

Risky vs Resilient family environments for children: when parents have alcohol and violence difficulties¹.

We actually know quite a lot about what makes a family environment risky for children, when parents have either alcohol, or domestic violence, problems. Much of this is reviewed in a recent paper published by my colleague Lorna Templeton and myself:

Velleman, R. and Templeton, L. (2007) Understanding and modifying the impact of parental substance misuse on children. *Advances in Psychiatric Treatment*, **13**, March 2007, 79-89.

Risk

Parental alcohol problems

Parental alcohol problems commonly have a wide range of effects on the family and on family functioning. These are summarised in Velleman (2004), Gorin (2004) and Velleman and Orford (1999).

In brief, some of the main impacts of living in a family where someone misuses alcohol (or drugs) are that:

- Family members often suffer many *negative experiences*, including violence, poverty, and social isolation.
- Family members, as well as the person misusing substances, will often *develop problems* as a result of these and other experiences.
- Some will be *individual problems* (such as anxiety and depression).
- Others will be *family problems* (such as breakdowns in such family structures and systems as rituals, roles, routines, communication structures, social life and finances).
- *Children may have particular difficulties.*

There are a number of common negative experiences that children and adolescents may have when living with a parent with a substance misuse problem. These include:

- High levels of violence
- Experiencing or witnessing neglect or abuse – physical, verbal or sexual

¹ Most of the following paper originates from review work I have undertaken with my colleague, Lorna Templeton, and from original research undertaken with Lorna Templeton, Jim Orford, and others over the years.

- Poor and/or neglectful parenting
- Inconsistency from one or both parents
- Having to adopt responsible or parenting roles at an early age
- Feeling negative emotions such as shame, guilt, fear, anger and embarrassment
- Possible neurodevelopmental consequences of substance misuse in pregnancy (e.g. foetal alcohol syndrome) that may contribute to developmental delays or intellectual disability

These and other disruptions can have a strong impact on children at all stages of their development, placing them at risk of developing a wide range of problems, including the following:

Negative effects of living with a parent with a substance misuse problem

Children

Children who have the experiences I have just outlined often subsequently demonstrate their negative effects, including higher levels of:

- behavioural disturbance, antisocial behaviour (conduct disorders)
- emotional difficulties
- behavioural problems and underachievement at school
- social isolation, because they feel that it is too problematic or shameful to bring friends home, or because they are not able to go out with friends as they have responsibilities of caring for other family members (e.g. siblings or the misusing parents)
- 'precocious maturity'

They also tend to have a more difficult transition from childhood to adolescence and increased likelihood of being referred to social services because of child protection concerns

Adolescents

Two common patterns often emerge:

- increasing introspection and social isolation, with friendship difficulties (e.g. the young person is unlikely to visit or invite friends to their own home), anxiety or depression (for which psychoactive medication may be prescribed); attempts to escape their family home (e.g. by leaving home at an early age or entering into a long-term relationship)
- development of strong peer relationships which are kept separate from their own family; these relationships may themselves involve early alcohol or drug use, participation in sub-

cultures perceived to be 'deviant', in antisocial activity, unsafe sex and unplanned and/or early pregnancy

Adulthood

- Some of the problems of childhood and adolescence can continue into adulthood
- There is some (although not as great as previously thought) evidence that adult offspring of substance-misusing parents have greater problems in terms of substance misuse or areas of adulthood adjustment
- Most have no more problems than do other adults within our society (Risk Over-Prediction!)

Domestic Violence

Some of the main findings of research (see eg Gorin, 2004 and Cleaver et al, 1999) which has looked at the impact on children of living in a family where domestic violence is rife are that, in brief, the impact of domestic violence is very similar to that of substance misuse: there are commonly effects on

- parenting skills,
- parents' perceptions of themselves and of the outside world,
- their attachment to their children and vica versa,
- their control of their emotions,
- and their attention to or neglect of their own and their children's physical and psychological needs.

There are a similar range of social consequences too: there are frequently

- effects on the family's living standards,
- a loss of contact with friends and family,
- and a disruption to family relationships.

The research, therefore, shows that both substance misuse and violence in the family can have very detrimental effects both on parents and on children.

There are also a number of issues which serve to *increase* the risks and *increase* the

likelihood of any negative effects on children, and to outline others which serve to protect children or make them resilient.

Extra Risk Factors

These exacerbatory factors include violence, marital conflict, parental separation and loss, inconsistency in parenting, ambivalent parenting, both parents misusing substances, the drinking or other substance misuse occurring within the family home, and high levels of family disharmony.

Similarly, the research into the impact of domestic violence on children and families has shown that the impact is more likely to have a detrimental effect on the children

- if they themselves are targets for parental aggression (or rejection);
- if they witness the violence between their parents;
- if they are drawn into the violence (eg by trying to protect one parent from the other one);
- if they are drawn into colluding with concealing the assaults;
- or if the domestic violence is combined with alcohol or drug misuse.

These factors have a cumulative effect: the more that are present, the higher the risk of negative outcomes.

Protection

Protective Factors

As well as Risk Factors, there are Protective Factors as well.

In families with parental alcohol problems these include

- the provision of stability, time and attention from at least one parent,
- the presence of a cohesive parental relationship with overt parental affection,
- the retention of a cohesive set of family relationships involving shared family activities and shared family affection,
- the ability of the child(ren) to disengage from the disruptive elements of their family lives,
- and the presence of significant external support systems which provide the stability which

may be absent from their normal family life.

There are a similar range of protective factors in the research literature on domestic violence: adverse effects on children are less likely when

- parental problems are not associated with family discord and disorganisation;
- do not result in the family breaking up;
- when the other parent or another family member can respond to the child's developmental needs for security and love;
- and when the child has inner resources (such as a positive sense of self esteem and self confidence, feeling in control and capable of dealing with change), and has a range of approaches for solving problems.

These are all traits fostered by secure, stable and affectionate relationships and experiences of success and achievement.

Are 'Protective Factors' the same things as 'Resilience Factors'? What are the conceptual differences between protective factors, and resilient characteristics

Resilience should be conceptualised as a *process*, rather than a static trait and/or something solely internal to the individual. And as a process it is the product of an interaction between the individual and their social context: hence, it is potentially open to influence.

It is useful to distinguish between protective factors (which make it more likely that a child *will develop* resilience) and evidence that the child *is being* resilient.

Resilience is self-perpetuating: behaving in a resilient way increases the probability of further resilient behaviour.

Protective factors and resilience have been identified in a number of studies, both general and specific to parental substance misuse (see eg Werner, 1993; Velleman & Orford, 1999; Beinart *et al*, 2002; Bancroft *et al*, 2004). For example, Bancroft *et al* (2004) interviewed 37 young people aged 15–27 who were children of substance-misusing parents, and found that 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.

[It should not be thought, however, that this was easy to maintain. Although the participants in this study said that some support from immediate and extended family was obtainable and was certainly beneficial, they also said that longer-term, unconditional support was rare, and certainly nowhere near the level they needed or desired.]

Strategies used to deal with the misuse included escape (e.g. spending time in their room or going to visit friends) and challenging the user (although this latter was rarely successful). In common with participants in other studies (e.g. Velleman & Orford, 1999), the young people interviewed by Bancroft *et al* were helped to move on from their difficult pasts by their own actions: identifying goals and dreams and making them happen; making the most of education or work opportunities; moving away from their parents; and developing their lives through their own family and children. A central issue in their success was the feeling that they had choices and were in control of their lives.

A list of the protective factors and evidence of consequent resilience, gleaned from these and other studies is as follows:

Protective factors and resilience

Protective factors

- The presence of a stable adult figure (usually a non-substance misuser)
- Close positive bond with at least one adult in a caring role (e.g. parents, older siblings, grandparents)
- A good support network beyond this
- Little separation from the primary carer in the first year of life
- Parents' positive care style and characteristics
- Being raised in a small family
- Larger age gaps between siblings
- Engagement in a range of activities
- Individual temperament
- Positive opportunities at times of life transition

- Continuing family cohesion and harmony in the face of the misuse and its related effects (e.g. domestic violence, serious mental health problems)

Evidence of resilience that these protective factors encourage

- Deliberate planning by the child that their adult life will be different
- High self-esteem and confidence
- Self-efficacy
- An ability to deal with change
- Skills and values that lead to good use of personal ability
- A good range of problem-solving skills
- Feeling that there are choices
- Feeling in control of own life
- Previous experience of success and achievement

The key issue for resilience is the overcoming of psychological risk. Protective factors make it more likely that a child can overcome this risk because they provide a more positive setting. Resilience makes this more likely because it equips the child with a set of skills and feelings that enable him (or her) to be forward-looking and to bounce back from adversity.

Modifying the impact: what can practitioners do?

Thus, there is clear evidence that some children are resilient, and that there are identifiable factors that seem to be associated with both their protection and their resilience.

But can we as practitioners do anything to promote resilient outcomes?

Yes - there are two clear ways in which we can:

- we can work with children,
- and we can work with families

Work with Children

Sarah Gorin's research (2004) on **Understanding what children say about living with domestic violence, parental substance misuse or parental health problems** enables us to know what we could do in work with children. She highlighted a number of issues. These included:

Enabling children to understand problems at home

Lack of communication is a major barrier to children and young people getting the help they need. There are problems of communication between parents and children and professionals. Within families this is often because of a shared desire to protect one another, secrecy and shame surrounding problems, parents finding it hard to know how to talk to children and feeling too upset themselves to talk about problems. Children in the studies on domestic violence, in particular, stressed wanting parents to talk to them more: **Not talking to children may perpetuate their confusion and isolation and lead to misunderstandings.**

Enabling children to talk about problems and access help

First and foremost, children use informal sources of support. They are most likely to turn to parents (usually mothers) and friends, then siblings, grandparents or pets. Support may come in the form of talking or spending time with someone and feeling safe. Children say that they want to talk to someone who they trust, who will listen to them and provide reassurance and confidentiality. Some children will not talk to anyone about the problems at home. This may be because of fear of violence, fear of the consequences of talking about problems (for example, being separated from parents, hurting other people), fear of not being believed or because of distrust, not feeling anyone can help, and possible stigma surrounding problems. Boys in particular may find it hard to talk about problems and they are more likely to leave talking to someone until nearer crisis point than girls. **Many children report using avoidance or distraction as a coping strategy when there are problems at home.**

Using this strategy is likely to make children even harder to identify and support. We do not really understand what would make boys more likely to talk about problems and seek support. Ensuring that children have a choice of a male or female helper and a helper of the same ethnicity may be advantageous. We know that children rarely approach professionals initially and do not know where to go to get formal help. Unwanted intervention and stigma are the main reasons children and parents give for not approaching professionals. They may be more encouraged to do so, either through helplines or by having spaces provided in which they can feel safe. **Having time to build up relationships of trust is likely to help children discuss problems at home.**

Respecting children, recognising and valuing their experiences and acting on concerns

Children's accounts of receiving professional help vary, but many report negative experiences. Children say that professionals do not always talk to them in a language they can understand, they are often afraid that professionals will not believe them and they are not confident that any professional action will make things any better. In many circumstances children are worried that involvement with professionals will make things worse. Children's accounts of coming into contact with professionals about domestic violence suggest that, in some cases, professionals involved did not speak directly to children. Children want to be respected and taken seriously by professionals. Where action is taken in their family, they want to be involved in decision-making, although this does not mean they want to take full responsibility for decisions. In the case of parental ill health, children feel frustrated at not being involved in decision-making about the care and support of parents. **Children also say that being involved in finding solutions to problems helps them to cope.**

Providing an appropriate range of support

Children mention a need for confidential support such as helplines, universal and specialist support. Although there are overlaps in the types of feelings and coping strategies children may use, there are many differences in individual experiences and there is a need for some specialist services that can work with children alongside those for parents. Children's most urgent request, however, is for age-appropriate information about the problems their parents are experiencing. **Children also talk about welcoming an opportunity to have a break away from home, have some fun and to get to know other children experiencing the same problems.**

Resilient children (and adults) share key characteristics: planning, high self-esteem and confidence, self-efficacy, the ability to deal with change, problem-solving skills, the feeling that they have choices and are in control, and previous experience of success and achievement. The task for practitioners, therefore, is to enable vulnerable children and young people to develop these attributes. Essentially, within the remit of a professional role that will dictate the level of contact with and responsibility for a child, practitioners can use this relatively basic knowledge of protective factors to contribute to the child's development of resilience. The practitioner needs to work directly with the children involved, enabling them to:

- maintain positive family rituals

- remove themselves from the disruptive behaviour of the problem parent or parents
- disengage from the disruptive elements of family life
- engage with stabilising people outside the family
- develop 'confidants' outside the family
- engage in stabilising activities (school, clubs, sports, culture, religion) within which the child can develop a sense of self and self-esteem
- develop a desire to be, and pride in being, a survivor.

A key task of the practitioner in developing children's resilience, then, is to help them to identify and build on their strengths, including the social support they can call on, enabling them to build meaning and motivation into their lives, helping them to acquire social skills that bring self-control, self-esteem and a sense of humour, and helping them to reframe negative events and emotions into positive ones.

Obviously, interventions should take into account the age, gender and developmental level of the child.

- For example, it may be more difficult for younger children to seek external support: there may be problems with transportation, money, parents' permission, protection and safety.
- Girls seem less affected by parental problem-drinking in the short term but if the situation continues then there is an increased likelihood of problems developing (Cleaver *et al*, 1999). Werner (1993) also found that individual disposition was more important for females, whereas external support was more important for males.
- Boys often feel that conflict is more of a threat to them, whereas girls tend to appraise conflict in terms of how it affects them and are more likely to blame themselves.
- The setting in which the intervention is undertaken can also be important: this work with children need not be conducted in individual counselling or case-work sessions: there is evidence that a group approach can be effective in promoting resilience in young people with stressful backgrounds, including parental substance misuse.

Gilligan (2000) and Newman (2002) offer further and more detailed guidance on increasing individuals' resilience. Although not written specifically for work with children who have experienced parental substance misuse, there is much within these two guides that is useful for such a situation.

As well as working with individual children, **we can work with families** by both Reducing Risk and Increasing Protective factors and resilience

Reducing risk

It is vital to promote a safe and stable family environment (maintaining family roles and rituals, ensuring family harmony).

The major risk factors relate to such family issues, as opposed to drinking alcohol in itself; and all of the major risk factors are amenable to intervention, even if the parental drinking is not at the time.

This means that we as practitioners, working with families in which parents have alcohol or domestic violence problems (or both) should not necessarily focus our risk-reduction efforts on enabling the alcohol misuser to change (although, of course, if this is a possibility it should be encouraged).

Instead, we need to work on:

- family disharmony, and in particular on
 - violence (including physical, verbal or sexual abuse)
 - parental conflict
 - parental separation and loss
- inconsistent, neglectful and ambivalent parenting.

This is for two reasons:

- because these things seem to pose the greatest risk to the short- and long-term well-being of children;
- and because they can all be worked on using the skills and techniques (conflict resolution, anger management, couples counselling, parenting skills training) that most practitioners will have been trained to undertake.

Increasing protective factors and resilience

The second way that practitioners can help to promote resilience is to work on protective factors and resilience itself. As far as protective factors are concerned, clinicians can work with:

- the other parent (if there is one and if they do not also have a substance problem), enabling them to provide a stable environment and give the time and attention that children require
- the parental relationship, enabling parents to retain its cohesion and present a united and caring front to the children
- the family, ensuring that family relationships, family affection and family activities are maintained
- adult figures outside of the nuclear family, ensuring that there is at least someone who can provide the necessary stabilising influence.

This work might involve direct intervention with other key adult figures, for example grandparents or teachers. In a qualitative study of 62 drug-using parents in Scotland, Barnard (2003) reported that the extended family's involvement in caring for the children and supporting the parents was pivotal to the children's well-being. Most importantly, they found a clear correlation between the absence of such support and the child being taken into local authority care.

These factors within a child's environment will mean that they are more protected and hence more likely to develop resilience.

Key common skills and contexts

Many child care practitioners have told us that they lack the skills to work with substance-misusing parents in order to reduce risk factors or increase protective factors for children. Strangely, many practitioners in substance misuse services tell us the converse: that they do not have the skills to work with children and the wider family to the same purpose. Our response to both groups is that all practitioners use the same basic skills of forming a therapeutic relationship and counselling. These skills are:

- be warm, empathic and genuine
- make a therapeutic relationship
- help clients to explore their difficulties
- enable clients to set achievable goals

- empower clients to take action to reach these goals
- stay with clients and help them to stabilise and maintain changes

I have outlined these skills in much more detail in my book on Counselling: Velleman (2001) *Counselling For Alcohol Problems*, 2nd Edition.

Clearly, especially with younger children, such skills must sometimes be used slightly differently or alongside other techniques, such as art or play therapy.

Clearly also, specific therapeutic techniques such as conflict resolution, couples counselling, parenting skills training, and so on may also be useful, as might therapeutic interventions aimed at enabling the adult family members to change.

But the essential skills base remains the same. Overall, skilled helpers use the same key core skills, irrespective of the age of the person with whom they are working or the number of people present in the room.

Responsibilities and holistic contexts

Even when practitioners have the skills, many feel that it is not their role to work with children, or families or parents with substance misuse problems.

We take the view that we all have both clinical and moral responsibilities to think about the wider systems and not solely about our identified and referred 'patients'. Indeed, the possibility that any case might involve child protection issues is a powerful argument for services to take a broader view of their remit.

Hence, in any adult healthcare service, practitioners need to know whether the adult they are helping has children and family, and what impact that person's problems and behaviour may be having on those family members.

Similarly, in child and adolescent services, practitioners must be alert to the influence on children of their parents' problems.

And 'alert' does not simply imply onward referral. Very often practitioners need to intervene in a more holistic and systemic way, and not imagine that intervening with the child in the absence of their problem parents, or the adult in the absence of their wider family, will lead to a successful outcome: dealing with the impact of parents' substance or domestic violence problems on their children is an issue not just for child and adolescent mental health or addiction services, nor just for Adult services: it is the responsibility of all healthcare practitioners.

The report in the UK on the inquiry into the death of Victoria Climbié, a child under the care of social services, made it clear that practitioners can no longer walk away from situations that might put anyone, child or adult, at risk (House of Commons Health Committee, 2003).

The key points here are

- that as practitioners we can intervene to help these children;
- and that the focus does not have to be on the parental substance misuse or domestic violence problem, but on promoting necessary beneficial factors in children's lives.

This is especially important: one of the main myths in the substance misuse field is that there is nothing that anyone can do (about anything) unless the substance misuser decides to change their substance misuse behaviour. This is entirely untrue!

There is a very large amount of evidence (summarised recently by Lorna and myself, with our colleague Alex Copello - Copello *et al*, 2005) that significant change can be brought about by focusing on other issues, and even by intervening with key family members in the absence of the substance-misusing adult.

In the context of this presentation, and this conference, which focuses on children, it is vital that practitioners do not get sidetracked into concentrating solely on parental problems: instead we must focus on the child's needs and how to meet them.

Conclusions

It seems to me that it is relatively clear how professionals can help families to reduce risk, develop protective factors and promote resilience in young people.

The four key points are:

- It is relatively clear how professionals can help to modify the impact of parental substance misuse on children: they should help them to reduce risk, develop protective factors and promote resilience
- Practitioners can intervene, and the focus does not have to be on the substance misuse, but on providing necessary beneficial factors in children's lives
- Practitioners must not be sidetracked into focusing on the parents' problems: the focus must be on the child's needs and how to meet them
- The problem is, not enough practitioners actually DO this! Further work is needed to encourage and train professionals to use this knowledge to work in a more focused and integrated way, looking at the full range of a child's needs within a broader context.

I hope that our work in ENCARE is one way that will encourage practitioners to do this, and take on more responsibility for promoting resilience.

Thank you.

**Richard Velleman,
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