

## **The Addiction Environment: The Impact on Children and Young People Living in Families with Addiction Problems**

TRISH GLEDHILL

### **Abstract**

This paper addresses the impact that an environment has upon children both in terms of the factors that place children at risk and the factors existing in home, school and community environments that provide resilience from harm. The material presented in this paper will be based on the presenter's book *21 Fun Street, Kool Kids - Therapeutic Programmes for Children Living with Addiction*. Other current literature and research will be included. Children living in these family environments have limited access to support and specialist services. Services continue to focus predominantly on the identified adult for treatment without considering the needs of the child in this context. The implications for policy and practice to address these needs are discussed and a therapeutic group environment is described that provides opportunities for these children to develop their strengths and resources.

### **Introduction**

There is now a great deal of research available regarding the experiences and outcomes for children living with addiction. Despite recognition of some of the limitations of earlier research, and some conflicting evidence regarding risk, it is generally accepted that children of alcoholics are more at risk of developing alcohol problems later in life or to experience other psychiatric, behavioural disorders or interpersonal difficulties (Casswell, 1996; Jansen, Fitzgerald, Ham & Zucker, 1995; Green, MacIntyre, West & Ecob, 1991; Velleman, 1992).

Our understanding of the effects of alcohol problems has continued to develop as later research attempts to more accurately define those factors which adversely affect children's functioning and their development as adults. More recent research focuses specifically on the dynamics within a family and the quality of interactions within the family.

By recognising the majority of children who do not develop major difficulties, research has begun to suggest factors that promote resilience in a child's functioning and the mechanisms by which these protective factors are able to limit the effects of risk (Werner, 1986; Wolin & Wolin, 1995).

Recent literature, however, continues to highlight the needs of these children and the lack of services available (Lindstein, 1996; Brisby, Baker, & Hedderwick, 1997; Coface & Eurocare, 1998).

This paper will briefly refer to alcohol and drug related harm in New Zealand followed by a definition of addiction as it impacts on family members. A description is provided of some of the characteristics of families living with addiction and some of the negative outcomes for children as they relate to key areas of children's well-being. The topic of resilience is explored with suggestions as to how we may apply this construct to working with children and young people living in these environments. Implications for practice and policy are described, followed by a brief outline of the Hawke's Bay Addiction Services Children's Programme.

### **Alcohol and drug related harm in New Zealand**

Alcohol related harm continues to have an impact on all levels of New Zealand society. Statistical evidence describes the direct effects on individuals, particularly young men, and the impact on families and the wider community. These effects include illness, injury, violence and offending. The social costs of alcohol abuse are difficult to determine but have been estimated to be between \$1 billion and \$4 billion per year (Devlin et al., 1997, cited Alcohol Advisory Council of New Zealand, 2001).

Men and younger people, especially males, are reported as having the highest risk of alcohol related problems, with Maori and Pacific adults more likely to demonstrate hazardous drinking patterns. However, women and children are most likely to suffer the indirect consequences of alcohol related problems (Alcohol Advisory Council of New Zealand, 1997).

### **Families living with addiction**

What is addiction? Various terms have been used in the literature to describe the degree of alcohol or other drug use that is said to have an impact on family members. The term addiction may be used as a way of describing a person's state where alcohol use totally dominates functioning, usually including a physical and a psychological dependence. The nature of an addiction problem is usually long-term and progressive and therefore has wide reaching effects on family and community (Gledhill, 1999).

In a range of earlier literature several authors (Cork, 1969; Black, 1982; Ackerman, 1983) describe some of the characteristics of families living with addiction problems. While it is not possible to describe a "typical family" with an alcohol problem, a number of common characteristics can be generalised from the literature and from personal experience working with children of alcoholics.

Conflict, unpredictability and inconsistency become common. As the alcoholic becomes more self-absorbed and focused on their drinking, they become less and less emotionally available as a parent. Likewise, the spouse, who is often pre-occupied with the drinking behaviour, is equally unavailable.

Children's needs are often neglected and an older child, especially in the case of an alcoholic mother often assumes parental roles.

Children also frequently feel responsible for a parent's drinking. They are often told that their behaviour causes the parent to drink.

Normal rituals and routines are hard to maintain as drinking behaviour increases and this unpredictability dominates the family environment.

Embarrassing incidents are common and as denial, shame and guilt develop, the family becomes a more tightly closed system. Social isolation can occur with less and less contact outside the family. Typically, for example, children are often reluctant to have friends over due to anxiety about how a parent may behave if they have been drinking.

The closed nature of the family means the true picture can be well hidden. (Gledhill, 1999, p. 15)

It is important to note that many of these children are living in environments with a number of other risk factors likely to impact on their well-being. For example, many of these families have low incomes and financial stress is particularly common especially in the case of gambling addictions. Violence and other forms of abuse are sometimes present in these families and mental illness may be a co-existing disorder. Separation and divorce are not uncommon as well as other stressful life events such as moving house frequently.

A very significant pressure on children of alcoholics is the chronic nature of the stress they live with. Orford (1994) is one of the few who research this chronic stress. He calculated that the average length of exposure to parental drinking problems for young people, aged between five and 15 years, was seven years. He refers to this type of stressful circumstance as a 'chronic life difficulty'. This is illustrated in the families seen in services that re-emerge every few years with a long-term pattern of drinking problems, as they move through stages of relapse and recovery.

The average length of exposure to problems may mean that for some children these issues dominate the period of time comprising most of their early childhood or adolescence, across many important stages of development. This has significance when providing support and intervention programmes for these children, remembering that the parent with an addiction problem may not be accessing services.

In his study of young offspring of parents with drinking problems, Orford (1994) reported the children as having:

- More traumatic childhood experiences;
- Negative and often violent parental and family relationships;
- Less happy and cohesive or stable relationships;
- Separations between home and outside social activities.

### **Mechanisms through which addiction affects children**

In earlier literature, Wegscheider-Cruse (1989) proposes three fundamental rules of the alcoholic family - 'Don't talk' 'Don't trust' and 'Don't feel'. Although descriptive rather than researched based, it is suggested that these features lead to limited emotional development and coping skills, affecting the potential of future relationships.

Another pathway through which addiction affects children is the modelling of behaviour such as excessive drinking and aggressive or violent behaviour. Parenting styles, which are consistent with families under stress, may mean more punitive and less flexible styles of parenting with limited supervision and monitoring of behaviour. Conflict and disharmony in parental relationships are also identified as mechanisms by which addiction will impact on children and young people.

### **Possible effects on children's well-being**

The outcomes for children living with addiction problems in their families described by several authors can be summarised in terms of the following domains of a child's well-being.

#### **(i) Physical health**

Although there are fewer studies looking at the relationships between parental addiction, and children's health, the following outcomes have been noted:

- Risk of Foetal Alcohol Syndrome or Foetal Alcohol Effects (Windle & Tubman, 1999; Ministry of Health, 1994);

- Low birth weights and birth related complications (Dobkin, Tremblay, Desmarais-Gerrais & Dépelteau, 1994);
- Higher frequency of ill health - hospital visits (Woodside, Coughy & Cohen, 1993);
- More accidents and injuries (Rydellius, 1981).

### **(ii) School and cognitive performance**

A number of authors have commented on a possible relationship between parental alcoholism and a child's cognitive development or school performance. Chandy, Harris, Blum, and Resnick (1993) noted the following outcomes for children living with alcohol problems:

- More likely to be absent or drop out of school;
- Negative attitudes to school;
- More likely to score low on school performance measures.

New Zealand studies support the findings of other international research. Connolly, Casswell, Stewart, Silva and O'Brien (1993) found that at ages nine and thirteen, sons of alcoholic parents, especially, demonstrated lower verbal and reading proficiency, which was associated with greater behavioural problems reported by teachers.

Robinson (1989) describes some of the factors at home, which affect daily performance. These included: lack of sleep, chronic stress, difficulties studying in chaos, and students being less supported by parents regarding school work.

In addition, family conflict, poor peer group relationships, health, attention span and other behavioural factors can all affect the ability to learn to full potential. Transient families may mean lack of early education, frequent changes of school, and increased absenteeism resulting in less continuity for learning. Lack of routines in the home means that children are less prepared for school and homework is not completed.

Research clearly illustrates the wide array of problems presented at school. Despite this, a number of children do very well at school, possibly using it as a coping mechanism and gaining further skills (O'Brien, 1989). Schools can provide a stable consistent environment with opportunities to develop strengths and interests and to experience positive role models and relationships with peers as well as supportive relationships with adults.

### **(iii) Emotional and behavioural difficulties**

These are the most likely ways in which children present with problems or are referred for intervention. However, when this happens, focus tends to remain on the child rather than taking a contextual view of the environment and how this impacts on the child's behaviour. Most of the research to date has focused on boys.

Several authors have described an increased incidence of behaviours of a similar nature (Jansen et al., 1995; Velleman, 1992; Robinson, 1989). They have used terms such as antisocial behaviours, conduct disorders, delinquency, management problems, difficult temperament, and aggression and problem behaviour and have consistently reported increased prevalence in boys. A recent study by Cuijpers, Langendoen, and Bijl (1999) reports these children as a high-risk group for a range of psychiatric disorders including mood and anxiety disorders, eating disorders and schizophrenia.

A longitudinal study of New Zealand children asked both teachers and parents to report behaviour problems. Interestingly, teachers reported more problems at age nine, while parents reported more problems at age thirteen. Teachers rated almost

three times more children having high levels of problems from alcohol problem families compared to other children (Connolly et al., 1993). These problems included: restlessness, irritability, disobedience, truancy, lying, stealing, speech difficulties and frequent unhappiness. By age thirteen one in five children was rated by parents as having difficulties compared to about one in ten children not exposed to alcohol problems. However, Connelly et al. comment that while these results certainly suggest an increased risk of problems most children in these circumstances do not demonstrate such difficulties.

In contrast, another New Zealand study by Lynskey, Fergusson and Horwood (1994) reported children of alcoholic parents with rates of disorder up to three times that of other children. These disorders included substance abuse, conduct, attention deficit and mood and anxiety disorders.

#### **(iv) Drinking patterns later in life**

Several studies have explored the possible relationship between parental substance abuse and the future drinking patterns of children in these families. An association has often been reported between early onset, and degree of severity of alcohol or drug problems and a family history of alcoholism (Plant, Orford & Grant, 1989; Green et al., 1991). The polarisation of later drinking patterns, i.e. abstinence or high volume drinking, is often evident when parents have been heavy drinkers. Although these young people tend to polarise with their drinking patterns, the majority are not heavy drinkers.

The influence that parents and the home atmosphere have on the adolescent and his/her drinking has been explored by Narusk (1991). Strict, unjust and indifferent home atmospheres have a clear influence on a son's increased alcohol use. It is also suggested that family disharmony leads to young people spending more time away from home, being more attracted to drinking and smoking and becoming heavier drinkers. Adolescents in his study were more attached to alcohol when they were less involved in joint family activities and parents were less aware of children's leisure activities.

Other research also describes how family relationship factors are among the most important influences on early adulthood drinking (Power & Estaugh, 1990). In this study, partnership breakdown was associated with heavier drinking established at age 16 years and with increasing consumption, whereas stable partnerships and family formation exert a moderating influence on consumption.

New Zealand studies tend to support the suggestion that early exposure to drinking and permissive attitudes towards alcohol promote more drinking in adolescence. (Casswell, Stewart, Connolly & Silva, 1991; Fergusson, Lynskey & Horwood, 1994).

It is apparent that there are implications for increased risk of alcohol problems for those children living with alcohol addiction. Of particular significance are the nature of parental relationships and parenting styles within these families.

### **Resilience**

Resilience is described as the successful adaptation of an individual despite risk and adversity (Luthar & Cicchetti, 2000). Resilience may also be described as the ability to bounce back, endure or even thrive in the face of stressful or negative life experiences (Wolin & Wolin, 1995).

In this context, resilience is a term which may be used to describe those children living with parental alcohol or other drug problems who continue to present with

apparently healthy and normal functioning despite their family situation and do not experience some of the negative life outcomes described in the literature.

A resiliency approach identifies those risk or vulnerability factors that exacerbate the negative effects of risk and the protective factors that modify the effects positively. This approach focuses on positive outcomes, with the identification of protective factors as they relate to individual strengths and attributes, and positive features of families and communities.

Resilience is described as a dynamic process in the context of the environment at any given time, rather than the static attribute of an individual (Rutter, 1987). The pathways or trajectories of risk include key turning points in the lives of children.

This issue of resilience is of particular significance when considering services for these children. This information can help us identify characteristics of children and the strengths and resources in their environments that can be developed through targeted interventions.

Recent literature has attempted to identify more factors that contribute to resilience amongst children of alcoholics. The following factors have been identified by several authors as contributing towards resilience in children and young people (Ackerman, 1983; Luthar & Zigler, 1991; Howard, Dryden & Johnson, 1999; Johnson, Howard, Dryden & McGuire, 1998; Velleman & Orford, 1993; Wolin & Wolin, 1995; Werner, 1986).

**(i) Characteristics of the child**

- Gender
- Temperament
- Communication skills
- Interests and talents
- Self esteem
- Humour
- Internal locus of control

**(ii) Characteristics of the family**

- Care giving in infant years
- Qualities of parenting
- Marital relationship
- Number of children
- Relationships - siblings and other family members
- Family rituals and routines - stability
- Strengths and assets

**(iii) Community**

- Caring and supportive adults e.g. teachers
- Supportive peer relationships
- Involvement in community activities e.g. sport
- Support agencies
- Family friends and neighbours
- Responsibilities in the community

Velleman and Orford (1993) comment on protective factors mentioned by numerous authors. These include the ability of the family to maintain planning and goal setting and family rituals such as mealtimes, birthdays and Christmas.

The existence of a positive relationship with the non-drinking parent has been identified as a factor by Orford (1994), as well as the importance of positive relationships with other adults possibly outside the family, as suggested by Ackerman (1983).

This last point is mentioned often as an important strategy for helping these children. Programmes providing support for children and young people can implement this strategy by ensuring that appropriately trained and supervised adults are available and that they are accessible, reliable, consistent and non-judgmental in their approach.

However, there are some cautions regarding the labelling of children as resilient. The survival roles described by Black (1982) and Wegscheider-Cruse (1989); namely, the 'hero', the 'scapegoat', the 'mascot', and the 'lost child' are said to provide protection through rigid defences and compulsive behaviours in the short term but are often experienced as dysfunctional later in life.

Robinson (1989) notes the similarities between descriptions of these children and the role of 'hero'. He suggests that while these children appear to be coping well, they may also have deep-seated and well-concealed problems that develop later. Remembering that resilience is part of a dynamic process and dependant on our measurement or perceptions of competency, children who appear to be resilient must not be ignored. Haskell (1993) also suggests that these many 'survivors' experience serious problems that they have compensated for, but which still affect their life course. Werner (1986) notes that the higher risk period of early adulthood was still to come after the period of his longitudinal study.

Wolin and Wolin (1995) describe the approach that focuses on risk, the Damage Model. With this approach Wolin and Wolin propose that children are portrayed as vulnerable and helpless and enmeshed within the family. In contrast, they propose the Challenge Model whereby children are challenged to act on their own behalf. It is suggested that the child's interpretation of these events will to some extent determine the influence of the family.

Wolin and Wolin have identified the following seven resiliencies, which children develop in the process of actively responding to experiences in their families:

- Insight - understanding self and others;
- Independence - separating from the family;
- Relationships - recruitment of supportive adult relationships and friendships;
- Initiative - goal directed behaviour;
- Creativity - opportunities for self-expression;
- Humour - minimises troubles and pain;
- Morality - development of principles and values and helping others.

### **Ways of promoting resilience**

The literature describes the following ways in which resilience may be promoted in working with children and young people (Gilligan, 2000; Luthar & Cichetti, 2000; Luthar & Zigler, 1991; Howard et al., 1999):

- Recognising strengths and abilities in the children - encouraging interests and talents;
- Identifying positive relationships and community support;
- Input at times of transition - major life decisions e.g. choosing schools.

Some of the mechanisms by which resilience may be developed include:

- Reducing risks;
- Enhancing protective factors e.g. self esteem, relationships;
- Reducing negative chain reactions - influencing pathways;
- Opening up opportunities. (Rutter, 1987)

### **Practice and policy**

In alcohol and drug services, we give parents many opportunities for treatment, yet children often have little or no input. Counsellors speak of working with the whole person, but what about the client's family and children? Is this not the usual setting in which many of our clients have experienced their problems and in which they must now integrate what they have learnt in treatment? What about their major role in life as a parent? Where is the opportunity for children to participate in this process and to gain some understanding of what is happening in their family environment? There is often little consideration to the potential role that services can play in providing input for these children.

The United Nations Convention on the Rights of the Child describes the rights of children to be ensured maximum development, to receive information and participate in matters that affect their well-being and to be protected from all forms of mental or physical abuse. We must therefore consider the child's right to services and the role of the family in the contextual picture of addiction.

These children are often only picked up through specialist services when there are serious concerns such as health, behaviour, or care and protection. Services providing early intervention or primary care are often unaware of addiction issues especially when the parent with an addiction problem has not presented for treatment or support. Assessment is required to identify children living with addiction and also to identify resilience factors e.g. current supports, interests and strengths.

It is important to aim towards an integration of services in order to provide a co-ordinated approach. This means collaboration between family service organisations and alcohol and drug services. Also, wherever possible, it is important to include the child or young person in plans that affect them (Luthar & Cichetti, 2000).

It is apparent that several blocks prevent this work happening at all levels. For example, services are not currently contracted to provide this work and in many areas staff do not necessarily have the training or support to provide programmes.

In our work we can focus on the strengths of the child and the mechanisms by which protective factors can be enhanced. We must also be mindful of the risks inherent in the fact that these children are often labelled at risk.

Recognition of these children's needs is necessary at a national policy level, a contractual level with providers, and at an intervention level with regional addiction services.

Training is needed for workers in addiction services that is focused on family aspects of alcohol problems and the impact on children in the context of their health and development.

Community workers and other primary care workers often require training on alcohol-inflicted harm on children and the need for early intervention. Specialist family agencies should ensure that adequate training in addiction issues is provided to staff.

Increased networking about appropriate information, support and counselling services for families living with addiction problems can only result in more children gaining access to support.

The following programme, developed with Addiction Services Hawke's Bay, responds to many of the issues outlined in the research presented in this field. More detail on the programme, including a follow-up study, is available in the book *21 Fun Street Kool Kids - Therapeutic Group Programmes for Children Living with Addiction*<sup>1</sup> (Gledhill, 1999).

### **21 Fun Street Kool Kids - The Children's Programme Hawke's Bay**

When the Children's Programme was started in 1989, there was a vision of a service that would be a vibrant and positive experience for children living with addiction problems in their family. For staff, it provided some different challenges to address what was seen to be a substantial gap in current services.

This programme provides both early interventions for some children and a therapeutic context for those children already having difficulties. It is a medium to long-term programme, which recognises the ongoing needs of some children, supporting them through transitions and providing opportunities for greater effectiveness (Luthar & Cichetti, 2000).

A group model was chosen for a number of reasons. Being part of a therapeutic group reinforces the message that these children are not alone in their experience. It provides a forum for support and an opportunity to practise skills in relating to others. Group work increases the chances of breaking the silence and denial associated with family addiction. At the same time it provides a process to monitor the safety and protection of children.

In 1997 the programme was reviewed leading to a number of recommendations for future service. These included comprehensive assessment to evaluate risk, retaining a medium to long-term programme and using an activity based group process.

A specific outcome of this review has been the development of a Parents' Programme, run in conjunction with the children's programmes. These programmes are aimed to complement and support the children's programmes by providing information to parents and a link with significant adults. They also focus on family issues in relation to addiction and the process of recovery with once again, an emphasis on resilience.

### **Programme aims**

- To provide for children at risk a supportive and safe atmosphere, in which to learn and grow.
- To recognise and develop the inner resources, strengths and skills which will aid in the prevention of major life problems.

This programme is aimed at enhancing and developing resilience factors for the children and, often indirectly, their families. Of particular interest, are self-esteem, support needs and communication skills, especially expressive skills.

Development of this group is founded on a number of different model and theory bases. Some of these are well known; others are specifically from the Occupational Therapy profession.

---

<sup>1</sup> Available through Addiction Services, Hawke's Bay District Health Board, Hawke's Bay, New Zealand, or by contacting the co-ordinator of Children's Programmes, Addiction Services.

### **Theoretical principles**

1. Addiction is a family process.
2. The behaviour of one member of a family affects the other members of the family.
3. Prevention is most effective when implemented as early as possible before the emergence of conditions is likely.
4. Activity promotes learning, creates a sense of well-being and encourages the development of new behaviour.
5. A therapeutic relationship supports the development and recognition of strengths and abilities.
6. The dynamics of group therapy can be used to foster change.
7. The use of activities or occupation as therapy enables holistic thinking about a person's function or dysfunction.
8. Play promotes self-esteem and the development of physical, cognitive, emotional and social skills.
9. Learning progresses through developmental stages. One stage must be integrated in order to progress easily to the next.
10. A sense of safety must exist in order for an individual to contemplate change.

The Hawke's Bay groups operate on a Therapeutic Activity Process best described by Borg and Bruce (1991). Here the goal is more than the task itself and is therapeutic in terms of enabling change of feelings, thought or skill. Within the activity group system, using Occupational Therapy models, these four elements are considered:

1. The environment - setting up the environment for success;
2. The participant - considering the individual needs and collective needs of the group members;
3. The activity - choosing appropriate activities and focussing on process;
4. The therapist - taking account of the roles of group leaders and the potential benefits of therapeutic relationships.

### **Group structure**

Two group programmes are offered in Hawke's Bay, one held in Napier entitled "21 Fun Street", and one in Hastings called "Kool Kids"; named by the original children forming the groups. Groups are held once a week for a period of two hours with up to 16 children attending each group at one time. Groups are open, although intake is carefully monitored. Programmes are medium to long-term in duration and operate in 20 week modules. The duration of these programmes recognises the long-term nature of addiction problems and their impact on family members.

### **Summary**

In New Zealand today, many children are living in family environments where alcohol, drug or other addictions are having an impact across the key domains of their development. Recent research is now helping to identify more clearly the nature of these outcomes, especially in relation to the family dynamics and parenting styles associated with severe alcohol and drug problems.

Resilience models, however, provide us with a framework to both recognise factors which can promote well-being despite risk and ways in which we can address these children's needs through interventions that are focussed not only on reducing

risk and developing skills but on intervening in pathways at important transition times and providing opportunities.

At present, both at a policy level and in practice, there are few targeted services provided for, or available to these children. The Hawke's Bay Addiction Services Children's Programme *21 Fun Street, Kool Kids*, currently offers support and education to children living with addiction through therapeutic activity groups. This intervention, by using a resilience approach, provides opportunities for children to develop, learn, and grow towards their potential, while keeping them safe.

### References

- Ackerman, R. J. (1983). *Children of alcoholics: A guidebook for educators, therapists and parents* (2nd ed.). Holms Beach, FL: Learning Publications Inc.
- Alcoholic Advisory Council of New Zealand. (1997). *ALAC on alcohol 1997. Fact pack*. Wellington: ALAC National Office.
- Alcohol Advisory Council of New Zealand. (2001). *Fact pack: Health & social impact of drinking*. Available: <http://www.alcohol.org.nz/effects/factpack/impacts.html> [12 December 2001].
- Black, C. (1982). *It will never happen to me*. Denver, Colorado: M.A.C. Printing and Publication.
- Borg, B., & Bruce, M. A. (1991). *The group system: The therapeutic activity group in occupational therapy*. Thorofare, NJ: Slack.
- Brisby, T., Baker, S., & Hedderwick, T. (1997). *Under the influence - coping with parents who drink too much. A report on the needs of the children of problem drinking parents*. London: Alcohol Concern.
- Casswell, S. (1996). Alcohol use: Growing up and learning about drinking - children in Dunedin in the 1980s. In P. A. Silva & W. R. Stanton (Eds.), *From child to adult: The Dunedin Multidisciplinary Health and Development Study* (pp. 206-224). Auckland: Oxford University Press.
- Casswell, S., Stewart, J., Connolly, G., & Silva, P. (1991). A longitudinal study of New Zealand children's experience with alcohol. *British Journal of Addiction*, 86, 277-285.
- Chandy, J. M., Harris, L., Blum, R., & Resnick, M. (1993). Children of alcohol misusers and school performance outcomes. *Children and Youth Services Review*, 15, 507-519.
- Coface & Eurocare. (1998). *Alcohol problems in the family. A report to the European Union*. Brussels, Belgium: Eurocare EU Liaison Office.
- Connolly, G. M., Casswell, S., Stewart, J., Silva, P. A., & O'Brien, M. K. (1993). The effect of parents' alcohol problems on children's behaviour as reported by parents and teachers. *Addiction*, 88, 1383-1390.
- Cork, M. (1969). *The forgotten children*. Ontario, Toronto: Alcoholism and Drug Addiction Foundation of Ontario.
- Cuijpers, P., Langendoen, Y., & Bijl, R. (1999). Psychiatric disorders in adult children of problem drinkers: Prevalence, first onset and comparison with other risk factors. *Addiction*, 94 (10), 1489-1498.
- Dobkin, P. L., Tremblay, R. E., Desmarais-Gerrais, L., & Dépelteau, L. (1994). Is having an alcoholic father hazardous for children's physical health? *Addiction*, 89, 1619-1628.
- Fergusson, D. M., Lynskey, M. T., & Horwood, L. J. (1994). Childhood exposure to alcohol and adolescent drinking patterns. *Addiction*, 89, 1007-1016.

- Gilligan, R. (2000). Adversity, resilience and young people: The protective value of positive school and spare time experiences. *Children & Society, 14*, 37-47.
- Gledhill, T. (1999). *21 Fun Street Kool Kids - therapeutic group programmes for children living with addiction*. Hastings, New Zealand: Healthcare Hawke's Bay.
- Green, G., MacIntyre, S., West, P., & Ecob, R. (1991). Like parent like child? Associations between drinking and smoking behaviour of parents and their children. *British Journal of Addiction, 1986*, 745-758.
- Haskell, R. E. (1993). *Adult - child research and experiences. Personal and professional legacies of a dysfunctional co-dependent family*. Westport, CT: Ablex Publishing Corporation.
- Howard, S., Dryden, J., & Johnson, B. (1999). Childhood resilience: Review and critique of literature. *Oxford Review of Education, 25* (3), 307-323.
- Jansen, R. E., Fitzgerald, H. E., Ham, H. P., & Zucker, R. A. (1995). Pathways into risk: Temperament and behaviour problems in three- to five-year-old sons of alcoholics. *Alcoholism: Clinical & Experimental Research, 19* (2), 501-509.
- Johnson, B., Howard, S., Dryden, J. & McGuire, A. (1998). Promoting resiliency in children: Review of literature and research plan. In N. J. Taylor & A. B. Smith (Eds.), *Enhancing children's potential: Minimising risk & maximising resiliency. Proceedings of the Children's Issues Centre second Child & Family Policy Conference, 2-4 July 1997, Dunedin* (pp. 165-179). Dunedin: Children's Issues Centre, University of Otago.
- Lindstein, T. (1996). *Working with children of alcoholics*. Stockholm Studies in Social Work 10. Stockholm: Stockholm University.
- Luthar, S., & Cicchetti, D. (2000). The construct of resilience: Implications for intervention and social policies. *Development and Psychopathology, 12* (4), 857-885.
- Luthar, S., & Zigler, E. (1991). Vulnerability and competence: A review of research on resilience in childhood. *American Journal of Orthopsychiatry, 61* (1), 6-22.
- Lynskey, M. T., Fergusson, D. M., & Horwood, L. J. (1994). The effect of parental alcohol problems on rates of adolescent psychiatric disorders. *Addiction, 89*, 1277-1286.
- Ministry of Health. (1994). *Alcohol: The Public Health Commissioner's advice to the Minister of Health 1993-94*. Wellington: New Zealand Health Information Service.
- Narusk, A. (1991). Transmission of drinking habits within the family. *Contemporary Drug Problems, 18* (4), 645-671.
- O'Brien, M. K. (1989). *The effects of parental alcohol problems on children's cognitive and behavioural development*. Wellington: Alcohol Liquor Advisory Council.
- Orford, J. (1994). Empowering family and friends: A new approach to the secondary prevention of addiction. *Drug and Alcohol Review, 13*, 417-429.
- Plant, M. A., Orford, J., & Grant, M. (1989). The effects on children and adolescents of parents' excessive drinking: An international review. *Public Health Reports, 104* (5), 433-442.
- Power, C., & Estaugh, V. (1990). The role of family formation and dissolution in shaping drinking behaviour in early childhood. *British Journal of Addiction, 85*, 521-530.
- Robinson, B. E. (1989). *Working with children of alcoholics: The practitioners handbook*. New York: Lexington Books.

- Rutter, M. (1987). Psychosocial resilience and protective mechanisms. *American Journal of Orthopsychiatry*, 57 (3), 316-331.
- Rydelius, P. A. (1981). Children of alcoholic fathers. Their social adjustment and their health status over 20 years. *Acta Paediatrica Scandinavica - Supplement*, 286, 1-89.
- Velleman, R. (1992). Intergenerational effects - A review of environmentally oriented studies concerning the relationship between parental alcohol problems and family disharmony in the genesis of alcohol and other problems. I. The intergenerational effects of alcohol problems. *The International Journal of the Addictions*, 27 (3), 253-280.
- Velleman, R., & Orford, J. (1993). The importance of family discord in explaining childhood problems in the children of problem drinkers. *Addiction Research*, 1, 39-57.
- Wegscheider-Cruse, S. (1989). *Another chance - Hope and health for the alcoholic family*. Palo Alto, CA: Science & Behaviour Books Inc.
- Werner, E. E. (1986). Resilient offspring of alcoholics: A longitudinal study from birth to age 18. *Journal of studies on Alcohol*, 47 (1), 34-40.
- Windle, M., & Tubman, J. G. (1999). Children of alcoholics. In W. K. Silverman & T. H. Ollendick (Eds.), *Developmental issues in the clinical treatment of children* (pp. 393-414). Boston: Allyn and Bacon.
- Wolin, S., & Wolin, S. (1995). Resilience among youth growing up in substance abusing families. *Paediatric Clinics of North America*, 42 (2), 415-427.
- Woodside, M., Coughney, K., & Cohen, R. (1993). Medical cost of children of alcoholics - pay now or pay later. *Journal of Substance Abuse*, 5, 281-287.

*Children and young people's environments*