enormous publicity through the mass media. An article in the London Evening Standard (July, 2008) for example headlined, *"Binge-drinking Britain on verge of tsunami of harm"*. Professor Ian Gilmore from the Royal College of Physicians said *"The Government is understandably anxious about being seen as a nanny state. But unless they take action their own figures suggest we are moving towards a tsunami of health-related harm."* Figures published in the article reported binge drinking cost the NHS £2.7billion a year, with more than 800,000 people being admitted to hospital with alcohol related problems. This was almost double the number of admissions since 2004.

More recently, an article in the Independent (January, 2010) headlined, *"Rise in number of people dying from alcohol"*, reporting the number of people dying from alcohol was on the rise despite increasing awareness of the damage it can do. The number of alcohol-related deaths has more than doubled since 1992, from 4,023 to 9,031 in 2008. Speaking in the article, Jeremy Beadles, chief executive of the Wine and Spirit Trade Association stated that:

While we should be concerned by the rise in alcohol-related deaths, it's important to remember that overall alcohol consumption has been falling now for several years, suggesting Government efforts to combat alcohol misuse should be focused on the ***minority of people*** *who drink excessively, not the vast majority who enjoy a drink in moderation.*

Defining PD and Alcoholism

The question of language and definition is both difficult and controversial. The term 'alcoholism' is most closely associated with a model of drinking which views such a problem as a 'disease'. Furthermore, this term is more readily used in the USA as opposed to the UK. This view of alcoholism being a disease has its advantages in that it offers family members a justification for someone's drinking. When alcoholism is deemed a disease it suggests it is not the family member's fault or done out of choice. It also provides a clearer idea of what should be done in terms of treatment i.e. aiming for pure abstinence. The self-help organisation Alcoholics Anonymous (AA) and its co-organisations Al-Anon and Al-Ateen relies heavily upon the disease model. Velleman and Orford (1999) argue despite these potential advantages, the disease model has not been successful in illuminating the origins of alcohol problems nor has it led to advances in treatment or prevention. Many researchers now choose to use the label 'problem drinking' (PD). Velleman (2004, pg. 185) defined PD as *"any drinking which causes problems to the drinker or to someone else"*. Furthermore, PD occurs with people who use alcohol inappropriately or in an unsafe or hazardous manner, as opposed to people who are seriously dependent or 'addicted' (Velleman, 2004). This definition of PD is similar to those used by medical professionals such as GPs and nurses. The website Patient UK for example offers the following definition:

Problem Drinking - This is where you continue to drink heavily even though you have caused harm, or are causing harm or problems to yourself, family, or society. For example, they may have problems in their relationships or at work because of their drinking. Many problem drinkers are not dependent on alcohol. They could stop drinking without withdrawal symptoms if they wanted to.

Psychosocial definitions of PD have also been put forward by researchers such as Velleman and Orford (1999). Their definition is based on the relatives' *"opinion"* that a parent's drinking constitutes a problem. When research is concerned with a social group such as the family this is considered appropriate. It is important to add that the definition of childhood exposure to a PDP, as occurs in most research studies, is not necessarily a confirmed diagnosis of alcohol dependence such as the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV-TR; 2000).

A shift in attention: From the addict to the family

For a long time, the impact of alcohol problems in the family was viewed as a 'sub-topic' in the field of alcohol studies (Orford, 1994), with the individual drinker typically holding 'centre-stage'. Over the years it has come to the attention of clinicians and researchers in the field, the importance in considering families affected by addiction problems. It is also recognised that alcohol (and drug) consumption is strongly linked to other problems such as domestic violence, homelessness and crime (Barber & Crisp, 1995; WHO, 1993). As a result of these problems, a significant number of close family members of people with alcohol and drug problems are themselves at risk of experiencing stressful circumstances. In his review, Orford (1994) suggested it was necessary for the family to be considered for two reasons. Firstly, family members in these circumstances show symptoms of stress which need help and support in their own right. Secondly, involving family members in the treatment of their relatives with a drinking problem can enhance positive outcomes.

Although researchers have examined the possible relationship between family history of alcoholism and its effects on the adaptation of offspring since the beginning of the 20th century (MacNicholls, 1905), widespread interest in the problems of COAs did not appear to gain momentum until the 1960s. In 1969, Cork gained much attention after conducting an extensive study interviewing 115 children. Of these 115 children, 98 reported *'parental fighting and quarrelling'* as their main worry. Moreover, it was a very small number of children who actually reported *'drinking'* or *'drunkenness'* as their main concern. Similar findings were replicated during the 1970s and 1980s with authors such as Wilson and Orford (1978) and Black, Bucky and Wilder-Padilla (1986), also reporting *'parental conflict'* was a feature particularly characteristic of families

where a parent has a drinking problem. Such findings are important for counselling psychologists and those working in drug and alcohol services because it indicates PPD is not always the central issue for treatment of offspring. These findings suggest associated factors such as family disharmony triggered by PD are of greatest concern and require more attention.

By the mid-1970s, a sufficiently large number of empirical findings enabled El-Guebaly and Offord (1977) to document a range of problems encountered by COAs across the lifespan. These included: foetal alcohol syndrome; emotional and conduct problems in adolescence; and alcoholism in adulthood. West and Prinz (1987) highlighted many limitations in the body of research into the effects on children. These included issues connected to the sampling such as children of all ages often being studied as if they were a *homogenous* group, without analysing different ages separately. Additionally, the majority of studies included more male than female problem drinkers and many consisted entirely of men, leading to less being known about the impact of maternal problem drinking. Furthermore, sex differences were ignored both in terms of a possible differential impact of sex of PDP on same-sex and opposite-sex children. *(I refer the reader to Section D of this portfolio for a comprehensive review on the role of gender and the effects on offspring).*

Research has however advanced on many levels and has helped to clarify the nature and extent of problems facing COAs as well as the numerous variables that must be considered when attempting to make generalisations about this group (Sher, 1991; Windle & Searles, 1990). Sher, (1997), reported the greatest difficulty facing researchers and practitioners about COAs which has been established, is the difficulty in making valid generalisations. The main reason being that alcoholics do not represent a *homogenous* group of people. Many for example, have co-morbid psychological disorders such as drug use, anxiety or personality disorders. As a result, difficulties often arise in attributing any apparent COA characteristics specifically to parental alcoholism. Even in the absence of significant co-morbidity, considerable differences exist amongst alcoholics such as age of onset and severity of dependence (Babor, Hesselbrock, Meyer & Shoemaker, 1994).

Introducing the 'Adult Children'

In his paper on epidemiology and prevention, Rangarajan (2008) highlights the move from the focus on COAs to Adult Children of Alcoholics (ACOAs). Although researchers continue to emphasise the effects of parental alcoholism on children and adolescents, the last two decades have witnessed widespread and sustained interest in examining the impact of parental alcoholism on 'adult children' as well. ACOAs are generally conceptualised as individuals over the age of 18 raised in homes where alcohol was abused to the neglect of the maintenance of the family unit (Black, 1982). The term 'adult child' is based on the assumption that PPD has the greatest influence on the outcomes of the offspring over any other factor. Moreover, the effects of PPD persist into adulthood. More recently, Ruben (2001, pg6) explains *"Since second-generation offspring manifested unique pathologies in childhood lasting into adulthood, researchers conceived the generic term ACOAs to cover adults suffering post-family effects of alcoholism"*.

The knowledge base about the physical and psychological concerns experienced by ACOAs has expanded rapidly over the past two decades. Many clinical, longitudinal and community studies suggested ACOAs are more at risk for the development of low self-esteem, difficulties with intimate relationships, substance abuse, eating disorders, depression, anxiety and personality disorders, than are individuals without such history (Finn, Sharkansky, Viken, West & Buffered, 1990; Jarmas & Kazak, 1992; Kashubeck & Christensen, 1992). In the 1990s a number of studies investigated the occurrence of psychiatric disorders in community samples with ACOAs. Mathew, Wilson, Blazer and George (1993) reported 14% of a total of 2992 adults reported PD in one or both of their parents. These ACOAs were then found to have significantly higher rates of anxiety disorders. Moreover, higher rates of alcohol and drug abuse problems were found among male ACOAs when compared to non-ACOAs. From the many concerns indentified by clinicians, depression and decreased self-esteem were most frequently identified (Domenico & Windle, 1993).

In her paper on a model of depression in ACOAs, Lease (2002) writes that similarly to questioning the homogeneity of alcoholics, researchers have also begun to question the assumption that all ACOAs are homogeneous in terms of their familial experiences and

the psychological effects that may result from these experiences. Those least at risk appear to be from families with high levels of family support, control and cohesion, where there is a non drinking parent who can mitigate the effect of the problem drinker, and those with fewer social-economic stresses (Foxcroft & Lowe, 1991). Although the earlier findings of distress could be the result of methodological flaws in sample selection (clinical versus nonclinical; Kashubeck & Christensen, 1992; West & Prinz, 1987) which will be discussed in more detail in the 'methodological limitations' section of this chapter, others have observed the differences in concerns experienced by ACOAs may be the result of the varying range and level of functioning experienced in the family system as a whole (Seefeldt & Lyon, 1992; Werner & Broida, 1991; Wright & Heppner, 1991). It is likely alcoholic families can be characterised on a continuum of dysfunction and there are numerous *within-group differences* in their environments and experiences.

Johnson and Rolf (1990) suggest 'parental drinking style' might account for some of the within-group differences for ACOAs. The authors report not all alcoholics exhibit the same effect or behaviour during the drinking period. Whilst some may exhibit violent and abusive behaviour during drinking, others may emotionally or physically withdraw from the family, creating a sense of being 'unavailable'. Moreover, in some families, drinking behaviour may be hidden altogether. However, specific behavioural drinking styles have not been defined or studied. Although a few studies (Kashubeck & Christensen, 1995; Stout & Mintz, 1996) have examined the abusive behaviour that may occur in the alcoholic family, no investigators have identified patterns of drinking behaviour or the relationships between those patterns and psychological outcomes. It is unclear how the varying behavioural expressions of abusive drinking may affect family interactions, intimate relationships, or the offspring's levels of self-esteem and depression.

One area that has been clinically identified as problematic for ACOAs is intimate relationships, yet has not been the focus of much research. Some studies have found ACOAs report their relationships to be more problematic than do non-ACOAs (Domenico & Windle, 1993; Fisher, Jenkins, Harrison & Jesch, 1992; Kerr & Hill, 1992). Stout and Mintz (1996), for example, found that college women with alcoholic

fathers reported significantly more distress arising from interpersonal problems than did non-ACOAs. Although these findings provide some support for the notion that ACOAs have difficulty in intimate relationships, they have not pin pointed which aspects of relationships are problematic and have typically assessed general relational problems as opposed to assessing problems in current, committed relationships.

Many researchers have been more interested in the effects upon adulthood personality than upon psychiatric disorder. Moreover, although it has often been assumed that PPD will leave its mark on the adulthood personality of the offspring, there has been little research to suggest this is the case. In 1990, Windle reviewed 27 studies of the personalities of offspring of problem drinkers and found very few differences. For example, three out of four studies of anxiety or neuroticism found no significant differences in COAs and controls, plus five studies of positive attributes such as self-esteem and outgoingness produced no differences. Again one needs to consider often occurring methodological limitations for the lack of findings such as the fact that some of the aforementioned studies only used University student samples, and the age of the offspring varied greatly.

Black (1979) has been a campaigner for children of problem drinkers (COPDs) in the USA for many decades. Her position is that all COPDs are affected in the long term. Black et al. (1986) compared 409 COPDs with 179 controls, all of which were in their mid-twenties and above, and investigated problems in personality. Over half the COPDs reported problems with trusting people, identifying their feelings and problems with putting themselves first. There were issues with recruitment which may have influenced the findings. The first was the way in which the study was advertised (mainly in specialist magazines and journals), which would have attracted those with a personal and/or professional interest in alcohol problems. Furthermore, one third of the COPDs described themselves as being alcoholics, with a further 21% considering themselves to be married to an alcoholic. These within-group findings possibly complicated findings.

Rhodes and Blackham (1987) developed a children of alcoholics family role instrument (CAFRI) based on Black's ideas to assess four roles: responsible child, adjuster, comforter (placatory) and acting out. The authors found higher scores on the acting-out role for a small sample of high-school students with parents with drinking problems

compared to controls, with borderline differences for adjustor and comforter (placatory). This study was criticised however by authors such as Velleman and Orford (1999) due to the age range of participants (mid-late teens). The study does not provide evidence that such roles have become rigid nor that they will necessarily be dysfunctional in the long term as Black suggests. Black's work has been criticised by researchers such as Burk and Sher (1988) because of the assumption made that *all* COAs either display clear signs of maladjustment, and have carried into adulthood dysfunctional, defensively adoptive roles. Burk and Sher (1988) suggest there is a danger of over predicting adulthood risk, or even of creating some additional harm by the process of labelling people as COAs who would not otherwise be at risk.

Are offspring at increased risk for substance abuse?

Although the possibility of a relationship between parental substance abuse and subsequent alcohol problems in their children has been documented extensively for many years (Chassin, Pillow, Curran, Molina & Barrera, 1993; Semlitz & Gold, 1986; Windle, 1997), it is again important to consider how children differ. Anthony (1974) suggested the possibility there were different groups of children of substance abusers and not all these children could be considered a single unitary entity. Similar experiences affect children differently because of individual factors such as temperament, intelligence and environmental resources. As a result, each review or summary of children of substance abusers should take into account that there is probably *no single profile* of children of substance abusers.

Throughout recent decades commencing in the 1970s authors such as Kandel, Kessler and Margulies (1978) found 82% of drinking parents raised offspring who also drank, and 72% of families who abstained from drinking alcohol had children who also abstained. Cotton (1979) conducted a key review examining 36 studies of ACOAs and adult children of problem drinkers (ACOPDs) with a drinking problem. Each study indicated adults who were drinking excessively were more likely to report having a PDP than would be expected from the general population figures. There are however difficulties with such research which have been conducted on samples who already have alcohol problems. Such difficulties are mainly due to the respondents' treatment status.

It is not known for example how representative those who are in treatment are compared with problem drinkers in the community at large.

Population surveys dating back to the 1970s (for example, Cahalan, 1970) have told us the majority of problem drinkers are not treated professionally. It is possible the greater representation of PPD among treated problem drinkers simply reflects the latter's greater tendency to seek treatment rather than their greater risk of developing problems. Moreover, by only examining those who are in treatment, no information is made available about the offspring who do well despite PPD. Even if it is accepted that having a PDP does raise the risk of offspring problem drinking, simply researching those who engage in treatment does not enable us to give an accurate assessment of the real degree of risk. Furthermore, there is a danger of over predicting the risk for people who have experienced difficult events in earlier life.

Several twin, adoption and family studies have shown the increased risk of becoming an alcoholic in ACOAs and especially in the sons of alcoholic fathers, to be due in part to genetic factors (Merikangas, 1990). Other studies have shown the risk status of ACOAs to be the result of psychological and social factors such as: disruption of family life; increased violence; the financial, occupational consequences of alcoholism; and the co-morbid psychiatric disorders of the alcoholic parent (Johnson, Sher & Rolf, 1991).

A later study by Kushner and Sher (1993) compared COAs with those without such problems and found the former were twice as likely as other children to show symptoms of an alcohol use disorder. COAs nonetheless do not necessarily develop substance problems and it was found a significant number do not become substance abusers as adults (Ullman & Orenstein, 1994). To the contrary, many demonstrate low levels of alcohol use or abstain altogether. Some abstain because they fear they will become alcoholics themselves and they have seen the negative consequences of their parents drinking (Rogosch, Chassin & Sher, 1990). Others do not develop problems because they attend self-help groups. Further evidence has been supplied by the most recent Diagnostic and Statistical Manual (DSM-IV-TR; American Psychiatric Association, 2000), whereby the offspring of parents diagnosed with alcoholism were said to be up to four times more likely to develop alcohol-related problems than individuals in the

general population. As it stands, there does not appear to be a clear cut answer to this question and research continues to yield mixed results.

Methodological Limitations

There are numerous methodological problems associated with the research on the long term effects of childhood exposure to parental alcoholism (Greenfield, Swartz, Landerman & George, 1993). These problems include: participant misclassification (Domenico & Windle, 1993); the excessive use of clinical samples and college student populations (Mintz, Kashubeck & Tracy, 1995); the lack of control groups, inconsistent definitions and respondent misunderstanding of terminology, such as the meaning of PD (Mathew et al., 1993), selective samples and small sample sizes. Additionally, Sher (1997) discusses further methodological complexities such as: how extensively alcoholism is assessed in the other family members; whether parental alcoholism is active or in recovery; the sex of the alcoholic parent; and the age and sex of the child.

Whilst investigating ACOAs, Shapiro, Weatherford, Kaufman and Broenen (1994) found significant differences between college students and non-students. Many researchers have nevertheless expressed their concerns regarding college student samples. Logue, Sher and Frensch (1992) for example stated that *"college students are not representative of the general populations"* (p. 231). Kashubeck and Christensen (1992) make a valid point that variations in findings may indicate *"negative effects of parental alcoholism are experienced later in life"* (p. 360). The use of college student samples thus need not be a problem if generalisations are limited to that population. Whether or not inferences are appropriate must be judged on a study-by-study basis. It is therefore important to recognise that issues regarding stability or change in an adult personality remain unresolved, with mixed opinions regarding the validity of applying the findings from college students to an adult population (McGue, Bacon & Lykken, 1993). Of the studies reviewed in the 1990s, over half contained college student samples. Moreover, at least 38 samples were composed entirely of college students. Lastly, between the years of 1986 - 1995, 61% of the studies on ACOAs contained college student respondents.

Problematic sample categorisation among studies using non-clinical, or community samples include: (1) a lack of specificity regarding non-clinical characteristics, (2)

respondents were not asked about current and past clinical experiences; (3) samples included persons who had past treatment experiences; (4) persons participating and not participating in therapeutic activities were grouped together, and (5) participants with various clinical experiences were not divided into subgroups. A group should only be labelled non-clinical when respondents are asked about therapeutic activities and researchers exclude those with past or present clinical experiences (e.g. outpatient therapy, support groups) (Orosz-Vail, Protinsky, & Prouty, 2000). Moreover, current non-participation in clinical activities does not cancel out past experiences.

Alcoholism: A continuum of seriousness?

Mintz et al. (1995) highlighted the disadvantage of treating parental alcoholism (or family dysfunction) as a single categorical variable, given the richness of data that may be lost. Bearing in mind that alcoholism exists on a *continuum of seriousness,* it is possible that studies clearly dividing participants into groups of COAs and non-COAs may be losing valuable information related to the effects of parental alcoholism. Orosz-Vail et al. (2000) have since urged researchers to address the question whether parental alcoholism ought to be treated as a 'categorical' or a 'continuous' variable. Exclusive reliance on a categorical approach to differentiate non-alcoholics' and alcoholics' offspring is problematic. Furthermore, the dividing lines between parents' social drinking, problem drinking, alcohol abuse, and dependence are ambiguous). The categorical approach raises concerns about research outcomes and fails to address variation among alcoholics and differential effects on children. Thus, for researchers who use the Children of Alcoholics Screening Test (CAST) developed by Pilat and Jones (1985), it is recommended scores be treated as a continuous variable, thereby increasing measurement sensitivity and possibly reducing between-study inconsistency. Moreover, descriptive data should be included with CAST results.

More recently, Rangarajan and Kelly (2006) have also discussed the general trend to dichotomise research participants into COA and non-COA groups within the research. The authors measured perceptions of seriousness of parental alcoholism as a continuous variable using a variation of a measure of parental alcoholism used by Kashubeck and Christensen (1995). Rangarajan and Kelly (2006) asked 227 participants to rate the perceived seriousness and intensity of both paternal and maternal alcoholism during the

first 16 years of their (the participants) lives on four items: two asked about paternal alcoholism and two about maternal alcoholism. Rangarajan (2008) went on to develop a measure specifically to assess participants' perceptions of their parents' alcohol use during the first 16 years of life. The scale comprised of 14 items (seven items each to assess paternal alcoholism and maternal alcoholism) assessing items including: participants' perception that their parent/s had an alcohol problem; perception of the seriousness and intensity of the problem; and participants' perception of themselves as ACOAs.

From impact to resilience

It would be easy to assume the outcomes for COAs and ACOAs are particularly negative given the aforementioned research. It should be highlighted that despite the dominant focus on negative impact, there are studies which have found no evidence of heightened risk for children stemming from parental substance misuse alone over recent years. Templeton, Zohhadi, Galvani and Velleman (2006) discuss that much of the research undertaken in the past 15 years has demonstrated that this population off spring is very heterogeneous, and that there is no pre-ordination for negative outcomes. Moreover, they seem to have a wide range of coping behaviours and resilience features. Following on from this, a philosophical shift in the literature towards resilience is occurring and this has clear potential when applied to children, and other family members, affected by (parental) substance misuse. This shift is of particular significance to counselling psychologists and other mental health professionals delivering services in order to identify and promote resilience factors and processes in families affected by substance misuse. There is growing evidence that a range of services and interventions for children and families is developing, but there is a need for continued expansion of such services (Templeton et al., 2006). Moreover, there is a need for more careful evaluation both in terms of service development and delivery incorporating the views of the children.

Little, Axford and Morpeth (2004) argue resilience should be conceptualised as a process rather than a static trait and/ or something solely intended to the individual. As a process, it is the product of an interaction between the individual and their social context. Resilience factors can and do serve as buffers to life stressors. They can also

serve as a protective mechanism for alcohol use, age of onset of drinking, and affective factors (Hall et al., 2003). As a result of their resilience, some children do not develop significant problems related to their parents' substance misuse. A well documented study by Velleman and Orford (1999), two of the fields most renowned researchers, based their study on a particularly large sample of 244 adults aged 16-35 years. Of the 244 adults, 164 were COPDs and the remaining 80 were a 'normal' comparison group, matched for age and recruitment source. Whilst a number of risk factors were identified in the COPDs group, many of the sample who had experienced difficult upbringing were *"well functioning, happy and successful as those in the comparison group"* (Velleman & Orford, 1999, p.246).

Similarly, Bancroft, Wilson, Cunningham-Burley, Backett-Milburn and Masters (2004) interviewed 37 young people aged 15-27 who were children of substance misusing parents. They found a number of protective factors could lead to more resilient outcomes. These included: support from school; immediate and extended family; and individuals and services outside of the family. Despite the participants in the study reporting support from immediate and extended family was both obtainable and beneficial, they also said that longer-term, unconditional support was not near the level they needed or desired. Some of the strategies used to deal with the parental substance misuse included escape (e.g. spending time on their own or visiting friends) and challenging the user.

Interestingly and similarly to Velleman and Orford's (1999) findings, the participants in Bancroft et al's. (2004) study all took their own steps and action to move on from their difficult pasts. Some examples included: moving away from their PDPs; excelling in their education and work; and establishing goals and dreams and making them come true. Of central significance was that participants felt they had choices and were in 'control' of their lives. Bancroft et al. (2004) refer to resilience as not necessarily meaning to grow up or be stronger, but that it:

> *Involved creating space to focus on themselves and their needs, and to have fun, without responsibilities for others …… they were often having to relearn, or learn for the first time, the joys and pleasures of being young, or being able to focus on themselves and their own needs* (Bancroft et al., 2004, p.78).

One might consider this to be an act of self-preservation and learning to put themselves first. Resilience therefore means re-focusing one's attention and energy from the external (for example, PDP) to the internal (self).

Velleman and Templeton (2007) refer to a number of protective factors and evidence of consequent resilience taken from the studies they reviewed. These were: the presence of a stable adult figure; engagement in a range of activities; and a close positive bond with at least one adult in a caring role (for example, older siblings or grandparents). These protective factors encouraged resilience in the following ways: deliberate planning by the child that their adult life will be different; and an ability to deal with change and self efficacy.

It is important to bear in mind that the processes which allow young people to become resilient may not all be entirely positive either in the short or long term. Werner and Johnson (1999) for example noted a number of strategies such as detachment, avoidance and withdrawal being used by young people. As a child, detaching oneself from family members whose emotional problems may feel overwhelming and overpowering are extremely effective. As an adult however, such strategies may trigger attachment and relationship difficulties. Similarly, in a longitudinal study, Werner (1993) noted some of the sample were detached from things and people: *"they had learned to keep the memories of their childhood adversities at bay by being in the world but not of it"*. (Werner, 1993, as cited in Velleman & Templeton, 2007, pg. 83). As adults, such people may come across as aloof or detached.

Family interventions in substance misuse

Whilst family members have previously been neglected with primary focus being on outcomes for service users, there is evidence this is slowly changing in the UK. A survey conducted by Alcohol Concern (Williams, 2004) found 59 agencies which offered some level of help to families and/or children affected by alcohol misuse. This is a far cry from the 14 agencies found in Robinson and Hassell's survey for the NSPCC in 2000. These were two child-focused services, five family-focused services and seven adult-focused services. Besides these few specialist services, there is limited help available. Al-Ateen, for example, helps COPDs but is not very widespread in the UK. Moreover, it will only help older children. Whilst Childline is an extremely supportive

telephone helpline, it is dependent on a child having access to a telephone and furthermore being able to use it independently. Child and Family counselling services are run by the NHS in most areas and can only offer treatment with parental consent. The issue of confidentiality arises for school counselling services and youth services. The need for more confidential services is therefore extremely self-evident.

Cuijpers (2005) reviewed the prevention programmes for COPDs. It was found the prevention programmes developed in past decades share some common components (Emshoff & Anyan, 1991; Emshoff & Price, 1999) including: social support; information; skills training; and coping with emotional problems. These are described briefly below:

Social support: Most prevention programmes are group interventions in which offering mutual support and exchanging experiences is one of the basic elements.

Information: Most programmes give information about alcohol use, PD and about the consequences of PPD for their children. In some cases, information is given about the increased risk of the COPDs developing drinking problems themselves.

Skills training: Most prevention programmes teach participants skills and how to deal with the problems they are faced with, such as how to explain the family situations to friends or how to deal with parental conflict in the home.

Coping with emotional problems: COPDs often have emotional and psychological problems such as feelings of guilt and anger. They also worry about their parents. Identifying and discussing these problems and feelings can be extremely important.

Although the aforementioned components are common to most of the prevention programmes for COPDs, there is no evidence for their effectiveness in reducing the high-risk status of COPDs (Cuijpers, 2005). There does not appear to be a clear answer as to what form of intervention would reduce the risk status of COPDs.

Domination of quantitative research

Understanding COAs and other children of substance users experiences has dominated the scientific literature for many decades. To date however, many of the empirical studies have relied primarily on quantitative data to understand the individual and

environmental factors associated with lives, and growth of COAs and other substance users (Moe, Johnson & Wade., 2007). Very few studies have used qualitative techniques to collect data and although it cannot be disputed that quantitative studies provide great insight, far more could be learned if data collection methods were used which could provide us with the family members' *experiences* of living with substance misuse.

Whilst Orford, Natera, Davies, Nava et al. (1998) was not the first qualitative study in this research area, it did represent a departure from the almost exclusively quantitative approaches used in the past. This was an extensive cross-cultural study, investigating stress, emotions and health in relation to drug and alcohol use and the family. The authors reported detailed analysis of 24 of the 207 participants interviewed. These were 12 English and 12 matched Mexican participants. The focus was on their descriptions of stressors they experienced, their emotional reactions and signs of mental and physical strain. Their findings were valuable in that the experiences were *"near-universal"* (Orford et al., 1998, p11), transcending culture, some economic circumstances, gender of relative, and relationship of relative to the alcohol or drug user. The various family members were nevertheless unequal in terms of numbers, with the majority of participants being the mother of a drug or alcohol user. Furthermore, the 'users' were predominantly male. If we are to take into account what the literature has told us about 'gender' playing a significant role in the 'impact' on family: meaning both gender of the user and gender of family member being impacted (Bradley & Schneider, 1990) then the study can offer limited understanding on their experiences.

Kroll (2004) reviewed seven predominantly qualitative studies which investigate the impact of parental substance misuse on children: five of which were UK studies; and two US. His content analysis showed the children's lives were affected by six themes, namely; denial; distortion and secrecy; attachment; separation and loss; family functions, conflict and breakdown; violence, abuse and living with fear; role reversal, role confusion and child as carer; and what the children said they needed. Such themes were similar to previous research such as Kroll and Taylor (2003) who investigated parental substance misuse and child welfare.

Most recently, Backett-Milburn, Wilson, Bancroft and Burley (2008) conducted a qualitative study on a sample of 38 young people (aged 15-27). Their study included the offspring of parents with alcohol, drug and poly-substance problems, and focused on young peoples' experiences of daily life and what helped them 'get by' (cope). Participants reported a large number of issues including: disrupted home lives and family relationships; neglect and poverty; disrupted schooling; and for a minority, their own drug use. A large majority of participants reported their substance misusing parents as not always looking after their basic needs. Moreover, half the sample described themselves as having been active carers as children meaning they looked after the practical and emotional needs of a parent and / or siblings.

One of the most common features of lives spent with substance-misusing parents was its unpredictability. For a minority of female participants, attending school (primary school in particular) on a daily basis offered respite from the pressures and unpredictability of home life. Male participants however spoke of disliking school. Moreover, secondary school in particular was used as a place to vent frustration at the home situation. Several young male participants reported it was *"a place of violence and bullying"* (Bancroft et al., 2008, pg. 471). They struggled to deal with authority which led to suspension or exclusion from school. Whilst substance abuse emerged as central to participants' experiences they were not in isolation (violence and mental health problems were also common, and sexual abuse was experienced by a few). This mirrors earlier findings such as Black et al. (1986) that the 'substance' is not always the central problem, but it is the associated factors that may come as a result of substance misuse which may require more attention.

Identifying a gap in the literature: Giving a voice to adult children

Up to this point I have focused on the extensive literature on the outcomes for children identifying the emotional issues they may face and detailing the risks such experiences pose for their future. Additionally, the factors which may make for more positive or resilient factors have been presented. Given the amount of stigma and secrecy surrounding substance misuse (Barnard & Barlow, 2003), there has been relatively little research into the '*perspectives'* of offspring themselves indicating a gap remaining in the literature. There is a distinct lack of investigation of children's '*views'* on their

parent's substance misuse. Gorin (2004) and Kroll and Taylor (2003) conducted two substantial reviews and identified a number of key themes in relation to children's views including: secrecy, isolation, emotions, conflict and disharmony, roles and coping. For the most part, these themes operate in two ways: within the family, that is between parents and children; and externally, between the child and the 'outside world'.

Gorin's (2004) review extended to research findings about children's experiences of domestic violence, parental substance misuse or parental health problems. It was conducted in conjunction with her work at the NSPCC and focused primarily on studies which sought to hear the 'voice' of children directly (under 18). The review was based on completed and ongoing research covering relevant research between 1990 and 2003. Gorin (2004) found that whilst experiences were all very different, there were common themes that arose when children spoke about their experiences such as their feelings, coping strategies and what would make things better. Children reported worrying excessively, particularly if they feared for their parents' safety. The review also reported children using mainly informal support and were most likely to talk to parents (mainly mothers) or friends, siblings and extended family. Moreover, children reported now knowing where to get formal support and rarely sought the help of professionals.

As authors such as Templeton et al. (2006), Gorin (2004) and Kroll and Taylor (2003) have found, there is a distinct lack of research that has directly explored children's views and experiences of parental substance misuse. As a result our understanding as practitioners and researchers of the impact, resilience factors, service needs, existing service provision and intervention and treatment lacks a fundamental and informative angle. Templeton et al.'s (2006) review recommended more work is required which directly explores the views and experiences of children living with parental substance misuse. More specifically, they suggested such work would need to include attempts to talk to a mixture children including: those of parents who are and who are not receiving treatment for their drug or alcohol problem; the voices of children whose parents misuse alcohol; the voices of children whose parents misuse drugs; and the voices of children from different cultural backgrounds. The majority of studies to date have reported the views and experiences of children who have been in contact with services which may have influenced the findings and conclusions drawn.

Templeton et al. (2006) conclusions and recommendations for further research have played a significant role in the main aim of the current study. The aforementioned studies have focused on young children, aged 18 and below, meaning research on the views of adult children remain neglected. The distinct lack of literature which is subjectively based means adult children in particular remain 'unheard'. This study therefore attempts to find the voice of adult children whose parents misuse alcohol. This study aims primarily to provide information for counselling psychologists on the experiences of adult children. Additionally, it aims to provide insight into the type of therapy and support required and desired by this group of individuals. It is hoped that by engaging in the participants' accounts, both as practitioners and researchers, we can build on pre-existing knowledge of this group. Given the complexity in making generalisations and the lack of homogeneity of both problem drinkers and offspring it seems appropriate to target smaller samples and partake in an in-depth study in order to gain a sense of what life is like for adult children, and hear directly from them as to how they may or may not have been affected by PPD.

To conclude, this study aims to fill a void in the research and explore the offspring's experiences of having a parent they 'perceive' to have a drinking problem, therefore contributing to the qualitative research in this area. The study aims to capture their views and perspective on family life where alcohol plays an important role. It is hoped by exploring their experiences, it will offer more knowledge about this group to counselling psychologists and furthermore, give an indication of what may be needed in terms of service provision. Additionally, because the study will be purely subjective, it allows for those who may otherwise be 'forgotten' or 'ignored' in the literature because their parents' level of dependence was not 'severe' enough to be included and 'have their say'. As a result, this study has the potential to target an otherwise highly neglected group of individuals who may be in great need of support and subjected to a unique set of issues practitioners are not aware of. Finally, and of greatest importance, by offering this group a 'voice' it aims to bring them further into our awareness.

Chapter Two: Methodology

Research Aims

This study aimed to explore the following primary question:

What are the life experiences of adults who view their parents as having a problem with alcohol?

As a counselling psychologist in training working in Primary Care, I have worked with numerous clients who have described their parents as being an 'alcoholic' or 'binge drinker'. Although these clients were not referred for counselling as a direct result of PPD, in many cases, sessions focused on their parent's alcohol use. Additionally, clients did not always link PPD to some of their current problems such as anxiety, boundary issues and interpersonal problems. I wanted to gain an in-depth understanding of what it is like to have a parent who uses alcohol problematically. Whilst I was to interview ACOPDs, meaning people over the age of 18, there was scope to ascertain valuable information in the interviews about the participants' experiences of PPD whilst they were children, as well in the present day as adults. By exploring childhood experiences, there is the potential to elicit information which may assist counselling psychologists working in schools and counselling services for adolescents and young people.

During my time as a trainee counselling psychologist, having worked in both primary and secondary schools, I felt under trained to work with children who may be living with parents using alcohol problematically because I did not have enough knowledge about the effects of PPD and moreover was unsure what signs may indicate a child is experiencing PPD at home. By listening to the accounts of young adults, it will enable counselling psychologists to be better able to identify children living in such situations, but also to intervene therapeutically. Given that children spend a substantial amount of time at school it is both a logical place to identify and assist such children (Berk, 2002). One would assume psychologists need to intervene according to particular life experiences but also according to their developmental stage. By learning from the participants' experiences, it is hoped our understanding of what type of intervention

they feel is needed as a child will increase, and we can hope to assist children in the future.

The following quote by Berger (1993) is a typical view of ACOAs:

> *ACOAs often don't relate their problems to having grown up in a family with an alcoholic parent. Many of them have problems of depression, aggression, or impulsive behaviour. Some studies have shown that ACOAs have problems with abuse of different psychoactive substances, and difficulty in establishing healthy relationships with others. They are frequently failures as parents themselves, often make poor career choices, and almost all ACOAs have a negative self- image* (Berger, 1993, p.67).

Based on this typical view I feel that as counselling psychologists it would be valuable to know if 'particular' life experiences lead to certain issues. Conversely, do particular experiences mean the children do not develop certain issues? Finally, regardless of age, are children seeking therapy and if so how has it helped or not? If they are not seeking support why is that? Most importantly, what else do they need and how could our services be improved? Taking these questions into account the study focused on the following areas employing a small sample design incorporating a qualitative methodology:

1) Experiences as a child
2) Experiences as an adult
3) How life may have been influenced by their parent's drinking
4) Coping mechanisms

Rationale for conducting a qualitative study

Psychology and counselling psychology in particular have been dominated by quantitative research methods anchored in the positivist research paradigm (McLeod, 2001; Morrow & Smith, 2000; Rennie, 2002). Over time however, counselling psychologists have been advocating for the increased incorporation of post-modern perspectives and associated qualitative methods in psychological research (Pontoretto,

2005). When conducting a piece of research the critical point for the researcher is to select the approach which is most appropriate for the question being asked. Given my interest was in gaining a greater understanding of the life experiences of children who *view* their parents as having a problem with alcohol, a qualitative research method was deemed the most appropriate.

Qualitative methods refer to a broad class of empirical procedures designed to describe and interpret the experiences of research participants in a context-specific setting (Denzin & Lincoln, 2000b), such as a *"real world setting (where) the researcher does not attempt to manipulate the phenomenon of interest"* (Patton, 2001, p. 39). Qualitative research is broadly defined as *"research that produces findings not arrived at by any means of statistical procedures or other means of quantification"* (Strauss & Corbin, 1990, p.17). Qualitative findings are generally presented in everyday language and often incorporate participants' own words to describe a psychological event, experience, or phenomenon (Taylor & Bogdan, 1998). Unlike quantitative researchers who seek causal determination, prediction and generalisation of findings, qualitative researchers instead seek illumination and understanding (Hoepfl, 1997).

Qualitative research demonstrates a number of commonalities (Powers & Knapp, 1995) such as the personal involvement between researcher and participants in the latter's natural setting. Interviews are intensive with detailed descriptions of conversations and observations. It allows for introspection and self-reflection to provide the researcher's individual responses to the data (reflexivity). Qualitative research allows for openness to discovery and unexpected findings. There is a willingness to re-direct the research on the basis of new understandings or insights emerging from concurrent data collection and analysis.

Rationale for using Interpretative Phenomenological Analysis (IPA)

I embarked on the research process with no hypothesis in mind. Given my aim was to investigate the personal understanding and meanings of having a parent who uses alcohol, IPA (Smith, 1995) was considered the most appropriate methodology. The greatest strength of IPA is that it provides insight into the participant's subjective lived experience. The phenomenological approach provides a rich and complete description

of human experiences and meanings. Findings are allowed to emerge, rather than be imposed by the researcher. Careful techniques are used to keep descriptions as faithful as possible to the experiential raw data. This is accomplished by extreme care in moving step by step, and in being ever mindful not to delete from, add to, change, or distort anything originally present in the participants' transcripts. The researcher attempts to "bracket" presuppositions and biases to hold them in consciousness through all phases of the research and minimise their influence on the findings. Whilst such insight is promoted, it recognises the potential influence of the researcher's own preconceptions on the research process (Shaw, 2001).

The main weakness of IPA, and other qualitative methods, is the question of validity. The discussion of quality in qualitative research, arose from the concerns about validity and reliability in quantitative tradition, which *"involved substituting new term for words such as validity and reliability to reflect interpretivist [qualitative] conceptions"* (Seale, 1999, p. 465). Although some qualitative researchers have argued that the term validity is not applicable to qualitative research, at the same time, they have realised the need for some kind of qualifying check or measure for their research. Creswell & Miller (2000) for example, suggest the validity is affected by the researcher's perception of validity in the study and his/her choice of paradigm assumption. As a result, many researchers have developed their own concepts of validity and have often generated or adopted what they consider to be more appropriate terms, such as, quality, rigor and trustworthiness (Davies & Dodd, 2002). In her criteria for validity, Yardley (2000) discusses the broad principle of 'impact and importance'. She argues that regardless of how well a piece of IPA research is conducted, a test of its real validity lies in whether is tells the reader something interesting, important or useful. Given the time and dedication required to conduct an IPA study, one would assume that any researcher would aspire to conduct a study which would meet such criteria.

The method depends on the articulate skills of the participants who provide the information. Conclusions made by the researcher will depend on the particular participants chosen for the study. In its orientation toward a particular time frame or moment, the method may miss information about broader periods or about the development (time course) of an experience. In focusing on a rich description of an

experience, the method may miss information about what led up to that experience, what its outcomes or consequences might be, and what the concomitants and other factors associated with the experience are. There is little interest in conceptualising the experience or in "explaining" it.

I also considered grounded theory (GT) before making my decision on which method to use. As with IPA, in GT the researcher begins with no pre-existing theory, hypothesis or expectation of findings, but rather permits a theory to emerge directly from the data – that is, the theory is grounded in the data (Willig, 2001). The aim of the approach is not only to describe the topic of study, but also to develop adequate theoretical conceptualisations of findings. This was not the aim of the study as I wished to explore the experiences of my participants as this area has yet to be researched extensively using a qualitative method. As a result, I was looking to extract themes and gain more of an understanding of the sample. As a result, IPA was chosen over GT.

Introduction to IPA

IPA came out as a specific approach to qualitative research in the mid-1990s (Smith, 1994; 1996) however it actually connects with much longer intellectual currents in phenomenology and hermeneutics which will be discussed in more detail in the following section. The focus of IPA studies is on how people *perceive* an experience, or rather what any particular experience means for them. This reinforces my reasons for using IPA in that I was interested in the child's perception or view of their parent's drinking. As previously mentioned, researchers do not enter the research process with a predetermined hypothesis but they will have a more general question that they wish to explore. It is the focus on the experience and the meaning it has for the participants which marks out IPA as a phenomenological method.

The role of the researcher is recognised through the way in which the analyst interprets a participant's understanding. This is referred to as the use of a *double hermeneutic* (Smith & Osborn, 2003), with the research trying to make sense of the participant's sense making. IPA is therefore intellectually connected to hermeneutics and theories of interpretation (Packer & Addison, 1989; Smith, 2007). A number of different interpretative stances are possible and IPA combines an empathic hermeneutics with a

questioning hermeneutics. Thus consistent with its phenomenological origins, IPA is concerned with trying to understand what it is like from the point of view of the participants.

IPA is phenomenological in that it strives to explore an individual's personal perception or account of an event or state as opposed to attempting to produce an objective record of the event or state itself. At the same time while trying to get close to the participant's personal world, IPA considers that one cannot do this directly or completely. Access is dependent on the researcher's own conceptions which are required to make sense of that other personal world through a process of interpretative activity. IPA is also a strongly idiographic approach concerned with detailed analysis of the case, either as an end in itself or before engaging in similarly detailed analyses of other cases. IPA is described as *"exploring the lived experience"* (Reid, Flowers & Larkin, 2005, p20). This type of research utilises participants themselves as experts in the chosen phenomenology analysed. *"IPA aims to capture and explore the meanings that participants assign to their experience"* (Reid et al., 2005). The authors also state that IPA is *"interpretative (the subjective); transparent (grounded in example from the data) and plausible (to participants, co-analysts, supervisors and the general reader)"*.

Theoretical underpinnings of IPA

The main theoretical underpinnings for IPA are phenomenology (Moran, 2000), hermeneutics (Palmer, 1969) and idiography (Smith, Harre & van Langenhove, 1995).

Phenomenology

Phenomenology (a compound of the Greek words *phainomenon* and *logos*) is the study of human experience and the way in which things are perceived as they appear to consciousness. More broadly, phenomenology is the name given to the philosophical movement beginning with Edmund Husserl (1859-1938) and then developed by Martin Heidegger (1889-1976) and followers. Husserl (1900/1970) criticised psychology as a science that had made the mistake of applying methods of the natural science to human issues. Moreover, he claimed that psychology *"deals with living subjects who are not simply reacting automatically to external stimuli, but rather are responding to their own perception of what these stimuli mean"* (Laverty, 2003, p4). Phenomenology is

essentially the study of lived experience or the life world (van Manen, 1997). This enquiry asks: *"What is this experience like?"* as it attempts to unfold meanings as they are lived in everyday existence.

Phenomenological research in psychology is concerned primarily with first person accounts of life experiences. A phenomenological investigation seeks to describe these accounts and arrive at an understanding of the meanings and essences of experience. The *epoche* is a Greek word used by Husserl (1967) to mean the process by which we attempt to abstain from our presuppositions. This meaning we must hold any preconceived ideas about what we are investigating in consciousness through all phases of the research, thus minimising their influence on findings. This is sometimes referred to as *"bracketing"*. Findings are therefore allowed to emerge rather than being imposed by the researcher. Husserl's goal in doing this was to actually see things *"as they are"* (Laverty, 2003, p6) through intuitive seeing.

Hermeneutics

Hermeneutics was derived from the Greek verb, *"hermeneueuein" or "exigisis" meaning "to interpret"* and from the noun, *hermeneia, or "interpretation"* (Bryne, 1996). Within the field of qualitative research this term still holds the connotation of *"interpretation"*. The depth and type of interpretation, and, the object under interpretation has changed throughout history. Hermeneutics originally emerged as a response to the debate about interpretations of biblical scriptures (Hunter, 2006). Reformers of the Roman Catholic Church felt that the true meaning of the biblical texts could only be extrapolated through the lens of tradition, and without tradition a biblical text could not be interpreted. To the contrary – and here we see the entry of a newer brand of hermeneutics – the Reformers believed that some version of the true meaning of these biblical texts could be derived from contemporary, ordinary readers, many of whom were not versed with the traditional viewpoints of Catholicism (Hunter 2006). Shortly thereafter, Freidrich Ast offered a new view (Ormiston & Schrift, 1990). He believed hermeneutics involved more than just the interpretation of biblical texts; rather, it involved interpreting text and uncovering the spirituality of both the person who reads the text and the author of that text. For Ast, hermeneutics involved an attempt, through analysis of text, to re-create as much as possible, the original intention of the author

without being limited by the lens of historical/religious tradition, nor the lens of contemporary culture (Hunter, 2006).

Like phenomenology, hermeneutic phenomenology is concerned with the life world or human experience as it is lived. The focus is toward illuminating details within experience with a goal of creating meaning and achieving a sense of understanding (Wilson & Hutchinson, 1991). Husserl was Heidegger's student who disagreed on the way in which the exploration of lived experience proceeds. Husserl focused on understanding beings or phenomena, whereas Heidegger (1889-1976) focused on *"Dasein"* translated as "*the mode of being human"* or "*the situated meaning of a human in the world"*. In Heidegger's view (1927-1962), consciousness is not separate from the world but is a formation of historically lived experience. Interpretation is seen as critical to this process of understanding. Furthermore, Heidegger stressed that every encounter involves an interpretation influenced by an individual's background. Heideggerian hermeneutics is a process of observing, interviewing, reading and writing in which participant generated data are fused with the researcher's previous knowledge to generate deeper understanding of a phenomenon (Annells, 1996; Koch, 1996). The interpretive process is achieved through a *hermeneutic circle* which moves from parts of experience, to the whole of the experience, and back and forth again to increase the depth of engagement with and the understanding of texts (Annells, 1996; Polkinghorne, 1983).

Hans-Georg Gadamer was influenced by the work of both Husserl and Heidegger and moved to extend Heidegger's work into practical application (Gadamer, 1976; Polkinghorne, 1983). Gadamer saw the work of hermeneutics not as developing a procedure of understanding but to clarify further the conditions in which understanding itself takes place. He believed that understanding and interpretation are bound together and interpretation is always an evolving process, thus a definitive interpretation is likely never possible (Annells, 1996). As Gadamer (1965/1989b) commented:

> *The social sciences must not suspend the subjectivity of the researcher-which would be impossible—but, rather, it must knowingly engage with his or her own prejudices in a continual meaning-bearing process. Challenging one's prejudices*

is done not to eliminate them eventually but to give them full play in their being challenged in dialogue. (Unger, 2005, p 5).

Gadamer offers a critical form of hermeneutics, whereby the analysis of conversations, whether that be through texts or other artifacts, the silent assumptions and prejudices embedded by a particular race, gender, or culture, are made visible.

Idiography

Allport (1897-1967) is noted for his concern that psychology should not neglect the unique individual experience and behaviour. He argued for the necessity of studying phenomena from the point of view of the participant and for the act of understanding. The use of the idiographic approach and the single person nonetheless, continues to be neglected within social psychology (Smith, 1993; 2004). IPA studies are committed to idiographic designs by not only the use of single case studies. but also analysing each individual case in a study before attempting cross case analysis.

Epistemological Reflexivity

Epistemology is the study of knowing and how we strive to generate truthful descriptions and explanations of the world (Pontoretto, 2005). The 'world' does not need to include the earth's entirety but the target of the research. When studying the research target, one is required to think about what one sees, make conclusions about them and ultimately based on one's 'thinking' and theorising explain what is seen. A research paradigm sets the context for an investigator's study (Pontoretto, 2005). There are several paradigms used to guide research such as: positivism; constructivism; and critical-ideology.

My epistemological standpoint is that of a constructivist. The constructivist paradigm can be perceived as an alternative to the positivist paradigm, and it adheres to a relativist position that assumes *"multiple, apprehendable, and equally valid realities"* (Pontoretto, 2005, p.128). Essentially, constructivists hold that *"reality is constructed in the mind of the individual, rather than being an externally singular entity"* (Hansen, 2004). The constructionist position espouses a hermeneutical approach, which maintains that meaning is hidden and must be brought to the surface through deep reflection

(Schwandt, 2000; Sciarra, 1999). This reflection can be stimulated by the interactive researcher-participant dialogue. A distinguishing characteristic of constructionism is the *"centrality of the interaction between the investigator and the object of investigation and only through this interaction can deeper meaning be uncovered"* (Ponterotto, 2005, pg. 129). With regards to the current study I believe that what participants' accounts will present the reality they have constructed. This constructivist standpoint therefore suits the application of IPA.

Early work by Kant (1881-1996) highlights a central tenet of constructionist thinking: that you cannot partition out an objective reality from the person (research participant) who is experiencing, processing and labelling the reality (Sciarra, 1999). In other words, reality is constructed by the 'actor' or research participant. Another significant figure in the development of constructivism was Dilthey (1894-1977). Dilthey argued that hermeneutics should become the method of the human sciences and its goal was 'understanding'. The lived experience was to be the focus of investigation and understanding the lived experiences from the point of view of those who live it day to day (Schwandt, 2000). The account was the objectification of lived experience, and understanding was the moment when *"life understands itself"* (Dilthey, 1976). Dilthey wanted to get as close as possible to other's experience. These ideas influenced Heidegger's thinking around hermeneutics; hermeneutics is not simply a method, rather the very nature of being in the world is hermeneutics. As in IPA, constructivists emphasise understanding the 'lived experience' from the point of view of those who live it day to day (Schwandt, 1994; 2000). Dilthey believed that these *'lived experiences'* may be outside the immediate awareness of the individual but could be brought to consciousness.

Evolving ideas

My ideas changed a number of times before coming to a final decision on the course of the study. Given my previous experience of working in an alcohol counselling service, I initially contacted my line former manager for advice on how to recruit the sample. My manager was extremely enthusiastic about the study and was keen to assist. I was told I could contact the adult offspring of the service users (the parents) attending the alcohol service in Essex. Due to the time restraints of the doctorate, this seemed a practical idea

especially after it was explained there were over 100 service users and the chances of recruiting the small number of participants needed for an IPA study (Smith & Osborn, 2003) seemed possible. I was to recruit the participants by sending an advert to the offspring explaining the study and asking them to make contact if they were interested in taking part. The sample was to be narrowly defined as adult children of alcoholics ('alcoholic' was the most commonly used label within the organisation) living in Essex. All participants were to be over 18 so as not to require parental consent and both males and females were invited to take part keeping with IPAs principles that the sample be 'fairly homogenous.' Smith and Osborn (2003) suggest homogeneity boundaries will partly depend on the research question and partly depend on pragmatics. My line manager was interested in developing a service for offspring and was therefore keen for the study to take place in the local area. At this point ethical approval was sought and granted from City University (Appendix A).

A number of important ethical considerations were missed at this point, which were brought to my attention by one of the key workers within the service. I was told that I could not contact the children directly because I ran the risk of breaking the service user's confidentiality. It was explained that many service users did not disclose they were attending counselling and / or support groups to their families. The key worker suggested I present the study to the service users during the weekly groups and ask them to speak to their offspring about taking part (acting as a 'go-between' myself and potential participants). I was ambivalent about recruiting in such a way as it meant not only relying on the service users to discuss the study with their children, but I was concerned it may cause tension between parent and child if they did choose to take part. I did not believe there was any reason for parents to be involved, as the study was purely about the child and putting the parent in the middle seemed to defeat the purpose. Although ethical approval had already been granted by City University, it did not feel appropriate to proceed. The ethical concerns were discussed in research supervision and it was decided I would not ensue with the study in this way.

Defining the sample

At this point my research supervisor and I took some time to think carefully about the most appropriate sample and a revised research proposal and ethical release form was

submitted to City University (Appendix B). The population I was interested in targeting were individuals who were not necessarily recognised as being COAs or ACOAs and had not been given that label: a population who on the surface may not be recognised as coming from a family where parental drinking was problematic. Furthermore, a group of individuals whose experiences were potentially left 'unheard' and were not seeking or being offered support. After careful consideration it was decided that I would recruit through the general population as opposed to recruiting purely through clinical settings (i.e. support groups, alcohol counselling) as this would allow for such a group to learn about the study and be identified.

I found re-defining the sample difficult in terms of avoiding previous methodological issues in this research area. As mentioned in chapter one, previous quantitative research on ACOAs have been confounded by participant misclassification (Domenico & Windle, 1983); respondent misunderstanding of terminology, such as the meaning of PD (Mathew et al., 1993); and reliance on college student samples (Mintz et al., 1995). In defining the sample, I consulted the literature and found the definitions of alcoholism and PD were unclear. Labels such as alcoholic, problem drinker and anti-social drinker are used interchangeably which was confusing. In Leonard and Eiden's (2000) study alone, they defined the parents as severe, anti-social and depressed alcoholics. I also considered the medical view of PD and consulted figures from the Department of Health (2007).

Due to the subjective nature of the study, I came to realise an official definition of 'PD' or 'alcoholism' was irrelevant. The parents were not required to have been classified as a problem drinker or alcoholic, nor was it relevant if the parent acknowledged their drinking was problematic. The study was purely from the *child's* point of view and whether they perceived their parent as having a problem with alcohol. Defining a parent as a problem drinker is a very subjective thing and each participant may well have a different idea of what constitutes PD. As long as participants perceived the drinking to be problematic they were deemed suitable to take part. To advance our knowledge, parental alcoholism ought to be treated as a continuous variable. Given variation in severity, children can be expected to be differentially affected by parents' alcoholism (Orosz-Vail et al., 2000).

As in Velleman and Orford's (1999) study, it is important to note the definition of childhood exposure to a parental 'drinking problem', is not identical to a confirmed diagnosis of alcohol dependence according to the DSM for example. As previously mentioned in Chapter one, Velleman and Orford (1999) used a psychosocial definition of PD which was based on a close relative's opinion. It was confirmed during the interviews with their participants that a parent's drinking, constituted a problem. When the focus of research is on a social group such as the family, as in the present study, this is appropriate. The sample was thus defined as *'adults who view their parents as having a problem with alcohol'*. This enabled those, who were perhaps unsure as to how to define their parents drinking, or were uncomfortable with labels such as alcoholic, were able to take part.

The final sample

Smith and Osborn (2003) state that there is no right number of participants to be included in an IPA study and that choosing sample size is dependent on a number of factors such as pragmatic restrictions and the richness of individual cases. This means that if the researcher considers the interviews they have analysed as being rich enough, they will not recruit further participants. IPA retains an individual focus, advocating the use of smaller sample sizes with ten participants being at the higher end of recommendations (Reid et al., 2005), and promotes purposive sampling and finds a more closely defined group for whom the research question will be significant.

Inclusion criteria

I aimed to recruit eight participants in line with City University's requirements for a Doctoral level IPA study. This choice was also guided by Smith and Eatough (2008) who suggested six to eight participants are enough for the similarities and differences between cases to emerge, whilst ensuring the researcher is not overwhelmed with the amount of data produced.

Both males and females were invited to take part in the study and were required to meet the following inclusion criteria:

1) They were to be aged between 18-30
2) Born and raised in the UK

3) They were required to have lived with the PPD for at least one year

At the time of writing the research proposal and the ethics form, I had considered recruiting participants of 18 years and above. Upon reflection and discussing this further in research supervision, this was considered too broad an age range. It was decided a narrower age range and subsequently a younger sample was required for two main reasons. Firstly, over the years, a large body of literature has shown humans display losses in memory with age (Grady & Craik, 2000). Given my interest in childhood, as well as adult experiences it was hoped that by interviewing a younger sample, memories would be more vivid in the participants' minds if they were not a substantial number of years ago.

Secondly, including participants across too large an age gap i.e. simply over 18, did not allow for the changes which have occurred in drinking patterns and trends over the past few decades (Simpura & Karlsson, 2001). A 60 year old for example may have very different ideas around drinking than a 20 year old. Societal norms and values have changed and I chose to recruit a younger sample so that the study was in line with current drinking trends and thus more relevant to our times. Furthermore, this is why I chose to include only those born and raised in the UK. Different cultures again may have different views on what is considered problematic drinking and the term 'drinking' can vary both technically and culturally (Simpura & Karlsson, 2001). I did consider limiting the sample to those whose parents had also been raised in the UK, however, due to concerns about recruitment and not wanting to restrict the sample excessively, I decided against this.

Previous research has been largely gender specific (Kultar, Unal & Ozusta, 2006). I chose to include both males and females as I felt it would enrich the project. Gender has been found to be significant in this field of research, both in terms of gender of the parent and offspring, and the different effect this may have on how offspring experience their parents problem with alcohol. A number of studies have concentrated on either the sons of alcoholic fathers (Furtado, Laucht & Schmidt, 2006), or the daughters of alcoholic fathers (Ackerman, 2002). The final criterion was that the child had lived with their parent for at least a year enabling them to experience life with their parent over

various significant occasions such as: birthdays; different seasons; and other significant anniversaries.

Demographics

As will be discussed in more detail below, recruitment proved problematic and ultimately only seven participants were interviewed for the main sample. I attempted to make the sample as homogenous as possible, as recommended by Smith and Osborn (2003). The participants were four females and three males. As can be seen in Table 1, aside from Richard, the participants viewed only parent as having a problem with alcohol, with the majority viewing their father as the PDP. All seven participants had lived with their PDP from birth for a substantial part of their lives. The youngest participants (Haleema and Aisha) still lived with their parents, whereas the remaining five participants had moved away from the familial home some years earlier. Rachael and Hannah were sisters who heard about the study via different means. In line with the inclusion criteria, all seven participants were born and raised in the UK.

Of the seven participants, only Hannah and Rachael had engaged in personal therapy as a direct result of their mother's drinking. Initially they attended family therapy, followed by a support group for family members, and finally one-to-one counselling. Richard sought Cognitive Behavioural Therapy (CBT) for Obsessive Compulsive Disorder (OCD) and depression and it was through this therapy that he started to link some of his issues to his parents' drinking. David also reported engaging in counseling as an adult for relationship issues.

Pseudonym	Age	Occupation	Parent viewed as having a problem with alcohol (mother/father/ both)	Ages between which the participant lived with their parent
Haleema	19	Student	Father	Birth – present day
Aisha	19	Student	Father	Birth – present day
Richard	27	Full-time employment	Father Step-Mother	From birth -18 years
Matt	28	Student	Father	From birth - 24 years
Hannah	26	Full-time employment	Mother	From birth - 22 years
Rachael	24	Unemployed	Mother	From birth - 20 years
David	30	Student	Father	From birth – 21 years

Table 1: Demographic Information

Procedure

In the following sections, I will discuss how I recruited the participants and the process of creating the interview schedule and conducting the interviews.

Recruitment

An advert was devised indicating the research area and inclusion criteria (Appendix C). I chose to advertise the study on a large geographical scale in order to optimise the chances of recruitment. In order to avoid previous methodological issues, I chose not to advertise only in what would be classified as purely 'clinical settings', such as organisations dealing with alcohol problems and support groups. I decided on a novel idea which was to combine clinical and non-clinical groups. This was considered in research supervision and it was felt that the combination would potentially enrich the study particularly in relation to participants methods of coping.

A number of organisations were contacted such as Al-Anon, Alcohol Concern and Turning Point however there was either no response or the organisations refused to advertise the study on their websites. This was primarily due to health and safety issues

such as being unable to those using the websites. They had concerns those using the website could be 'posing' as COAs or COPDs, and could have untoward intentions, meaning my safety could be at risk if an interview were to be arranged. Additionally, for the same reason they felt uncomfortable with me meeting with website users face to face because they did not know me personally. I was, nonetheless, granted permission to advertise on one website, namely, The National Association for Children of Alcoholics (NACOA), based in Bristol which is an organisation offering support and information for COAs. Although the founder of the website 'Living with Addicted Parents'[2] shared similar views to some of the other organisations, she agreed to circulate the details of the study to her colleagues.

I also advertised on two different non-clinical United Kingdom (UK) websites, which were chosen in order to target as large a population as possible. Gumtree.com was started in March 2000 as a local London classified advertisement and community website. The advert was placed in both the 'research participation' and 'health and well being' categories. Additionally, the leading social networking website Facebook was chosen as it had the ability to reach a vast number of people. I used the website in several ways initially searching the website for pre-existing groups such as 'children of alcoholics' and 'children of problem drinkers', most of which were based in America. I therefore posted the advertisement on the two UK groups available. In order to maximise use of the website, I created my own group, 'psychology study – adults who view their parents as having a problem with alcohol'. I asked potential participants not to join the group but to contact me directly if they were interested in taking part in order to protect their anonymity from other Facebook users. When neither option attracted any participants, I attempted one final method of using the website which was to use a peer's 'friends list' of people unknown to me. These Facebook users were emailed the details of the study by my peer asking them to make direct contact with myself if they were interested in taking part. This meant my peer would have no knowledge if any of their friends took part in the study. This method proved successful and a number of people showed interest in the study.

[2] The name of the website has been changed to protect the anonymity of the participant

Nevertheless, overall the recruitment process was extremely slow and subsequently I broadened recruitment to include academic settings in and around London. This method also proved successful with a number of students coming forward. This had previously been avoided due to previous research being dominated by student samples. Of the seven participants interviewed for the main sample, three were recruited via Facebook, three via the advertisements circulated in academic settings and one a team member from the 'Living with Addicted Parents' website.

Data collection and creating the interview schedule

The interview remains the most common method of data collection in qualitative research, employed in various forms by every main theoretical and methodological approach within qualitative psychology (King, 2004). Kvale (1983) defines the qualitative research interview as; *"an interview, whose purpose is to gather descriptions of the life-world of the interviewee with respect to interpretations of the meaning of the described phenomena"* (Kvale, 1983, pg. 174). The goal of any qualitative research interview is therefore to see the research topic from the perspective of the interviewee, and to understand how and why they have come to this particular perspective. Moreover, the interviewee is seen as a 'participant' in the research, actively shaping the course of the interview rather than passively responding to the interviews pre-set questions (King, 2004).

Smith and Osborn (2003) describe semi-structured interviews as the exemplary method for IPA and the vast majority of IPA studies adapt this method. Semi-structured interviews were used in this study in order to gain a detailed picture of the participant's beliefs, perceptions or accounts of their life experiences. Such a method gives the researcher and the participant more flexibility than a conventional structured interview, questionnaire or survey. I was able to follow up particularly interesting avenues that emerged in the interview and the participant was able to expand on what they felt was of most importance. Questions were open-ended and non-directive giving participants control over the subjects discussed.

A number of issues were considered when creating the interview schedule. As recommended by King (2004), I wanted to open with a question which could be

answered easily without potential embarrassment or distress. King (2004) also suggests more difficult or sensitive questions be held back until later in the interview, allowing time for researcher and participant to feel relaxed and to build rapport. Questions considered more factual or asking for descriptive information can be useful opening questions. I therefore opened the interview by asking participants to describe their parent's use of alcohol. The way in which questions are asked during the interview can have a major impact on the nature of the responses. Further considerations included not using multiple questions as this can confuse participants as to what question they are supposed to be answering.

Given the sensitive research topic great attention was paid to questions not being leading. Such questions impose the researcher's own perceptions on the participant and may cause them to agree with the researcher in order to be polite or to please them. Additionally, I was conscious a negative connotation was not attached to any of the questions. Whilst agreeing to take part in the study meant participants perceived their parent/s use of alcohol was problematic, this did not necessarily mean life had been continuously difficult. In keeping with IPAs principles I did not want to make any assumptions (Smith & Osborn, 2003) and I attempted to keep the questions as neutral as possible. Questions were left open and asked purely about the participants 'experiences' throughout their lives, giving participants the choice of which experiences they wanted to share.

A provisional interview schedule was devised (Appendix D) however it was considered too structured by my research supervisor. I was directed to Lyons and Coyle (2007) and I also consulted previous IPA studies such as Osborn and Smith (2006) to gain an understanding of how 'open' the questions needed to be and moreover how many questions were appropriate. I found the schedules to be extremely varied and thus used my own judgement. The revised schedule included four main questions (Appendix E) with additional prompt questions to assist participants to expand their answers or to further explore particular lines of questioning. The schedule was used as a guide and not strictly adhered to. Despite following other interesting lines of enquiry all four questions were covered throughout the interview. Attention was paid not to end the interview on a topic which was difficult or painful. Instead an opportunity was given to

participants to make any comment about the research area which had not been covered in the rest of the interview.

The pilot study

The term pilot study can be used in two different ways. Firstly it can refer to so-called feasibility studies which are *"small scale version(s), or trial run(s), done in preparation for the major study"* (Polit, Beck & Hungler, 2001, pg. 467). Secondly, it is useful for pre-testing a particular research instrument (Baker, 1994), such as an interview schedule. It can provide valuable information as to whether the instrument is inappropriate or too complicated. Qualitative data collection and analysis is often progressive in that a second or subsequent interview in a series should be 'better' than the previous one. The interviewer may have gained insights from previous interviews which are used to improve the interview schedule and / or specific questions. Some have therefore argued that in qualitative approaches separate pilot studies are not necessary (Holloway, 1997). Piloting of qualitative approaches can be useful if *"the researcher lacks confidence or is a novice, particularly when using the interview technique"* (Holloway, 1997, pg. 121).

As I had not previously conducted qualitative research I decided to conduct a pilot study using two participants. I believed this would be enough to get a feel for conducting the interviews whilst also gaining some feedback on the questions. The main reason for conducting the pilot interviews was to test the interview schedule, primarily to determine if any of the questions were leading. At this point in the research process it was proving problematic to recruit for the main sample and in order not to utilise participants already waiting to take part, one pilot interview was conducted on a university peer and the other on an associate of a colleague. van Teijlingen, Rennie, Hundley and Graham (2001) suggest the steps used to pilot, include utilising a small group of volunteers who are as similar as possible to the target population. Both participants met at least of the three inclusion criteria. The first participant was over the age limit and the second had not been born in the UK but had lived in England for several years. This meant however there were some language barriers and she did not understand all of the questions.

Feedback from the interviews suggested questions were neither leading or suggestive. Additionally, the participants reported my interview style had allowed them to speak freely. Moreover, it was fed back that whilst I had been directive enough (i.e. not allowing participants to drift too far away from the original research topic), they had been able to speak about what was important to them. As a result I did not make any amendments to the interview schedule prior to interviewing the main sample, other than increasing the number of prompt questions. As a novice to IPA, I wanted to engage in the entire analytical process before conducting the main interviews. Both interviews were transcribed and analysed, however due to not meeting all the inclusion criteria, the analysis is not included in the write up of the study.

Conducting the interviews

Interviews were conducted at City University either in the library or a private study room. As a safety precaution, my co-researcher was given a schedule of the interview dates and times, and was contacted prior and after the interview took. Prior to the interview beginning, participants were asked to read an information sheet giving an outline of the study (Appendix F) and asked if there were any questions or concerns. Particular attention was paid to explaining confidentiality and the right to withdraw which will be discussed in more detail in the 'ethical considerations' section. A consent form (Appendix G) was then read and signed by the participants which included consent to the interview being recorded. Demographic information was also provided by participants at this point. This included information such as their age, occupation, which parent they viewed as having a problem with alcohol and the approximate length of time they had lived with this parent (Appendix H). A final opportunity was given for any questions prior to the interview commencing.

Each interview lasted approximately one hour. I referred to the schedule (Appendix E) covering the four main questions during the course of the interview. The schedule was flexible and further interesting lines of investigation were pursued according to the participants' responses. Following the interview, participants were debriefed verbally and a written debrief was also supplied (Appendix I). The debriefing process was significant for a number of reasons such as enabling me to receive some feedback on the interview process and to determine whether any psychological distress had been caused

to the participant either by a particular line of questioning or as a result of speaking about their parents drinking in general. This enabled participants to raise any questions and concerns. A resource list was incorporated in the written debrief including the contact details of a number of specialist organisations nationwide where participants could seek further support or information. In addition to exploring any possible causes of distress, the debriefing was also used as an opportunity to speak more openly about the study and what would be done with the interviews (i.e. analytic strategy, writing up of the thesis). Before ending, participants were reminded of their right to withdraw at any stage of the research process, and told that all personal details would be changed in order to protect their identity. The contact details of both my research supervisor and I were provided to participants in case of further questions and/or a request to withdraw.

Ethical Considerations

Ethical approval was obtained from City University prior to any contact or recruitment of participants. To ensure ethical practice throughout the study, the Code of Conduct, Ethical Principles and Guidelines for conducting research was followed (British Psychological Society, 2002). Cohen, Manion and Morrison (2000) suggest that *"Ethical concerns need to be addressed at the outset of the research process and acknowledged as it is undertaken. Professional codes exist to provide guidance, but the responsibility for upholding them must lie with the individual researcher"* (Cohen et al., 2000, pg. 49). Ethical considerations of informed consent, confidentiality and anonymity, and discomfort and harm were considered as was the use of monetary incentives for participation.

Informed consent

With regards to informed consent, it was explained to participants their participation was voluntary and they were able to withdraw their consent at any stage of the research process. It was made clear this included after the interview had taken place, and even when the data-collection phase was complete and analysis was underway. Moreover, it was explained that if this were to occur, all information would be deleted immediately. It was further explained that despite showing initial interest, participants were not obliged to take part, and a consent form would need to be completed before the interview took place.

The issue of consent came up numerous times throughout the entire research process. My original research idea had been to interview adolescents between 13 and 18 year olds. Discussing this in research supervision a number of pitfalls were identified such as requiring parental consent which had the potential to cause problems with the child and school teachers, especially if the parent did not acknowledge they had a drinking problem. Additionally, the children would have needed to be identified as COAs or COPDs by means of a standardised tool. This would have given rise to issues of confidentiality with teachers needing to intervene accordingly if any children were identified as having a PDP. Given the time frame for the study I decided to keep with interviewing adults over 18 whereby parental consent would not be required and moreover they did not need to disclose to their PDP that they were taking part if they did not wish to.

Confidentiality and anonymity

Before agreeing to take part in the study participants were told all information gathered would remain confidential within the research team (myself, my research supervisor and a co-researcher who would be assisting with the analysis). All names were changed to pseudonyms in order to protect the identity of the participants. Moreover, the participants' real names were not found anywhere other than on the consent forms, which were stored in a separate secured cabinet away from the other research materials. Any other personal or indentifying information used during the interview such as geographical locations were removed from the recording. So as not to disrupt the flow of the reading of the transcripts alternatives were implemented in the text. All relevant research materials were kept at home and securely locked. Participants were informed that when the study had been completed, all relevant documents would be destroyed. Finally, they were informed from the outset that the information they gave may later be published. I also adhered to the Data Protection Act 1998 at all times.

In order to remain sensitive to participants' anonymity following the interview I asked how they would like me to respond if I were to come into contact with them again (i.e. whether they would want me to acknowledge them or not). This was considered most relevant for the three participants recruited via academic settings in London where I had

known associates. As with the clients I work with in my clinical practice I was conscious a 'chance meeting' may cause third parties to question our relationship potentially causing confidentiality to be broken (i.e. the participant feeling the need to disclose to a friend they took part in the study, hence revealing they feel their parent uses alcohol problematically). During the interview, I was sure not to place any signs on the door which may suggest a research interview was taking place, and moreover I chose to interview participants in rooms where there was no window panel in order to prevent people seeing us together. Participants were not interviewed in the Psychology building with the majority taking place in the Main building or private study room in the library.

My reasons for this were to prevent my own peers in the department seeing me with participants, and possibly making the link they were involved in the study. My intention was again to protect their identity.

As mentioned earlier participants were instructed not to join the Facebook groups and to contact me directly for confidentiality reasons. By joining the group other users of the website would be made aware of the participant's association with the study. The decision was therefore left to each participant.

Discomfort and harm

Given the qualitative nature of the study, I did not foresee any physical harm nonetheless, I could not guarantee that no psychological distress would be caused given the sensitive nature of the research area. I anticipated however no more harm than that associated with any previous conversation concerning the participants' parent/s and their perceived drinking problem. Nevertheless, I was conscious that for some participants this may be the first time they were discussing their experiences of PPD and may have a negative emotional impact. With this in mind participants were told at the outset that they were not obliged to answer any question which they believed to be too invasive or personal. Additionally, they were told they could take a break and the interview could be terminated altogether at any time should they begin to feel distressed. None of the participants were visibly distressed during the interview. As mentioned earlier at the end of the interviews participants were given a verbal debriefing so as to determine whether any distress had been caused. A list of relevant

organisations and counselling services was also supplied (Appendix I), if they felt they needed further support or advice following their participation in the study.

Use of incentives

I debated for some time whether to offer participants an incentive for their time. I had some concerns participants may fabricate a story in order to receive a monetary reward. Offering participants money to be involved may cloud judgement on whether they really want to take part, for example if in debt. I wanted to be sure those who took part in the study were doing so because they felt they would gain something valuable from it, such as being heard and possibly finding a voice for a unique group of individuals. With this in mind no incentive was given but travel expenses were reimbursed.

Analytic strategy

IPA is not a prescriptive approach (Smith & Osborn, 2003); rather it provides a set of flexible guidelines which can be adapted by individual researchers in light of their research aims. This is particularly true when it comes to analysis (Smith & Eatough, 2003). Each transcript was examined in detail before moving on to examine the other interviews, case by case. This follows the idiographic approach to analysis, beginning with particular examples and slowly working up to more general categorisation or claims (Smith, Harre & van Langenhove, 1995). To illustrate the various stages of the analytic strategy I will provide the reader with excerpts from Haleema's interview.

Initial reading of the transcript

To commence the analytic procedure the recorded interviews were transcribed verbatim. I also chose to record pauses, laughter, sighs and changes in tone of voice on the transcripts. Following this, I read the transcripts a number of times so as to become familiar with the participant's account. In the left hand margin of the transcript, I noted down anything which I thought was of interest or significant regarding what the participant said. I did not follow any strict rules as to what I commented on and did not necessarily comment on each sentence. Some parts of the interview were richer than others and required more focus and attention. Summarising and paraphrasing of the

participant's account also occurred at this point. This process was conducted for the entire transcript.

Identifying and labelling themes

The next stage of the analysis involved returning to the transcript and using the notes which had previously been made in the left hand margin to create themes. I noted the themes in the right hand margin which were more succinct phrases or theoretical concepts of what I had previously written in the left hand margin. On the occasions where similar themes emerged throughout the transcript, I utilised the same theme title or phrase. Although themes often entail using more psychological terminology, the link back to what the participant first said, and the researcher's initial notes should be evident. At this stage the emerging themes were not necessarily the final product. As the analysis progressed some themes changed and/or were adapted. Smith and Osborn (2003) reflect that at this stage, the entire transcript should still be thought of as data and no attempt should be made for omitting or selecting particular passages for attention. An excerpt from Haleema's annotated transcript can be found in Appendix J.

Clustering of themes & producing a summary table

The next stage of the analysis entailed listing the emergent separately on a sheet of paper in chronological order (i.e. in the sequence they appeared in the transcript). An excerpt of Haleema's list is found in Table 2.

Facing reality
No way out
Acceptance
Respect or fear?
Roles, respect
Need for control
Superiority
Female underdog

Table 2: List of themes

I then attempted to look for connections in the list by grouping together the themes which were similar. This involves a more theoretical and analytical ordering, as the researcher attempts to make sense of these connections between the themes. Smith and Osborn (2003) express this form of analysis as iterative as it involves a close interaction between the researcher and the text. As the clustering of themes emerged I returned to the original transcript to ensure that the interpretations made could be linked back to the participant's account. This not only develops the skill to understand what the participant was saying but also the skills of one's own interpretations forming some cohesion and order (Smith, Jarman & Osborn,1999).

At the end of the analysis a summary table of the themes was produced. The above step produced certain superordinate themes which captured most strongly a participant's views and concerns regarding the research topic, such as 'parent child / relationships' or 'coping mechanisms'. Further sub-themes also emerged from the data including, 'view of a drinking parent' which referred to how participants such as Haleema perceived their PDP, i.e. as 'distant'. Care was given at this stage to ensure each theme had representation from the verbatim transcript and had not been distorted by any researcher bias in the selection process (Smith et al., 1999). At this point, certain themes were dropped which did not fit into the structure of superordinate themes or sub themes, or if they are not well represented within the transcript. Throughout the analytic process the themes were discussed with my co-researcher. An excerpt from Haleema's summary table is found below in table 3 (please refer to Appendix K for the complete table). It indicates the themes which emerged from the data, the relevant quote and its location in the transcript.

Theme	Quote	Location (pg. no, line no.)
Parent / Child Relationships		
View of drinking parent	*He's just there as a picture but not actually close like, yeah not mentally and physically really*	7, 22
Protective Relationships	*She tried to like protect us like kind of blind us from what he was doing*	10, 12
Coping Mechanisms		
Avoidance and escapism	*He comes home sometimes and I see him there I just turn off the light go upstairs cos I don't want to see his face like like that*	3, 18
Trying to make sense of parental problem drinking	*He sees alcohol as like his way out, like to escape from like the pressures of work and family and everything*	8, 21

Table 3: Excerpt of summary table

Master table of themes for the group of participants

As mentioned earlier the same process was repeated for each participant. I was conscious of not being influenced by the previous interview and the themes which had emerged and would therefore take a break between analysing each transcript. The final stage of the analysis involved integration of the seven cases. To begin this process, I laid out the summary tables from each of the seven participants on the floor in front of me. Following this I began looking for patterns across the tables. Master themes were chosen through the frequency of their occurrence across cases. Throughout the process some themes were re-labelled where appropriate. The process continued until I felt the participants' accounts had been captured and the important themes had been presented to the best of my ability. These were then integrated into a table of master themes and sub-themes (Appendix N). A frequency table illustrating the number of times a theme occurred across the participants can be found in Appendix O.

Validity

Evaluating the validity of research involves making a judgement about how well the research has been carried out and whether the findings can be regarded as trustworthy and useful (Yardley, 2008). The concept of validity is described by a wide range of terms in qualitative studies. This concept is not a single, fixed or universal concept, but *"rather a contingent construct, inescapably grounded in the processes and intentions of particular research methodologies and projects"* (Winter, 2000, p.1). Although some qualitative researchers have argued that the term validity is not applicable to qualitative research, at the same time they have realised the need for some qualifying check or measure for their research. Creswell and Miller (2000) for example, suggest that the validity is affected by the researcher's perception of validity in the study and their epistemological standpoint. As a result many researchers have developed their own concepts of validity and have generated or adopted what they consider to be more appropriate terms, such as quality, rigor and trustworthiness (Davies & Dodd, 2002; Mishler, 2000; Stenbacka, 2001).

Triangulation

Triangulation is typically a strategy for improving the validity of research or evaluation of findings. It can be defined as *"a validity procedure where researchers search for convergence among multiple and different sources of information to form themes or categorises in a study"* (Creswell & Miller, 2000, p.126). Healy and Perry (2000) explicate judging validity and reliability within the realism paradigm which relies on multiple perceptions about a single reality. They argue the involvement of triangulation of several data sources and their interpretations with those multiple perceptions in the realism paradigm. After analysing the transcripts myself, I discussed emerging themes with the research team who had also read the transcripts. Such discussions were used to help identify themes in the data which I may have not extracted, or perhaps missed during my analysis. It allowed me to increase consistency and coherence of emerging themes.

Disconfirming case analysis

It is also helpful to seek 'disconfirming instances' or 'negative cases' once a set of themes and patterns has been identified. It involves searching for data which does not fit the themes or patterns which have been identified (Pope & Mays, 1995). By reporting disconfirming cases, it will show the reader that I have taken into account all the data. Disconfirming cases can provide an indication of the limits of the generalisability of the analysis and may suggest further research for example, if two of my seven participants suggest very different experiences it will be important to investigate further into why that was.

Paper trail

A paper trail of the analysis was also kept (Flick, 1998; Smith & Osborn, 2003). This allows for all stages of the analysis to be re-traced if required, such as the development of themes and interpretations of any notes taken.

Reflexive statement

A reflective diary was kept throughout the research process. In this section I summarise some of my reflections relating to the methodological issues encountered and the process of conducting the interviews. Defining the sample and recruiting participants was challenging. As a novice to IPA, the idea of a homogenous sample was difficult to grasp. I became overly concerned about whether the inclusion criteria meant my sample was *'homogenous enough'*. Additionally, like previous researchers in the field, I found myself struggling with terminology and definitions about alcoholism and PD and in my attempt not to repeat the same methodological errors, it took some time to define the sample.

I wanted the definition to be broad so it would apply to more people, yet at the same time I did not know if by using a broader meaning I would be moving away from a homogenous sample. I was, nonetheless, uncomfortable with using a term such as alcoholic, and how I would define that on the recruitment advertisement. I felt by doing so, I might be neglecting people who wanted to speak about their experiences of PPD

but because their parent/s were not deemed to be an alcoholic either by the child or society (e.g. health statistics, or DSM-IV category) they would not have been eligible to take part. Would this mean I was leaving a unique group of people *'unheard*?': A group who knew their parent's use of alcohol was problematic, but they themselves did not know how to categorise or label it. Discussing this with my research supervisor I came to realise that defining the parents' alcohol problem was irrelevant, as my interest lied in the participants' experiences and their perception of the drinking problem. It was at this time I decided to drop all labels and descriptions and opened the study to those who *'view'* their parents as having a problem with alcohol.

I was slightly ambivalent prior to interviewing participants for the main sample following two different pilot interviews. The first had felt very comfortable and the participant was extremely articulate, elaborating on her answers and required minimal prompting. The second was somewhat difficult and the participant's answers were relatively short and required far more prompting. As previously mentioned the participant, the participant had not been born in England and thus did not always understand the questions. Given these different experiences, I was unsure how the main sample interviews would unfold. Furthermore, I had some concerns that participants may get upset, and my falling into the 'therapist role'. My research supervisor and I discussed the importance of boundaries and that the verbal debrief and the resource list would be extremely important.

As discussed in the ethical considerations earlier, I did not offer a monetary incentive for participation. I debated this for some time. On the one hand, I considered it might encourage more participants to take part in the study nevertheless, on the other side, I speculated some people may not take the interview as seriously if they are being paid. My slightly cautious mind set has possibly been influenced by many years in academic settings, whereby some students would participate in studies purely *"for the money"* or vouchers and had little interest in the study. I wanted to interview people who were genuinely interested in the study and who felt they had something valuable to contribute. Anyone who was willing to meet for an hour to speak about PPD, without getting paid, would surely think it was a worthwhile study to participate in.

I found each interview both moving and inspiring. Despite troubled lives, the participants were trying to find a way to deal with their past and present, and the complex relationship with their PDP. The majority of participants repeatedly thanked me for carrying out the study and were grateful of the opportunity to share their experiences. After interviewing all seven participants, I did question whether I should have given greater consideration to gender and whether a male participant would have preferred to be interviewed by a male researcher. As it was the first time I was conducting such an extensive piece of research, I wanted to be actively involved in every stage of the process and therefore chose to conduct each interview myself.

Chapter Three: Analysis of Data

Five master themes emerged from the data, each comprising of interrelated subthemes. The narrative account which follows contains relevant extracts in the participants' own words which will not only enable the reader to assess the pertinence of my interpretations, but also retain the voice of each participant's personal experience. Throughout the chapter, I will make reference to relevant literature in the field which echoes the participants' experiences.

Master Themes	**Sub- Themes**
1. Parent / Child Relationships	**1.1 View of problem drinking parent** *1.1.1 A distant Parent: "He's just there as a picture"* *1.1.2 Like a child: Out of control* *1.1.3 A hypocritical figure* **1.2 Mixed emotions** **1.3 Protective relationships**
2. Communication Problems	**2.1 The barriers** **2.2 The rejection & giving up**
3. Coping Mechanisms	**3.1 Avoidance & Escapism** *3.1.1 Creating a fantasy life: "Not really being fully engaged in reality"* *3.1.2 Withdrawing physically or emotionally from the drinking parent* **3.2 Acceptance or giving up?** **3.3 Trying to make sense of parental drinking** **3.4 Keeping it a family secret**
4. The Road to Recovery	**4.1 Labelling the problem & seeking support** **4.2 Self-preservation: Keeping a safe distance**
5. Impact on the Self	**5.1 Impact as a child: Being 'different'** **5.2. The adult child: Who have I become?** 5.2.1 Life choices: to drink or not to drink?

Table 4: Master table of themes and sub-themes

Master Theme One: Parent / Child Relationships

This section focuses on participants' experiences of their relationships with both their problem drinking parent (PDP) and their non-drinking parent, and the various dynamics within those relationships. Participants expressed difficulties in the relationship with their PDP both when the parent was actively drinking and sober. Moreover, for those whose PDP had been in recovery for some years, participants continued to struggle with the relationship with their parent. Over time, participants had developed a particular view of their PDP, perceiving them in a certain way. As a result of the complicated dynamics within the relationship, participants experienced and expressed mixed emotions towards their PDP. Participants often presented one emotion (e.g. anger), but were clearly struggling with another underlying emotion. For the majority of the participants this was fear. The relationship with the participants' non-drinking parent was also extremely important with the main focus being on the protection they felt towards this parent.

Subtheme 1.1. View of problem drinking parent

As mentioned in chapter one, parental drinking style has been considered as a variable which may account for some within group differences for ACOAs (Johnson & Rolf, 1990). Lease (2002) discusses that alcoholics will behave differently during the drinking period. They may for example, be violent and abusive. In some families the alcoholic may withdraw emotionally and physically, thus being 'unavailable' to the family. Participants' accounts suggested their place in the latter category with the parent being perceived as 'distant', 'emotionally unavailable' or 'physically absent' from the family.

1.1.1. A distant parent: "He's just there as a picture"

Participants' accounts created a 'picture' of a parent with two sides. Other than when the drinking was most severe, the PDP was presented as being 'functional' - meaning they were able to go to work and provide for the family. Participants never went 'without' and their basic needs were met. On the other side however, participants viewed their parent as serving no other role in the family; they were merely a physical

presence in the home and normally disengaged. The PDP was typically described as showing little interest in the participants' schooling, friends or life in general. Matt, for example, often referred to the relationship with his father as *"matey"* rather than father and son. The word *"matey"* in itself illustrated the distance between them. Following the death of Matt's mother, his father raised the children alone. This had been a struggle and he was unable to engage emotionally with any of the children. He was nonetheless *"functionally"* there for the family and acted as a financial provider.

> *Matt: He was functionally there for us but not really engaging.*

This view of the PDP being unavailable was displayed for some participants such as Haleema and Aisha, in their PDP's absence from the home. Both the participants' fathers spent their time drinking away from home, typically with their own families (i.e. siblings) which was described as a *"cultural norm"*. Furthermore, even when the PDP was home they spent little, if any, time engaging with the family. Haleema's account below provides a powerful image of her father as merely a *"picture"* in her mind. This is an extremely detached image and demonstrated the distance between father and daughter. A picture not only illustrates a lack of physical presence but also emotion. Additionally, the secrecy within the family about the PD and the idea of the family being 'picture perfect' to the outside world also came to mind. It was nonetheless a facade and a far cry from reality.

> *Haleema: He's just there as a picture but not actually close like, yeah not mentally and physically really.*

In the extract that follows, Aisha also presents an extremely diminished relationship with her father. There is a sense of her simply acknowledging him as her biological father, and a financial provider but nothing else. When Aisha says *"it's going to sound bad"* I wondered if this reflected a conflict within herself and her feelings towards her father. She did not want to sound cruel, and possibly experienced some guilt speaking about her father in this way. Given her strong cultural background it may have been considered disrespectful to speak of her father in this way, given the superiority males receive in some cultures. The phrase *"how I see it"* also illustrated a re-occurring issue in her family, whereby Aisha often viewed things differently to other family members.

She could almost be considered the 'rebel' in the family – wanting to fight against her culture and the traditions, and wanting her parents to separate so they could be free from her father's drinking. Aisha's mother did not like her speaking badly of her father, and Aisha was often careful what she said about him. In the interview however, Aisha could speak freely about how she viewed her father.

> *Aisha: Fair enough he is still my dad but how I see it he is just there like to... I'm probably going to sound really bad but to provide money.*

A further illustration of a PDP being unavailable came from David who appeared to question his father's presence in the family. The phrases *"I'm not even sure"* and *"I'm not quite sure"* illustrated his uncertainty and confusion as to his father's role in the family. His father's disengagement meant he eventually went unnoticed in the family resulting in being merely a physical presence.

> *David: I'm not even really sure where dad was throughout all of this. I know he was there, but I'm not quite sure what…what…what he…what role [[3]?] he.*

The participants' accounts appeared to lack emotion. As they spoke of their PDP's distance and unavailability, they did not appear overly upset or angry. Moreover, they looked and sounded indifferent. Rachel was the only participant to openly and strongly articulate anger towards her PDP. Whilst this lack of expressed emotion was initially interpreted as resulting from the length of time their parents had been drinking problematically and subsequently the breakdown of the relationship, it is possible the participants were dissociating.

Originally formulated as a discontinuity in awareness in Pierre Janet's psychopathogical theory, dissociation is generally conceptualised as a protective response to severe trauma. These include psychological ill treatment, violence or sexual abuse. It serves as a defence mechanism against overwhelming pain, fear, feelings of hopelessness and anger (Sheiman, 1999). For the youngest participants (Aisha and Haleema), the living situation was particularly hopeless given their inability to leave the family home until

[3] A (?) has been placed in the text where the recording was unclear.

they were married. They felt somewhat trapped. By dissociating, they were better able to cope with living at home. Aisha was the only participant to disclose an incident of physical violence by her father, which may have caused her to dissociate further. Furthermore, Aisha admitted suppressing her anger so as not to upset her mother. By distancing herself from the emotions she felt towards her father, she could continue living with him and this served as not disrupting the family environment any further.

Anger is considered a basic emotion, often connected with fear; it can be expressed outwardly, inwardly, held in or controlled and resolved (Parker, 1998). Expressed anger may lead to interpersonal, occupational and family conflicts, negative evaluations by others, negative self concept and low self-esteem (Kassinove, 1995). The experience of anger is salient in female development and there are social pressures toward the assumption of traditional sex role coping strategies (Cox, Stabb, & Bruckner, 1999). In certain social-cultural contexts, anger in females has been, and continues to be especially threatening for gender self-image (Thomas, 1991). Aisha and Haleema may have been more resistant to expressing their anger as a result of their cultural background. This inability therefore to express themselves may have caused them to dissociate.

Trauma is however not the only cause of dissociation and moreover the development of dissociation in the context of trauma may be buffered by familial environmental factors, such as supportive family relationships. The majority of participants referred to at least one stable adult being involved in their lives. Recent research has revealed a number of family environmental factors significantly associated with dissociation such as lack of parental care and warmth (Modestin, Lotscher & Thomas, 2002), inconsistent discipline (Mann & Sanders, 1994), parental control (Modestin et al., 2002) and poor relationship between parents (Maaranen, Tanskanen, Haatainen, Koivumaa-Honkanen, Hintikka & Viinamaki, 2004). These factors are extremely relevant to the majority of participants who felt their parents were not available to them, and moreover had little attachment to the PDP. Developmental researchers have began to explore the role of early childhood attachment and parenting in the development of dissociation. Considering attachment style in terms of a bipartite typology (secure vs insecure pattern) several studies have

reported a strong connection between insecure attachment and pathological dissociation (Liotti, 2006).

1.1.2. Like a child: Out of control

Participants' accounts created an image of their PDP acting childlike and being 'out of control' whilst under the influence of alcohol. Moreover, their parent was described as being unable to control their actions and needing looking after a certain amount of alcohol. The roles in the family sometimes reversed with participants acting and feeling like the parent. This has been cited in the literature as a common issue in PD families. Most recently, Backett-Milburn et al. (2008) reported their participants often had to look after their parents. In the present study, this sense of being 'out of control' triggered a number of strong emotions for participants. Haleema for example, sounded frustrated at her father's inability to control himself. She spoke of him being the *"adult"* and how he should know better. In the extract which follows, Haleema questioned what kind of example her father was giving to Haleema and her siblings. Although Haleema rarely spoke of her father's behavior when sober, he clearly turned into a person she neither respected nor admired when he was drunk. Haleema seemed to be expressing her inner thoughts, questioning *"can't he take control of himself"* and appeared to struggle with his behaviour *"he should know when to stop"*.

> *Haleema: I would kind of think can't he take control of himself because he should know his limits, he should know when to stop like instead of being like this other person, what kind of example is that for us?*

In the extracts to follow, both Haleema and Aisha respectively discuss experiences whereby their fathers' drinking was so excessive it became extremely unpleasant.

> *Haleema: I remember erm he was throwing up at one point and everything and my uncle had to take care of him and it wasn't pleasant for me or my sister.*

> *Aisha: He has his good points when he's mildly drunk but when he gets really really drunk he doesn't know where the bathroom is, wherever he is he'll do what he has to and obviously if he has drunk too much and he wants to like*

vomit it out he can't get to the bathroom cos he's got no sense of what's going on.

Haleema looked sickened as she spoke about her father's behaviour and he was portrayed as a child who needed looking after. The phrase *"it wasn't pleasant"* nonetheless did not feel strong enough. Moreover, it was considered extremely incongruent with her tone and facial expression. There was some ambivalence in Aisha's accounts of her father's drinking behaviour. When he was mildly drunk for example, she could almost manipulate the situation to her advantage, such as asking him for more money. Conversely, at its worse, and when he was completely out of control, it was highly unpleasant and almost repulsive for her. Aisha's account triggered an image of a teenager who *"didn't know their limits"*. They would get carried away and drink to the point of being physically sick and, similarly to her father, have *"no sense of what's going on"*.

1.1.3. A hypocritical figure

Several studies have identified and clarified some of the basic 'rules' operating in an alcoholic home. Ruben (2001) for example, presented one rule as 'Do what I say, not as I do'. Many parents who have problems with alcohol urge their children not to engage in similar behaviour. Unfortunately, the modelling behaviour of the parent is a very strong learning tool and many times children do follow some behavioural patterns of their parents. A number of participants described their PDP as a *"hypocrite"* or someone with *"double standards"*. Both Haleema and Aisha in particular felt strongly about their fathers behaving in a hypocritical manner especially in relation to the participants' own drinking habits. The repetitive questioning in Haleema's extract below - *"do you drink do you drink?"* felt overwhelming. Haleema's father was portrayed as having a strong presence in the family with his daughters abiding by his rules. Although he was viewed as a hypocrite, they feared him.

Haleema: He just always asks that question like do you drink do you drink? cos he doesn't like the idea of us drinking.

Similarly, Aisha refers to her father's questioning of her eldest sibling's drinking habits. She spoke in a humorous and sarcastic manner, finding it almost laughable her father

would question his daughter's drinking habits. Aisha sounded very unimpressed as she said "*he can just sit there and drink*". It conjured up an image of her father sitting on the sofa drinking much of the time. Additionally, Aisha sounded frustrated when she said "*practically allowed to be living out*". This was considered to be a reference to the cultural restrictions she was abiding by, such as not leaving home before getting married and not being allowed to drink:

> *I just find it really ironic that he can just sit there and drink as much as you want yet someone who is 26 years old who is practically allowed to be living out not with the family anymore isn't allowed to drink*

And later in the interview:

> *I think the funny thing is that when he finds a bottle in her room he questions her why have you got a bottle in your room*

Subtheme 1.2. Mixed emotions

This sub-theme concentrates on the many emotions experienced by participants such as embarrassment/shame, fear and anger. The complexity of these emotions came through the participants' accounts in a way that the named emotion often masked another underlying emotion towards their PDP. The emotional responses captured in the participants' dialogue related solely to the occasions where their parents were drinking. Moreover, the experiences shared in the interview were from when participants' were young children or during adolescence. In his paper on treatment issues with ACOAs, Ryan (1991) discusses a sense of public humiliation for the child to be seen with the drinking parent and a sense of self-shame that one might be ridiculed through one's identification with the parent. The following extracts by Aisha and David highlight the embarrassment endured when their parent's drinking occurred in front of other people and there was no control over the parents' behaviour.

> *Aisha: He was causing such a scene in my road when he was only like, only wearing the shorts and like having an argument and people I know are seeing that and it was really embarrassing trying to get him indoors to get him indoors*

so people can't see cos once they know what's going on in your family it's not something to be proud of.

David: I remember once we had the neighbours coming…a neighbour came, and said, I'm terribly sorry, but your dad's in the road, he's drunk.

Aisha sounded almost desperate as she repeatedly reported her attempts*"to get him indoors to get him indoors"*. Whilst the situation was clearly embarrassing, she also sounded afraid – afraid of what people might think and say about the family. This was further highlighted by her suggestion *"it's not something to be proud of"*. Fear and shame of the family secret being 'found out' has been reported as a frequently occurring concern amongst COAs (Ryan, 1991). Ruben (2001) discussed how children may 'limit communications' with others outside the home in order to maintain the family secrets. When her father was indoors, the secret could be maintained, but when her father was roaming around the street the scandal could be revealed for all to see. This was also true for David's account for whom when his father was passed out on the sofa, the secret was contained behind closed doors however when his father was stumbling around on the street in the neighbours' view, the secret was revealed causing immense embarrassment.

Whilst embarrassment and shame are interlinked, Rachael's extract expressed embarrassment on a deeper level with her openly admitting she did not want her mother as a parent because she felt so ashamed. Rachael's repetitive use of the word *"embarrassed"* indicated the severity of her feelings. Additionally, the words *"totally"* and *"utterly"* also emphasised the enormity of her feelings. There was a desire or wish to have a different mother so that she would not have to contend with such behaviour.

Rachael: Totally embarrassed, totally and utterly embarrassed and then just shameful like you don't want her to be your mother, you are just embarrassed you know there is no other way to describe it.

In the extract which follows, Rachael clearly indicates the complexity of emotions felt towards a PDP and is based on a reflection of her time in therapy. Rachael felt the complex nature of her emotions towards her mother needed to be addressed in order for her to recover. There were points in Rachael's life where her mother's drinking was

extremely severe, drinking for the duration of the day. Rachael openly expressed her anger towards her mother, nonetheless she acknowledged the complexity of this emotion as it led to feelings of guilt. It became a vicious cycle.

> *Rachael: She had a problem and she couldn't help herself and you would be so angry and hating her, and then you would feel so guilty for feeling angry, and then you'd get angry again.*

Richard had lived away at University, meaning he was away from the family environment for long periods of time. When they had not met for some months his father's drinking was far more prominent. Richard spoke of being *"quite embarrassed"* by his father's behaviour because people would stare at them wondering what was going on.

> *Richard: And, um, so I recently I've been quite embarrassed about that sort of thing. It's, it, it's not, ah, and, and he's started singing loudly in pubs and that sort of thing. And I could see teenage kids looking and thinking, oh my God, what's going on there?*

Towards the end of her interview, Aisha disclosed Social Services had been involved with the family when she was much younger. It was at this point she recounted a serious incident when her father attempted to physically harm her. It became much clearer she was afraid of him and why she reported hating him on many occasions. The fear was combined with immense feelings of anger.

> *Aisha: There was a cup of coffee on the table and he he was about to throw it on me and got obviously I got angry and I got scared so I went off to my room ...he was knocking on the door and saying "open the door now" and I wouldn't open it and he was like "you better open the door now listen to me ok", so I open the door and he kind of pushed me and nearly strangled me.*

Anger is often presented as a primary emotion and it was interesting Aisha acknowledged her anger before her fear in the extract above. It is possibly easier for people to admit to being angry over being afraid. As she recounted the incident there was a sense of resignation in Aisha's voice. It was as though she had been placed in a

'no-win' situation and was trapped. Whether she opened the door in that instance or later, the result was going to be the same with Aisha at risk of being harmed by her father.

Subtheme 1.3. Protective relationships

The participants' relationship with their non-drinking parent was equally important. Apart from Richard, who experienced PPD on behalf of his father and step-mother, the remaining participants had a non-drinking parent whilst they were growing up who they considered to be a stable figure, hence serving as a protective factor. Velleman and Templeton (2007) suggest that a close positive bond with at least one adult in a caring role (for example, older siblings or grandparents), can promote resilience in offspring of problem drinkers. This sub-theme had three variations. Firstly, and of most significance, was the participants' protection of their non-drinking parent. Aisha for example, speaks of not wanting to discuss her father's alcohol use with her mother in order to protect her mother's feelings. Aisha described it being *"painful"* for her mother and there was a sense of putting her mother's needs first, leaving Aisha unable to express her feelings.

> *Aisha: I try not to talk about it too much cos obviously it's painful for her to like talk about the whole drinking problem.*

There is another layer of protection in terms of protecting the non-drinking parent's well being (emotional and physical) by not leaving them alone with the PDP. Both Haleema and Aisha for example, remained at home despite being old enough to live out at University (both had chosen to remain at home for the duration of their undergraduate degree). There appeared to be an underlying fear of what would happen if they were no longer living in the family home, *"knowing what he is like"* suggested a lack of trust in her father as to how he would treat her mother if Aisha left. There was a sense of the participants feeling responsible for their non-drinking parent and wanting to look after them. In Haleema's extract below, she says her mother will have to deal with her father for *"the rest of her life"*. There was a sense of Haleema feeling both sad and possibly guilty that whilst she may eventually be freed from the situation (when she gets married), her mother will be trapped in the situation forever. Haleema therefore wanted to look after her mother until the time came for her to leave home and start her own family.

Aisha: Knowing what he is like at home I didn't want to leave my mum like that so that's why I haven't moved out.

Haleema: I think even sometimes when I'm older and my sister and I will move out of the house and it will just be my mum and my dad and we feel sorry for my mum who will have to deal with it basically for the rest of her life.

Backett-Milburn et al. (2008) discuss how the reactions of siblings to their parents' alcohol use will be different. Whilst Aisha's siblings were still living at home, the eldest daughters no longer paid attention to their father's drinking behaviour and did not spend much time at home (they were both in full time employment). Drawing on siblings' experiences illustrates the double-edged nature of potentially resilient practices, as for some, it evidently entails severing ties and leaving people behind, something some children are unwilling to do Backett-Milburn et al. (2008). In the following extract by Aisha there was again a sense of guilt around leaving the mother alone. Her sisters had made their own decisions as to how to deal with their father's drinking and it felt as though Aisha would be abandoning her mother if she did the same. Haleema's account also suggested a sense of feeling indebted to her mother. As an adult, Haleema felt she should pay her mother back for looking after her as a child hence staying at home until she gets married. Additionally, an important cultural difference may have influenced Haleema and Aisha's reasons for staying at home. They were both Asian, and it is extremely common even in today's times for the children to remain in the family home until they are ready to get married.

Aisha: I don't want to leave my mum to deal with it all alone, my sisters have obviously done what they want to do and like I don't want to leave my mum like that.

Haleema: Yeah I think it's just like say my mum protected us when she was younger so I think that we should do the same, it's not right, I've seen how my dad is with us and I don't want her having to deal with that on her own.

A second form of protection related to participants' experiences of protecting their PDP's reputation from others. Haleema's accounts suggest despite her feelings about

her father's drinking, she still respects him. There was a strong cultural aspect in both Haleema's and Aisha's families with males always being viewed as more superior than females. There was therefore an immense amount of respect for the father because he was the 'head of the house'. Haleema seemed torn between her feelings of upset and anger towards her father and her cultural values. Another possibility could be that Haleema chose not to discuss her father's drinking in order to keep the problem secret within the family which, as mentioned previously, is very common amongst family members of problem drinkers (Ruben, 2001; Orford, Natera, Copello, Atkinson, Mora, et al., 2005).

> *Haleema: I wouldn't want them thinking bad of my dad like he just drinks and that's all he does I wouldn't want to disrespect.*

And later:

> *Haleema: I still have respect for my dad and I wouldn't want him thinking, I don't want them thinking badly of him.*

Finally, participants' experiences of being protected by their non-drinking parent was prevalent amongst their interviews. Use of the phrase *"blind us"* by Haleema was an extremely powerful image of the children being 'kept in the dark' and illustrated the extent to which Haleema's mother went to keep her husband's drinking and associated behaviour hidden from the children. When Haleema again made reference to her father behaving like a *"boy"*, an image was created of a teenager 'coming and going' from the house, not saying where he was going or when he would be back. There was a complete lack of consideration for anyone else in the house.

Haleema: She tried to like protect us like kind of blind us from what he was doing like just coming in and leaving and going out and doing what he wanted like he was a little boy.

David speaks with almost a sense of admiration for his mother's ability to protect him and his siblings from the truth. His mother had clearly been successful in keeping their father's drinking away from the children for quite some years.

> *David: I don't think even… I mean, my mum did such a remarkable job, I think, of somehow, you know, keeping us away from his problem, I'm not really sure how she did it.*

And later:

> *David: Um, but I think his problem had been longer than I'd been aware of it. Um, my mother had been determined that she would somehow protect me and my two sisters from awareness of his problem until we were old enough to understand, ah (?), for ourselves.*

In his paper Ryan (1991) discusses how the non-drinking parent is often 'idealised'. This was because they were so deprived by their relationship with their PDP. Ryan (1991) found that his clients often used phrases such as *"she was always there for us"* and *"we are really close"*. It felt this was the case to some extent in the participants' accounts. There appeared to be an immense amount of gratitude and admiration to their non-drinking parent.

Master Theme Two: Communication Problems

Participants' accounts indicated family communication is an exceptionally important variable influenced by PPD. Participants' attempts to communicate with their PDP took two forms: directly challenging their parents' drinking behaviour; and in an attempt to bond with their PDP and improve the current parent/child relationship. The participants' focus was very much on their parent's response or lack of response, to their attempts to communicate, and the impact this had on their feelings. Two sub-themes emerged from the participants' accounts namely, 'the barriers' and 'rejection and giving up'. Participants shared experiences whereby attempts to challenge their parent's drinking behaviour had been futile because the PDP put up a barrier. The majority of participants described their PDP not wanting to discuss the problem or did not believe they had a drinking problem. The second sub-theme related to a feeling of 'rejection' by the parent when participants made attempts to communicate. Additionally, such attempts were often one-sided, with participants approaching their PDP. Nevertheless, there would finally come a point whereby participants reported giving up trying to communicate with their PDP, and were immensely frustrated.

Subtheme 2.1. The barriers

Black (1982) suggested in alcoholic families, children are instructed not to talk about anything that might upset the alcoholic parent/s). Children's attempts to communicate are occasionally actively punished and parents use communication to control the child. This was most apparent in Haleema and Aisha's extracts respectively. Whilst attempts were still made to challenge their respective father's drinking, there was an underlying fear of doing so. The 'barrier' was therefore two-fold. Firstly, the father's behaviour whilst drunk provided a barrier between parent and child because there was a fear of what might happen if they challenged their PDP. Secondly, there was the actual denial expressed by the PDP that there was a problem to be discussed.

As previously mentioned in subtheme 1.3, there was a strong cultural influence in both Haleema and Aisha's interviews with the 'male' being superior in the family. Moreover, there was a cultural fear of confronting the male head of the house and they were not to be disrespected in any way. In the extract below, Haleema speaks of how her father saw their challenges to his drinking behaviour as disrespectful. It was noted how she also says *"like generally he doesn't like talking to us"*. This indicated a deeper communication problem in the family possibly unrelated to the drinking. Whilst Haleema did not disclose any violence in the family, she frequently discussed her father *"getting angry"*. Similarly, Aisha discussed her father getting *"angry"* and *"defensive"* and not discussing the issue. She repeatedly states they *"tried"* to discuss the problem with her father but with no success. This was further emphasised with Aisha saying *"when he's sober when he's drunk"*, it appeared to make no difference.

> *Haleema: He just puts up a barrier and he doesn't like talking about it, like generally he doesn't like talking to us like even still when talking about his drinking or behaviour he just sees us as like disrespecting him so he doesn't like talking about it.*
>
> *Aisha: We've tried talking to him before plenty of times and it hasn't worked when he's sober when he's drunk and when we do try and tell him when he is actually like obviously once he's drunk a bit and we do try telling him he gets angry, he gets really defensive*

Rangarajan and Kelly (2006) found paternal alcoholism to be more disruptive than maternal alcoholism, therefore influencing family communication patterns. This is possibly because male problem drinkers are more likely than females problem drinkers to display an angry/violent drinking pattern. A pattern which Lease (2002) found to be associated with a dysfunctional family environment. As previously mentioned in subtheme 1.2 'mixed emotions', Aisha did disclose her father had been physically abusive towards her which therefore influenced the extent to which she confronted him about his drinking.

Further extracts illustrated the PDP's lack of engagement in conversation with their children if approached about their drinking habits. Rachael reports how her mother out rightly refused to discuss her drinking and Matt also struggled to communicate with his father who would dismiss the idea there was an issue altogether.

> *Rachael: She would black it out erm the next day if you tried to approach the subject she wouldn't talk about it, there was absolutely no communication.*

> *Matt: He's dismissive. He hasn't even acknowledged that it is an issue. You, you can't argue or debate something with someone, if they don't think there's a debate to be had.*

In Matt's case there was a sense of him being 'geared up' for an argument. This never prevailed because his father would not acknowledge his drinking as being problematic. There was a sense of helplessness and frustration in both their extracts. With neither parent willing to engage in conversation there was little else either participant could do.

Subtheme 2.2. The rejection and giving up

As previously mentioned, this sub-theme relates to participants' attempts to communicate and bond with the PDP being rejected, thus causing them to give up trying altogether. As Haleema speaks in the following extract below, there is a strong sense of her being completely ignored. The conversation is initiated by Haleema with absolutely no response from her father, as though she was speaking 'to a brick wall'. She spoke very softly and bowed her head indicating her sadness. Later in the interview Haleema

spoke of still wanting to have *"better communication"* with her father and how she believed this would strengthen their relationship.

> *Haleema: He doesn't talk to me like if I start having a conversation with him he just pretend like he couldn't hear me and wouldn't answer back.*

Aisha similarly refers to her efforts to communicate with her father, again with no response. Both participants were being totally ignored. This was particularly moving especially when the children were seen to be making the effort. There was a feeling of the participants being *"parentified"* (Bancroft et al., 2004, pg. 124), meaning the children behaving more like the parent. It is common for roles to reverse in PD families. One might assume the parent would approach the child to communicate, however, it was extremely common in the participants' accounts for this to be in the reverse. There was a real sense of a struggle to communicate in Aisha's account *"really awkward conversation"*. It created an image of two strangers not knowing what to say to one another. Whilst one tries to make conversation the other responds monosyllabically or not at all.

> *Aisha: It would just be really awkward conversation and like I'm trying to make an effort yet there's no response back.*

There came a point in the participants' accounts where they had simply had enough of trying and had now 'given up' both in terms of addressing the alcohol issue with the PDP and trying to build on the relationship. When Aisha says *"he just wouldn't listen"*, it indicated her attempts had been futile and there was no point trying any longer. Both Haleema and Aisha sounded frustrated by the situation, however where the participants differed, was that some still desired to have better communication, whereas Aisha in particular gave the impression of no longer caring. Her tone of voice and look of disinterest indicated the relationship with her father could not be saved. Jones and Hotus (1992) reported PPD was related to negative family communication characteristics such as less positive regard and less expression of feelings.

> *Haleema: He just won't respond back to me and then some days he does that with my sister as well and we've both just given up trying to make an effort with him because it just doesn't go anywhere.*

Aisha: We've all tried on numerous times to try and talk to him you have an alcohol problem you have to stop drinking but he just wouldn't listen.

To conclude, similarly to Backett-Milburn et al. (2008) participants' direct challenges to their parents' behaviour were mostly reported as futile and counterproductive, sometimes leading to a worsening of the situation such as through increased violence. Moreover, Johnson (2001) found parental alcoholism negatively affected several dimensions of family functioning that are clearly communications related (i.e. conflict and expressions of positive feelings and caring).

Master Theme Three: Coping Mechanisms

This master theme focused on participants' experiences of trying to cope with their parents' drinking problem. This was by far the most prevalent master theme amongst participants' accounts, with many subthemes also emerging. These took various forms such as finding ways to escape or avoid the drinking parent to accepting the situation and / or giving up.

Subtheme 3.1. Avoidance and escapism

This particular subtheme was vast with further sub-sub-themes emerging from the data. The desire to avoid and or escape PPD took different forms. Some participants chose to escape by fully disengaging with reality and creating a fantasy world. Others chose to withdraw from the PDP either emotionally or physically. This has been discussed most frequently by authors as a form of avoidance with children being known for escaping to their rooms or to another person's home (Jorgensen & Jorgensen, 1990; Backett-Milburn et al., 2008).

3.1.1. Creating a fantasy life: "Not really being fully engaged in reality"

In order to introduce participants' use of fantasy, a well known ACOA is used as an example, namely Ronald Regan. In his writings, Pemberton (1997) described that as a child, "*Ronald Reagan often denied unpleasant realities by fabricating rationalisations behind which he would hide, and/or construct dream worlds in which he would live. These dream worlds existed only in his imagination but were very real to him nonetheless*" (Pemberton, 1997, pg. 5). Quoting Reagan, "*As a kid, I lived in a world of*

pretend .... I had great imagination ... I used to love to make up plays and act in them myself"(Fitzgerald, 2000, pg. 44). Since lying is intrinsic to the family system contaminated by alcohol, disturbing realities are covered up, ignored or denial.

Children use fantasy to survive chaos and pain. Children in dysfunctional homes frequently invent *"a private world that gives them a way to escape from time to time so that they can keep from being pulled in the craziness"* (Seixas & Youcha, 1985). The make believe world becomes a sanctuary. In a similar manner, Richard described how he too would escape his parents' drinking by not being fully engaged in reality. Describing himself as a *"prolific reader"*, he would continuously lose himself in the words and writings of other people. Whilst all children may be guilty of fantasising about being a pop-star or a footballer, the frequency within which Richard engaged in this fantasy world was excessive and in his own words looks back on it as a *"slightly mad way of dealing with it"*. There was a sense of it not feeling normal.

> *Richard: I spent most of my child life, I think, sort of in my head imagining things and I also had a very good imagination [laughs] it was… um, if I wasn't, you know, the lead striker of some, um, football team in my head, I was, ah, the biggest pop-star or whatever, um, or I was engaged in reading. Um, so I suppose, ah, one… a slightly mad way of dealing with it was not really being fully engaged in reality.*

And later:

> *Richard: Um, I was always a day-dreamer and, um, I, I'd read prolifically and watch fairly, um, wacky films that weren't very grounded in life and, as we know it, science fiction or fantasy, whatever. Um, so I think another strategy was perhaps sort of escape into, into my own head.*

Richard's use of the phrase *"I was always a day-dreamer"* indicated the frequency within which he would allow himself or need to escape into his dream world. He had always been surrounded by alcohol whether it was his biological mother, his father or his step-mother. Daydreaming was found to be one of the ways children were able to 'shut off' from parental drinking by Velleman and Orford (1999). Richard's disengagement in reality meant he actively chose film genres which would enable him

to completely disengage *"wacky films that weren't grounded in real life"*. He did not want to be a part of his own real life or anybody else's. Such films enabled him to escape into his *"own head"*.

Rachael's writings appeared to serve two functions. Similarly to Richard, it enabled her to escape her real world and live in the fantasy world she created, *"I would write stories about how I would like my life to be"*. This indicated her longing for life to be different and to have the *"nice life"* other children her age had, instead of being surrounded by chaos and instability. Her writings nonetheless also served as an emotional release enabling her to externalise her feelings. When Rachael says *"that was the only cathartic thing I did"*, it indicated the importance in finding an outlet for her emotions. Using *"angry poetry"* enabled her to release the negative emotions she had towards her mother and the chaos within which she had lived for so long.

> *Rachael: I would write stories about how I would like my life to be, I mean it wouldn't be as translucent as that I mean now I look back that's what I was doing, but I would write fairy tales, or nice life that somebody my age would have or if I was angry I would write angry poetry erm or just stream of consciousness erm so I've got massive collections (laughs) of just random bits of writing but that was the only cathartic thing that I did.*

3.1.2. Withdrawing physically or emotionally from their drinking parent

Backett-Milburn et al. (2008) described how for much of the time, particularly when younger, children have little option but to find ways of dealing with the situation within the home. In their study, participants frequently reported removing themselves from the situation by going to their own rooms (often with siblings), or reading, watching TV, crying, or expressing their feelings in some other way. Such methods of escaping had previously been reported by Velleman and Orford (1999).

Hall and Webster (2007) suggest many children develop a variety of 'conflict avoidance techniques' (conflict with the PDP). These may include withdrawing to their bedroom or a family friend's home or disassociating whilst remaining present in the parent's presence, in order to minimise them becoming involved when family dynamics are

intense and potentially physically and/ or emotionally upsetting. The goal of these strategies is to keep things running smoothly and at least have the pretence of calm. In general, such strategies are often very effective in warding off anxiety or reducing the child's active involvement in the family conflict. Although physical and emotional abuse was not prevalent amongst participants, for some like Haleema, it was easier not to be around her father when he was drinking and would actually remove herself from the situation. In addition to simply not wanting to observe him whilst he was drinking, there appeared to be an underlying fear of what might happen. Her father was prone to becoming confrontational when he was drunk and it was often best to leave him alone.

> *Haleema: I just go into a different room cos I don't want to be there when he is drinking.*

Ruben (2001) found escaping or avoiding conflict often becomes routine. If a behaviour has been positively reinforced (the behaviour allows the person to avoid or escape an aversive stimuli) for many years, and shown to be effective in reducing anxiety and threat to the child, it is especially difficult to change this coping strategy (Hassija & Gray, 2007). The following extract is interesting in providing an image of Haleema actually shutting out her father, *"I just turn off the light"* and darkening the room not even wanting to look at him - *"I don't want to see his face like like that"*. Additionally, the image of switching off the light and leaving a room when someone arrives home suggests a sense of resignation, of being fed up and needing to remove oneself from a situation.

> *Haleema: He comes home sometimes and I see him there I just turn off the light go upstairs cos I don't want to see his face like like that.*

Both Hannah and David's accounts describe deliberate attempts to be away from the family home. Hannah's extract described the intense relationship she developed with friends enabling her to remove herself from the family home as often as she wanted and needed to. The phrase *"expect them to provide me with everything"* indicated her need to feel nourished by other people because she felt deprived in her family environment and most obviously by her mother. Additionally however it illustrated the high expectations she placed on her friends.

Hannah: So I didn't have many other friends I'd always have you know.. expect them to provide me with everything, any friendship ever should provide you with erm so so I would stay at their houses, sleep over at their houses a lot so as to not be at home.

David explained how he would go out with friends frequently so as not to be at home. This gave David the opportunity to pretend it was not happening enabling him to block it out. Additionally, David engaged in stabilising activities (hobbies) such as swimming which he did daily. In the studies they reviewed, Velleman and Templeton (2007) found engaging in a range of activities served as a protective factor enabling offspring to be more resilient. Whilst this may be true for some offspring, David admitted that whilst being away from home was an effective coping mechanism at the time, his academic studies suffered as a consequence.

David: While you're away from home, it's like, the problem's not really there, and so, one way of dealing with it was trying to not be there as much.

Although Rachael's mother was not physically aggressive she was often inappropriate when she was drunk. By her mid-teens Rachael had become more conscious of her mother's drinking affecting her, that she started to withdraw from her by ignoring her.

Rachael: Erm 14, 15, 16 erm so I suppose that's when the drinking I think that's when it I knew that it had started to affect me that's when I became more conscious and I would ignore her when she was drunk.

Some forms of escape echoed those of Jorgenson and Jorgenson (1990) who described that imagining ways of to 'get out' of the family home was a method of relief invented by COAs to gain control over their fears and helplessness. Haleema and Aisha in a similar way clung onto the hope they would eventually be freed from this life once they got married and were able to leave the family home.

Aisha: I don't really think, now it's like something to look forward to getting out of this family home, I'm like 19 now so I've got like 6 years, 6 years odd to go.

The way the participants viewed their eventual release from home was as though they were completing a prison sentence *"I've got like 6 years, 6 years odd to go"* and *"it's something to look forward to getting out*". Until that point they would try to manage one day at a time.

Subtheme 3.2. Acceptance or giving up?

The subtheme which emerged relates to the majority of participants' experiences of accepting and being resigned (prepared to accept) to the fact the situation will not change. For other participants there were elements of simply giving up. Orford et al. (2005) suggest there are no rules about how to act if a close relative is drinking excessively and family members typically need to work it out for themselves. Those who express a sense of resignation have usually arrived at such a position after engaging in much more active attempts to deal with the problem. Such acceptance, or 'putting up with it', means they cease confronting the problem.

Backett-Milburn et al's. (2008) findings indicated challenging or confronting the parent about their alcohol use had usually taken place when children were younger. Moreover, such attempts at 'direct control' (e.g. hiding bottles, pouring alcohol away), by themselves or by siblings had been described in hindsight by almost all their participants as a somewhat hopeless cause. The experiences of the participants in the current study mirrored those of Backett-Milburn et al. (2008). Also, in a similar way to having given up on trying to communicate with their PDP participants had started to 'give up' on the idea they might be able to control or change their parent's alcohol use. Similar findings were found by Orford et al. (2005) who reported after numerous attempts to change their drinking parent or spouse, some family members were prepared to accept the situation or gave up. They started to feel powerless that more active attempts to deal with the problem had failed.

Orford et al. (2005) described four ways of 'putting up with' a family member's drinking problem, namely: inaction, accepting, sacrifice and support. What participants had in common in the current study was that they had accepted the situation for what it was. Hannah, who had always been extremely vocal in her family, sometimes verbally provoking her mother, eventually accepted she could not help her mother until she herself sought help. When Hannah says *"I would just scream"*, this illustrated her

immense frustration at the situation and her desire for her mother to admit she had a problem. Hannah also experienced feeling "*powerless*" because of her mother's drinking. Interestingly in the extract below she is speaking about how her mother's drinking left her feeling powerless in the past, however Hannah initially speaks in the present, *"It leaves me feeling"*, which suggests Hannah still struggles with the feelings surrounding her mother's drinking despite her current sobriety. Use of the word *"accepted"* again illustrates the fact that there was nothing she could do.

> *Hannah: As soon as I realised I was very verbal about it erm I was like the verbal person in the family I would often call her an alcoholic err bitch err excuse the language I would often call her something derogatory erm of an evening when we would end up screaming or shouting or sometimes I would just scream out that she had a problem with drink.*

And later:

> *Hannah: Well it leaves me feeling... well a year ago it left me feeling very powerless and hurt but now I've just accepted that there is nothing I can do.*

Both Haleema and Aisha's accounts are similar in that they both explain they are *"used to"* the situation. Haleema emphasises the point that she *"tried"* to change the situation - she tried taking action in the past, but it made no difference. Her father's drinking is something beyond her control. Whereas previously Haleema had been desperate to change the situation because her father's drinking worried her (health issues, his safety), she was now resigned to the fact nothing would ever change.

> *Haleema: I think I just got used to it now cos I can't change it. I tried to change it.*

Aisha's account also indicates further inactive/passive forms of putting up with her father's drinking, in that she no longer believes in him (Orford et al., 2005). Her tone suggested her lack of belief things will ever change and she no longer cares. Whilst this may have been the impression she wanted to give off, a defence perhaps, she appeared to be angry. In his paper on treatment of ACOAs, Ryan (1991) argues anger and rage often surface before sadness. Moreover, he suggests it would be a 'therapeutic error' to

consider the anger as the central issue. He argues that underneath the anger is the sadness of not 'getting enough' from the parent and feeling deprived of the relationship. Whilst Aisha said *"it doesn't affect me anymore"*, it felt this was not completely true as she was clearly angry. It was perhaps easier to get on with her life by pretending it was not affecting her.

> *Aisha: Yeah but I've come to deal with it now .. I'm used to it cos its been happening for such a long time I'm used to it so it doesn't affect me anymore.*

Reaching a point of acceptance or resignation could be likened to the stages of loss / grief described by Kubler-Ross and Kessler (2005). Participants experienced similar stages such as denial, anger, depression (albeit more sadness) before reaching a stage of acceptance. By accepting the situation that their parents use of alcohol would not change, and that as their child they could not do anything else about it, they learned to accept this as their new reality. To quote Kubler-Ross and Kessler who wrote *"We will never like this reality or make it okay, but eventually we accept it"* (2005, pg. 25).

Subtheme 3.3. Trying to make sense of parental drinking

A further sub-theme which emerged in the participants' accounts was trying to 'make sense' or 'understand' the reasons and triggers for their parents' drinking problem. Similarly to the respondents in Backett-Milburn et al. (2008), whilst participants spoke of experiencing many emotions towards their PDP, over the years they had developed some understanding of their behaviour. Backett-Milburn et al.'s (2008), participants' accounts suggested PPD seemed to be something, if not ever accepted by their child, could, nevertheless, be made sense of, perhaps with help and especially if that child was now out of the family situation (which as was the case for the majority of participants in the current study).

David for example, now in his twenties, was better able to make sense of, and put together a *"sequence of events"* which may have triggered his father's drinking. Whilst this was never confirmed by his father as the reason for his drinking (the drinking problem was never discussed, even after his father recovered), in David's mind multiple losses was a valid enough reason for someone to turn to alcohol. He described his father's losses as a *"massive trauma"* expressing the severity of what he felt his father

endured. By saying he understood better *"now"* than he did at the time illustrates how much children's perceptions and understanding changes over time. Having said this however, there still appeared to be some uncertainty. David's use of *"so I think"* and *"I kind of see"* suggests that whilst he was better able to understand why his father would drink, he would never be certain.

> *David: Okay, so I think I understand what he went through, a lot better now than I did then. And I…and I can kind of see the sequence of events, and, you know, the way my mum was always looking after him, and then, um, living with his grandfather, ah, his father, and then granddad dying, losing both his parents was…it's obviously traumatic (?) obviously that's just a massive trauma.*

David also took another approach to making sense of his father's drinking. In the extract below, he refers to his learning during his Psychology degree whereby they were taught the disease model of alcoholism. He undertook this course many years after his father's recovery and suggested such knowledge would have been helpful at the time. As mentioned in chapter one, Velleman and Orford (1999) discuss the potential advantage for children and other family members to consider alcoholism as being a *"disease"* because it clarifies what is wrong with the family member. As David continues to say *"it's not their fault"*, it gave him a justification for his father's drinking. Moreover, thinking about alcoholism in this way enables children to believe their parents would not voluntarily choose to drink in this way, it is in fact beyond their control. To some extent, it lets parents 'off the hook'. It allows participants to feel some empathy for their parents, enabling them to deal with the anger and frustration whilst also trying to maintain a relationship with them.

> *David: Um, the disease model of alcoholism was talked about, ah, as the kind of…the pers…the…the alcoholic as being someone who's essentially got…and it's not their fault, it's a disease, and that was really useful, to understand that afterwards. Um, but, so that kind of understanding at the time would have been really helpful.*

Similarly, Matt also believed bereavement caused his father to develop a drinking problem. He uses the phrase *"to stave off depression"* which suggested he believed his

father would have developed some form of psychological problem as a result of the bereavement whether it be depression or a drinking problem. Matt's use of the phrase *"to maintain his equilibrium"* was interesting and created an image of his father being unable to 'keep upright' without a certain amount of alcohol in his system. Moreover, alcohol enabled his father to keep functioning.

> *Matt: I think that he's habituated himself to drink, to stave off depression that came after my mother's death, or even before that, from the death of his sister and his father.*

And later:

> *Matt: It seems that to maintain his equilibrium, he has a number of drinks, you know, three or four drinks every day.*

Rachael tried to make sense of her mother's drinking by referring to the *"horrendous"* and *"traumatic"* childhood her mother had experienced. Throughout her account Rachael repeatedly reported her mother would *"never"* have been a *"normal mother"* because of her own childhood experiences. Alcohol was a way to *"numb it"* – numb the painful feelings.

> *Rachael: She had a horrendous childhood, I'm not even gonna touch on what my mother went through you know horrendous things and we knew this from a young age so I suppose it was understanding for us.*

And later:

> *Rachael: I think she used it because she'd had, I know she had a very traumatic childhood herself erm and she'd never really dealt with it and she had serious mental issues herself and she used the alcohol to numb it.*

Rachael appeared to feel sorry for her mother, nonetheless later in the interview she stated that whilst her mother's childhood provided some understanding for her problem drinking it was not enough to keep excusing her behaviour.

Subtheme 3.4. Keeping it a family secret

Referring again to Ruben's (2001) basic 'rules' operating in alcoholic homes, two are relevant for this emerging sub-theme of 'keeping it a family secret'. These are *"don't talk about family problems"* and *"limit communications"*. Although stated as separate rules they somewhat overlap. As it suggests, the rule of 'keeping it in the family' means keeping the problems the family encounter within the family. Furthermore, it is deemed unacceptable and forbidden to share problems with outsiders. This is possibly why many alcohol abuse problems go undetected by external family members or friends. Moreover, children are strongly pressured by the family to present with a 'fictionalised normalcy' both at home and to the community (Ruben, 2001). Whilst participants in the present study described different ways of keeping their parents drinking a secret, the end goal was always the same; to prevent anybody finding out. Both David and Richard's use of the word *"never"* indicates discussing their father's drinking with other people was unheard of -*"It just wouldn't be suggested"* as David says below.

> *David: And I…I never… I don't think I…I can't recall that I ever talked to friends about it, they just wouldn't come round, and we'd nev…it just wouldn't be suggested.*

> *Richard: I didn't really confide in my friends, um, I had… I mean, I had very good friends, but I never discussed my, my family in any depth.*

Finally, Rachael's extract below refers to a situation where she had to physically keep her friends away in order to prevent them seeing her mother passed out on the sofa. As Rachael described the situation she sounded frantic -*"please don't leave the room"* the potential embarrassment and shame of her friends seeing her mother this way was unbearable. The fact that she needed to lock friends in cupboards illustrates her desperation for no one to find out.

> *Rachael: Those scenarios we have locked friends in a cupboard in my room before saying please don't leave the room I'm just going to go sort something out and then I'd just put my mum in her room or whatever.*

There are numerous reasons why participants kept the secret to themselves. Bancroft et al., (2004) found there was a need for children to keep boundaries around access to their homes and knowledge of their circumstance to save becoming embarrassed.

Master Theme Four: The Road to Recovery

A fourth master theme which emerged related to the participants' attempts to recover from their parent's drinking. Whilst this theme could be considered a potential 'coping mechanism' it differs in that it refers specifically to a 'turning point' in how participants dealt with PPD thus enabling recovery. It is important to consider the term 'recovery' was interpreted differently by participants. Giving the 'problem' a label for example, was immensely significant for some participants and was viewed as the start of the recovery process. For others it meant addressing confidence and self-esteem issues or working through the complex emotions surrounding PPD in therapy.

Subtheme 4.1. Labelling the problem & seeking support

A sub-theme which emerged was that of 'labelling the problem and seeking support'. Whilst some participants engaged in professional support, others developed their own (informal) support, typically a network either within their own family or with a friend. Rachael considered the 'turning point' in her life as being when her mother went into rehabilitation for her alcohol addiction. The act of labelling the problem was said to be a *"massive relief"*, and a huge weight had been lifted from her shoulders. In turn, Rachael had been freed from the secret she had kept hidden for so long, both within the family ("*the first time we discussed it as a family*") and to the outside world. Rachael could finally say, with some ease, her mother's drinking was a problem and she had been right to struggle with this and be angry. The problem was not in her imagination, it genuinely existed. This in turn enabled Rachael to commence her own recovery because she felt she was *"allowed to get help"*.

> *Rachael: She went to the Priory into rehab and for the first time we discussed it as a family and used the word alcoholism which was a massive relief to be able to give it a name.*

As previously mentioned, in the past it was the 'addict' who held the attention of practitioners and researchers, whereas now family members are widely acknowledged

as requiring their own support and treatment (Orford, 1994). Rachael's accounts suggested participants were not aware they were entitled to psychological treatment and support themselves. Rachael continues to say she may not have sought help had her mother not gone into rehab. It took for the 'Professionals' involved to tell Rachael she was entitled to have her own recovery and gave her a 'voice'. In her following accounts Rachael demonstrates some ambivalence about 'getting help' – *"I'm not sure"* and *"I might not have done"*. This may have been because Rachael did not want to address her mother's drinking or as suggested previously she may not have thought that as the offspring she was able to receive help.

In the extracts which follow there was nonetheless a sense of gratitude – (*"I wouldn't be in the same situation now)* - to her mother for going into rehab. This resulted in Rachael being offered the opportunity for her own self- recovery. Rachael's reference to the Priory, they *"told us"*, suggests she may not have been aware she was meant to be thinking about her own recovery. The repetitive use of the word *"allowed" – "I was allowed to get help at that point, and it was allowed to be about me"*- indicated the shift of focus from her mother to herself albeit she was being given 'permission' by an external source (the professionals). The emphasis on those at the Priory telling Rachael she needed to focus on her own recovery may have alleviated any potential guilt at focusing on herself. Her mother had experienced a *"horrendous childhood"* which in Rachael's mind had triggered the drinking problem and other mental health issues. It was her mother who needed help and Rachael may have been in conflict with herself about whether she deserved to focus on her own life and recovery.

> *Rachael: I wouldn't be in the same situation now if my mum hadn't gone into rehab I don't think, I'm not sure I might have gone to get help, I might not have done, I was allowed to get help at that point, and it was allowed to be about me.*

And later:

> *Rachael: Because that's what the Priory told us, they then said to us look guys it needs to be about you from now on you need to start looking at your own recovery so I wonder if I would be as forward in my own recovery if she hadn't had gone into rehab and hadn't got sober.*

Hannah's experience of attending a support group provided a turning point in her recovery in that she felt able to use to the terms *"addict"* and *"alcoholic"* with some confidence. As with Rachael there was a sense of relief at using such labels. Hannah felt she was allowed to speak about her mother in a certain way and use the term *"alcoholic"* because those around her supported using such terms. There was again a sense of being given permission by an external source to express themselves in a certain way. There was no need to shy away from reality any longer. Moreover, those in the support group supplied Hannah with the understanding she needed because they were in a similar situation themselves – 'like-seeking-like'. Both Gorin (2004) and Kroll and Taylor (2003) found that offspring desired to be with people who have similar experiences. Use of the word *"accepting"* suggested that until this point, on some level Hannah may have been in denial about the extent of her mother's drinking problem. It was now time to face up to the reality of the situation.

> *Hannah: That's what happened at the support group because other people were using the terms addict and alcoholic I became confident in referring to my mum as one accepting the fact that she that she was an alcoholic.*

Prior to leaving home, Hannah's family had not used the term alcoholic, moreover, the drinking itself was very much *"swept under the carpet"*. Whilst engaging in the group however, Hannah's view of her mother's drinking as being problematic was confirmed. As previously mentioned, Hannah had always been the most verbal about her mother's drinking in comparison to other family members and often felt alone in her feelings. In the group however, her concerns and negative feelings were accepted and validated.

> *Hannah: We didn't really use the term that much whilst I was living with her in the house erm because it was all very kind of swept under the carpet in the family which is the nature of addiction anyway erm and it was only when I went to the support group I confidently was able to use the term erm because everyone else was validating and confirming my truth.*

As indicated earlier, participants' experiences of support did not always take the form of professional services. For participants such as Haleema and Aisha, support networks were developed either within the family home or with close friends. It is possible that the family's desire to keep it a family secret prevented these participants from seeking

outside professional support. The strong cultural background may also have influenced this decision. Loyalty is paramount in Asian families meaning they often do not seek professional support in any capacity, it is therefore perhaps not surprising they would not consider seeking mental health support. Nonetheless an outlet for their negative feelings was established. Similarly to Hannah there was the sense of wanting to share with people who would understand their situation. Haleema for example, would talk to her mother and siblings as described below.

> *Haleema: We always talk like sit around the table and just talk and just talk about our feelings and what we are going through.*

Aisha also developed her own informal form of support outside of the family home with friends. The first turning point came about when Aisha was a young child and her friend uncovered that Aisha's father was a problem drinker. Later, as a teenager, a bond was formed with another friend when it was discovered that both their fathers were considered to be *"alcoholics"*. The significance of sharing common experiences thus appeared paramount to participants.

> *Aisha: She used to sleep at mine and obviously from there she found out about my dad and stuff was drunk so I used to talk to her a lot but when I was small I wasn't actually sure what was going on .... I met this other mate ok at high school we got really close and we actually found out that both of our dad's were alcoholics.*

This friendship proved invaluable and continued into adulthood. Aisha's inability to express herself at home because of not wanting to show her sadness in front of her mother meant this particular friendship provided an immensely important outlet. There was a strong focus on participants being understood whether it be by professionals, fellow adult children or family. When Aisha says *"I could be myself"* this indicated her desire to put aside any pretence. Aisha was unhappy and she was able to share this without worrying about anybody else. Also, when she says *"I'd only cry in front of her"* this signified the importance of this support, her friend Shana was the only person in her life she could truly rely on to share how she felt.

Aisha: We would always talk together like anytime I've had a really really bad argument with my dad or you know he's just really really got on my nerves I'll just call her up and we'll talk about it, or she'll be like just come over for a bit, so we'll actually sit down, it was her that I'd talk to and I'd only cry in front of her I don't like crying in front of my mum cos I wouldn't want her to see me upset but yet with Shana I could be myself and talk about being upset and talk to her about anything.

It was apparent from the participants' accounts and the literature (Barnard & Barlow, 2003), that trying to keep the problem drinking secret and seeing few options but to live with it, characterised participants' childhoods. Nevertheless, being able to turn to a close friend as in Aisha's case, or a supportive relative in Haleema's, was clearly important for the majority of participants. Managing to get away from their families for a while was one of the few options open to participants as children. Reports about support from friends and their families have suggested that important help can be given by a range of people who are able to provide respite, even if they do not intervene (Backett-Milburn et al., 2008).

Subtheme 4.2. Self-preservation: Keeping a safe distance

A second sub-theme which emerged from the participants' accounts was self-preservation, taken to mean learning to 'put themselves first' and keep a safe distance from their PDP. Participants' accounts revealed there came a point whereby they made a conscious decision to start putting their emotional well-being '*firs*t'. This mirrored Bancroft et al.'s (2004) findings of offspring re-focusing attention onto self. Apart from Haleema and Aisha, the remaining participants had moved away from the family home, putting some distance between themselves and their PDP. In addition to this physical distance, participants had put up a 'barrier' or 'defence' between themselves and their PDP. This was a protective measure to ensure their own emotional well-being regardless of whether their PDP was actively drinking or in recovery.

Rachael's repeated use of the word *"obviously"* in the following extracts suggested there was still a sense of guilt at putting herself first, as previously mentioned in subtheme 4.1. It felt as though she did not want to give the impression of not caring

about her mother. Nonetheless, Rachael wanted the focus to be on her. The phrase *"be able to extract the difference"* suggests the previously enmeshed relationship Rachael had with her mother whereby Rachael did not appear to have her own presence had now changed. Use of the phrase *"number one"* below further illustrates the shift in focus from her mother to herself.

> *Rachael: Obviously her health and her sobriety is important to me but now I would be able to extract the difference between her happiness and my happiness.*

Also:

> *Rachael: Obviously when she's happy it's nice to see her happy but my happiness will now remain number one and I won't allow it to be affected by her mental state.*

As Rachael spoke above she used the word *"nice"* which felt a very understated reference to a parent's happiness. There appeared to be some distance in the way she spoke about her mother and there was little emotion in her voice. Interestingly, both extracts commenced by putting her mother first, such as wishing her well, hoping she was healthy and so on, however they were promptly followed by a *"but"* and a reference to Rachael's own happiness. The phrase *"I won't allow"* above however, also illustrates how adamant Rachael is not to be affected by her mother's emotional well-being, which had clearly impacted on her in the past, especially as a child. There was a sense of her being in conflict with herself, not wanting to look selfish but equally unwavering that she would not let her mother affect her anymore.

Similarly, Hannah had developed strategies to protect herself from her mother's actions which had previously caused her emotional upset. A combination of professional support and her own *"self healing"* as Hannah often described it meant she was better able to keep her mother's actions at a safer 'distance', hence maintaining her own emotional well-being. Hannah's use of the phrase *"I started to heal myself"* was interesting in that although she attributes her recovery to the self-help group and counselling she engaged in, the use of *"I"* indicates her being in control. Life with a PDP was often described as *"unpredictable"* and *"out of control"* by participants, and Hannah was now in a position to take control of her own life and well-being.

Hannah: I had learned coping strategies a lot of tools through counselling and support groups I realised that I can say no to things I am uncomfortable with whereas before I didn't know how to negotiate boundaries I didn't know how to be able to take a step back I allowed myself to get into uncomfortable positions erm and I didn't know how to pull myself away from them.

Similar to Rachael's experience, Hannah speaks of previously not knowing how to *"take a step"* back from her mother and had often experienced boundary issues. When Hannah uses the phrase *"I didn't know how to pull myself away"*, it conjured up a powerful image of Hannah trying to detach herself from her mother but kept getting pulled back into their unhealthy relationship. There was a distinct undertone that like Rachael she was adamant not to allow certain things to happen again which would affect her own happiness or well-being. A boundary had been put in place separating herself from her mother and Hannah now had a better sense of her own identity.

Master Theme Five: Impact on the Self

Participants' experiences of PPD impacted them both as children and as adults to some extent. This 'impact' took various forms including how they viewed themselves, their behaviour and life choices. Moreover, this theme relates to the impact participants were aware of and actually attributed to PPD. As children for example, participants reported feeling *"different"*, not knowing normality and having few or no boundaries in place. In subtheme 5.2, participants reflect on their experiences and identify the positive outcomes they attribute to being an ACOPD. A final sub-sub-theme which emerged is associated with the ongoing debate of whether ACOPDs are more likely to use alcohol problematically.

Subtheme 5.1. Impact as a child: Being 'different'

Participants' experiences were predominantly concerned with not knowing 'normality' and feeling 'different' as children. This has been discussed extensively in the literature originally by Woititz (1983) who described ACOAs as sharing thirteen characteristics, one of which was 'guessing at what normal is'. Furthermore, Woititz (1983) found many ACOAs did not have a 'frame of reference' as to what it was like to be in a normal household, especially as a child. Looking back on her childhood experiences

from an adult's point of view, Rachael attributed her negative sense of self to her mother's drinking. In particular, Rachael felt the fact her life was very unstable was the main contributing factor to her feeling different from other people. Furthermore, she attributed feeling different to her being bullied at school. When a child feels different, they already feel as though they do not 'fit in' which can again make someone stand out amongst a crowd. Her insecurities made her very *"sensitive"* which meant she stood out amongst her peers, making her an easier target for bullies.

> *Rachael: The reason I always felt different was because of the rubbish that was going on at home erm and it was always very unstable.*

> *Rachael: I had major issues with insecurity and I got bullied a lot and I think it's cos I always felt different.*

Hannah's experience relates to Woititz's (1983) no frame of reference of normality where alcohol is involved in family life. The extract is concerned with what Hannah believes is required to aid an Adult Child's recovery - *"learning how to do life"*. She described feeling *"weird"* because she did not know how to *"behave"* until she was no longer in the family environment and observed 'healthy' behaviour by other people. Ackerman (2002) discusses the importance of the adult child surrounding themselves with 'healthy' people to aid recovery.

> *Hannah: It's like learning how to do life, it's like basic things that people who grow up in healthy families already know that I didn't, and that's why I felt weird and it's only until I got with the boyfriend who I'm with now that I observed how he behaved with people and I was able to re-learn how to be sociable.*

There was a time however when Hannah had wanted to be this *"different"* – *"weird"* and *"crazy"* type of person. Being 'quirky' enables people to stand out from the crowd as expressed in the extract below, in being called "*Hannah the crazy one*". The extract again refers to needing normal behaviour to be *"modelled"*. Speaking for COAs as group, she feels they do not know how to be normal. There appeared to be some unease with the word *"normal"*, and perhaps the negative connotation associated with mental health.

Hannah: I wanted to be different and people used to call me Hannah the crazy one or Hannah the weird one or whatever erm and that was because like I did things that were out of the norm that other kids were doing so I think kids of addict kids don't know how to be normal.

And later:

They have to experience it being modelled so they can learn from it themselves and they have to kind of be put in an environment where they can see how to be normal, I hate the word normal but healthy, mentally healthy people behave.

Matt and Richard's respective accounts also illustrate not having a frame of reference of normality. Alcohol was an everyday part of life. Matt who had lost his mother at a young age and was raised by his father who drank daily to maintain a level of functioning had no other role models to go by. Even his grandmother who assisted in raising him when his father was at work was claimed to have an *"interesting relationship with alcohol"*. The closest adult figures in his life, his *"role models"* both used alcohol daily which meant that was all Matt knew as 'normality'. Looking back on his experiences, Richard says *"even at the age of 13"* suggesting he should have known by this point that his father's drinking was problematic and impacting the family. Alcohol was however very much a part of family life and felt *"normal"*.

Matt: But that's possibly due to the fact that I didn't have any other role models to go by.

And:

Richard: Um, so alcohol, even at the age of 13, I still didn't really have a sense that, that this was a severe thing that's actually impacting lives. I thought it was a normal part of life.

Subtheme 5.2. The adult child: Who have I become?

The subtheme which emerged was concerned with participants perception of their childhood experiences and the impact this had on the type of adult they have become. This included developing a certain type of character and accomplishing goals.

Participants provided snapshots from their earlier years which they now viewed as proving advantageous in adulthood. Velleman and Orford (1999) discuss the possibility that some of the long-term effects at having been brought up in a home where a parent had a drinking problem might be seen as positive and adaptive rather than negative and harmful. If, as was found by Berkowitz and Perkins (1988), increased independence or autonomy occurs in male COPDs, such qualities may be useful in adulthood. David for example, was appointed *"head of the house"* when his father's drinking became very severe. He and his siblings would help around the house and run errands from a young age which in turn made each of them extremely independent. David viewed this independence as a positive outcome with him successfully going off to University and building a life for himself.

> *David: Because in spite of everything that went on with dad's drink problem, and apparently gambling problem before that, she brought up three independent kids who all went to…or they brought up three independent children who all went to university and have done pretty well for themselves.*

In the following extract Rachael is referring to the instability she experienced as a child when her family kept moving house. As an adult she looks back on this experience as invaluable because when Rachael went travelling she was more than able to deal with change and instability more effectively than other people. She explains her past experiences aided her to be able to cope in the here and now. The phrase *"I could handle it"* demonstrated her confidence. Where she had previously felt *"bad"* about herself because of her mother's drinking as an adult she was resilient. In the extract below use of the word *"traumatic"* was interesting and possibly reflected the trauma she had felt as a child when her family kept moving.

> *Rachael: I've just come back from travelling, for most people who have lived in one home their entire lives living out of a bag for one year solid, moving places every few days can be quite traumatic whereas for me that is my normality.*

Making specific reference to her mother's PD and mental health issues, Rachael appeared to be saying her childhood had made her a better person; less judgmental and

less ‘sheltered’. Despite her experiences, Rachael did not regret her childhood. Moreover, Rachael had experienced personal growth from her experiences.

> *Rachael: It made me very open minded erm its made me very interested in things I wouldn’t normally have been interested in before, its let me look beyond the usual bubble that I live in or people around me live in and it’s made me appreciate different different people it’s helped me be less judgemental of people more understanding of other people with mental health issues erm yeah so I mean I don’t I don’t regret it at all.*

Hannah’s extract also suggested she would not be the person she is today had she not gone through certain experiences. The laughter at the end of the following extract was nonetheless noticeable with Hannah possibly trying to distract from talking about the pain she endured. There was however a serious undertone of counting herself lucky at not having experienced any form of abuse. Hannah’s comment above about being *“very thankful for the pain”* was particularly interesting yet unclear at first. Following a similar account from Rachael found below, it became apparent that there was an appreciation for the happiness the participants are experiencing in their lives now. Hannah’s experiences had enabled her to grow into the woman she was today- a person she was happy with.

> *Hannah: Well I feel that erm it affected me erm really badly erm because I got to my own lowest point which was really horrible but when I look back in hindsight at my experiences I’m first of all I’m very thankful for the pain I went through because it’s made me into who I am today which I’m very pleased about thank you very much (laughs).*

In the following extracts, Rachael repeatedly uses the phrase *“wouldn’t want to let go”,* signifying the importance of the pain she endured as a child, enabled her to understand and appreciate her happiness more so in the present day and not take it for granted. Use of the words *“fire”* and *“passion”* illustrated the intensity of Rachael’s feelings.

> *Rachael: The hurt and pain it has a fire inside you that I wouldn’t want to let go of because otherwise I would never understand my happiness I could never compare it.*

And later:

> *Rachael: I probably wouldn't want to let go of, that raw and that hurt and that it provides a certain passion and a certain understanding and what have you of other people and in life.*

To conclude, the participants' experiences imply the outlook for adult children is not as bleak as previously suggested by research in this field. Moreover, many of these children go on to have happy lives and are successful in their endeavours. Velleman and Orford (1999) also found this to be the case when they compared offspring of drinking and non-drinking parents. The work of Moos, Finney and Cronkite (1990) has also shown how resilient children of parents being treated for drinking problems can be those whose parents were successfully treated were subsequently found to be indistinguishable from community control children. This and other similar findings such as Chassin et al. (1993) raise the possibility that most of the effects of PPD might only last as long as offspring endure the stress of living with a parent.

5.2.1: Life choices: To drink or not to drink?

A further theme which was prevalent amongst participants' accounts was the impact their parents' drinking had on their own alcohol use. There has been much debate regarding whether the offspring of problem drinkers are likely to develop a problem with alcohol themselves. Each participant made reference to their own alcohol use during the interviews without being asked directly, signifying the importance of the topic. Apart from Matt who abstained from alcohol altogether, each participant reported drinking but they kept their alcohol use to a minimum. Participants' accounts alluded to a number of underlying fears surrounding alcohol; a fear of the person they may become whilst drunk; and a fear of alcohol dependence.

To illustrate this further:

> *Aisha: I know not to get too drunk, I know yeah maybe the bad side of me will come out when I am drunk, but I won't let it get to that.*

Aisha's extract suggested she had developed a fear of who she might 'turn into' when she was drunk. She questions whether a *"bad side"* will come out potentially modelling her father's behaviour, who had been violent towards her when he was drunk. Getting drunk felt too risky for Aisha and so she kept her alcohol use to a minimum. Throughout her interview, Aisha had expressed her anger and hatred towards her father for what he had done and his behaviour. She could not forgive him. There was therefore a fear she would also not be forgiven and other important relationships would be damaged in the same way.

As mentioned in Chapter one, Rogosch, Chassin and Sher (1990) found some children abstain from alcohol because they fear they will become alcoholics themselves and they have seen the negative consequences of their parents drinking. Haleema also expressed a concern she would behave like her father if she drank too much. She refers to her father being *"too drunk and over the limit"* suggesting that up to a certain point alcohol does not have to be problematic, and why did he have to take it so far. Having been on the receiving end of her father's drinking ("*what he says to me and how he treats me"*), she does not wish to inflict the same on someone else.

> *Haleema: Like I've seen my dad and how he is and see he's too drunk and over the limit and things he does, and what he says to me and how he treats me like the next day and so I know if I was to drink I would keep it a glass or one or two glasses.*

Both Haleema and Aisha's accounts suggest drinking equates to hurting others. They did not want to be that kind of person causing pain and upset. Similarly, Matt's account suggested his desire to be 'different' from his father and his fear of becoming dependant on alcohol.

> *Matt: I made an active choice to learn by other peoples' experiences, and so I denied... first of all it's not that I didn't like it - I think similar to a how a lot of vegetarians say they don't like meat but really have issues with what's associated with it - and I didn't want to drink. I think it was a control thing about realising that I didn't want to be dependent on anything, having seen it in my father.*

Having seen his father's need to drink everyday in order to *"maintain his equilibrium"* as previously mentioned, Matt made an active decision to abstain altogether. He speaks about *"association"* and there was clearly a negative association with alcohol in his mind. The analogy he used to explain his reasons for not drinking, of vegetarians not eating meat, was extremely interesting. Just as some vegetarians do not eat meat because they only associate it with animals being killed, Matt's idea of drinking equated to dependence. The idea of being dependant on something like alcohol could not be comprehended by Matt - he liked to be in control.

Whilst David chose to drink alcohol he was aware of the problems that come with drinking alcohol excessively - "*our relationship with alcohol is one of, awareness"*. David uses variations of the word *"aware"* three times in the extract below. It was as though he was trying to convince himself that he truly knew the problems he could face if he were to drink excessively like his father. Nonetheless, being aware did not guarantee David would not follow the same path as his father. There remained an underlying fear of developing a problem with alcohol illustrated by David admitting he refrains from alcohol on occasions such as lent, to test himself - "*just to show that I can"*. He needed to prove to himself he could stop drinking if he wanted to, and that he was in control.

> *David: I guess our relationship with alcohol is one of, awareness of, ah, what the problems can be, to be certain that we never go the same way, so it makes you more, you know, aware…aware of it, so I'll, I don't know, give up alcohol for Lent every year, just to show that I can.*

Unlike the other participants' experiences, Richard believed he had developed a problem with alcohol. Richard's drinking patterns had changed over time from drinking daily *"I'd drink on my own"* to binge drinking on weekends or nights out. Richard openly admits this is an unhealthy way of drinking and has the possibility of spiralling out of control, admitting that if it were not for his employment he feared he would start drinking daily again. One might argue that Richard's problem developed as a result of living with two problem drinking parents (father and step-mother) (Sher, 1991) and would take into consideration that Richard described his biological mother as also having some form of drinking problem. Nevertheless, it is possible Richard's alcohol

use developed naturally following the realisation that it enabled him to have a relationship with his father *"developed a bit of a relationship with him in that alcohol has become something useful"*. Alcohol has become a way of forming a relationship between Richard and his father *"a way that we can bond"* enabling them to spend time together, without which a relationship may not be possible. Brown (1988) reported that for some adult children, alcohol is used as a *"binding agent in attachment between child and parent*" (pg. 152).

> *Richard: It got to the extent that if I'd drink on my own I'd have a bottle of wine, maybe a bottle and a half of wine, in the evenings and I was hung-over pretty much every day.*

And later:

> *Richard: Um, so yes, he, he… I've, I've, I've sort of unfortunately developed a bit of a relationship with him in that alcohol has become something useful; a way that we can bond because we haven't been that close as I, as I think I have mentioned.*

There appeared to be a gender difference in the participants' accounts with males being more afraid of becoming dependent on alcohol like their same-sex parent, than female participants. Velleman and Orford (1999) observed that males are more affected by their fathers' misuse of alcohol than their mothers' and that girls, conversely, are more affected by their mother's misuse of alcohol than their fathers. Furthermore, the authors observed children will be more likely to imitate the behaviour of parents of their own sex. For some time, it has been assumed that children with one or more PDPs are more likely themselves to develop problematic drinking patterns in adulthood (Sher, 1991). Whilst such intergenerational continuities can occur (Pandina & Johnson, 1990), this assumption may have been exaggerated. Velleman and Orford (1999) found most adults who had PDPs did not have worse problems than others in terms of substance misuse.

Overview of findings

Whilst there were numerous common themes between the participants, particular themes were more prevalent than others amongst their accounts, such as Parent/Child Relationships. Although the level of parental alcohol dependence varied massively for the participants, it was interesting that their PDPs behaviour was extremely similar with parents being perceived as 'distant' and 'unavailable'. Moreover, this appeared to be true for experiences both when parents were sober or actively drinking. There is therefore some debate whether alcohol was the sole factor or simply a contributing factor to the development of such a distant relationship. The PDPs general parenting style may have always prevented a close relationship being formed with their children. Nonetheless, this in turn caused numerous issues surrounding communication, with participants often feeling rejected and ignored by their parents. Relationships were also presented as fairly one-sided with the participants making most of the effort to form a relationship with their parent. The majority of interviews also indicated how participants grappled with a mixture of emotions such as anger and immense fear.

Master theme three 'Coping Mechanisms' as a whole was the most prevalent amongst participants' interviews, with each of the four sub-themes also frequently occurring within participants' accounts. The sub-theme 'Making sense of parental drinking' for example, was extremely common with all participants being able to rationalise or provide a valid reason why their parents would drink. For the majority of the participants, this occurred following some consideration of their parents' own childhood and the significant events they experienced in their lives. The realisation that their parents' loss and grief, or other trauma may have triggered the PD was a frequent occurrence among participants' accounts.

A further sub-theme which was highly prevalent amongst participants' accounts was 'life choices: to drink or not to drink', with each participant making reference to their own drinking habits. Moreover, participants provided a clear explanation or rationale for their decision. The majority of participants chose to drink minimally, whilst Matt and Richard appeared as outliers within the group with Matt abstaining from alcohol altogether and Richard admitting he felt at risk of developing a problem with alcohol. 'Fear' typically underpinned participants' decisions about drinking alcohol, with the

majority fearing becoming dependant on alcohol like their parents. For others, there was a fear of 'turning into' their parents whilst under the influence of alcohol. The fear being participants would behave in an unforgiving manner, potentially confrontational or violent.

Finally, whilst participants' accounts of their childhoods were clearly difficult and challenging, the majority of participants were content with where they were in their lives today as adults. Participants referred to their success stories of going to University. Additionally and of greater importance to participants was how certain aspects of their character had developed as a result of their past experiences. This included being independent; the ability to tolerate change and instability; and being able to appreciate their happiness more so given the troubled times they experienced. This was true for all participants other than Haleema and Aisha who had yet to leave the family home and were continually subjected to their respective parents' drinking on a daily basis.

Chapter Four: Discussion

The chapter begins by returning to the main research aims of the study and reflecting on the findings. This is followed by my own reflexivity and use of methodology. The strengths and limitations of the study are evaluated and improvements to the study are considered. The implications the findings have for counselling psychology and other mental health professionals working in both the addiction field and generic services are addressed. To conclude the chapter, recommendations for future research studies will be made followed by a summary of the research.

Returning to the research aims and reflecting on the findings

As presented at the end of chapter one, the main aim of the study was to offer a 'voice' to ACOPDs and gain more of an understanding of their experiences, in the hope of filling this important gap in the current literature. The study also hoped to contribute to the limited qualitative research in the field. Given the exploratory nature of the study there was the additional possibility of eliciting participants' views on support services. I embarked on the process with an open mind taking into account Smith et al's. (2009) suggestion that both the interviews and the analysis could potentially lead the research in unexpected directions. This occurred on numerous occasions. The greatest surprise by far was the role culture played in participants' experiences and how despite very different upbringings, Haleema and Aisha shared many common themes with the other participants.

Additionally, I was taken aback by the emphasis on 'informal' over 'professional' support. After consulting relevant literature in the field it became apparent this is quite common. Gorin (2004) for example, found that young children opted to talk with friends over professionals because they feared their parents would be contacted and involved. More recently, Backett-Milburn et al. (2008) reported that the majority of participants found turning to a close friend, neighbour or relative as being very important. There was in fact no mention of professional support in their participants' accounts. Given my work as a trainee counselling psychologist and the immense value I put on psychological therapy I had naively assumed participants would be keen to engage in professional psychological services. This opposite was in fact true for the

majority of participants. When working in the field of psychology it is easy to forget that not everyone is 'pro-therapy'.

Finally, I had not anticipated such 'fear' amongst participants' accounts regarding the possibility of developing a drinking problem of their own. The interaction I have had with ACOPDs in my clinical practice has been limited, and many of my clients were of a much older age and their parents had been in recovery for many years. The fear of 'dependence' in the participants' accounts was immensely powerful. Moreover, I had been surprised by the fear of 'becoming like their parent' if they drank too much (i.e. potentially confrontational, violent, or uncommunicative).

Research on PPD is extremely sensitive with many negative associations still attached, despite a shift in research from the negative impact on offspring to resilience. Wilson, Harris, Sherritt, Lawrence, Glotzer, Shaw and Knight (2008) for example, suggest that not only are COPDs more likely to witness domestic violence, but they also have a greater chance of becoming victims of all forms of child maltreatment, including neglect, physical abuse, and sexual abuse. Whilst every attempt was made not to lead participants in any way and questions were open i.e. asking about childhood experiences in general, participants were inclined to share their more negative experiences. Although some participants did share 'happier' times, the majority needed prompting. As the interviews progressed and conversation moved onto life as an adult, the experiences shared were more varied depending on whether the parent was still drinking. For particular participants such as Aisha and Haleema the focus was on the continued difficulties of living with 'actively' drinking fathers. For others such as Hannah and Rachael the focus was on their experiences of professional support. What participants had in common was that problems continued in the relationship with their PDP regardless of their drinking status, and whether the participants themselves had received some form of support.

The reality was each participant had a very unique experience of PPD. Even within this small and comparatively homogenous sample, a number of variables came into play which potentially impacted the findings. These included: the varying degrees of seriousness of PPD; the duration participants lived with the parent; and level of engagement in informal and / or professional support services. Despite these variances

many common themes emerged which mirrored Gorin's (2004) findings. These included dealing with a mixture of feelings, being aware of PPD from a young age, but not understanding what was happening and why, and the development of coping strategies.

My own reflexivity

Reflexivity entails reflecting, or thinking critically, carefully, honestly and openly, about the research experience and process. It should not be inward looking or self-indulgent with the researcher's self at the centre of the research. Practising reflexivity effectively can therefore be difficult and complex and I initially reflected in quite a cathartic manner. This was because I found the research an emotional experience and I was unsure how do manage this both whilst conducting the research but also once it was completed.

When I reflect on the interviews I felt I engaged well with the majority of the participants. I went into each interview determined to be myself (warm, empathic, relaxed). Equally, the participants appeared very comfortable in my presence, making good eye contact and their body language was open. They did not appear to hold back with what they wanted to say. Their anger and frustration was present in the room, as was their sadness. There was also a great deal of laughter in the room as participants reported particular occasions when their parent had been drunk. Initially I was unsure if it was appropriate to laugh along with the participants, yet it felt unnatural not to engage with them. I was of similar age to my participants and could easily relate to them.

Nevertheless, I did find it harder to engage with Matt and David and the interviews did not feel as relaxed in comparison to the other five participants. When I reflected upon this I realised a number of factors came into play and my performance as researcher had not been the same during these two interviews. This combined with the participants' demeanour meant the interviews were not as free flowing. Matt's interview had been arranged for some weeks and involved travelling out of London. Unfortunately I was unwell on the day of the interview but it was too late to re-schedule. I believe this impacted the interview slightly in that my questions were not always clearly formed. Additionally however it felt as though a slight hierarchy came into play. Matt was in the final year of his Psychology Undergraduate degree and I was studying at Doctoral level.

He kept introducing psychological terms and it felt he was trying to impress me. The over use of 'big words', psychological terms and complicated analogies took away the natural feel of the interview. Matt would often say *"you understand what I mean by that don't you"* which felt competitive and as though he was testing my intelligence.

David's interview took place some months after the other participants because I needed to re-advertise the study due to a lack of participants. I felt 'out of practice' by this stage and quite nervous. Whilst I had enjoyed the previous six interviews, as a novice interviewer there had always been some anxiety in the room. Additionally however, David found it quite difficult to keep focused on the questions, moving from one point of interest to another then losing track of what he was saying. I sometimes found it hard to follow his train of thought.

Despite these two more difficult interviews I was happy with the overall interview process. Each interview took a similar direction and the questions were covered in roughly the same order. The interview schedule was fairly simple meaning for most participants there was a natural progression through the four broad areas: childhood experiences; adulthood experiences; impact on life; and coping. I feel this was a result of the participants answering questions in a logical manner and in enough depth that there would come a clear point to move onto the next area of interest. The interview schedule was covered in its entirety with relative ease with each participant. They were each extremely articulate and Hannah and Rachael in particular expressed themselves using interesting language. I felt I could really engage with them.

As mentioned in my personal statement I am not an ACOA or ACOPD. Given the sensitive nature of the research topic I had anticipated participants asking me about my own family background either prior to the interview or during the debrief. This was possibly my own assumption they may be curious, in the same way that I have often wondered why other researchers choose their topics of interest. I questioned whether this would influence the interview in any way. Would they feel more or less inclined to share their true feelings if they thought we had something in common? In fact none of the participants asked me if I was an adult child myself nor did they question my interest in the research field. The majority of participants left the interview room showing their appreciation for the opportunity to voice their experiences and expressed

their eagerness for more research to be conducted in this area. During the debrief a number of participants commented on the continued emphasis on the 'addict' or 'problem drinker'. Rachael in particular reported finding very little literature on offspring for her own personal reading which had left her feeling disappointed. This was extremely moving and I was more eager to do the study justice and bring this unique group further into peoples' awareness.

Reflections on the chosen methodology

I chose IPA because of its focus on the lived experience of the participant and the meaning which the participant gives to that experience (Smith et al., 2009). Given my interest lied in participants' perception and experience of PPD, IPA was appropriate. Furthermore, the idiographic nature of IPA was ideal because it allowed for detailed analysis of each case before moving on to similarly detailed analyses of other cases (Smith et al., 2009). As previously mentioned the participants' experiences were unique and IPA allowed me to fully engage with their distinctive differences before bringing together a number of their valuable and interesting commonalities. IPA allowed for the 'best of both worlds'.

The final result in the process of conducting IPA is always based on what the researcher thinks the participant is thinking – the double hermeneutics (Smith et al., 2009). I was often concerned at whether I was interpreting the participants' accounts 'correctly'. IPA is an extremely flexible approach (Smith & Eatough, 2008) which in theory is liberating nevertheless, the no right or wrong way of doing IPA which Smith et al. (2009) discuss was in fact more unnerving. As a novice to IPA and qualitative research in general I felt I needed more guidelines. After some time it became apparent this flexible approach went against my natural way of working and thinking. It was a relief when this 'trouble spot' was identified by my research supervisor and suggestions were made on how to implement slightly more structure into the analytic process. This enabled me to fully engage in the transcripts and I eventually started to enjoy the process especially when I could see the common themes emerging.

A final hurdle did however arise at the point of creating the master table of themes which took quite some time. In theory it appeared to be a simple task but in practice it was a very different story. I had the common themes so clearly in my mind beforehand,

but when I had the participants' separate tables laid out in front of me I was lost as to where to begin. Smith et al. (2009) suggest master themes be created according to the frequency in which they occur across interviews as well as importance. I struggled with this because I was unsure whether to place more emphasis on frequency or importance. I felt it was important to keep the participants' differences in order to retain each participant's 'voice'. There were some unique differences which I felt were valuable to discuss. Moreover there was a sense of loss of the participants' individual experiences when I started putting the master table together. I also temporarily fell into the trap of using typically used labels which had undoubtedly emerged from the many research journals I have read over time which were by and large quantitative studies, using clinical terms. As discussed by Taylor and Bogdan (1988) qualitative findings tend to be presented in everyday language often incorporating participants' own words. There was a constant conflict between my former quantitative self the new emerging qualitative researcher.

My co-researcher was an invaluable source of support at this point, and who continually questioned my choice of themes and pointed out when they did not quite 'fit' the master theme. The theme labels themselves were also debated numerous times with both my co-researcher and I working together to create terms which really represented what participants were trying to say. The trouble I had with labelling the themes was also pointed out in research supervision, whereby it was felt I was over complicating what I needed to say. It was suggested I use simpler and more 'punchy' labels. As a result, one might argue that a number of the master theme labels such as 'coping mechanisms' are quite simplistic. My intention was nevertheless to present the findings clearly. The master table was re-created numerous times before my co-researcher and I were both confident the common themes had been identified and placed under the correct master theme. Whilst using IPA was certainly challenging I endeavoured to describe my participants' experiences to the best of my ability. I certainly feel IPA was incredibly well suited to the study enabling me to extract many themes of great relevance to professionals working therapeutically with this group.

Strengths and limitations of the study

The greatest strength of the study was not using any standardised or official measure to classify participants as ACOPDs. By allowing the study to remain subjective and entirely from the participants point of view enabled a unique group of individuals to be identified and heard thus fulfilling the aim of the study. There are potentially thousands of adult children being 'left out' of research studies because of rigid classification methods meaning they are not eligible to take part. By keeping the study broad it meant participants such as Haleema, Aisha and Matt whose fathers did not drink to excess were able to share their experiences and voice their views. Their fathers did not drink beyond three to four drinks per evening, which according to the website Drinkaware is within the Government's daily recommendations for men. By official standards therefore, these parents may not be considered problem drinkers, nevertheless their level of consumption was enough to cause disruption in the family in the participants' opinion.

As described in chapter one, Velleman and Orford (1999) described the use of psychosocial definitions of PD as being from the family member's point of view. I felt this was more appropriate than using a label such as 'alcoholic' which some people may be uncomfortable with or do not feel describes their parents drinking problem. Moreover, it allowed for PD to be viewed on a 'continuum of seriousness' as suggested by Orosz-Vail et al. (2000) and other authors referred to in chapter one. Whilst it was a strength to keep the study more open and subjective as it improved on previous methodological limitations, it did mean the participants' experiences were varied. When looking across the group as a whole however, the differing levels of alcohol dependence did not appear to impact the findings to any great extent and many common themes still emerged.

The main limitation of the study was the within-group differences in the sample of participants. Despite attempts to keep the sample as homogenous as possible in keeping with IPA's principles (Smith & Osborn, 2003) such as limiting the age range and restricting the study to those born and raised in the UK, numerous within-differences still occurred. This is a re-occurring problem with research on offspring. In addition to the severity of dependence other factors which came into play included: parent / child

gender combinations (e.g. sons of problem drinking fathers; daughters of problem drinking mothers); status of parental drinking (active or in recovery); whether participants lived at home with PDP; cultural background; and engagement in professional support by either the participants or their PDP. Whilst attempts could have been made to refine the sample further (i.e. only recruiting female participants with problem drinking mothers) I was wary of doing so given the immense difficulty with recruitment with the limited inclusion criteria already in place and samples always being somewhat dependent on pragmatic factors such as who is available. These within group differences did not necessarily impact the findings in a negative way and to an extent enriched the study. It is possible parental drinking style, a factor which Johnson and Rolf (1990) have discussed, resulted in the overall commonalities between the participants (despite the other within group differences) because the majority of the PDPs shared a similar drinking style in that they were typically 'unavailable' to the family when they were drinking.

Despite the small sample size I was able to extract the differences in participants' experiences according to parent / child gender combinations. One of the most obvious differences was the greater fear of developing a drinking problem in the male participants with PD fathers such as David and Matt. Conversely, the daughters of PD fathers (Haleema and Aisha) feared becoming like their fathers if they were to get drunk. Additionally, daughters of PD mothers such as Rachael and Hannah indicated more relationship issues. These included difficulties with implementing boundaries and trusting people (particularly women). This knowledge is extremely valuable for counselling psychologists and other practitioners and can be applied to formulations and subsequent treatment plans. The choice of therapeutic model may also be influenced dependent on which issue has arisen with the client (e.g. working more cognitively with negative thoughts or fear around alcohol).

As discussed in chapter one, I decided against recruiting participants whose parents were also born and raised in the UK for fear of excluding too many potential participants. Although Haleema and Aisha were born and raised in UK, their parents were not. Haleema's parents were raised in Pakistan and Aisha's in Singapore. As a result, they had been raised with very different values and views around alcohol. Additionally, their dialogue on family roles and what was considered acceptable

behaviour by a male were particularly different to rest of the sample of participants who were English. I had initially concluded Haleema and Aisha's cultural background would impact the findings by serving as outliers because their interviews were quite different to the other participants. Nonetheless, they still had many things in common with the remainder of the sample. Moreover, this cultural difference proved to be quite a strength and enriched the study because it highlighted some of the differences culture may have on offspring experiences.

A further factor which needs addressing is the use of siblings within the sample. Although it was of interest to have siblings involved in the study (Hannah and Rachael) because I believed they would offer unique perspectives (which was the case) it did mean there was only one PD mother included in the study, which is limited. Moreover, their mother had numerous mental health issues which may have contributed to some of her behaviour. This means Hannah and Rachael had a very unique experience of maternal PD, which may not apply to offspring experiencing PPD in isolation.

Recruitment of participants was difficult and despite advertising in a variety of places such as social networking websites, universities, and websites specifically for COPDs, the majority of the sample were students. Whilst attempts were made to recruit a different kind of sample with fewer students, given the time frame for the study I was unable to continue re-recruiting and therefore conducted the study on the sample available. My reasons for attempting to avoid a student sample was due to the large number of studies based purely on student samples, which has been criticised by authors such as Mintz et al. (1995). Two of the four students were in fact mature students over 25 years of age and therefore not representative of your average student sample. Moreover, in a qualitative study such as the present one based on participants experiences it is not felt that occupation is particularly significant.

Improvements to the current study

The study has contributed to a large gap in the field previously identified by Templeton et al. (2006) and other authors such as Gorin (2004) and Kroll and Taylor (2003) in terms of directly exploring the views and experiences of COPDs. This offers valuable information on impact and resilience factors. The study failed to grasp enough of the participants' views on service needs and existing service provision. Whilst this was not

the main aim for the study it had been hoped that the study would elicit some useful information for counselling psychologists and other mental health professionals as to what offspring want and need in terms of support. In order to guarantee ascertaining participants' views on service provision I might have considered designing a questionnaire focusing on this topic for participants to complete following the interview. An example of which has been included (Appendix P). Exploring participants' views on service provision however is worthy of consideration as a study in its own right, and would be extremely valuable to counselling psychologists as well as others working in the addiction field. I had perhaps been overly optimistic that I would gain enough information on both experiences and service provision in such an exploratory study. Moreover, in order to improve on previous research the sample would ideally consist of participants who have never engaged in professional support as was suggested by Templeton et al. (2006).

Implications and recommendations for practice

In this section reference is made to the research findings in terms of implications and recommendations for clinical practice. Firstly, considerations will be presented for specialist services in the addiction field which will then be followed by implications for practitioners working in generic services.

Specialist services

Although recovery and support were amongst the common themes in the findings, very little was extracted from interviews in terms of participants 'views' on professional support services. Four participants had engaged in psychological counselling as adults but only Hannah and Rachael had attended therapy specifically to deal with their mother's PD, and as mentioned earlier were offered support by the Priory. As a result they were the only participants in a position to share their opinion on professional support for ACOPDs. Participants' accounts suggested informal support (speaking with friends and family), or no support whatsoever, largely outweighed contact with professional services.

To expand on this further, whilst I acknowledge this is a small sample within which to make any generalised statements nor is that the intention of the study, the 'lack of discussion' about support services stood out. Even when I asked hypothetical questions

about what participants may consider discussing in counselling for example, participants were not particularly forthcoming. As a future counselling psychologist I was both curious and concerned why COPDs and ACOPDs were not engaging with professional services. Is it a question of services not being readily available or are practitioners not knowledgeable enough about the group to be able to support them effectively? For younger children is the ongoing issue of 'confidentiality' found by Gorin (2004), still preventing them from speaking up if they are experiencing PPD because they fear their parents will be contacted and involved. Other than Aisha who spoke to her teachers on one occasion, none of the other participants spoke to anyone about their parents drinking problem whilst they were children or as teenagers. There appears to be a 'barrier' between COPDs and 'professionals'.

In her review, Gorin (2004) found children frequently highlighted the importance of establishing trust when discussing their needs. The 'personal qualities' of the helper was described as being extremely important for children, for example, being able to confide in someone who will listen and is kind (Bancroft et al., 2004). This may appear to be an obvious expectation yet Templeton et al.'s (2006) scope study indicated a number of studies reported children often feel professionals talk in a different language, and fail to listen or understand. This mirrored Haleema's interview who said: *"If I talk to like a counsellor they just like agree with it or they'll be like I understand but it's not really them understanding it."* There appeared to be a lack of faith that therapy would be beneficial and that the counsellor would truly understand Haleema's situation.

Based on both Gorin (2004) and the current study's findings, those working in psychological services may need to approach younger children and teenagers differently. This suggests psychologists may require further training in working with young people (courses, workshops) to increase and improve their therapeutic skills. Based on my own training background I would argue the lack of focus on working with children means that as a profession we are possibly under skilled to work with young people. Moreover, our skills will very much depend on the counselling placements we have embarked on. Additionally, services may need to be more explicit about what they can offer clients. Whilst psychologists may not share the same experience of being a COPD or ACOPD, they can empathise with the client's situation; offer them a safe place to explore their feelings; support them in increasing their assertiveness skills; and

work in the therapeutic model which suits the presenting problem most effectively. There is a need to emphasise the benefits of engaging in psychological counselling and also clarify that we are not there to advise clients on what to do regarding their PDP.

Returning to my earlier point regarding being 'understood', both Gorin (2004) and Kroll and Taylor (2003) reported children longing to meet others who have had or are having similar experiences. In their study which included discussing impact and need with the following groups: children; young people; and professionals, Hill, Laybourn and Brown (1996) reported *"Many wished they could meet with others in the same position, so they could feel less isolated and learn from each other"* (p.159). This mirrored Hannah's positive experience and view of attending a support group and was preferable over one-to-one counselling. Moreover, Aisha and Haleema also expressed wanting to speak with people who really *"understand"*, hence their reason for choosing to speak with friends and family who were in the same position. This suggests that on a practical level an increased number of support groups is required. Moreover, I would argue a combination of groups are needed; groups purely for offspring; and groups for family members where the offspring could attend with their non-drinking parent. This could increase communication between family members about how the drinking problem affects the family as a whole, in a contained environment. A further variation could be a group whereby a close friend is invited to hear about addiction and listen to people's experiences. The aim again being for the offspring to increase communication about life with a PDP with those closest to them.

A number of the findings in the present study mirrored those in Templeton et al.'s (2006) review such as children's reluctance to speak to people outside of the family for fear of bringing shame on the family and wanting to be loyal to the PDP. I mention this point because it is particularly relevant in certain cultures and was true for Haleema and Aisha. Haleema was extremely conscious of not sharing her feelings with anyone outside of the family and wanting to protect her father's reputation. Aisha also felt under pressure not to talk about her father's drinking because her mother did not want other people thinking badly of her family especially as the daughters were unwed. Even when she did confide in a friend instead of family, she chose to speak to someone of the

same cultural background, thus suggesting a longing to keep things within the community.

Orford et al. (1998) also discussed cultural beliefs and values as being a barrier to obtaining support in their Mexican participants. Family problems were not to go outside the family because that would violate the intimacy and loyalty in the family. There was a high level of tolerance of men's consumption of alcohol and drunkenness, (men drink and their wives are supposed to 'put up' with it) however the same did not apply to women. Where the husband was the problem drinker there was also 'fear' of what he would do if problems were spoken outside the family, and a general fear of what others would say. Many of these cultural beliefs mirrored those of Haleema and Aisha. Experiences of PPD vary immensely and it would be beneficial to discuss these issues and share experiences with people of the same background. I would therefore argue that culturally specific support groups need to be increased.

When addressing the needs of young children Gorin (2004) reported children wanted to leave the house and engage in childhood activities. Additionally, Gance-Cleveland (2004) reported young people benefited from experiential knowledge gained at school-based support group for adolescents because groups *"enhanced self-knowledge and led to self-care and self-healing"* (pg. 379). Hannah's idea of 'seasonal camps' could be ideal *"where kids come from across the country and go away for like four weeks erm and they get to learn about all different things like expressing themselves, releasing feelings, err being creative, having fun, learning about addiction and how to communicate positively that's what I think kids need something that's really intense"*. The aforementioned findings clearly suggest a great need to increase the services available to young children. These camps or activities could be set up and encouraged by schools and those working most closely with COPDs.

I have paid particular attention to a number of comments Hannah made because of her personal experience and the knowledge she has gained from developing her website. Hannah sounded immensely frustrated when she said *"if the government want to find out what they need funding for all they need to do is look at the website (the one Hannah has developed) and find out what the issues kids are going through."* There was a sense of having been let down. Kroll and Taylor (2003) also found children were

angry that people had not tried hard enough to break down the barriers. As practitioners we need to listen to what clients want and need. If research suggests informal support is more strongly desired by this population, then this needs to be addressed. The number of support groups led by offspring themselves for example could be increased, as could websites like Hannah's which offer information on PD but also allow people to share their experiences and respond to each other's stories.

Generic services

Up to this point the focus has been on suggestions to improve services as a whole. This section will return to the issues raised in chapter two regarding the need for counselling psychologists working across various contexts (Primary Care, Schools, general counselling services) to increase their knowledge on offspring on problem drinkers. There may be occasions where clients are referred for anxiety or depression for example and not as a direct result of PPD. The fact that they are the offspring of a problem drinker may nevertheless be relevant for formulation purposes. To illustrate this point, Richard was referred to a psychologist for both anxiety and depression. It was only whilst he was in therapy that he and his psychologist realised part of the problem was as a result of the criticism and insults he received from his step-mother when she was drunk. This had affected his confidence and self esteem.

Although each client will present with a unique set of issues there are clearly common themes which are helpful for psychologists to have in mind. Velleman (2004) concluded clients need specific help with stress-management, assertiveness training and self-esteem improvement which need to be applied in specialist and generic services. Given the current findings I would add that clients need support with developing and maintaining healthy relationships, communication skills and managing a multitude of emotions felt towards a PDP. Counselling psychologists have the ability to work with such issues within different therapeutic models such as humanistic and CBT. An additional and highly important issue, based on the prevalence of this theme amongst participants, is the need to work therapeutically with the fear associated with PPD. This being both in terms of a fear of dependence which was more prevalent amongst the male participants and a fear of 'becoming like' their PDP whilst under the influence of alcohol. Both had a major impact on participants' alcohol use either by restricting

alcohol intake, or abstaining altogether. A counselling psychologist may therefore consider implementing cognitive techniques into their treatment plan with a client presenting with such fear.

Recommendations for future research

Two main areas were identified as needing further research. Firstly, a sub-group within the participants which stood out in particular was adult children still living at home with actively drinking parents. For adults such as Haleema and Aisha who remained at home partly for cultural reasons, life continues to be extremely difficult and the negative impact continues (life remains on hold; parent / child relationship deteriorates further; loss of self-esteem; fear of the PDP and problems with assertiveness). It must be noted that not all the aforementioned issues are specific to adults still living at home but there is the potential for such issues to get worse. Their interviews were noticeably different from the other participants who were no longer living at home. There was quite a strong sense of helplessness which the other participants who had been living apart from their PDP for some years no longer experienced.

Aside from Mackrill (2008) I did not find another study which focuses on ACOPDs living at home. He described 'leaving home' as a significant step in the recovery for ACOPDs. Interestingly, the treatment of ACOPDs has been compared with the treatment of sufferers of post-traumatic stress disorder (PTSD), such as war survivors (Cermak, 1985). Many war survivors and ACOPDs share the experience of having lived under stressful conditions for prolonged periods of time. Entry into a safe haven or stable context is considered of paramount importance if therapy is to be effective. One cannot effectively treat people for the effects of prolonged stress if they continually live under highly stressful conditions, and have no control upon these conditions. This parallel suggests that leaving home is a significant step in ACOPD recovery. The study however described the significance of leaving home for ACOPDs in a Danish context. Leaving home may have different meanings for ACOPDs in other cultural contexts; cultural differences would therefore need to be considered (Cable, 2000).

Secondly, the cultural differences on both impact on the children but also on seeking professional support needs further investigation. Both Gorin (2004) and Kroll and Taylor (2003) have also argued children from different cultural backgrounds be

interviewed on their experiences of PPD. Orford et al.'s (1998) cross cultural study was extremely informative however very few children were involved in the study which included various family members. It would be of great interest and value to carry out a similar study to the current one within specific cultural groups such as purely Asian offspring. The sample could be made even more homogenous by recruiting children from particular countries such as India or Pakistan.

Conclusions

It is felt this study is a valuable contribution to the field and has also raised some important points for practitioners in terms of improving service provision for ACOPDs. The outcomes for ACOPDs will always be varied based on their unique life experiences. Even with this small sample of participants however, a number of themes emerged which can be used to increase our knowledge of this group thus bringing them further into our awareness. Although I was able to discuss my findings in relation to previous research in the area, it was limited to a small number of renowned authors who clearly have a strong interest in the field. Far more qualitative research is still required.

This study suggests that despite significant difficulties throughout their lives the outcomes for the participants were for the most part not as severe as expected. They have shown immense resilience and demonstrated various methods of coping with PPD. If the consensus is that COPDs and ACOPDs prefer to engage with those in a similar position so that they can share their experiences and not feel so alone, then the answer lies in implementing and raising awareness of support groups, websites and forums. It is unfortunate how extensive PD has become in the UK and as a result there will be thousands if not millions of offspring who will continue to deal with similar issues to the participants in this study. It is an ongoing problem without a quick and easy solution in sight. It is of upmost importance to continue listening and trying to make sense of their experiences. They need no longer be *"the forgotten children"*.

A final reflection: Working together

Whilst this study has shown that life is undoubtedly challenging for the offspring of problem drinkers, the participants' accounts on the whole suggested a hopeful future. During the course of this chapter I have suggested that as practitioners we need to do

more to support this group of individuals. Nonetheless, Hannah's account leaves me feeling encouraged that as a group of professionals we are already making a difference. I commenced this doctorate with one thought in mind *"if I can help even one person change their life then it was worth it"*. Although the majority of participants were not inclined to engage in professional support services Hannah admitted she would not have been where she was in her life today without it. The reality will always be that there is only so much I / we as a group will ever be able to do and the client has to want to help themselves. We need to work together!

I recognise a part of Hannah in myself, because in addition to therapy she tried to gain more of an understanding of her mother's drinking problem by being proactive and developing her website. Similarly, I chose to embark on a career in Psychology and build on my understanding of mental health to better understand my parent's depression. There is no question that some problems can develop as a result of parental mental health however over time and with the right support things can improve. I leave you with some final words from Hannah which inspire great hope for COPDs. She took the opportunity to make great change and has found inner peace and happiness, *"It's taken a long time to get to where I am now and a lot a lot of hard work. I've put in a lot of hard work and realised it had to be* ***me*** *to make the difference... I am so happy I couldn't be any happier really."*

A final word to my participants

"Thank you for your invaluable words .... you have been heard!"

References

Ackerman, R. J. (2002). *Perfect Daughters*. Revised Edition. Adult Daughters of Alcoholics. Health Communications, Inc.

Alcohol Concern: www.alcoholconcern.org.uk

Allport, G. W. (1897-1967). In Smith, J. A. (2008). *Qualitative Psychology: A Practical Guide to Methods.* London, Sage.

American Psychiatric Association (2000). Diagnostic and statistical manual of mental disorders-text revision, 4th edn, (DSM-IV-TR), Washington, DC.

Annells, M. (1996). Hermeneutic phenomenology: Philosophical perspectives and current use in nursing research. *Journal of Advanced Nursing*, *23,* 705-713.

Anthony, H. (1974). In Johnson, J., & Leff, M. (1999). Children of substance abusers: An overview of research findings. *Pediatrics*, *103,* 1085-1099.

Babor, T., Hesselbrock, V., Meyer, R., & Shoemaker, W. (1994). In Sher, K. (1997). Psychological Characteristics of Children of Alcoholics. *Alcohol Health & Research World, 21(3),* 247-254.

Backett-Milburn, K., Wilson, S., Bancroft, A., & Cunningham-Burley, S. (2008). Challenging Childhoods: Young people's accounts of 'getting by' in families with substance use problems. *Childhood, 15,* 461-479.

Baker, T. L. (1994). *Doing Social Research* (2nd Edn.), New York: McGraw-Hill Inc.

Bancroft, A., Wilson, S., Cunningham-Burley, S., Backett-Milburn, K., & Masters, H. (2004). *Parental Drug and Alcohol Misuse: Resilience and Transition Among Young People*, Joseph Rowntree Foundation, Drug and Alcohol Research Programme. York: Joseph Rowntree Foundation.

Barber, J., & Crisp, B. (1995). The 'pressures to change' approach to working with the partners of heavy drinkers. *Addiction, 90(2),* 269-276.

Barnard, M., & Barlow, J. (2003). Discovering parental drug dependence: Silence and disclosure. *Children and Society, 17(1),* 45-56.

Beck, A. T., Wright, F. D., Newman, C. F., & Liese, B. S. (1993). *Cognitive Therapy of Substance Abuse.* The Guilford Press.

Berger, G. (1993). *Alcoholism and the family*. New York: Franklin Watts.

Berkowitz, A., & Perkins, H. (1988). Personality characteristics of children of alcoholics. *Journal of Consulting and Clinical Psychology, 56,* 206-209.

Black, C. (1979). In Black, C., Bucky, S., & Wilder-Padilla, S. (1986). The interpersonal and emotional consequences of being an adult child of an alcoholic. *International Journal of Addiction, 2,* 213-31.

Black, C. (1982). In Hall, C., & Webster, R. (2007). Risk factors among adult children of alcoholics. *International Journal of Behavioral Consultation and Therapy, 3(4),* 494-511.

Black, C., Bucky, S., & Wilder-Padilla, S. (1986). The interpersonal and emotional consequences of being an adult child of an alcoholic. *International Journal of Addiction, 2,* 213-31.

Brown, S. (1988). *Treating adult children of alcoholics: A developmental perspective*. New York: John Wiley & Sons, Inc.

Burk, J., & Sher, K. (1988). The “forgotten children” revisited: Neglected areas of COA research. *Clinical Psychology Review, 8,* 285-302.

Cahalan, D. (1970). In Velleman R., & Orford, J. (1999). *Risk and Resilience: Adults who were the Children of Problem Drinkers.* London: Harwood Academic.

Chassin, L., Pillow, D., Curran, P., Molina Brooke, S., & Barrera, M. (1993). Relation of parental alcoholism to early adolescent substance use: A test of three mediating mechanisms. *Journal of Abnormal Psychology, 102,* 3-19.

Chassin, L., Curran, P., Hussong, A., & Colder, C. (1996). The relation of parent alcoholism to adolescent children of alcoholics - A comparison of three subject sources. *Journal of Studies on Alcohol*, *53*, 316-319.

Cohen, L., Manion, L., & Morrison, K. (2000). *Research Methods in Education London* (5th edition). Routledge Falmer.

Cork, R. M. (1969). *The forgotten children: A study of children with alcoholic parents*. Paperjacks.

Cotton, N. (1979). The familial incidence of alcoholism: a review. *Journal of Studies on Alcohol*, *40*, 89-116.

Cox, D. L., Stabb, S. D., & Bruckner, K. H. (1999). In Calamari, E., and Pini, M. (2003). Dissociative Experiences and Anger Proneness in Late Adolescent Females with Different Attachment Styles. (Retrieved September 2010, http://findarticles.com/p/articles/mi_m2248/is_150_38/ai_109027881/?tag=content;col1).

Creswell, J. W., & Miller, D. L. (2000). Determining validity in qualitative inquiry. *Theory into Practice, 39(3),* 124-131.

Cuijpers, P. (2005). Prevention programmes for children of problem drinkers: A review. *Drugs: education, prevention and policy*, *12(6)*, 465-475.

Davies, D., & Dodd, J. (2002). Qualitative research and the question of rigor. *Qualitative Health Research, 12(2),* 279-289.

Denzin, N. K., & Lincoln, Y. S. (2000b). In Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology, 52(2),* 126-136.

Department of Health (2007). Drinking: Adults' behaviour and knowledge.

Dilthey, W. (1894-1977). In Willig, C., & Stainton-Rogers, W. (2008). *The Sage Handbook of Qualitative Research in Psychology*. London, Sage.

Dilthey, W. (1976). In Willig, C., & Stainton-Rogers, W. (2008).*The Sage Handbook of Qualitative Research in Psychology*. London, Sage.

Domenico, D., & Windle, M. (1993). Intrapersonal and interpersonal functioning among middle-aged female adult children of alcoholics. *Journal of Consulting and Clinical Psychology, 61,* 659-666.

Drinkaware: http://www.drinkaware.co.uk/

El-Guebaly, N., & Offord, D.(1977). The offspring of alcoholics: A critical review. *American Journal of Psychiatry, 134,* 357–365.

Emshoff, J., & Anyan, L. (1991). From prevention to treatment. Issues for school-aged children of alcoholics. *Recent Developments in Alcohol,* 9, 327-46.

Emshoff, J., & Price, A. (1999). Prevention and Intervention Strategies with Children of Alcoholics. *Pediatrics,103(5),*1112-1121.

Finn, P., Sharkansky, E., Viken, R., West, T., Sandy, J., & Buffered, G. (1990). In Edwards, E., Leonard, K., & Eiden, R. (2001). Temperament and behavioral problems among infants in alcoholic families. *Infant Mental Health Journal, 22(3),* 374-392.

Fisher, G. L., Jenkins, S. J., Harrison, T. C., & Jesch, K. (1992). Characteristics of adult children of alcoholics. *Journal of Substance Abuse, 4,* 27-34.

Fitzgerald, F. (2000). In Gilbert, R. (2008). Ronald Reagan's Presidency: The Impact of an Alcoholic Parent. *Political Psychology, 29(5),* 737-763.

Flick, U. (1998). In Smith, J. A. (2008), *Qualitative Psychology: A Practical Guide to Methods.* London, Sage.

Foxcroft, D., & Lowe, G. (1991). Adolescent drinking behaviour and family socialisation factor: a meta-analysis. *Journal of Adolescence, 14,* 255-273.

Furtado, E. F., Laucht, M., & Schmidt, M. H. (2006). Gender-related pathways for behaviour problems in the offspring of alcoholic fathers. *Brazilian Journal of Medical and Biological Research, 39(5),* 659-669.

Gadamer, H. (1976). In Laverty, S. M. (2003). Hermeneutic Phenomenology and Phenomenology: A Comparison of Historical and Methodological Considerations. *International Journal of Qualitative Methods, 2(3),* 1-29.

Gance-Cleveland, B. (2004). Qualitative Evaluation of a School-Based Support Group for Adolescents With an Addicted Parent. *Nursing Research, 53(6),*379-386.

Goodchild, S. (2008, July 22nd). Binge-drinking Britain on verge of 'tsunami of harm'. *London Evening Standard.*

Gorin, S. (2004). *Understanding what children say: Children's experiences of domestic violence, parental substance misuse and parental health problems.* National Children's Bureau in association with the Joseph Rowntree Foundation.

Grady, C. L., & Craik, F. I. (2000). Changes in memory processing with age. *Current Opinion in Neurobiology, 10 (2),* 224-231.

Greenfield, S., Swartz, M., Landerman, L., & George, L. (1993). Long-term psychosocial effects of childhood exposure to parental problem drinking. *American Journal of Psychiatry, 150,* 608-613.

Hall, C. W., Webster, R. E., & Powell, E. J. (2003). Parental alcohol use in adult children of alcoholics. *Alcohol Research, 8,* 157-162.

Hall, C., &Webster, R. (2007). Risk factors among adult children of alcoholics. *International Journal of Behavioral Consultation and Therapy, 3(4),* 494-511.

Hansen, J. T. (2004). Thoughts on knowing: Epistemic implications of counselling practice. *Journal of Counselling & Development, 82,* 131-138.

Harter, S., & Taylor, T. (2000). Parental Alcoholism, Child Abuse, and Adult Adjustment. *Journal of Substance Abuse, 11(1),* 31-44.

Hassija, C., & Gray, M. (2007). Behavioural intervention for trauma and posttraumatic stress disorder. *International Journal of Behavioural Consultation and Therapy,* 3, 166-175.

Healy, M., & Perry, C. (2000). In Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report, 8,* 597-607.

Heidegger, M. (1889-1976). In Burch, R. (1989). Phenomenology, Lived Experience: Taking a Measure of the Topic. *Phenomenology & Pedagogy, 8,* 130-160.

Hoepfl, M. (1997). In Golafshani, N. (2003). Understanding reliability and validity in qualitative research. *The Qualitative Report, 8,* 597-607.

Holloway, I. (1997). *Basic Concepts for Qualitative Research,* Oxford: Blackwell Science.

Hunter, I. (2006). The History of Theory, *Critical Inquiry, 33,* 78-112.

Husserl, E. (1859-1938). In Ricoeur, P & Ballard, E. (1967). Husserl: *An Analysis of His Phenomenology*. Published by Northwestern University Press.

Husserl, E. (1900-1970). In Willig, C., & Stainton-Rogers, W. (2008). *The Sage Handbook of Qualitative Research in Psychology*. London, Sage.

Jaegar, E., Hahn, N., & Weinraub, M. (2000). Attachment in adult daughters of alcoholic fathers. *Addiction, 95,* 267-276.

Jarmas, A., & Kazak, A. (1992). Young adult children of alcoholic fathers: Depressive experiences, coping styles, and family systems. *Journal of Consulting and Clinical Psychology, 60(2),* 244-251

Johnson. J., & Rolf, J. (1990). In Lease, S. (2002). A model of depression in adult children of alcoholics and nonalcoholics, *Journal of Counselling & Development, 80(4),* 441-451.

Johnson, J., Sher, K., & Rolf, J. (1991). Models of vulnerability to psychopathology in children of alcoholics: An overview. *Alcohol Health Research World, 15,* 33-42.

Johnson, J., & Leff, M. (1999). Children of Substance Abusers: Overview of Research Findings. *Paediatrics, 103(5),*1085-1099.

Johnson, P. (2001). Dimensions of functioning in alcoholic and non-alcoholic families. *Journal of Mental Health Counselling, 23,* 127-136.

Jones, D., & Hotus, R. (1992). In Rangarajan, S., & Kelly, L. (2006). Family communication patterns, family environment, and the impact of parental alcoholism on offspring self-esteem. *Journal of Social and Personal Relationships, 23(4),* 655-671.

Jorgensen, D., & Jorgensen, J. (1990). *Secrets told by children of alcoholics*. Blue Ridge, Summit, PA: Tab Books.

Kandel, D., Kessler, R., & Margulies, R. (1978). Antecedents of adolescent initiation into stages of drug use: A developmental analysis. *Journal of Youth and Adolescence, 7(1),* 13-40.

Kant, I. (1881-1996). In Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology, 52(2),* 126-136.

Kashubeck, S., & Christensen, S. A. (1992). Differences in distress among adult children of alcoholics. *Journal of Counselling Psychology, 39,* 356-362.

Kashubeck, S., & Christensen, S. (1995). In Lease, S. (2002). A model of depression in adult children of alcoholics and nonalcoholics. *Journal of Counselling & Development, 80(4),* 441-451.

Kassinove, H. (1995). Anger disorders: definition, diagnosis and treatment. Taylor & Francis, Ltd.

Kerr, E., & Hill, W. (1992). An Exploratory Study Comparing ACoAs to Non-ACoAs on Current Family Relationships. *Alcoholism Treatment Quarterly,* 9(1), 23-38.

King, N. (2004). In Cassell, C. & Symon, G. (2004). *Essential guide to qualitative methods in organisational research*. Sage.

Kirby, J. (2010, January 28th). Rise in number of people dying from alcohol. *Independent.*

Koch, T. (1995). Interpretative approaches in nursing research: The influence of Husserl and Heidegger. *Journal of Advanced Nursing, 21,* 827-836.

Koch, T. (1996). In Laverty, S. M. (2003). Hermeneutic Phenomenology and Phenomenology: A Comparison of Historical and Methodological Considerations. *International Journal of Qualitative Methods, 2(3),* 1-29.

Kroll, B. (2004). Living with an elephant: Growing up with parental substance misuse. *Child and Family Social Work, 9,* 129–140.

Kroll, B., & Taylor, A. (2003). *Parental substance misuse and child welfare.* London: Jessica Kingley.

Kubler-Ross, E., & Kessler, D. (2005). *On Grief and Grieving: Finding the Meaning of Grief through the Five Stages of Loss*. Scribner Book Company.

Kultur, S. E., Unal, M. F., & Ozusta, S. (2006). Psychopathology in children of alcoholic fathers. *Turk Psikiyati Dergisi, 17(1),* 3-11.

Kushner, M., & Sher, K. (1993). Comorbidity of alcohol and anxiety disorders among college students: Effects of gender and family history of alcoholism. *Addictive Behaviors, 18,* 543-552.

Kvale, S. (1983). The qualitative research interview: A phenomenological and hermeneutical mode of understanding. *Journal of Phenomenological Psychology, 14(2),* 171-196.

Laverty, S. M. (2003). Hermeneutic Phenomenology and Phenomenology: A Comparison of Historical and Methodological Considerations. *International Journal of Qualitative Methods, 2(3),* 1-29.

Lease, S. (2002). A model of depression in adult children of alcoholics and non alcoholics, *Journal of Counselling & Development, 80(4),* 441-451.

Leonard, K. E., & Eiden, R. D. (2002). *Drug and Alcohol Dependence, 67(2),* 139-147.

Liotti, G. (2006) A model of dissociation based on attachment theory and research. *Journal of trauma and dissociation, 7,* 55-74.

Little, M., Axford, N., & Morpeth, L. (2004). In Velleman, R. & Templeton, L. (2007). Understanding and modifying the impact of parents' substance misuse on children. *Advances in Psychiatric Treatment, 13,* 79–89.

Logue, M., Sher, K., & Frensch, P. (1992). In Hawkins, C. (1997). Disruption of family rituals as a mediator of the relationship between parental drinking and adult adjustment in offspring. *Addictive Behaviors, 22(2),* 219-231.

Lyons, E., & Coyle, A. (2007). Analysing Qualitative Data in Psychology. SAGE Publications Ltd.

Maaranen, P., Tanskanen, A., Haatainen, K., Koivumaa-Honkanen, H., Hintikka, J., & Viinamaki, H. (2004). Somatoform dissociation and adverse childhood experiences in the general population. *J Nerv Ment Dis*, 192, 337-342.

MacNicholls, T. (1905). In Johnson, J., Sher, K., & Rolf, J. (1991). Models of vulnerability to psychopathology in children of alcoholics: An overview. *Alcohol Health Research World, 15,* 33-42.

Mackrill, T. (2008). Pre-treatment change in psychotherapy with adult children of problem drinkers: The significance of leaving home. *Counselling and Psychotherapy Research, 8(3),* 160-165.

Mann, B, and Sanders, S. (1994). Child dissociation and the family context. *J Abnorm Child*, 22, 373–388.

Mathew, R. J., Wilson, W. H., Blazer, D. G., & George, L. K. (1993). Psychiatric disorders in adult children of alcoholics: data from the epidemiologic catchment area project. *American Journal of Psychiatry, 150,* 793-800.

McGue, M., Bacon, S., & Lykken, D. (1993). Personality stability and change in early adulthood: A behavioral genetic analysis. *Developmental Psychology, 29,* 96-109.

McLeod, J. (2001). *Qualitative research in counselling and psychotherapy.* London: Sage.

Merikangas, K. (1990). The genetic epidemiology of alcoholism. *Psychological Medicine, 20,* 11-22.

Mintz, L. B., Kashubeck, S., & Tracy, L. S. (1995). Relations among parental alcoholism, eating disorders, and substance abuse in non-clinical college women: additional evidence against the uniformity myth. *Journal of Counselling Psychology*, *42*, 65-70.

Modestin, J., Lotscher, K., & Thomas, E. (2002). Dissociative experience and their correlates in young non-patients. *Psychological Psychotherapy*,75, 53–64.

Moe, J., Johnson, J., & Wade, W. (2007). Resilience in children of substance users: In their own words. *Substance Use & Misuse, 42(2-3),* 381-398.

Moos, R., Finney, J., & Cronkite, R. (1990). In Velleman R., & Orford, J. (1999). *Risk and Resilience: Adults who were the Children of Problem Drinkers. London*: Harwood Academic.

Moran, D. (2000). *Introduction to Phenomenology*. London: Routledge.

Morrow, S. L., & Smith, M. L. (2000). Qualitative research for counseling psychology. In S. D. Brown & R. W. Lent (3rd ed.,), *Handbook of counseling psychology* (pp. 199-230). New York, Wiley.

National Association for the Children of Alcoholics: www.nacoa.org.

Orford, J., Natera, G., Davies, J., Nava, A., Mora, J., Rigby, K., Bradbury, C., Copello, A., & Velleman, R. (1998). Stresses and strains for family members living with drinking or drug problems in England and Mexico. *Salud Mental, 21(1),* 1-13.

Orford, J. (2004). Empowering family and friends: a new approach to the secondary prevention of addiction. *Drug Alcohol Review, 13,* 417-429.

Orford, J., Natera., G., Copello, A., Atkinson, C., Mora, J., Velleman, R., Crundall, I., Tiburcio, M., Templeton, L., & Walley, G. (2005). *Coping with alcohol and drug problems: The experience of family members in three contrasting cultures.* Routledge, Taylor & Francis Group.

Ormiston, G., & Schrift, A. (1990). *The hermeneutic tradition: from Ast to Ricoeur*. SUNY Press.

Orosz-Vail, M., Protinsky, H., & Prouty, A. (2000). Sample issues in research on adult children of alcoholics: Adolescence and beyond. *Adolescence, 35(137),* 113-119.

Osborn, M., & Smith, J.A. (2006). Living with a body separate from the self. The experience of the body in chronic benign low back pain: an interpretative phenomenological analysis. *Scand J Caring Sci, 20,* 216-222.

Packer, M., & Addison, R. (1989). In Smith, J. A. (2008). *Qualitative Psychology. A practical guide to research methods* (2nd ed.). SAGE Publications.

Palmer, R. (1969). In Lyons, E., & Coyle, A. (2007). *Analysing Qualitative Data in Psychology*. SAGE Publications.

Pandina, R., & Johnson, V. (1990). Serious alcohol and drug problems among adolescents with a family history of alcoholism. *Journal of Studies on Alcohol, 51,* 278-282.

Parker, T. (1998). In Calamari, E., and Pini, M. (2003). Dissociative Experiences and Anger Proneness in Late Adolescent Females with Different Attachment Styles.(Retrieved September 2010, http://findarticles.com/p/articles/mi_m2248/is_150_38/ai_109027881/?tag=content;col1).

Patient UK: www.patient.co.uk

Pemberton, W. (1997). In Gilbert, R. (2008). Ronald Reagan's Presidency: The Impact of an Alcoholic Parent. *Political Psychology*, 29(5), 737-763.

Pilat, J. M., & Jones, J. W. (1985). Identification of children of alcoholics: Two empirical studies. *Alcohol Health Res World, 9,* 27-36.

Polit, D. F., Beck, C. T., & Hungler, B.P. (2001). *Essentials of nursing research methods, appraisal, and utilization***.** (5th Edition). Philadelphia: Lippincott.

Polkinghorne, D. E. (1983). In Laverty, S. M. (2003). Hermeneutic Phenomenology and Phenomenology: A Comparison of Historical and Methodological Considerations. *International Journal of Qualitative Methods, 2(3),* 1-29.

Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology, 52(2),* 126-136.

Pope, C., & Mays, N. (1995). In Smith, J. A. (2008), *Qualitative Psychology: A Practical Guide to Methods.* London, Sage.

Powers, B. A. & Knapp, T.R. (1995). In Appleton, N. (2006). Analysing qualitative interview data: addressing issues of validity and reliability. *Journal of Advanced Nursing, 22(5),* 993-997.

Rangarajan, S., & Kelly, L. (2006). Family communication patterns, family environment, and the impact of parental alcoholism on offspring self-esteem. *Journal of Social and Personal Relationships, 23(4),* 655-671.

Rangarajan, S. (2008). Epidemiology and prevention. Mediators and Moderators of Parental Alcoholism Effects on Offspring Self-Esteem. *Alcohol & Alcoholism, 43(4),* 481-491.

Reid, K., Flowers, P., & Larkin, M. (2005). Exploring lived experience. *The Psychologist, 18(1),* 20-23.

Rennie, D. L. (2002). In Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology, 52(2),* 126-136.

Rhodes, J., & Blackham, G. (1987). Differences in character roles between adolescents from alcoholic and non-alcoholic homes. *American Journal of Drug Alcohol Abuse*, 13, 145-155.

Roberts, M., Fox, C. & McManus, J. (2001) *Drink and Disorder: Alcohol, Crime and Anti-Social Behaviour*. Nacro Publications.

Robinson, W., & Hassell, J. (2000). Alcohol problems and the family: From stigma to solution. London: ARP and NSPCC.

Rogosch, F., Chassin, L., & Sher, K. J. (1990). Personality variables as mediators and moderators of family history risk for alcoholism: Conceptual and methodological issues. *Journal of Studies on Alcohol, 51,* 310-318.

Royal College of Physicians (1987). *A Great and Growing Evil: The Medical Consequences of Alcohol Abuse*. Royal College of Physicians.

Ruben, D. (2001). *Treating Adult Children of Alcoholics: A behavioural approach*. San Diego, CA: Academic Press.

Ryan, W. (1991). Treatment Issues With Adult Children of Alcoholics. *Psychoanalytic Psychology, 8(1),* 69-82.

Schwandt, T. A. (1994). Constructivist, interpretivist approaches to human inquiry. In Denzin, N. K. & Lincoln, Y. S. (2003) *Handbook of qualitative research.* Thousand Oaks, CA, Sage.

Schwandt, T.A. (2000). In Ponterotto, J. G. (2005). Qualitative research in counselling psychology: A primer on research paradigms and philosophy of science. *Journal of Counselling Psychology, 52(2),* 126-136.

Sciarra, D. (1999). The Role of the Researcher. In Kopala, M., & Suzuki, L. Using Qualitative Methods in Psychology (pg. 37-49). SAGE Publications.

Seale, C. (1999). In Golafshani, N. (2003). Understanding Reliability and Validity in Qualitative Research. *The Qualitative Report,* 8(4), 597-607.

Seefeldt, R., & Lyon, M. (1992). Personality characteristics of adult children of alcoholics. *J. Couns. Dev, 70,* 588-593.

Seixas, J. S., & Youcha, G. (1985). *Children of alcoholism: A survivors manual.* Philadelphia: Harper & Row.

Semlitz, M., & Gold, M. (1986). Adolescent drug abuse: Diagnosis, treatment, and prevention. *Psychiatric Clinics of North America, 9(3),* 455-473.

Shapiro, D., Weatherford, V., Kaufman, E., & Broenen, R. (1994). In Harter, S. (2000). Psychosocial adjustment of adult children of alcoholics: A review of the recent empirical literature. *Clinical Psychology Review, 20(3),* 311-337.

Shaw, R. L. (2001). Why use interpretative phenomenological analysis in Health Psychology?. *Health Psychology Update, 10(4),* 48-52.

Sheiman, J. (1999). In L. M. Williams & V. L. Banyard (Eds.), *Trauma & Memory* (pp. 139–148).Thousand Oaks, CA: Sage Press.

Sher, K. (1991). Children of Alcoholics: A critical appraisal of theory and research. *Clinical Psychology Reviews, 14,* 87-90.

Sher, K. J. (1997). Psychological characteristics of children of alcoholics. *Alcohol Health and Research World, 21,* 247-254.

Smith, J. A. (1993). In Lyons, E., & Coyle, A. (2007). *Analysing Qualitative Data in Psychology*. SAGE Publications.

Smith, J. A. (1994). Reconstructing selves: An analysis of discrepancies between women's contemporaneous and retrospective accounts of the transition to motherhood. *British Journal of Psychology, 85,* 371-392.

Smith, J. A. (1995). Semi-structured interviewing and qualitative analysis. In Smith, J.A., Hare, R., & Van Langenhoven, L. (Eds.), *Rethinking methods in psychology*. London: Sage.

Smith, J. A. (1996). 'Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology'. *Psychology & Health, 11*, 261-271.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*, 39-54.

Smith, J. A. (2007). Hermeneutics, human sciences and health: linking theory and practice. *International Journal of Qualitative Studies on Health & Well-Being, 2,* 3-11.

Smith, J. A. (2008). *Qualitative Psychology: A Practical Guide to Methods.* London, Sage.

Smith, J. A. & Eatough (2008). Interpretative phenomenological analysis. In Lyons, E. &
Coyle, A. (2008). *Qualitative data in psychology.* (pp.35-50) London: Sage.

Smith, J. A., & Osborn, M. (2003). 'Interpretative phenomenological analysis'. In J.A. Smith. *Qualitative Psychology: A Practical Guide to Research Methods* (pp, 59-69). London: Sage.

Smith, J.A., Flowers, P., & Larkin, L. (2009). *Interpretative Phenomenological Analysis: Theory, Method and Research.* London: Sage Publications.

Smith, J.A., Harre, R., & van Langenhove, L. (1995). In Lyons, E., & Coyle, A. *Analysing Qualitative Data in Psychology*. SAGE Publications.

Smith, J. A., Jarman, M., & Osborn, M. (1999). In Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*, 39-54.

Stenbacka, C. (2001). Qualitative research requires quality concepts of its own. *Management Decision, 39(7),* 551-6.

Stout M. L., & Mintz, L. (1996).Differences among nonclinical college women with alcoholic mothers, alcoholic fathers, and non-alcoholic parents. *Journal of Counselling Psychology, 43,* 466–472.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage Publications, Inc.

Taylor, S., J. & Bogdan, R. (1998). *Introduction to qualitative research methods: A guidebook and resource.* (3rd ed.). New York: Wiley.

Teijlingen van, E., Rennie, A.M., Hundley, V., & Graham, W. (2001). The importance of conducting and reporting pilot studies: the example of the Scottish Births Survey. *Journal of Advanced Nursing, 34,* 289-295.

Templeton, L., Zohhadi, S., Galvani, S., & Velleman, R. (2006). *"Looking Beyond Risk"*
Parental Substance Misuse: Scoping Study. Scottish Executive. Retrieved in February 2010 from *www.informaworld.com/index/913171162.pdf.*

Unger, M. P. (2005). Intersubjectivity, hermeneutics, and the production of knowledge in qualitative Mennonite Scholarship. *International Journal of Qualitative Methods, 4(3),* 1-11.

Ullman, A., & Orenstein, A. (1994). Why some children of alcoholics become alcoholics: Emulation of the drinker. *Adolescence, 29,* 1–11.

van Manen, M. (1997). *Researching lived experience: Human Science for an action sensitive pedagogy* (2md Ed.). London, Canada: The Althouse Press.

Velleman, R. & Orford, J. (1999). *Risk and Resilience: Adults who were the Children of Problem Drinkers.* London: Harwood Academic.

Velleman, R. (2004). Alcohol and drug problems in parents: an overview of the impact on children and implications for practice. In Gopfert, M., Webster, J., & Seeman, M. *(2nd ed). Parental Psychiatric Disorder. Distressed Parents and their Families* (pg. 185-202). Cambridge.

Velleman, R. & Templeton, L. (2005*a*). Alcohol use and misuse (ed. L. Elwes). *In Key Topics in Public Health,* (pp. 177-196). Elsevier.

Velleman, R. & Templeton, L. (2007). Understanding and modifying the impact of parents' substance misuse on children. *Advances in Psychiatric Treatment, 13,* 79–89.

Werner, L., & Broida, J. (1991). Familial Alcoholism and Dysfunction. Journal of studies on alcohol, *52(3),* 249-252.

Werner, E. (1993.) Risk, resilience and recovery. Perspectives from the Kauai Longitudinal Study. *Development and Psychopathology, 5,* 503–515.

Werner, E. & Johnson, J. (1999). In Velleman, R. & Templeton, L. (2007). Understanding and modifying the impact of parents' substance misuse on children. *Advances in Psychiatric Treatment, 13,* 79–89.

West, M. O., & Prinz, R. J. (1987). Parental Alcoholism and childhood psychopathology. *Psychological Bulletin, 102,* 204-218.

Williams, B. (2004). *Review of projects and initiatives that support children and families affected by alcohol misuse.* Retrieved in February 2010 from Alcohol Concern.

Willig, C. (2001). *Introducing qualitative research in psychology. Adventures in theory and method.* Buckingham: Open University Press.

Willig, C., & Stainton-Rogers, W. (2008). *The Sage Handbook of Qualitative Research in Psychology*. London, Sage.

Wilson, H. S., & Hutchinson, S. A. (1991). Triangulation of Qualitative Methods: Heideggerian Hermeneutics and Grounded Theory. *Qualitative Health Research, 1(2),* 263-276.

Wilson, C., & Orford, J. (1978). In Orford, J. (1984). The prevention and management of alcohol problems in the family setting: A review of work carried out in English-speaking countries. *Alcohol and Alcoholism, 19(2),* 109-122.

Wilson, C., Harris, S., Sherritt, L., Lawrence, N., Glotzer, D., Shaw, J., & Knight, J. (2008) Parental Alcohol Screening in Pediatric Practices, *Paediatrics,* 122, e1022-e1029. Retrieved on 2nd April from http://www.pediatrics.org/cgi/content/full/122/5/e1022.

Windle, M. (1990). Velleman, R. & Orford, J. (1999). *Risk and Resilience: Adults who were the Children of Problem Drinkers. London*: Harwood Academic.

Windle, M. (1997). Concepts and Issues in COA Research. *Alcohol Health & Research World, 21(3),* 185-191.

Windle M., & Searles, J.S. (Eds.) (1990). *Children of alcoholics: Critical perspectives.* New York: Guilford Press.

Winter, G. (2000). A Comparative Discussion of the Notion of 'Validity' in Qualitative and Quantitative Research. *The Qualitative Report, 4(3-4),* Available: http://www.nova.edu/ssss/QR/QR4-3/winter.html.

Woititz, J. (1983). *Adult Children of Alcoholics*. Hollywood, FL: Health Communications.

World Health Organization (1993). Psychological impact of substance use on families: A literature review. Geneva: World Health Organization.

World Health Organization (2007). WHO, expert committee on problems related to alcohol consumption. Geneva: World Health Organization.

Wright, D., & Heppner, P. (1991). Coping among nonclinical college-age children of alcoholics. *Journal of Counselling Psychology*, 38(4), 465-472.

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In Smith, J. A. (2008), *Qualitative Psychology: A Practical Guide to Methods.* London, Sage.

Appendix A

Ethics Release Form for Psychology Research Projects

All students planning to undertake any research activity in the Department of Psychology are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department of Psychology does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2004) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by 2 members of Department of Psychology staff.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc ☐ MPhil ☐ MSc ☐ PhD ☐ **DPsych** n/a ☐

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

A qualitative analysis on the life experiences of adult children with parents who have a problem with alcohol.

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2. Name of student researcher (please include contact address and telephone number)

Miss Jacqueline Iacovou, [redacted]

---

3. Name of research supervisor

Ms Susan Van Scoyoc

---

4. Is a research proposal appended to this ethics release form? **Yes**

5. Does the research involve the use of human subjects/participants? **Yes**

If yes, a. Approximately how many are planned to be involved? **8-10**

b. How will you recruit them? **Via the Substance Misuse Engagement Team in Barking**

c. What are your recruitment criteria? **males & females, 18 years of age & over with at least one parent they believe has an alcohol problem**
(Please append your recruitment material/advertisement/flyer)

d. Will the research involve the participation of minors (under 16 years of age) or those unable to give informed consent? **No**

1

e. If yes, will signed parental/carer consent be obtained? **N/A**

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

Participants will be required to take part in one semi-structured interview which will last approximately one hour

7. Is there any risk of physical or psychological harm to the subjects/participants?

No Physical Harm.

If yes, a. Please detail the possible harm? **As with any sensitive research topic the researcher cannot rule out the possibility of some psychological harm or distress being caused. Having said this it is not anticipated that the interview would be any more distressing than an everyday conversation they have had about their parents' alcohol problems.**

b. How can this be justified? **Participants will be informed that the interview can be terminated at any time should they feel distressed and a verbal & written debrief will take place at the end.**

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes

(*Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

9. Will any person's treatment/care be in any way compromised if they choose not to participate in the research?

No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes

(*Please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Tape recordings of interviews, plus typed transcripts

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12. What provision will there be for the safe-keeping of these records? ----------

They will be kept at home in a locked desk, in an office used only by the researcher. Codes will be used instead of names on any transcripts on the computer

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13. What will happen to the records at the end of the project? ----------

All recordings and transcripts will be destroyed and/or deleted once the project ends.

---

14. How will you protect the anonymity of the subjects/participants? ----------

No names will feature on any documents or recordings – codes will be used instead.

---

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Participants will be debriefed verbally and will also be given a written debriefing. This will include the number for their local counseling services and support groups. The researcher's details will be given to participants in case they have any questions following the interview and if they feel distressed.
(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in bold print, please provide further explanation here:

Signature of student researcher [redacted] Date 22.01.2008

Section B: To be completed by the research supervisor

Please mark the appropriate box below:

Ethical approval granted ☑

Refer to the Department of Psychology Research Committee ☐

Refer to the University Senate Research Committee ☐

Signature ---------- [redacted] ---------- Date 11 February 08

Section C: To be completed by the 2nd Department of Psychology staff member *(Please read this ethics release form fully and pay particular attention to any answers on the form where bold items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above ☑

Signature ---------- [redacted] ---------- Date 20/3/08

Appendix B

Ethics Release Form for Psychology Research Projects

All students planning to undertake any research activity in the Department of Psychology are required to complete this Ethics Release Form and to submit it to their Research Supervisor, **together with their research proposal**, prior to commencing their research work. If you are proposing multiple studies within your research project, you are required to submit a separate ethical release form for each study.

This form should be completed in the context of the following information:

- An understanding of ethical considerations is central to planning and conducting research.
- Approval to carry out research by the Department of Psychology does not exempt you from Ethics Committee approval from institutions within which you may be planning to conduct the research, e.g.: Hospitals, NHS Trusts, HM Prisons Service, etc.
- The published ethical guidelines of the British Psychological Society (2004) Guidelines for minimum standards of ethical approval in psychological research (BPS: Leicester) should be referred to when planning your research.
- **Students are not permitted to begin their research work until approval has been received and this form has been signed by 2 members of Department of Psychology staff.**

Section A: To be completed by the student

Please indicate the degree that the proposed research project pertains to:

BSc ☐ MPhil ☐ MSc ☐ PhD ☐ **DPsych** n/a ☐

Please answer all of the following questions, circling yes or no where appropriate:

1. Title of project

A qualitative analysis on the life experiences of adult children of alcoholics

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2. Name of student researcher (please include contact address and telephone number)

Miss Jacqueline Iacovou, [redacted]

---

3. Name of research supervisor

Ms Susan Van Scoyoc

---

4. Is a research proposal appended to this ethics release form? **Yes**

5. Does the research involve the use of human subjects/participants? **Yes**

If yes, a. Approximately how many are planned to be involved? **8-10**

b. How will you recruit them? **General population – advertisements, and snow balling technique**

c. What are your recruitment criteria? **Males & females, over the age of 18, at least one alcoholic parent, can offer 1 – 1 ½ hours of their time for an interview**
(*Please append your recruitment material/advertisement/flyer)*

d. Will the research involve the participation of minors (under 16 years of age) or those unable to give informed consent? **No**

1

e. If yes, will signed parental/carer consent be obtained? **N/A**

6. What will be required of each subject/participant (e.g. time commitment, task/activity)? *(If psychometric instruments are to be employed, please state who will be supervising their use and their relevant qualification).*

Participants will be required to take part in one semi-structured interview which will last approximately one hour

7. Is there any risk of physical or psychological harm to the subjects/participants?

If yes, a. Please detail the possible harm? **There is no risk physical harm however it cannot be guaranteed that no psychological distress will be caused due to the sensitivity of the research area. Having said this it is not anticipated that the interview would be any more distressing than an everyday conversation they have had about their parents' alcoholism.**

b. How can this be justified? **Participants will be informed that the interview can be terminated at any time should they feel distressed. A verbal & written debrief will take place at the end of the whereby participants will also be given the details of appropriate support organisations.**

8. Will all subjects/participants and/or their parents/carers receive an information sheet describing the aims, procedure and possible risks of the research, as well as providing researcher and supervisor contact details?

Yes

(*Please append the information sheet which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

9. Will any person's treatment/care be in any way compromised if they choose not to participate in the research?

No

10. Will all subjects/participants be required to sign a consent form, stating that they fully understand the purpose, procedure and possible risks of the research?

Yes

(*Please append the informed consent form which should be written in terms which are accessible to your subjects/participants and/or their parents/carers)*

11. What records will you be keeping of your subjects/participants? (e.g. research notes, computer records, tape/video recordings)?

Tape recordings of interviews, plus typed transcripts

---

12. What provision will there be for the safe-keeping of these records? ----------

They will be kept at home in a locked desk, in an office used only by the researcher. Codes will be used instead of names on any transcripts on the computer

---

13. What will happen to the records at the end of the project? ----------

All recordings and transcripts will be destroyed and/or deleted once the project ends.

---

14. How will you protect the anonymity of the subjects/participants? ----------

No names will feature on any documents or recordings – codes will be used instead.

---

15. What provision for post research de-brief or psychological support will be available should subjects/participants require?

Participants will be debriefed verbally and will also be given a written debriefing. This will include the number for their local counseling services and support groups. The researcher's details will be given to participants in case they have any questions following the interview and if they feel distressed.
(Please append any de-brief information sheets or resource lists detailing possible support options)

If you have circled an item in bold print, please provide further explanation here:

Signature of student researcher [redacted] Date 7/8/2008.

Section B: To be completed by the research supervisor

Please mark the appropriate box below:

Ethical approval granted ☑

Refer to the Department of Psychology Research Committee ☐

Refer to the University Senate Research Committee ☐

Signature ---------- [redacted] ---------- Date 7th August 2008

Section C: To be completed by the 2nd Department of Psychology staff member *(Please read this ethics release form fully and pay particular attention to any answers on the form where bold items have been circled and any relevant appendices.)*

I agree with the decision of the research supervisor as indicated above ☑

[redacted] 14/8/08

3

Appendix C

Recruitment Advertisement

Do you think your parent has a problem with alcohol?

My name is Jacqueline & I am conducting a piece of research as part of my D.Psych at City University, London, on the experiences of adults who view their parent/s as having a problem with alcohol.

To take part you need to meet the following criteria:

- Between 18 & 30 years of age.
- Born & raised in the UK
- Have lived with the parent for at least 1 year.
- Can offer 1 hour of your time to take part in a face-to-face interview.
- For your convenience I am willing to travel to you.

To find out more all you have to do to is contact

Jacqueline Iacovou

Mobile: [redacted]

[redacted]

Project supervisor

[redacted]

Appendix D

Provisional Interview Schedule

1. Childhood Experiences	**Can you tell me what life was like for you as a child?** (Prompts: boundaries in terms of bedtimes, mealtimes. Promises being kept/broken; meals being cooked; clean clothes, hair brushed, clean house, were friends invited over; were experiences the same or different to friends; was there concern about what you would come home to? Was there violence; trust issues; childhood anxiety, what was your role in the family?). **When did you start to realise their drinking could be a problem?** (Prompt: how old were you? what did you do (if anything)? Did you tell anyone? Did you think it was normal until you were no longer in that environment?) **If you can remember, how did you feel towards your parent when you were young?** (Prompt: did you try to keep them happy? Were you afraid when they had been drinking? Did you ever feel angry, embarrassed, ashamed or guilty? Did you believe it was your fault? **Which areas of your life were most affected by having a parent with an alcohol problem?** (Prompt: school life; friendships; relationship with non-drinking parent &/or siblings)
2. Adulthood	**N.B. If they still co-habit: What is life like for you at home these days?** **In what way has having a parent with an alcohol problem affected/shaped where you are in your life today?** (Prompt: forming of relationships; having your own family; choice of partner; emotional well being; social functioning; education; employment; housing situation) **How have you coped with having a parent who has a problem with alcohol?** (Prompt: counselling; ignoring the problem; avoidance of parent) **How do you feel towards your parent now?** (Prompt: resentment; anger; have you resolved any issues you had with them) **What can you tell me about your own drinking patterns?** (Prompt: if they do drink: amount, frequency, age at which they first started drinking, If they abstain: reasons for abstinence; Has having a parent with a problem with alcohol influenced your own drinking patterns?)

3. Support	**What are some of the support groups or other services available to adult children (e.g. counselling, carers support groups)?** (Prompt: Do you use them? If yes, how have they benefitted you? If not, why not? Has using these services helped with some of the aforementioned areas e.g. mental health, relationships etc) **What kind of support do you believe would be most beneficial for you to have available as an adult child?** (e.g. more support groups, drop in centres, family therapy) **What about when you were a child?** (e.g. family therapy, school counselling, education about alcoholism)
4. Final Question	**What else would you like to tell me about your life experiences which we have not yet discussed?**

Appendix E

Main Interview schedule

1. **How would you describe your parent's use of alcohol??**

(label/category; frequency of drinking; what were they like when they were drinking; how was this different to when they were sober)
Prompt: at what point do you think it becomes problematic for you/for them/others?

2. **Can you tell me what life was like for you as a child?**

At what point did you start to realise your parent's use of alcohol may be a problem?
Prompt: How did you realize, what age, what did you do (if anything)?
Can you tell me about the best/worse experiences when alcohol was a factor?

3. **How has your parent/s use of alcohol influenced where you are in your life today?**

(Prompts: work/forming of relationships/emotional well being/choice of partner/education/
What kind of adult are you today? Have you carried any of your childhood patterns into your adult life? If so, do these patterns help or hinder you?)

4. **How have you dealt/coped with having a parent who you view as having a problem with alcohol?**

(Prompt: professional counseling/support groups – if yes, when & for how long; sharing experiences with others – family members/friends; avoidance of parent, denial, leaving home)

Final questions:

How do you feel about things now?

Is there anything that hasn't come up which you expected to?

Appendix F

Information Sheet

Project Title - Parental Problem Drinking: The Life Experiences of The Adult Child

My name is Jacqueline Iacovou & I am conducting the above D.Psych project under the supervision of Susan van Scoyoc [redacted] at City University, London.

The purpose of the study is to explore the experiences of adults who view themselves as having a parent with a problem with alcohol. It is not important whether your parent/s have been officially classified as a problem drinker or alcoholic or whether they even believe their drinking is a problem, this is about your views as their child.

By speaking about some of your experiences it is hoped that our knowledge of this group of individuals will increase. Additionally as counselling psychologists it may raise awareness of some of the key issues necessary to explore in therapy which we do not yet know about.

If you agree to take part you will be asked to participate in a tape-recorded interview lasting approximately one hour, providing an opportunity to speak about your experiences both as a child and in the present day. The structure of the interview will be very loose in the hope that we will discuss what you believe is most important.

Participation in this study is voluntary and you are able to withdraw at any time, including after the interview has taken place. All information will remain confidential and anonymous at all times in accordance with the British Psychological Society Ethical Guidelines. Please bear in mind that the data collected from this study may be published, however all names and locations would be changed to protect your identity.

Although it is not intended that any emotional distress be caused by the interview, if given the nature and sensitivity of the research area you do become distressed at any point during the interview we take a break, or stop the interview altogether.

Thank you for considering taking part in this study.

Appendix G

Consent Form

Project Title - Parental Problem Drinking: The Life Experiences of The Adult Child

Name of Researcher: Miss Jacqueline Iacovou - [redacted]
Name of Supervisor: Susan Van Scoyoc - [redacted]

Please read the following before signing below:

- I confirm that I have read or been read, and understood the Information Sheet provided for the above study, and that any questions have been answered by the researcher satisfactorily.
- I understand that my participation is voluntary, and I have the right to withdraw at any time without reason.
- I consent to having the interview taped.

Name of Participant:	Name of Researcher:
Date:	Date:
Signature:	Signature:

Appendix H

Demographics Sheet

Interview date:

Participant code:

About you:

Gender: ..... (Please state)

Age: ..... (Please state)

Occupation: .....(Please circle)

Full time
Part time
Student
Unemployed
Other .....(Please state)

About your parent/s:

Which parent do you consider to have a problem with alcohol?
Please circle..... Mother / Father / Both

Did you still live with this parent/s?
Please circle .....Yes / No

If you answered No, between which ages did you live with your parent?
.....

Appendix I

Debriefing Sheet

Project Title- Parental Problem Drinking: The Life Experiences of The Adult Child

Thank you for participating in the above research project.

The aim of the study was twofold: firstly it was to provide you with the opportunity to speak openly about your experiences of having a parent whom you view as having a problem with alcohol. Additionally, the reason behind the loose interview schedule is because I was interested in finding out what was most important to you and did not wish to make any assumptions about what life is like having a parent you consider uses alcohol problematically. The information provided from the interview will now be analysed and used to generate themes so as to determine what information may be valuable for counselling psychologists.

It is possible the study may identify what type of support is most/least helpful and moreover what support they would like to see offered by psychologists and other health care professionals in the future. It is hoped that with the data collected from your interview it will assist professionals in providing appropriate support at different stages of life including both child and adulthood. By establishing which areas of life are most severely affected by having a parent with alcohol problems (e.g. employment, mental health, relationships, and social functioning) counselling psychologists can broaden their knowledge and again become better equipped to support adult children, and refer you to the appropriate services if you so wish.

I would like to remind you that if you do not feel comfortable with your interview being used for this study you still have the right to withdraw and can do so at any time.

If you require any further information or have any concerns about the interview please contact me on [redacted] You may also contact the research supervisor of this project, Susan van Scoyoc at City University, London [redacted]

Although it was not anticipated that any distress be caused by the interview please see below for your local support groups and counselling organisations should you need any support in the future:

www.al-anonuk.org.uk The Al-Anon Family Groups are a fellowship of relatives and friends of alcoholics who share their experience, strength, and hope in order to solve their common problems.

www.adultchildren.org (adult children of alcoholics world service organisation)

Children of addicted parents and people www.coap.co.uk – a website created to share experiences and stories

National Carers Line - Tel: 0808-808-7777

NAPAC – the national association for people abused in childhood.
www.napac.org.uk; 0800-085-3330

Samaritans
www.samaritans.org; 08457-90-90-90.

Transcripts have been removed for confidentiality purposes.

These can be consulted by Psychology researchers on application at the Library of City, University of London

Pg. No	**Appendix K** **Excerpt List of Initial Themes** Themes
9	Rejection No communication Excluded Given up trying No communication Distance / No relationship Separate life Relationship with alcohol Provider Routine, normality Unity / support network Outsider
10	Conflict Protection Children turned against dad Hatred Protection (father by mother) Making up her own mind Childish Double standards / hypocrite Strict, little freedom House treated like hotel, dad like a lodger Normality Unable to change situation / put up with it Acceptance Rejection Rejection
11	Ignored / rejected Dad has different priorities Routine, norm Cultural influence Suppression / Cultural restrictions Familial conflict Thoughts of separation Nothing changes Reality No release, no way out Acceptance Hatred Superiority Cultural expectations, respect
	- 167 -

12	Roles, respect Superiority Females underdog Normality Future – culture changing Wanting life to be different Wants to be treated with respect Equality Control Wanting things to be different Wanting a different life
13	Equality Wanting things to be different Absence / unavailable Wanting to be treated differently Desire to be different Impact on own drinking Doesn't want to be like her dad Not wanting to be out of control Wants to be different
14	Drinking viewed as pointless Pointless Within limits, controlled self Friends share her values Dad only person who drinks Similar values (friends) Pointless getting drunk Achieve nothing Been on the receiving end Don't want to cause pain / needing to be looked after Wants to be different
15	Drinking unnecessary, pointless Protection Protecting him Sharing would ruin dad's reputation Drunk – that's not all he is Keeping secrets No communication Understanding Kept a secret Support network / coping Misunderstood Misunderstood Like seeks like

Appendix L

Cluster Labels

Trying to make it better
Attempts to build relationship, rejected
Rejection
Ignored
Still trying to be build relationship
Longing for relationship
Attempts to build relationship, rejected

Escape / Avoidance
Out of sight, out of mind
Avoidance
Avoidance
Physically withdrawing
Excludes self

Out of control
Dad not in control
Loses control
Rule breaking
Dad out of control
No limits

Dad's normality
Routine, norm
Normality
Routine, normality
Routine, norm

Nothing gained
Drinking seen as pointless
Excessive drinking, pointless
Drinking viewed as pointless
Achieves nothing
Pointless getting drunk
Achieve nothing
Drinking unnecessary, pointless
Nothing is achieved
Nothing gained by drinking

Communication
No communication

Excluded
No relationship
No communication
Need for (better) communication
No communication
Dad absent, no communication
Little communication

History not to repeat itself / A different life

Future – culture changing
Wanting life to be different
Wants to be treated with respect
Wanting things to be different
A need for things to be equal
Wanting things to be different
Wanting to be treated differently
Desire to be different
Doesn't want to be like her dad
Not wanting to be out of control
Wants to be different

Coping – acceptance and resignation

Nothing changes
Acceptance (nothing will change)
Normality
Unable to change situation / put up with it
Acceptance
Learn to deal with it
Nothing is going to change
Have to adapt to life
Unable to change situation / put up with it
Have to deal with it
Acceptance
Given up trying

Culture

Family tradition
Drinking as a tradition
Family tradition

Feelings

Anger
Ashamed (of his behaviour)
Ashamed (of him, disappointed)
Anger, arguments
Confrontational
Frustration, fed up

Appendix M

Haleema's Summary Table

Theme	Sub-theme	Quote	Pg No. Line
Parent / Child Relationship	View of drinking parent: unavailable	He's just there as a picture but not actually close like, yeah not mentally and physically really	7, 22
		I would that and I would kind of think can't he take control of himself because he should know his limits, he should know when to stop	4, 19
	View of drinking parent: hypocrite	He just always asks that question like do you drink do you drink, cos he doesn't like the idea of us drinking	5, 24
	View of drinking parent: out of control	There have been times when he's just drunk too much and gone too far and someone else has to take care of him	5, 36
	Protective Relationships	To protect us cos she doesn't want us to turn out like him or like that drinking behaviour or anything	5, 3
		She tried to like protect us like kind of blind us from what he was doing like just coming in and leaving and going out and doing what he wanted like he was a little boy	10, 12
		Just like my mum protected us when she was younger so I think we should do the same	18, 7
Communication Problems	Putting up a barrier	He just puts up a barrier and he doesn't like talking about it, like generally he doesn't like talking to us like even when talking about his drinking or behaviour he just sees us as like disrespecting him so he doesn't like talking about it	17, 7
		He knows that he's like drunk and everything, but he just doesn't like to talk about it he doesn't want someone else to tell him that	2, 4
		We don't say anything to him because he's just he'll just get angry so we don't confront him on anything.	2, 16
	Lack of communication	All my dad does is go out and do what he does and likes to do and then comes home and sleeps but we have no communication between us	16, 17
Coping Mechanisms	Acceptance or giving up?	I think I just got used to it now cos I can't change it. I tried to change it	10, 28
		It happens and I just have to deal with it	11, 27
	Avoidance and escapism	I don't really sit with him when he is drinking I just go into a different room with my cousins	1, 23
		I just go into a different room cos I don't want to be there when he is drinking	3, 18
		He comes home sometimes and I see him there I just turn off the light go upstairs cos I don't want to see his face like like that	6, 21

	Trying to make sense of parental problem drinking	It's just that he has to drink to like find his way out and get away from the family and stuff . He sees alcohol as like his way out, like to escape from like the pressures of work and family and everything	8, 18 8, 22
The Road to Recovery	Seeking support	We are on the same level my mum tells us like, she tells us how she feels and then we feel it as well We always talk like sit around the table and just talk and just talk about our feelings and what we are going through I only speak to my sister who can actually relate to it and talk to me because I wouldn't disrespect my dad like that and talk to anyone else	7, 5 7, 15 15, 17
Impact on self	Life choices: to drink or not to drink?	I've seen my dad and how he is and see he's too drunk and over the limit and things he does, and what he says to me and how he treats me like the next day and so I know if I was to drink I would keep it a glass or one or two glasses I've never got to that stage when I don't remember the night before cos I've drunk too much, I wouldn't do that cos it's just like erm like contradicts everything that I've gone through like what my father's been like and everything I wouldn't want to be that person like I wouldn't want to be drinking and going to that limit and seeing someone else like the way I am and I wouldn't want that Growing up I've seen how it is on the receiving side of it so I don't want to be that person who has to cause all this pain for everybody and they have to look after me	13, 22 13, 30 13, 37 14, 34

Appendix N

Table of Master Themes and Sub-Themes

Master Themes	Sub- Themes
Parent / Child Relationships	**View of problem drinking parent** A distant parent: *"He's just there as a picture"* Like a child: Out of control A hypocritical figure **Mixed emotions** **Protective relationships**
Communication Problems	**The barriers** **The rejection & giving up**
Coping Mechanisms	**Avoidance & escapism** Creating a fantasy life: "*Not really being fully engaged in reality*" Withdrawing physically or emotionally from the drinking parent **Acceptance or giving up?** **Trying to make sense of parental drinking** **Keeping it a family secret**
The Road to Recovery	**Labelling the problem & seeking support** **Self-preservation: Keeping a safe distance**
Impact on the Self	**Impact as a child: Being 'different'** **The adult child: Who have I become?** Life choices: to drink or not to drink?

Appendix O

Master Themes	Sub themes	Themes	Hal	Ais	Rach	Han	Rich	David	Matt
Parent / Child Relationships	View of problem drinking parent	A distant parent: *"He's just there as a picture"*	X	X				X	X
		Like a child: Out of control	X	X					
		Hypocritical	X	X					
	Mixed emotions		X	X	X	X	X	X	
	Protective relationships		X	X	X	X	X	X	X
Communication Problems	The barriers		X	X	X				X
	The rejection & giving up		X	X					
Coping Mechanisms	Avoidance & Escapism	Creating a fantasy life: *"Not really being fully engaged in reality"*			X		X		
		Withdrawing physically or emotionally from the drinking parent	X	X	X	X	X	X	
	Acceptance or giving up?		X	X		X			X
	Making sense of parental drinking		X	X	X			X	X

	Keeping it a family secret		X	X			X	X	
The road to recovery	Labelling the problem & seeking support		X	X	X	X			
	Self preservation: Keeping a safe distance				X	X			
Impact on the self	Impact as a child: Being 'different'				X	X	X	X	
	The Adult Child: Who have I become?	Life Choices: To drink or not to drink?	X	X	X	X	X	X	X

Appendix P

Service Provision Questionnaire

Have your say!

Thank you for taking the time to complete the following questionnaire. The information you provide will be used to assist counselling psychologists and other mental health professionals improve on the support services available to Adult Children of Problem Drinkers.

1. Have you received any formal (one to one counselling; support group) or informal (speaking with friends / family; chat rooms/forums) support to help you deal with your parent/s drinking problem?

   Yes / No

If you answered Yes, please answer questions 2 – 5 and 8 - 10, if you answered No, please answer questions 6 - 10.

2. What type of support did you receive?

3. What were your reasons for choosing this particular form of support?

4. Did you find the support helpful? Yes / No
   (please state the reasons for your answer)

5. How could you have been supported more effectively?

6. What are your reasons for not seeking support?

7. What would make you more likely to seek support?

8. How do you feel services could be improved overall?

9. Do you feel there are *enough* support services available to children of problem drinkers?

   Yes / No

10. What kind of service would you like available for Adult Children of Problem Drinkers?

Thank you for your time your views are important to us.

Section C

Working with the Long Term Effects of a Challenging Childhood

The Professional Practice Component of this thesis has been removed for confidentiality purposes.

It can be consulted by Psychology researchers on application at the Library of City, University of London.

Section D

Does gender of the problem drinking parent make a difference to the issues experienced by offspring?

KEYWORDS: paternal alcoholism, maternal alcoholism, children of alcoholics (COAs), adult children of alcoholics (ACOAs), children of problem drinkers (COPDs), gender, gender differences, treatment, interventions, parental problem drinking (PPD), adult children of problem drinkers (ACOPDs).

Introduction

The challenges facing children growing up in families where parental alcohol use is problematic is of increasing concern for policy, practice and research (Backett-Milburn, Wilson, Bancroft & Cunningham-Burley, 2008). There is extensive literature on the outcomes for the offspring indicating the emotional and physical neglect they may face and detailing the risks such experiences pose for their future lives. Nevertheless, more recently researchers have explored the factors which may make for more positive and resilient outcomes (Velleman & Orford, 1999; Velleman, 2002). A number of reviews such as Barber and Crisp (1994) and Zeitlin (1994) have tried to combine findings and, to disentangle the results of growing up in a drinking environment from any possible genetic factors and, any effects associated with a mother's drinking in pregnancy. There has, nonetheless, been more limited research on factors which may impact findings such as gender of the problem drinking parent (PDP).

Research findings have been mixed regarding the impact of gender of the PDP on the level of difficulty experienced by offspring. It has been suggested by Bennett, Wolin and Reiss (1988) for example, that the gender of the PDP are unrelated to the frequency of psychopathology in the children. Nonetheless, an early study by Steinhausen, Gobel and Nesler (1984) indicated the *symptoms* the children display is related to the gender of the PDP. They found for example, that paternal alcoholism correlated with conduct disorders, whilst maternal alcoholism correlated more with emotional disorders.

Rationale for the review

The review therefore seeks to explore whether gender makes a difference to the effects of PPD on offspring. It reviews the literature on both maternal and paternal problem drinking and the subsequent effects on offspring. It also considers sex of offspring as a mediator in the effects of PPD by attempting to identify any differences or similarities

between same sex and opposite sex parent child relationships (e.g. sons of problem drinking fathers; daughters of problem drinking mothers).

Counselling psychologists will inevitably work therapeutically with offspring in drug and alcohol focused, or generic services. With more counselling psychologists now working within the National Health Service (NHS), school settings and many voluntary organisations the chances of being required to provide treatment for offspring are now extremely high. If gender plays a significant role in the effects on offspring this could have potential implications for clinical practice. By exploring any such differences the counselling psychology profession can ascertain if treatment needs to be tailored according to these individual differences. By increasing our knowledge, it means counselling psychologists will have better insight into their formulations, subsequent treatment plans, and choice of therapeutic model. The main aim of the review is therefore, to increase counselling psychologists' knowledge of an extremely specific area of an otherwise well researched field.

Does being a COA affect development?

Research over the past two decades has shown parental alcohol problems are related to a greater risk of behavioural and emotional problems in children (West & Prinz, 1987). It has been found that compared to normal control groups, children of alcoholics (COAs), have more externalising problems (conduct disorders, hyperactivity), internalising problems (depression, anxiety, low self-esteem, and psychosomatic reactions), more social and interpersonal problems, more problems in school and lower scores on measures of cognitive achievement (Bennett et al. 1988). The high risk status for COAs is found to be evident in families with additional problems to alcohol, such as poverty (Nylander & Rydelius, 1982), but also in studies comparing COAs from intact, middle class families with children from matched non-alcoholic families (Werner, 1986).

Research has documented the increased risk for maladaptive developmental outcomes among COAs. The risk for future alcohol and substance use problems for example, has been shown in studies of young adults (Finn, Sharkansky, Viken, West, Sandy & Bufferd, 1997; Sher, Walitzer, Wood & Brent, 1991), as have higher levels of depression, anxiety and lower levels of self-esteem (Belliveau & Stoppard, 1995). Studies of older and younger adolescents have also demonstrated that offspring are at an

increased risk for problems in emotional and behavioural adaptation (Weinberg, Dielman, Mandell & Shope, 1994).

Does the gender of the parent make a difference?

In their research, Velleman and Orford (1999), found on average sons and daughters experienced similar negative childhood environments and tried to cope in the same way. One of the few differences was more males reported violence towards them than females. The authors discussed the differences they found were in terms of gender of the PDP. They have suggested the COPD mothers would be more severely affected than if the PDP was the father. This is because it is believed the mother is more important than the father in terms of maintaining family unity and is more likely to drink at home. This is suggested to have a greater impact on the developing child. Velleman and Orford (1999) also suggest this issue is important because it relates to the suggested relationships between the gender of the PDP and that of the child. They offer the suggestion that children will be more likely to imitate the behaviour of parents of their own sex; or alternatively, they will be more likely to be influenced by the behaviour of opposite sex parents. This mirrored earlier findings by Annis (1974) who reported a same sex, same use pattern, seemed to exist. It was found that mothers and daughters have similar patterns of substance abuse (mostly painkillers and tranquilisers) and fathers and sons share their choice in drugs (usually alcohol and cigarettes). The differential impact of maternal and paternal alcoholism on family environment may be due to divergent behaviour patterns of male and female alcoholics brought about by gender socialisation (Velleman & Orford, 1999).

What are the differences associated with maternal and paternal PPD?

In the following section, the author presents relevant literature from the field which illustrate the effects of both paternal and maternal alcoholism on offspring. It will include studies of both young and adult offspring. Given the limited research available on maternal alcoholism, the author will present the studies according to the specific issues the studies were investigating, such as: attachment styles; behavioural problems and drinking behaviour. A number of psychological issues, specifically relating to paternal alcoholism and maternal alcoholism, will also be reported.

Gender, attachment style and relationships

In appreciation of the significant roles mothers and fathers each play in the development of their children, it is important to explore the differences with regard to the impact of maternal and paternal alcoholism. Mothers and fathers have unique roles in the family, it is therefore reasonable to expect that there would be different effects on children depending on which parent was dysfunctional (Bradley & Schneider, 1990). Research investigating maternal versus paternal alcoholism suggests that maternal alcoholism may more negatively impact children's social development (Orosz-Vail, Protinsky, & Prouty, 2000).

In comparison to fathers, alcohol-misusing mothers may drink more discreetly and in the home (Berkowitz & Perkins, 1988; Stout &Mintz, 1996). During adolescence the mother–daughter relationship is especially complex and emotionally charged. For females, healthy adolescent development is defined by deepening emotional ties to the family, especially to the mother (Jordan & Surrey, 1989). Female ACOAs tend to be more sensitive to family problems and appear more likely to internalise interpersonal problems than males (Berkowitz & Perkins, 1988). As a result of alcohol-misusing mothers potentially being unable to support their daughters' emotional needs, the quality of attachment to mothers may be affected to a greater degree (Kelley, French, Schroeder, Bountress, Fals-Stewart, Steer & Cooke, 2008). Ballard (1993) found no difference between ACOAs and non-ACOAs in security of attachment to parents; however, ACOAs who reported their mothers as the alcohol-misusing parent reported more avoidant attachment.

Several studies based on attachment theory have found a greater proportion of insecure attachment styles among ACOAs, mirroring the findings with respect to infant COAs (Eiden, Edwards & Leonard, 2002; Eiden and Leonard, 1996). Latty-Mann (1991) examined the attachment styles of a sample of college students and found the majority of ACOAs were classified as having an insecure attachment pattern, whereas the control participants were more securely attached. Held (1991) also found non-COAs most often identified with secure bonding patterns both in childhood relationships with parents and adult relationships, whereas ACOAs most often identified with insecure bonding patterns.

Other researchers, such as Houlihan (2001), have also found living with an alcoholic parent appeared to influence emotional development specifically in areas that affect intimate relationships. Differences between ACOAs and adult children of non-alcoholics (ACOnAs) in attachment styles and levels of differentiation were noted with both gender and age cohorts. ACOAs in the present study reported less secure attachment styles and lower levels of differentiation, both of which are connected with less satisfying intimate interpersonal relationships. Across genders there is also a tendency among ACOAs not to acknowledge the need for, or seek, nurturing and support. One of the explanations for this is that compensating for unmet emotional needs necessitates premature self-reliance which may be a contributor to later relationship difficulties. Although all the ACOAs in Houlihan's study indicated less secure attachment styles than ACOnAs, the attachment style attributes differed for male and female ACOAs. Despite considering age, gender, and treatment history of the ACOA, it would have been useful to look at the gender of the alcoholic parent (something which is lacking in much of the literature).

A few studies have examined the relationship functioning of ACOAs more specifically. Parker and Harford (1988) used a sample of 1,772 adults in the United States (US) to examine the impact of parental alcoholism on alcohol-related problems, marital disruption, and depressive symptoms in ACOAs. Their results showed having a parental history of alcoholism placed both sons and daughters at risk for later divorce or separation. Domenico and Windle (1993) found increased marital conflict, decreased marital satisfaction, and decreased family cohesion among female ACOAs in a middle-aged community sample.

More recently, Watt (2002) reported COAs were less likely to marry; more likely to be unhappy in their marriage; and more likely to divorce. Watt (2002) had used the data from the National Survey of Families and Households. Although there is some evidence suggesting parental alcoholism is associated with insecure attachment patterns and relationship difficulties in adulthood, this research is limited in several ways, such as research primarily focusing on children of alcoholic fathers and relatively little is known about the impact of maternal alcoholism on relationships.

Kearns-Bodkin and Leonard (2008) examined the impact of both maternal and paternal alcoholism on the relationship functioning of husbands and wives over the early years of marriage. For both husbands and wives, the appraisal of their marriage was associated with alcoholism in the opposite gender parent. For husbands, alcoholism in the mother was associated with lower marital satisfaction across the four years of marriage. For wives, alcoholism in the father was related to lower marital intimacy. A limitation of the current study was the use of self-report measures to assess family history of alcoholism. It would be beneficial for future research to obtain information from further family members (e.g. spouse, siblings) to corroborate reports of family history of alcoholism. Moreover, the current study could not address the potential influence of the severity of parental alcoholism on relationship dysfunction.

Behavioural effects of PPD

Recent research has begun to document that many of the problems affecting offspring may be observed prior to adolescence, and possibly in early childhood. Clark, Moss, Kirisci, Mezzich, Miles and Ott (1997) compared pre-adolescent sons (ages 10-12) of fathers with and without substance use disorders. Paternal substance abuse was associated with a higher prevalence of disruptive disorders and anxiety disorders among the boys. Carbonneau, Tremblay, Vitaro, Dobkin, Saucier and Pihl (1998) collected teachers' reports of boys who were either 6 or 12 years old. Paternal alcoholism was related to oppositional and hyperactive behaviour, but this effect was not moderated by the child's age. One potential pathway for the behavioural problems observed among the COAs is through the impact of the father's alcoholism and associated factors on infant temperament (Jansen, Fitzgerald, Ham & Zucker, 1995). Among younger children, Jansen et al., (1995) examined the relationship between temperament and problem behaviour. They found that the sons of alcoholics who scored in the clinically significant range on the Child Behaviour Checklist were more likely to have difficult temperamental characteristics.

Although the research does indicate that growing up with an alcoholic father will have some effect on the behaviour and psychological well-being of offspring (especially males), the age of onset for these problems is still debatable, with studies yielding very different results. One example is the study by Leonard and Eiden (2000). Infants were

tested at a very young age and no significant differences were found between controls and infants of severe alcoholics with regards to mental and language development as a function of their father's alcoholism. In their study, infants were tested at 12, 18 and 24 months, whereas in other studies where significant differences have been found, the children had often been much older. Kultur, Unal and Ozusta (2006) for example, evaluated children in terms of behavioural and psychopathological differences between the ages of 6 and 16. Furtado, Laucht and Schmidt (2006) also yielded significant results in their longitudinal study which evaluated children at various points from birth until 11 years of age. Starting at the age of just two years old, Furtado et al., (2006) found significant higher numbers of externalising symptoms among COAs. Moreover, similar patterns emerged between male and female COAs with the predominance of delinquent and aggressive behaviour. Female COAs nonetheless showed an increase of internalising symptoms up to the age of 11, with somatic complaints revealing the strongest discriminating effect in 11 year old females.

There are a number of possibilities as to the varied results in the aforementioned studies. One of the main methodological issues is the sample size and groups chosen for the studies, especially in the case of Leonard and Eiden (2000) and Furtado et al., (2006). In their study, Furtado et al., (2006) used seven times more children of non-COAs than COAs (N=219; 193 non COAs and 26 COAs). Whilst it was important to have a comparison group, it was not well balanced. If it had proved difficult to recruit COAs then it may have been appropriate to use an equal number of non-COAS. It was also unclear as to why Leonard and Eiden (2000) chose to have three groups of differing sample size. Participants were 102 families where the father was an alcoholic, 20 families where the father was an alcoholic and the mother was a heavy drinker, and 104 control families which were matched in terms of maternal education, child gender and marital status.

Although it was clear these studies were designed specifically to investigate paternal alcoholism (Furtado et al., 2006; Kultur et al., 2006), it would have been appropriate to have further comparison groups on the offspring of alcoholic mothers which is an area which continues to be neglected. This could be the result of social denial and / or cultural issues. In certain cultures, many gender norms and expectations exist. It is often far less acceptable for females to drink than males. This may be a reflection of what

Orford, Natera, Copello, Atkinson, Mora et al., (2005) termed the 'gender-polarised' nature of heavy drinking when discussing their findings of a sample of Mexican participants. It is considered unacceptable to admit talking about family troubles in which the wife and mother is the problem drinker. Returning to Kultur et al., (2006), the number of children compared to the number of fathers suggests that some of the children must have been siblings. It is surprising therefore that no analysis was conducted on siblings, especially when there is evidence to suggest that siblings resemble each other in their alcohol use (Trim, Leuthe & Chassin, 2006). Additionally, recent studies such as Backett-Milburn et al. (2008) have indicated the reactions of siblings to parental substance misuse varied which would suggest further attention in this area would be beneficial.

A final issue which is found in much of the literature in this field is the problem with definitions, not only with defining the parent as having a drinking problem, but also identifying the child as being a COPD. Numerous labels such as alcoholic, problem drinker and anti-social drinker are used interchangeably which can be confusing. In Leonard and Eiden's (2000) research alone, they defined their participants as severe, anti-social and depressed alcoholics. It would perhaps be more beneficial to the research if just one definition was used (e.g. DSM-IV classification, 2000). Bearing in mind some of the limitations, Edwards, Eiden, Colder and Leonard (2006) extended the work of Leonard and Eiden (2000). In the more recent study, Edwards et al., focused on children with either alcoholic fathers and mothers and assessed the children at later intervals (18, 24, 36, 48 months). As hypothesised, children with one or more alcoholic parents displayed higher levels of aggressive behaviour than girls at all stages, as compared to controls. Furthermore, boys had higher levels of aggressive behaviour at all ages than girls regardless of group status.

Gender and drinking behaviour in offspring

The idea that parental alcoholism will increase the likelihood of PD in COAs and ACOAs has been explored for some time (Cloninger, Dinwinddic & Reich, 1989). What is now gaining more attention is what role gender plays in the drinking behaviour of offspring. Evidence from some of the earliest studies on ACOAs offer some support for offspring sex as a mitigating factor among ACOAs. Winokur, Reich, Rimmer and Pitts

(1970), found that sons of alcoholics demonstrated increased risk for developing alcoholism while daughters of alcoholics were at higher risk for developing affective disorders. This was supported by Goodwin (1977) who found the rate of alcoholism among sons of alcoholics was 18% while the rate for daughters was 4%. The higher rates of alcoholism among sons of alcoholics may be preliminary evidence that a sizeable percentage uses substance abuse as a means of coping while most daughters of alcoholics employ other coping skills. Werner (1986) found that female ACOAs tended to be more resilient than male ACOAs.

Results have indicated that as maternal alcohol problems increase, the likelihood of adolescent alcohol use will also increase (Coffelt, Forehand, Olson, Hones, Gaffney & Zens, 2006). Paternal alcohol problems have also been associated with an increased likelihood of alcohol use for girls only (Coffelt et al.., 2006). Furthermore, female children of active problem drinkers (CAPDS) are also said to be at increased risk of depressive symptoms and co-morbidity of depressive symptoms and alcohol abuse, whereas males are only at risk of depressive symptoms (Chen & Weitzman, 2005). Coffelt et al.'s (2006) analysis of both parent and child gender revealed depressive symptoms among female COPDs were affected by both paternal and maternal drinking, whereas among males, depressive symptoms were present only when the affected parent was the father. Finally, male children of recovered problem drinkers were more likely to seek and receive counselling than male CAPDs. To conclude therefore, the risk of COPDs varied by respondent, parent gender and whether the parent was reported to be actively drinking or in recovery. Such results suggest more attention is needed in the area of gender specific interventions.

Paternal Alcoholism: Sex of offspring as a mitigating factor

The following issues have been identified specifically with the daughters of alcoholic fathers (Ackerman, 2002).

(1) Daughter's need for alcoholic father's approval.

(2) Relationship with non-alcoholic mother: Relationships with the mother can range from appreciation for helping with the alcoholic father, to holding them accountable for family problems. It is often suggested that many of the mothers' behaviours

established negative role models for them. Adult daughters are very aware if their mother's reaction to an alcoholic spouse negatively influenced their opinions not only about their mothers, but also about spousal relationships, expectations in marriage and attitudes about how to relate to males. Early research indicated that when a non-alcoholic parent is highly co-dependent, the effects on the children are the same as if the children had two alcoholic parents (Obuchowska, 1974).

(3) Relationships: There are two major relationship issues for daughters of alcoholic fathers, (1) relationship with the father and (2) current male relationships. For many daughters, these two issues are not separate, but rather one primary issue that affects the other.

(4) Role confusion: Many daughters express role confusion because with an alcoholic father, they often feel that they were taking the place of their mother. Some daughters for example have stated that their mothers are emotionally absent and full of resentment towards the father. As a result, fathers then expect the daughters to understand and support them.

(5) Intimacy: Daughters develop low opinions or expectations about intimacy. Others indicate that they equate being intimate with not being in control and being too vulnerable. This fear of intimacy has often been the result of not being accepted by fathers or having attempts at intimacy rejected. Lack of trust, fear of feeling, being alone and unable to trust others are factors that can hinder intimate relationships (Schutt, 1985).

ACOAS are often unable to maintain close relationships over long periods of time because they have difficulty trusting others and they lack positive role models to seek advice and comfort. Moreover, ACOAs may be unable to regulate self-esteem, and to form and maintain healthy intimate relationships (Lewchanin & Sweeney, 1997). Hardin (2000) examined the differential role of maternal Vs paternal alcoholism with regards to fear of intimacy and loneliness in ACOAs. With a sample of 120 ACOAs, Hardin (2000) allocated ACOAs to four groups, namely, females with alcoholic mothers, females with alcoholic fathers, males with alcoholic mothers and males with alcoholic fathers. Results indicated female ACOAs of alcoholic mothers reported greater fear of intimacy and greater loneliness than female ACOAs of alcoholic fathers.

In addition, male ACOAs of alcoholic fathers reported greater loneliness than male ACOAs of alcoholic mothers. Although male ACOAs reported greater loneliness than did female ACOAs, no difference was found between males and females with regards to fear of intimacy.

(6) Sense of self: Alcoholic fathers often instil in their daughters' problems of self-concept and self-esteem. Daughters find valuing themselves difficult, which may explain the strong need for approval and acceptance from their fathers. When approval or acceptance is withheld, children are left with their own interpretations of themselves. Several studies indicate that COAs exhibit lower self-esteem and great self-depreciation when compared with non COAs (e.g. Beaudoin, Murray, Bond & Barnes, 1997; Berkowitz & Perkins, 1988). Alcoholism typically affects the parent's behaviour in negative ways (e.g. he/she may become argumentative, violent or neglectful). Such behaviours influence family processes, such as communication between parents and children, which arguably play a role in the development of children's self-esteem. Domenico and Windle (1993) found ACOAs reported more problems in their relationships than non-ACOAs. Stout and Mintz (1996) for example, found college women with alcoholic fathers reported significantly more distress arising from interpersonal problems than did non-ACOAs. Although these findings provide some support for the notion that ACOAs have difficulty in intimate relationships, they have not pin pointed which aspects of relationships are problematic and have typically assessed general relational problems rather than assessing problems in current, committed relationships. Information gained on the effects of alcoholism on self-esteem, locus of control and role designations can be used for guiding interventions that will assist in keeping the alcoholic family unit intact and improving its function (Malone, 2003).

(7) Sexual abuse: Ackerman (2002) suggests that almost 20% of adult daughters indicate that while they were growing up, sexual abuse occurred in their families and that the fear, rage, anger and emotional impact of being sexually abused dominated their childhoods. Although virtually all adult children feel that their childhoods have been taken away from them, sexually abused adult daughters also share loss of identity, personal boundaries, emotional support and personal security.

Research suggests that group psychotherapy for adults with a history of childhood sexual abuse (CSA) is generally beneficial. Lau and Kristensen (2007) compared the effects of analytical and systemic group psychotherapy on a sample of CSAs. A sample of 151 females with interfamilial CSA were randomly allocated to either treatment group. Issues regarding quality of life, psychosocial function, psychological distress and flashbacks were assessed before and after treatment. Both therapies led to improved quality of life, fewer psychopathological symptoms and better overall functioning, but the outcome of systemic group therapy was significantly better than the outcome of analytical therapy. In the short term therefore, systemic group therapy is both statistically and clinically proven to be more effective than analytical therapy. Long-term follow up data would be necessary for any conclusions to be made on the maintenance of therapeutic gains.

Lubin (2007) questioned whether individual or group therapy was more effective for childhood sexual abuse survivors. It was found that the combination of individual and group therapy may be more successful than either alone. Due to the similarities in results, it is possible that both treatments are applying similar therapeutic factors. In addition, future studies might attempt to identify whether there are certain client-related characteristics, in addition to client preference that may serve as a basis for referral to group versus individual treatment. Much of the literature has been concerned with female CSA and as a result cannot be generalised to male survivors of CSA.

Maternal Alcoholism

As previously mentioned, it has been suggested that COAs might be more adversely affected by a parent's drinking if the mother is the drinking disordered parent (Moser & Jacobs, 1997). Alcoholism is often considered especially deviant when expressed by women (Straussner, 1997). Social supports may be fewer for alcoholic women than men, generating a more severe degree of disorder among them (Biener, 1987). Other social factors may contribute to differences in parentally conferred risk, including the breakdown of rituals and family observances that disproportionately involve the mother's role (Farrell, Barnes & Banerjee, 1995).

The centrality of the parents' role in children's emotional socialisation is highlighted both in Tomkin's (1962) affect theory, and Bowlby's (1969) attachment theory. Both theories appeared to agree on the following four points: (1) whilst some emotional development is based on self-regulatory principles, parents play a powerful role in the child's acquisition of emotion skills and idiosyncratic patterns of affect regulation; (2) the manner in which parents respond to their children's emotional experiences has implications for the latter's emotional maturity in childhood; (3) parents transfer their own biases or preferential affect patterns through their articulation of ideologies about affect, the affective behaviour they themselves display, and the actual number in which they respond to their child's affect (Magai, 1991) and; (4) the mother, more so than the father plays an important role in the socialisation of children's emotions (Garside & Klimes-Dougan, 2002).

Within the context of an alcoholic home, maternal alcoholism is likely to result in inconsistent reactions to a child's emotional displays. Further, as Black (1981) pointed out, children being raised in alcoholic homes, where the *"Don't feel"* rule is enforced as a way of denying the problem, learn to repress their true emotions either because such displays are negatively sanctioned or because of a belief that emotional expressions will elicit a negative response from the alcoholic parent/s (Black, 1981; Perez, 1983).

The author found the research available on the particular issues associated with maternal alcoholism, to be extremely limited. This was surprising given that there are several core issues experienced at least by daughters of alcoholic mothers. These issues are centred on role models, relationships, parenting, identity, trust, people-pleasing and shame (Ackerman, 2002).

(1) Role models: gender identification stems from connecting with people of the same sex: daughters of alcoholic mothers consistently report that their mother's negative role performance made them feel angry, disappointed and confused.

(2) Relationships: A healthy relationship with their mothers was not established in many cases and they did not really know their mothers or even want to relate to them. In adulthood, they often find it difficult to trust other women.

(3) Parenting skills: these women know that they did not learn positive parenting skills from their own parents. As an adult can only guess at what a healthy parent-child relationship should be.

(4) Female identity: having an alcoholic mother raises female identity issues for adult daughters due to their lack of positive gender identification. Their family environment and relationships did not help them develop an appreciation for their own femininity, often resulting in a poor self-concept and issues around being female.

(5) Trust: many adult daughters know that they have problems trusting other women because they instinctively relate to not being able to trust their mothers and equate their mothers with all women.

(6) People-pleasing: as children they worked hard to please a mother who was never satisfied with them or anything they did leading to low self-esteem. Adult daughters of female alcoholics often try to please everyone in their lives, particularly those who deny them support and tell them they are not good enough.

(7) Shame and fear: female daughters of alcoholics are often ashamed of their painfully dysfunctional family and upbringing. Their greatest fear is growing up and resembling their alcoholic mothers.

Change in Research Focus

Between 2000-2005 there was more of a focus on gender and how this may play a role in the possible symptoms offspring may experience as a result of parental problem drinking. Since this time however, interest in this specific area has reduced. Moreover, upon updating the review in 2009, it proved particularly difficult to find any relevant literature in recent years. There has been a clear shift in focus in substance misuse literature as a whole over the past three to four years. Given previous research has already told us a great deal about the potential effects of alcoholism, both on the individual and the family, and because alcoholism and problem drinking remains a significant societal concern, the focus appears to have shifted more to how practitioners can support those drinking problematically.

The centre of attention is now on screening for alcohol misuse, and the development of appropriate therapeutic interventions. Solberg, Maciosek, Nichol and Edwards (2008) for example performed a review on primary care interventions to reduce alcohol misuse. The review considered literature from 1992 through 2004 to identify relevant randomized controlled trials and cost-effectiveness studies. The review addressed the effectiveness of screening based on adherence of screening, sensitivity of screening tools, effectiveness of counselling in producing behaviour change, and efficacy of behaviour change in reducing the health consequences of hazardous drinking. The results indicated that alcohol screening and counselling were the highest-ranking preventive services. More recently, Vogl, Teesson, Andrews and Bird (2009) considered computerised harm minimisation prevention programme for alcohol misuse and related harms.

Practical Implications

Having identified the gender of the PDP is important in relation to the experiences of the children, considerations for treatment need to be addressed. In spite of a vast amount of research on offspring, there is still limited research available regarding treatment of these client groups. It is therefore not surprising that the author was unable to retrieve any journals relating to gender specific interventions. It may, therefore, not be a question of implementing gender specific interventions per se, but applying treatment according to particular psychological issues which may have resulted in experiencing maternal or paternal alcoholism / PD. It is important to remember that adult offspring may not be referred for therapy as a direct result of PPD, but another issue which they need support with. It may be, therefore, that counselling psychologists use the knowledge about the effect gender has on offspring which this literature review has highlighted, to inform their formulation and subsequent treatment plans.

The focus of therapy may, for example, need to be on a specific issue such as self-esteem in females with alcoholic fathers. Children in alcoholic families are identified as having difficulty developing trust in others. Therapy can be an arena for the development of trust and can assist in establishing consistency and can encourage healthy interactions between individuals. It can assist to increase self-esteem and help build personal identities apart from being a COA or ACOA. A counselling psychologist

faced with such a client may choose to work in CBT model, given research has shown it to be effective when working with low self-esteem (Taylor & Montgomery, 2007). It may also be appropriate to treat a young male in a more behavioural way as research has shown that boys with alcoholic fathers tend to display more behavioural problems from a young age (Edwards, Leonard & Eiden, 2001). As it stands, psychologists and counsellors are able to choose any form of treatment they see fit based on their assessment, but it would be beneficial if there was actual evidence to suggest that CBT for example, is the optimal form of treatment for males of alcoholic fathers with behavioural problems.

Future Directions

In terms of future research, there is still great need for further studies into the effects of maternal PD which continues to be neglected in the field. It is unclear whether this is a result of paternal PD simply being reported more than maternal PD, or whether the former occurs more frequently than the latter. MacPherson, Stewart and Williams (2001) for example, had difficulty considering maternal and paternal alcoholism separately in their study due to the infrequent presence of maternal alcoholism in their sample. However, this was not seemed as a huge surprise given early figures by Merikangas (1990) indicated that men are about six times more likely to develop alcoholism than women. Additionally, Velleman and Orford's (1999) observation that boys are more affected by their fathers' misuse of alcohol than their mothers' and that girls conversely, are more affected by their mother's misuse of alcohol than their fathers could be explored in future studies on adolescents' motives to use alcohol.

Summary

Returning to the question, there are a number of differences on the effects of PPD on offspring dependant on the gender of the parent. The gender of the offspring in itself also creates further differences. To summarise the findings, paternal PD / alcoholism accounts for more behavioural problems in boys than girls, however the aforementioned research has illustrated the 'age' of offspring is often an important additional factor, leading to mixed results. Signs of behavioural problems can be observed from the age of two, as can aggressive play, whereas PD and intimate relationship issues may not be observed until adolescence or early adulthood. Maternal PD is associated with

attachment issues especially in daughters. The daughters of alcoholic mothers also demonstrate difficulties around trust especially of other women (Ackerman, 2002), whereas daughters of alcoholic fathers tend to have issues around intimacy (Kearns-Bodkin & Leonard, 2008). There is clearly a great deal of literature regarding COAs and the possible issues they may encounter whether it be their own substance abuse, relationship or behavioural problems.

Conclusions

Despite the literature, it remains to be seen which form of treatment would be best suited to the offspring of problem drinkers. The literature does suggest that to a degree, the gender of the PDP will contribute to specific issues in offspring, both as children and in adulthood. There is scope of counselling psychologists working both in drug and alcohol focused services and generic services to apply treatment depending on what is deemed more appropriate. By this, the author means working with the client in a more general way because they are the offspring of a PDP or by structuring the course of therapy to address specific symptoms resulting from factors, such as gender of their PDP. If a female client for example, is struggling with self-esteem issues and negative thinking, a course of CBT may be considered appropriate. Ultimately, each counselling psychologist will be required to work collaboratively with the client and tailor the course of treatment according to their needs. Counselling psychology is an ideal area in which to develop research in the area.

References

Ackerman, R. J. (2002). *Perfect Daughters*. Revised Edition. Adult Daughters of Alcoholics. Health Communications, Inc.

American Psychiatric Association (2000). Diagnostic and statistical manual of mental disorders-text revision, 4th edn, (DSM-IV-TR), Washington, DC.

Annis, H. M. (1974). In Johnson, J. L., & Leff, M. (1999). Children of substance abusers: Overview of research findings. *Pediatrics, 103(5),* 1085-1099.

Backett-Milburn, K., Wilson, S., Bancroft, A., & Cunningham-Burley, S (2008). Challenging Childhoods: Young people's accounts of 'getting by' in families with substance use problems. *Childhood, 15,* 461-479.

Ballard, M. (1993). In Kelley, M., French, A., Schroeder, V., Bountress, K., Fals-Stewart, W., Steer, K., & Cooke, C. (2008). Mother–Daughter and Father–Daughter Attachment of College Student ACOAs, *Substance Use & Misuse, 43,*1562–1573.

Barber, J. G., & Crisp, B. R. (1994). The effects of alcohol abuse in children and the partner's capacity to initiate change. *Drug and Alcohol Review, 13,* 409-416.

Beaudoin, C. M., Murray, R. P., Bond, J. Jr., & Barnes, G. E. (1997). Personality characteristics of depressed or alcoholic adult children of alcoholics. *Personality & Individual Differences, 23,* 559-567.

Belliveau, J. M., & Stoppard, J. M. (1995). Parental alcohol abuse and gender as predictors of psychopathology in adult children of alcoholics. *Addictive Behaviours, 20,* 619-625.

Bennett, L.A., Wolin, S. J., & Reiss, D. (1988). Cognitive, behavioural and emotional problems among school-age children of alcoholic parents. *American Journal of Psychiatry, 145,* 185-190.

Berkowitz, A., & Perkins, H. W. (1988). Personality characteristics of children of alcoholics. *Journal of Consulting and Clinical Psychology, 56,* 209-209.

Biener, L. (1987). In Weitzman, E. R., & Wechsler, H. (2000). Alcohol use, abuse, and related problems among children of problem drinkers: Findings from a national survey of college alcohol use. *The Journal of Nervous & Mental Disease, 188(3)*, 148-154.

Black, C. (1981). *It will never happen to me.* Denver: MAC Printing and Publications Division.

Bowlby, J. (1969). *Attachment and Loss*, Vol. 1: Attachment, New York: Basic Books.

Bradley, L., & Schneider, H. (1990). Interpersonal trust, self-disclosure and control in adult children of alcoholics. *Psychological Reports, 67,* 731-737.

Carbonneau, R., Dobkin, P. L., Pihl, R., Saucier, J., Tremblay, R. E., & Vitaro, F. (1998). Paternal alcoholism, paternal absence and the development of problem behaviours in boys from age six to twelve years. *Journal of Studies on Alcohol, 59(4),* 387-398.

Chen, Y., & Weitzman, E. R. (2005). Depressive symptoms, DSM-IV alcohol abuse and their comorbidity among children of problem drinkers in a national survey: Effects of parent and child gender and parent recovery status. *Journal of Studies on Alcohol, 66(1),* 66-73.

Clark, D. B., Moss, H. B., Kirisci, L., Mezzich, A. C., Miles, R., & Ott, P. (1997). Psychopathology in preadolescent sons of fathers with substance use disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 36(4),* 495-502.

Cloninger, C. R., Dinwinddic, S., & Reich, T. (1989). In Mack, A. H., & Frances, R. J. (2003). Treatment of alcohol use disorders in adolescents. *Journal of Psychiatric Practice, 9(3),* 194-209.

Coffelt, N. L., Forehand, R., Olson, A. L., Jones, D. J., Gaffney, C. A., & Zena, M. S. (2006). A longitudinal examination of the link between parent alcohol problems and youth drinking: The moderating roles of parent and child gender. *Addictive Behaviors, 31(4),* 593-605.

Domenico, D., & Windle, M. (1993). Intrapersonal and interpersonal functioning among middle-aged female adult children of alcoholics. *Journal of Consulting and Clinical Psychology, 61,* 659-666.

Edwards, E. P., Eiden, R. D., Colder, C., Leonard, K. E. (2006). The development of aggression in 18 to 48 month old children of alcoholic parents. *Journal of Abnormal Child Psychology, 34(3),* 409-423.

Edwards, E. P., Leonard, K. E., & Eiden, R. D. (2001). Temperament and behavioural problems among infants in alcoholic families. *Infant Mental Health Journal, 22(3),* 374-392.

Eiden, R.D., & Leonard, K.E. (1996). Paternal alcohol use and the mother-infant relationship. *Development & Psychopathology, 8,* 307-323.

Eiden, R.D., Edwards, E.P., & Leonard, K.E. (2002). Mother-infant and father infant attachment among alcoholic families. *Development & Psychopathology, 14,* 253-278.

Farrell, M., Barnes, G., & Banerjee, S. (1995). Family cohesion as a buffer against the effects of problem drinking fathers on psychological distress, deviant behaviour and heavy drinking in adolescents. *Journal of Health and Social, 36(4),* 377-385.

Finn, P. R., Sharkansky, E. J., Viken, R., West, T. L., & Buffered, S. (1997). Heterogeneity in the families of sons of alcoholics: The impact of familial vulnerability type on offspring characteristics. *Journal of Abnormal Psychology, 106,* 26-36.

Furtado, E. F., Laucht, M., & Schmidt, M. H. (2006). Gender-related pathways for behaviour problems in the offspring of alcoholic fathers. *Brazilian Journal of Medical and Biological Research, 39(5),* 659-669.

Garside, R. B., & Klimes-Dougan, B. (2002). In Rangarajan, S. (2008). "Emotional Expressivity and Social Support Among Adult Daughters of Alcoholic Mothers" *Paper presented at the annual meeting of the International Communication Association, TBA,*

Montreal, Quebec, Canada Online <PDF>. 2010-03-12 from http://www.allacademic.com/meta/p233237_index.html.

Goodwin, D. (1977). In Johnson, J., & Leff, M. (1999). Children of Substance Abusers: Overview of Research Findings. *Paediatrics, 103(5),*1085-1099.

Held, S. (1991). In Kearns-Bodkin, J., & Leonard, K. (2008). Relationship Functioning Among Adult Children of Alcoholics. *Journal of Studies on Alcohol and Drugs, 69(6),* 941-950.

Houlihan, B. L. (2001). *The intimate interpersonal relationships of adult children of alcoholics.* Dissertation Abstracts International: Section B: The Science and Engineering, 61(10-B), pp. 5621.

Jansen, R. E., Fitzgerald, H. E., Ham, H. P. & Zucker, R. A. (1995). Pathways into risk: Temperament and behaviour problems in the three to five year old sons of alcoholics. *Alcoholism: Clinical & Experimental Research, 19(2),* 501-509.

Kearns-Bodkin, J., & Leonard, K. (2008). Relationship Functioning Among Adult Children of Alcoholics. *Journal of Studies on Alcohol and Drugs, 69(6),* 941-950.

Kelley, M., French, A., Schroeder, V., Bountress, K., Fals-Stewart, W., Steer, K., & Cooke, C. (2008). Mother–Daughter and Father–Daughter Attachment of College Student ACOAs, *Substance Use & Misuse, 43,*1562–1573.

Kultur, S. E. C., Unal, M. F., & Ozusta, S. (2006). Psychopathology in children of alcoholic fathers. *Turk Psikiyati Dergisi, 17(1),* 3-11.

Latty-Mann, H. (1991). In Kearns-Bodkin, J., & Leonard, K. (2008). Relationship Functioning Among Adult Children of Alcoholics. *Journal of Studies on Alcohol and Drugs, 69(6),* 941-950.

Lau, M., & Kristensen, E. (2007). Outcome of systematic and analytic group psychotherapy for adult women with history of intrafamilial childhood sexual abuse: A randomised controlled study. *Acta Psychiatrica Scandanavica, 116(2),* 96-104.

Lewchanin, S., & Sweeney, S. (1997). A developmental approach to the group treatment of adult children of alcoholics. *Alcoholism Treatment Quarterly, 15(2),* 51-62.

Leonard, K. E., & Eiden, R. D. (2000). Cognitive functioning among infants of alcoholic fathers. *Drug and Alcohol Dependence, 67(2),* 139-147.

Lubin, H. (2007). Group and individual therapy for childhood sexual abuse survivors. *International Journal of Group Psychotherapy, 57(2),* 257-262.

Magai, C. (1991). Emotional socialization: Its role in personality and developmental psychology. In D. Cicchetti & S. L. Toth (Eds.), *Internalizing and externalizing expressions of dysfunction* (pp. 203-224). Hillsdale, NJ: Lawrence Erlbaum Associates.

Malone, T. L. S. (2003). Differences in self-esteem, locus of control and family of origin health of African American adult children of alcoholic and non-alcoholic parents. Dissertation Abstracts International: Section B: The Sciences and Engineering. 63(10-B), pp.4883.

MacPherson, P., Stewart, L., & Williams, L. (2001). Parental problem drinking and anxiety disorder symptoms in adult offspring examining the mediating role of anxiety sensitivity components. *Addictive Behaviors, 26,* 917-934.

Moser, R. P., & Jacobs, T. (1997). Parent-child interactions and child outcomes as related to gender of alcoholic parent. *Journal of Substance Abuse, 9,* 189-208.

Nylander, I. & Rydellus, P.A. (1982). In Christensen, H. B., & Bilenberg, N. (2000). Behavioural and emotional problems in children of alcoholic mothers and fathers. *European Child & Adolescent Psychiatry, 9(3),* 119-226.

Obuchowska, I. (1974). In Ackerman, R. J. (2002). *Perfect Daughters*. Revised Edition. Adult Daughters of Alcoholics. Health Communications, Inc.

Orford, J., Natera., G., Copello, A., Atkinson, C., Mora, J., Velleman, R., Crundall, I., Tiburcio, M., Templeton, L., & Walley, G. (2005). *Coping with alcohol and drug problems: The experience of family members in three contrasting cultures.* Routledge, Taylor & Francis Group.

Orosz-Vail, M., Protinsky, H., & Prouty, A. (2000). Sample issues in research on adult children of alcoholics: Adolescence and beyond. *Adolescence, 35(137),* 113-119.

Parker, D., & Hartford, T. (1988). Alcohol-related problems, marital disruption and depressive symptoms among adult children of alcohol abusers in the United States. *Journal of Studies on Alcohol, 49,* 306-313.

Perez, J. (1983). *Relationships: Adult children of alcoholics.* New York, NY: Gardner Press.

Schutt, M. (1985). In Glover, G. J. (1994). The hero child in the alcoholic home: Recommendations for counsellors. *School Counsellor, 41(3),* 185-191.

Sher, K. J., Walitzer, K. S., Wood, P. K., & Brent, E. E. (1991). Characteristics of children of alcoholics: Putative risk factors, substance use and abuse, and psychopathology. *Journal of Abnormal Psychology, 100,* 427-448.

Solberg, M. D., Maciosek, M. V., Nichol, M., & Edwards, M. S. (2008). Primary Care Intervention to Reduce Alcohol Misuse. Ranking Its Health Impact and Cost Effectiveness. *American Journal of Preventative Medicine,* 34(2), 143-152.

Steinhausen, H., Gobel, D., Nesler, V. (1984). Psychopathology in the offspring of alcoholic parents. *American Academy of Child Psychiatry, 23,* 465-471.

Stout, M., & Mintz, L. (1996). In Harrington, C., & Metzler, A. (1997). Are adult children of dysfunctional families with alcoholism different from adult children of dysfunctional families without alcoholism? A look at committed, intimate relationships. *Journal of Counselling Psychology, 44(1),* 102-107.

Straussner, S. L. A. (1997). In Weitzman, E. R., & Wechsler, H. (2000). Alcohol use, abuse, and related problems among children of problem drinkers: Findings from a national survey of college alcohol use. *The Journal of Nervous & Mental Disease, 188(3),* 148-154.

Taylor, T. L. & Montgomery, P. (2007). Can cognitive-behavioral therapy increase self-esteem among depressed adolescents? A systematic review. *Children and Youth Services Review, 29*, 823-839.

Tomkins, S. S. (1962). *Affect, imagery, consciousness: Vol. I. The positive affects.* Oxford, England: Springer.

Trim, R. S., Leuthe, E., Chassin, L. (2006). Sibling influence on alcohol use in a young adult, high-risk sample. *Journal of Studies on Alcohol, 67(3),* 391-398.

Velleman, R., & Orford, J. (1999). *Risk and resilience: Adults who were the children of problem drinkers*. Harwood Academic Publishers.

Velleman, R. (2002) *The Children of problem drinking parents: An Executive summary*, Executive Summary Series; Centre for Research on Drug and Health Behaviour, *Executive Summary, 70,* 1 -5.

Vogl, L., Teesson, M., Andrews, G., Bird, K., Steadman, B., & Dillon, P. (2009). A computerized harm minimization prevention program for alcohol misuse and related harms: randomized controlled trial. *Addiction*, 104(4), 564–575.

Watt, T. (2002). Marital and Cohabiting Relationships of Adult Children of Alcoholics. *Journal of Family Issues, 23(2),* 246-265

Weinberg, N. Z., Dielman, T. E., Mandell, W., & Shope, J. T. (1994). Parental drinking and gender factors in the prediction of early adolescent alcohol use. *International Journal of Addiction, 29,* 89-104.

Werner, E. E. (1986). Resilient offspring of alcoholics: a longitudinal study from birth to the age of 18. *Journal of Studies on Alcohol, 47,* 34-40.

West, M. O., & Prinz, R. J., (1987). Parental alcoholism and childhood psychopathology. *Psychological Bulletin, 102,* 204-218.

Winokur, G., Reich, J., Rimmer, J., & Pitts, F. (1970). In Rangarajan, S. (2008). Mediators and Moderators of Parental Alcoholism Effects on Offspring Self-Esteem. *Alcohol & Alcoholism*, *43(4)*, 481-491.

Zeitlin, H. (1994). Children with alcohol misusing parents. *British Medical Bulletin*, *50(1)*, 139-151.