Living with an elephant: Growing up with parental substance misuse

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ABSTRACT

Although parental substance misuse is now a focus of concern in child welfare practice, we know little about what it is really like for children who grow up in families where adult drug and/or alcohol use is an issue. Set against a backdrop of research links between parental substance misuse and child maltreatment, this article examines a number of studies that focus on the experiences of children and young people in this context. Emerging themes are identified which provide insight into the world of children for whom a substance is, effectively, a family member – 'the elephant in the living room' – and the implications for practice, particularly in relation to children's visibility, disclosure and confidentiality, are considered. It is argued that a focus on the 'elephant' often leads to children remaining 'invisible' to those whose role it is to ensure their welfare.

INTRODUCTION

> 'Ma Mum got hurt on the outside and we got hurt on the inside.' (Child respondent in Laybourn *et al.* 1996, p. 55)

Parental substance misuse is now a significant feature in relation to children in need, presenting a range of challenges for professionals in child and family health and social care (Bates *et al.* 1999; Forrester 2000; Kroll & Taylor 2000, 2003; Harwin & Forrester 2002) as well as adult services (Weir & Douglas 1999). It is estimated that about a million children in the UK may be living with parents with problematic drinking patterns (see for example Brisby *et al.* 1997; Orford 2001), and that between 250 000 and 350 000 are in the care of problem drug users (Advisory Council on the Misuse of Drugs 2003). However, we know very little about their lives as, for various reasons, their voices are rarely heard.

Any consideration of parental substance misuse, child welfare and child maltreatment needs to be placed in context by defining a number of terms and acknowledging some of the methodological land mines that litter this area of research. The term 'substance misuse' is now generally understood to refer to alcohol, drug or polydrug use 'which leads to social, physical and psychological harm' (SCODA 1997, p. 36). It is also less about quantity than patterns of use, motivation for use and consequences (Kroll & Taylor 2003), and encompasses both the licit (alcohol, prescribed drugs, including methadone, and solvents) and illicit (heroin, amphetamines, cocaine, crack, cannabis, ecstasy, etc.). 'Child welfare' encapsulates the totality of child well-being at every level which depends on the often complex dynamic between parenting capacity, environmental factors and individual development (Department of Health 2000). Child maltreatment – defined as neglect and abuse, and encompassing acts of omission as well as commission (Stevenson 1998) – can occur for a range of reasons and it is only relatively recently that the part played by parental problems, including substance misuse, has been fully acknowledged (Cleaver *et al.* 1999).

Not all parents who use alcohol or drugs mistreat their children (Barnard 1999; Harbin & Murphy 2000). However, research suggests that parental substance misuse can adversely affect attachment (Brooks & Rice 1997; Klee *et al.* 1998; Howe *et al.* 1999; Flores 2001), family dynamics, relationships and functioning (Cleaver *et al.* 1999; Velleman & Orford 1999; Harbin & Murphy 2000) and significantly increases the risk of violence (Brookoff *et al.* 1997).

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This can be exacerbated where there are also mental health problems (Mulvey 1994), and the combination of maternal depression and alcohol misuse has been found to be a particularly high-risk mix (Woodcock & Sheppard 2002). Neglect and emotional, sexual and physical abuse have also been linked to substance misuse (Famularo *et al.* 1992; Jaudes *et al.* 1995; Chaffin *et al.* 1996; Ammerman *et al.* 1999; Alison 2000), as has child homicide (Reder *et al.* 1993; Besharov 1994; Reder & Duncan 1999).

Researching the links between parental substance misuse and child maltreatment is complicated by some of the shifting definitions used, the sample (whether clinical or community), study design and contradictory findings (Parton *et al.* 1997). Significantly, amidst all this, is the dearth of research actually based on accounts from children and young people themselves. This paper seeks to highlight children's experiences by drawing on some of these accounts in order to inform practice with families where substance misuse is an issue.

How many children are affected?

Although child protection registers and social services records have been used to gain a sense of the extent of parental substance misuse (see for example Forrester 2000; Kearney *et al.* 2000; Hayden *et al.* 2002), this obviously only identifies people who have come to the notice of statutory services. Studies do not always distinguish between drug use, alcohol use or both, and there are further complications where there is polysubstance use and a mental health problem (Kearney *et al.* 2000). In other words, there is often a constellation of problems that may skew the way in which data are categorized. In addition, many families present for services for problems other than substance misuse that may remain undetected or denied (Tunnard 2002b) and problems with alcohol, in particular, are often underestimated or under-recognized by social workers (Forrester 2000; Hayden *et al.* 2002). Figures emanating from studies based on social services' data vary considerably in relation to the proportion of families where substance misuse is an issue. Cleaver *et al.* (1999), for example, suggest that 20% of child and family referrals feature substance misuse in some form, rising to 25% at the case conference stage. Forrester (2000), however, in his study based in Southwark social services, found that substance misuse was an issue in 52% of cases, and in their analysis of the care plans of 100 children Harwin *et al.* (2003) found it a major factor in care proceedings for 40% of their sample of children subject to care orders. In a separate study of children on the child protection register, parental substance misuse was a factor for 62% of children subject to care proceedings (Forrester & Harwin 2002). A study based in Bolton found that over 30% of children on the child protection register and 75% subject to care proceedings had parents misusing substances (Murphy & Oulds 2000), while a study based on four children and family focused teams in Portsmouth found there was concern in almost 33% of cases (Hayden *et al.* 2002).

Children's experiences: sources of data

Glimpses into the world of children with substance misusing parents come from two main sources. The first is accounts from adults who have grown up with such parents and are recalling their experiences and emotions at a distance (see for example Woititz 1990; Sher 1991; Tweed & Ryff 1991; Newcomb & Rickards 1995; Brooks & Rice 1997; Robinson & Rhoden 1998; Velleman & Orford 1999). The second source springs from accounts gained from children themselves in the present or recent past (see for example Cork 1969; Laybourn *et al.* 1996; Brisby *et al.* 1997; ChildLine 1997; Howland Thompson 1998; Barnard & Barlow 2003). In this article seven of these accounts have been analysed in depth so that the voices of children, young people and adults – albeit at second hand – can be heard on the subject of what it is like to grow up with parents who have substance problems. This analysis will be informed by some of the other studies mentioned above as well as research that focuses on substance misusing parents. The implications of the findings for social welfare practice will then be considered.

EVALUATING THE RESEARCH STUDIES

Various methodological problems are encountered when looking at research in this area. Questions arise about the reliability of adults' recollections and these have been addressed by many of the researchers concerned (see for example Velleman & Orford 1985, 1999; Sher 1991). Other factors which need to be taken into account include sample bias (whether respondents, both adult and child, are taken from clinical, community or specialist settings), how 'child of alcohol or drug user' status is established, and the way in which other factors that influence development and adult adjustment are considered. Therefore only cautious conclusions can be drawn. In relation to

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cultural differences and their impact, some studies do not break down respondents in terms of ethnicity or race (Tunnard 2002a), although this is recorded when the information is volunteered. Studies that focus on specific ethnic and racial groups do exist although do not specifically address the child's experience from their perspective (see for example Besharov 1994; Fitzgerald *et al.* 2000; Patel 2000).

In relation to both children's and adults' accounts, there was far more material in relation to parental alcohol use than to drug use, for obvious reasons. Although alcohol-related behaviour will be judged and labelled, it does not carry with it the same kind and level of stigma associated with illegality and the stereotype of the drug user that pervade much of public thinking. As a result, people may be more prepared to talk about the issues connected with it and allow freer access to their children for research purposes. There are far more difficulties in accessing a sample of children living with parents who misuse drugs due to fears and anxieties about the potential for welfare intervention and the child's removal. Indeed, as Barnard and Barlow discovered during the course of their two-year qualitative study involving 36 children and young people who had drug misusing parents:

> To interview the children proved an enormously difficult and time consuming task . . . it is rarely possible to approach children directly without the mediation of adult gatekeepers who frequently make decisions for children over the appropriateness of their participation. (Barnard & Barlow 2003, p. 46)

Such children therefore are likely to remain even more 'invisible' to professionals than the children of parents who have problems with drink.

Adults who have grown up with parental drug use are also hard to find, although, in some studies which explore experiences with alcohol misusing parents, drugs are also a feature of the substance misuse pattern and can thereby be incorporated (see for example Brooks & Rice 1997). As a consequence, in line with the approach taken by some other commentators (for example Woititz 1990; Robinson & Rhoden 1998), the following analysis will extrapolate from findings in relation to children's accounts of parental alcohol misuse, as far as seems sensible, and specific differences will also be emphasized where appropriate.

SAMPLE AND METHOD

The sample consisted of seven published studies that featured accounts from children, young people and young adults about growing up with parents with either drug or alcohol problems. They were chosen on the basis that five were the only available UK studies of their kind and the two US studies represented findings based on case histories and lengthy clinical experience which reflected both child and adult voices, as well as reflecting a family systems perspective so central to the Framework for the Assessment of Children in Need and Their Families (Department of Health 2000). Of the five UK studies, four focused on the impact of alcohol misuse (Laybourn *et al.* 1996; Brisby *et al.* 1997; ChildLine 1997; Velleman & Orford 1999) and one on drug misuse (Barnard & Barlow 2003). All five studies used largely clinical samples, apart from Velleman and Orford's, with ages of respondents ranging from 4 to 35 years and all, apart from the ChildLine study (which was a case record analysis) were based on personal interviews with participants and, in some cases, their parents/families. Sample size was small (between 3 and 36) apart from in the Velleman and Orford study (164 adult offspring and a comparison group of 80). Of the two US studies, Brooks & Rice (1997) focused on both drug and alcohol problems whilst Robinson & Rhoden (1998) explored the impact of alcohol use alone.

A content analysis was used to search for themes relating to the impact on the individual in a range of areas (May 2001; Robson 2002). Initially categories for analysis, drawn from the child development domain of the Framework for Assessment (Department of Health 2000), were fairly broad (for example emotional and behavioural development, family and social relationships). These were then subcategorized to include more subtle divisions ('emotional development', for example, eventually included attachment, separation and loss, and 'family relationships' included violence and abuse and the child as carer). In addition, a detailed literature review (see Kroll & Taylor 2003) highlighted additional categories including the impact of the denial and secrecy that characterizes much substance use, particularly in relation to drugs (Barnard 1999; Hogan & Higgins 2001).

The final list of categories included:

- denial, distortion and secrecy;
- attachment, separation and loss;
- family functioning, breakdown and conflict;
- violence, abuse and fear;
- role reversal, role confusion and the child as carer;
- what children said they needed;
- chaos and control;
- children's roles;
- coping strategies;

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- a model for problem solving;
- implications for friendships; and
- the benefits of having substance misusing parents.

For the purposes of this article and due to limitations of space, six themes have been chosen to reflect some of the emotions, adjustments and behaviours that children of substance misusing parents may have to manage (for a full analysis of all these themes see Kroll & Taylor 2003). Debates will also be linked with studies based on parents' accounts of managing childcare alongside drug and/or alcohol problems (Hogan 1997; Klee *et al.* 1998; Hogan & Higgins 2001; Klee *et al.* 2001; McKeganey *et al.* 2001).

ELEPHANT? WHAT ELEPHANT? DENIAL, DISTORTION AND SECRECY

> 'I was already, at nine years old, used to covering up, pretending that life inside our house was as pretty as the outside.' (Somers in Robinson & Rhoden 1998, p. 130)

In all the studies secrecy and denial, with the resultant confusion, tensions and anxieties that arose, were issues for the children of substance misusing parents. The dynamic of denial, distortion, confusion and secrecy often resulted in the substance use becoming the 'central organizing principle' of the family, with all the family members operating around it, and in relation to it (Brown 1988; Woititz 1990; Robinson & Rhoden 1998) and 'whose rhythm is drawn from meeting the needs of a drug habit' (Barnard & Barlow 2003). From the child's point of view, a 'don't talk' rule was imposed and children were encouraged, from an early age, not to 'tell'. If challenged, the child's perceptions of the realities of the family were called into question (Brooks & Rice 1997):

> . . . children know that the household revolves round something other than themselves but they are not allowed to know what it is and they are not allowed to ask what it is . . . this persists even once children have worked out that drug dependency is at the heart of their family dynamic. (Barnard & Barlow 2003, p. 52)

What seemed to evolve for many of the children was 'a conspiracy of silence' where shame and fear of consequences effectively cut families off from both wider family and community (Laybourn *et al.* 1996, p. 71). This had obvious implications in that children were effectively muzzled and isolated from potential sources of support that might foster resilience. Drug misuse, in particular, connected children and parents to a subculture in which secrecy was essential, due to anxieties about police raids, imprisonment and the consequences of criminal activity (Hogan 1997; Hogan & Higgins 2001). As Fixy, aged 15, observed:

> 'There were so many things I had to keep quiet so I just didn't bother to say anything in case I let something slip out that I shouldn't have done so whenever they started talking about things I'd just say I didn't know.' (Barnard & Barlow 2003, p. 52)

The longer this culture of denial and secrecy persisted, the harder it was to penetrate, with children admitting to becoming mistrustful of outsiders, reluctant to confide and fearful of attempts to help, support or simply ask questions (Laybourn *et al.* 1996; Brisby *et al.* 1997; Brooks & Rice 1997; ChildLine 1997). Knowing but being forced into denying that you know, as Barnard and Barlow have argued, made it difficult for the 'knowing' self to discuss that which is being denied. Hogan's (1997) study also suggests that parental secrecy breeds secrecy in children about more than just the drug use because of the atmosphere of furtiveness created in the home, due to locked doors and other types of suspicious behaviour. The experience of constantly feeling shut out and excluded, literally and metaphorically, contributed to children's sense of being unwanted, rejected and unimportant (Hogan & Higgins 2001; Barnard & Barlow 2003). Ironically, although they worked hard to keep 'the secret', children also felt aggrieved because people did not try to discover the 'secret' or make attempts to find out what was wrong, although they acknowledged how difficult this would be (Robinson & Rhoden 1998).

Here the elephant is encountered – a huge, significant, but secret presence which takes up a lot of space, uses considerable resources, and requires both a great deal of attention and the adjustment of all those in its vicinity. The image of the 'elephant in the living room', first used by Hastings & Typpo (1984) in relation to the impact of alcohol misuse, vividly evokes the sense of a huge and dominating presence impossible for children to ignore. The process of denial, where the adult has an emotional attachment to either drugs or alcohol (Flores 2001; Kroll & Taylor 2003), makes acknowledging the presence of the elephant very difficult. The elephant can also obscure the child, rendering them 'invisible' to those whose job it is to care for them (Kroll & Taylor 2000).

> A child would never overlook an elephant in the living room ('Hey there is an elephant in the living room. Doesn't anyone else see it?'). When adults behave as if there is no elephant, the child experiences a distorted reality. (Brooks & Rice 1997, p. 93)

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The consequences of experiencing this 'distorted reality' can be manifold. Confusion about the elephant increases, as does the child's capacity to trust his/her own perceptions – 'it must be me; there must be something wrong with the way I see things – I can no longer trust my own judgement'. The world therefore becomes an uncertain place, as the child ceases to know whether what he/she is seeing or experiencing is real or not – 'a world of mirrors where nothing is as it seems' (Barnard & Barlow 2003, p. 54).

Alongside this is the issue of the child's management of the anxiety that is provoked by the 'elephant' which might be paraphrased like this – 'I don't like this elephant, but no one else ever admits it's there, so what do I do with my fear?' This in turn can lead to what Brooks & Rice (1997) refer to as the 'don't feel' rule which often means that children are discouraged not just from feeling but from talking about feelings as well. As one parent observed:

> 'That was a big thing that I done . . . I never taught her to be able to share honestly about her feelings or anything . . . I just taught her to hide things.' (Barnard & Barlow 2003, p. 51)

The issue of secrecy is likely to loom particularly large for ethnic minority groups, when it comes to accessing services. Seeking help outside the community can be problematic for a range of cultural reasons, since admitting to substance problems may lead to exposure and censure. A range of assumptions are often made based on cultural stereotyping – certain groups are not 'supposed' to have such problems and so it is hard for them to be heard by others, including those providing services (Awiah *et al.* 1992; Brisby *et al.* 1997; Patel 2000). These beliefs can lead either to the realities of children's lives being ignored or to assumptions being made about the way in which the extended family will swoop in and save them if need be.

ATTACHMENT, SEPARATION AND LOSS

> 'You feel like you're always put on the second shelf. You feel like you're not number one in your parents' life and that makes you feel horrible . . . When you see 'em do drugs long enough you know you're not number one; you know you're always put second and the drugs are put first . . . It takes a long time to get over 'cos you just can't believe it.' ('Jessica', aged 15, in Howland Thompson 1998, p. 34)

In their work with adult children of alcoholics, Brooks and Rice found that 'two of the most compelling issues . . . are the pervasive losses children experience and the accompanying, often unresolved, grief' (Brooks & Rice 1997, p. 108). Of particular significance were the invisible losses – the loss of a feeling of being loved, for example – that, because they were so hard to put into words and explain to anyone else, often remained a source of pain: 'I knew they loved me but they just didnae care that I was there . . . they were just away taking drugs and stuff', Elaine, aged 14, told researchers, whilst Anne, aged 11, reflected back on her feelings about her mother's drug use, '. . . I used to think how could this have happened to me? It was just sad all the time and then I would get angry' (Barnard & Barlow 2003, p. 53).

Losses included loss of a reliable, consistent and responsive parent, loss of confidence and self-esteem, loss of a 'normal' lifestyle in which it was safe to bring friends home or go off to school (Cork 1969; Howland Thompson 1998). Parental substance abuse also often resulted in the temporary loss of parents due to imprisonment, being accommodated by the local authority or permanent separation as a result of care proceedings (Hogan 1997; Cleaver *et al.* 1999). Fears about parents 'disappearing' unexpectedly – going out and never coming back – and the insecurity and uncertainty generated by these fears ('Will I be picked up from school? Will he/she still be there when I get home?') were also clearly conveyed (ChildLine 1997). Actually being abandoned was a reality for many children, as was *feeling* abandoned, both by the substance misusing parent and, sometimes, by the non-substance misusing parent, whose preoccupation with the 'misusing' partner often left less time, energy and attention for the child (Brisby *et al.* 1997; Velleman & Orford 1999). Awareness of the fact that drugs caused death was also an omnipresent source of anxiety and fear for some (Barnard & Barlow 2003). In addition there were issues in relation to loss of normal developmental stages and the experience of being 'lost' as individuals and, as a consequence, 'invisible' to those whose role it was to care for them (Laybourn *et al.* 1996; Robinson & Rhoden 1998; Hogan & Higgins 2001). As Jessica, Elaine and Anne imply, when parents' main attachment is to a substance, this has implications for the child's sense of worth, so crucial for a sound internal working model (Howe *et al.* 1999).

Loss of childhood was a theme in several of the studies and there were clear links here with the role of the child as carer, to be discussed later. 'I don't remember much of my childhood', observed Gina, whilst another adult child of an alcohol misusing parent recalled watching other children playing, very much as an outsider: 'They seemed so young and I felt so old . . . standing inside the hallway as I worried

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about my mother. I was 8' (Brooks & Rice 1997, pp. 108–109). Young adults in the study by Laybourn and colleagues recalled the sense of 'having missed out on vital components of childhood' (Laybourn *et al.* 1996, p. 97), particularly when they compared themselves with what they imagined to be the experiences of 'ordinary' children, or the family lives of friends in which it was possible to have 'normal' experiences such as birthday parties without the fear of the occasion being spoilt by chemically induced inappropriate and embarrassing behaviour (Laybourn *et al.* 1996; ChildLine 1997). Children and adults also felt that they had lost opportunities for fun and laughter and that this sense of losing out, on a number of levels, had had a significant impact on their sense of identity (Cork 1969; Velleman & Orford 1999).

FAMILY FUNCTIONING, CONFLICT AND BREAKDOWN

> 'Mum is fond of drink . . . gets grumpy and shouts a lot which makes dad angry. I think they might get separated and I don't think they want me.' (Gemma, aged 13, in ChildLine 1997, p. 32)

All the studies reviewed here identified parental conflict, fighting and arguing as a major source of stress and anxiety. By the same token, the level of family support available profoundly affected both childhood experiences and adult adjustment (Newcomb & Rickards 1995). In other words, parental drug or alcohol use had very little adverse impact, provided the family was functioning and supportive. Substance use per se did not mean that everything automatically fell apart; families could be dysfunctional and unsupportive for a whole range of reasons.

The relationship between family conflict and disharmony and substance abuse could often be a complex one in relation to causation. From the children's perspective, in fact, this was irrelevant since what they talked about was the impact of living with family stresses, irrespective of the way in which they evolved. Causation, however, did feature in relation to the part they felt they might have played in the family's situation. Children often expressed an acute sense of responsibility for what had happened and this had implications for their sense of power and control – if they had started it, could they stop it?

One common consequence of family disharmony in general, and violence and abuse or threats of it, in particular, was that the whole family organized itself around the substance using member (Brooks & Rice 1997; Robinson & Rhoden 1998). Children then effectively disappeared in their own right because their lives were dominated by the needs and feelings of the parents. Their actions, as a result, were governed by avoidance strategies and fear (Woititz 1990; Robinson & Rhoden 1998). Accounts suggested that children frequently denied their own feelings and that their good or bad days were determined, not by what *they* did or how *they* felt, but by how their parents were feeling and the way in which they were behaving. Consequences of this were isolation, loneliness and a feeling that there was no one to turn to and no one to trust (ChildLine 1997). Several factors could be seen to be contributing to these feelings, not just within the immediate family but also within the wider family system and the community at large. If others made disparaging, unkind or offensive remarks about parents, causing friction between parents and those outside the family, stress was significantly increased. These experiences inevitably made children more vulnerable (Barnard & Barlow 2003).

Substance misuse and its consequences often lead to parental separation, and children experienced a range of emotions in relation to this. They expressed fears about not being wanted by either parent, or concerns about having to pick up the pieces and support the parent with whom they had remained (ChildLine 1997). It often seemed to children that parents felt able to leave them in situations that they themselves found intolerable, although it must also be acknowledged that, for some, there was no other choice (Laybourn *et al.* 1996). Whether children always appreciated this, however, was debatable. For some children, parental separation was clearly a relief from conflict and violence; for others, however, the impact of the breakup was as bad if not worse than the behaviour that had provoked the separation. The loss of a parent – even when their substance misuse had caused anxiety and fear – was still mourned very deeply, as was loss of a sense of family and a feeling of somehow being different, as a result (Laybourn *et al.* 1996). Children also spoke of the other aspects of family dislocation that caused additional stress – changing schools, moving house and losing touch with friends.

In some cases the separation precipitated a parent's substance misuse rather than being triggered by it. Children in this situation watched parents battle with grief, loss and anger, using drink and drugs to manage pain (ChildLine 1997). This often left children to manage their own pain alone.

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VIOLENCE, ABUSE AND LIVING WITH FEAR

> 'Ever since I can remember I've been scared. It's affected us all our lives.' (Secondary school-aged child in Laybourn *et al.* 1996, p. 56)

What children saw as their greatest problem was the violence often associated with substance misuse (particularly alcohol) which frequently caused aggressive behaviour. Attempts to intervene by either child or non-using parent tended to make matters worse and, even when the violence was directed at objects rather than people, the consequences were devastating, with children traumatized or inconsolable for significant periods of time. Children's accounts vividly convey that one major consequence of living with substance misuse is fear – the fear of arguments, actual physical violence or the threat of it, either to a parent (usually the mother) or to themselves and, at times, fear of sexual abuse. Witnessing parents attempting to injure themselves, when under the influence of drink or drugs, also had a profound impact (Howland Thompson 1998), as did conflicts of loyalties and real fears about a parent's welfare. As Alex, aged 12, observed:

> 'Since mum left, dad's been drinking more and hitting me. I don't want him to get into trouble and I think if I went to live with mum he might kill himself.' (ChildLine 1997, p. 27)

Situations like this were often hard for children to talk about due to fears about the consequences or because of threats from parents about what would happen to them if they did.

> 'If I have bruises, he locks me in the house and stops me going to school. He says that if we ever tell anyone he will kill us. I'm scared . . . it's getting worse.' (Tracy, aged 12, in ChildLine 1997, p. 23)

Children were often encouraged to view outsiders with suspicion or mistrust, fearful that someone would find out about parents' problems (particularly drug use) and that this would lead to separation or exposure (Barnard & Barlow 2003). Some young people described being encouraged to see social workers as a threat, rather than a source of support, and even if they were in touch with a social worker, they stated that all they revealed were 'snippets' about what was happening at home, rather than the whole story (Laybourn *et al.* 1996). Children also reported having to lie to hospital staff about the causes of injuries or to collude with explanations provided by the abusive parent (ChildLine 1997).

A range of assaults and injuries were inflicted on children, often accompanied by verbal abuse, derogatory remarks about abilities or appearance, and comments about not being loved or wanted (ChildLine 1997). Children were clear that the emotional abuse was as painful, if not more so, than the physical. Being told by a parent that s/he wished their child had never been born was a commonly reported experience. Taunting, unprovoked humiliation in front of others and other types of emotional abuse were also commonplace (Laybourn *et al.* 1996; ChildLine 1997).

Children were frequently baffled by the fact that they were left in the care of the violent or abusive drinking parent by the non-drinking parent, and the feelings this engendered were powerful. Apart from disbelief and feelings of betrayal and not being cared about, children often expressed rage, anger and murderous feelings towards both the adults concerned. Feelings of vulnerability were often expressed and children were unsure whether they could really tell the non-substance using parent about the reality of being left with the other parent. Their concern was that this might either raise the parent's anxiety level, or simply confirm their suspicion that nothing could be done about the situation. Being confronted with the reality that one parent could not protect the child from the other often undermined confidence in, and respect for, the parent concerned (Laybourn *et al.* 1996; ChildLine 1997).

Although most of the violence was perpetrated by the substance misusing parent – usually but by no means exclusively the father – the stress levels in the family, whether due to the drinking per se or the stressors that precipitated the drinking, would often cause violent responses in the non-substance misusing parent, too (ChildLine 1997). Children were often very sympathetic to this parent's position, aware that they were trying to keep the family together. However, they also felt, understandably, that things were being taken out on them that were none of their making (Laybourn *et al.* 1996). As a result, some felt that they were simply adding to an already stressful situation and that there was no source of safety or support available to them. Their contradictory feelings were also hard to manage, in that they would have to cope with angry and anxious feelings, generated by difficult parental behaviour, one minute and yet have to respond to overtures of remorse and conciliation the next (Laybourn *et al.* 1996; Velleman & Orford 1999).

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ROLE REVERSAL, ROLE CONFUSION AND THE CHILD AS CARER

> 'Dear Mommy,
> Don't worry. I went out to play. I let you sleep . . . Harry will be in the yard and I will be at Joanne's or Mary Anne's. Harry wore a sweatshirt . . . and . . . play jacket with just the hood on his ears. I wore my red pants with my red and white hat with hood.' (Linda, aged 8, in Brooks & Rice 1997, p. 110)

Becoming a young carer, as research has shown in other contexts, can sometimes effectively hijack childhood, and place adult burdens on children's shoulders (Becker *et al*. 1998). In addition, the fact that children are 'young carers' often prevents them from being seen as 'children in need', with the attendant danger of falling through the net in relation to services (Dearden & Becker 2001).

The studies considered here vary in relation to the extent to which role reversal was identified as an issue for children of substance misusing parents. Laybourn *et al*. (1996) found very few of the 28 children and young people that they interviewed fell into the 'young carer' category. For many, caring responsibilities were episodic, often amounting to the kinds of tasks that many children might be called upon to perform in a family context – looking after a brother or sister or helping with housework. However, some did occasionally care for parents in other ways that included dealing with debts and managing finances as well as aspects of physical care: 'When my mum's drunk . . . I always walk her and help her', recalled one primary school-aged child, whilst another secondary school-aged boy occasionally had to sleep with his mother when she had DTs – 'I used to go into bed with her . . . so that she could get a sleep instead of getting up and walking about and seeing things' (Laybourn *et al*. 1996, pp. 64–65).

In contrast, the ChildLine study (ChildLine 1997), based on 3255 records of calls from children and young people whose parents or carers were affected by alcohol, found that many children said that they were the main carer and had to carry out anxiety provoking, inappropriate and often very intimate tasks for parents:

> 'She has no control and falls over all the time. She pees on the settee and me and my brother have to clean up after her. She fits, too.' (Debbie, aged 13, in ChildLine 1997, p. 39)

In their study of the impact of drug use on parenting, Hogan & Higgins (2001) found that both parents and professionals felt that children were often placed in positions where they were taking on caring responsibilities and becoming adults very young.

Some research indicated that role *confusion* rather than *role reversal* could occur in families where substance misuse is a feature (Laybourn *et al*. 1996). Here, parents' behaviour caused such embarrassment or was seen to be so stupid, childish or out of control that the child lost all respect for them. Children then felt that the parent had forfeited any right to have authority over them and the balance of power shifted as a consequence – 'You behave badly, so don't try telling me what to do'. Often such children would appear to behave just like children until the parents' problem behaviour occurred, whereupon they would become very assertive and parental. In response, parents would become sneaky in their behaviour and dread being told off. This kind of role confusion and reversal often left children unsure about who they were and what was going on. It often also led to strong feelings of disgust and, at times, hatred towards the substance misusing parent (Laybourn *et al*. 1996; ChildLine 1997).

WHAT CHILDREN SAID THEY NEEDED

> 'That's how I'd feel all the time: I'd feel alone. Drugs were more important than me. I didn't come first in my mother's life . . . she was more worried about drugs.' (Felicia, aged 17, in Howland Thompson 1998, p. 34)

The 'hurt on the inside' experienced by many children and young adults was clearly the element requiring the most pressing response. This emotional pain had a significant impact on the internal world of the child, particularly in relation to self-esteem. Isolation and lack of support were also identified as contributing to that 'hurt'. Feeling safe, wanted and important – central concerns for Felicia – were also critical, as was protection from violence and conflict, and freedom from fear.

Another theme that emerged was the degree to which children affected by parental substance misuse were a 'hidden' group – invisible to professionals unless the child or adult came to the attention of welfare services for some other reason. Even then, the needs of the child often remained unseen or secondary to those of the adult concerned. Because of children's innate sense of loyalty, their awareness of people's opinions of drinkers and 'druggies' and fears about professional intervention, they were often trapped in a position where they could not ask for help or acknowledge their fears to outsiders, remaining weighed down by 'silent knowledge' (Barnard &

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Barlow 2003, p. 55). At the same time, they could not manage the situation in which they found themselves. It seemed important for professionals to be patient and simply notice that something was wrong (Woititz 1990; Robinson & Rhoden 1998).

For many children, actually telling anyone what was going on at home, while they were still living there, was a real issue (Harbin 2000). It was therefore crucial for any confidant to be clear about issues of confidentiality, so that children knew what would happen to the information they gave and that they would not be punished, judged or blamed for talking about parents' behaviour. Children often expressed real fears about being separated from family and 'taken away' somewhere (ChildLine 1997). They also implied that, when they had summoned up the courage to try to tell someone about what was happening at home, they had not always felt listened to, understood or taken seriously, and this had a significant impact.

Practical help and physical protection featured more in some studies than in others. Witnessing and managing violence, however, were persistent worries, and the impact of family disharmony was often seen as more of a problem than the substance misuse. Many children felt that it would help to have someone to confide in or to be able to talk to openly about the problem within the family. Some also expressed a desire to meet other children in similar circumstances, to share experiences. Others would have welcomed a break, some time away. Younger children simply wanted someone 'to tell mummy to stop drinking' (Brisby *et al.* 1997, p. 14). Valuable ways of supporting children under stress included freeing them from guilt about parents' substance use, helping them regain some sense of control over their environment, giving them space to be children, if this was hard within the family, and reassuring them that people can 'get better' (Brisby *et al.* 1997; Robinson & Rhoden 1998).

It is generally assumed that, since it is the substance misuse that causes problems for children, once this is 'treated' or parents are helped to manage their substance use, the problems will go away and all will be well. What was apparent, however, was that children needed continued support, even after treatment, due to unresolved feelings, adjustments to new roles, rules and behaviours, new fears and anxieties. 'Although their parent may receive help, they [he children] frequently do not' (Brisby *et al.* 1997, p. 14). Children, as a consequence, could feel abandoned once again.

IMPLICATIONS FOR PRACTICE

This analysis highlights the extent to which the world of the child with substance misusing parents can be a difficult, dangerous, distressing and violent place where it is hard to be oneself and reach adulthood unscathed. The implications for all the dimensions of the child development domain are all too obvious and many children may be living in circumstances that render them not just 'in need' but significantly 'at risk'. Despite the fact that children can be surprisingly resilient in the face of adversity, and that it is tempting to rely on this in a range of situations, children have their limits and it is clear that, for many children of substance misusing parents, these limits are sorely tested. Obviously the implications for practice are complex and cannot be addressed in full within the scope of this article. However, a few key points can be identified.

Gaining access to children's feelings about and responses to parental substance misuse is, as we have seen, not without its problems; children are often very loyal to their parents, irrespective of their actions (Harbin 2000). The ethnic and cultural context in which children live will also affect the extent to which they feel able to talk to professionals or are indeed given permission to do so. However, research shows that children are very good at making their needs and wants known if the right climate is created for discussion to take place and provided workers take the time to listen (see for example Bell 2002). As well as creating an environment where children feel able to talk, it is also important to give them permission *not* to say anything, mindful of the fact that mistrust and suspicion may be issues. In many households where there is substance misuse, domestic violence, mental health problems and/or some kind of child abuse or maltreatment may also be issues. Potentially, then, children may be being asked to reveal a constellation of difficult things happening in their lives. There is no set pattern of behaviour that might suggest the child is living with substance misuse but it is always worth considering whether this is an issue where there is evidence of concerning behaviour. Children, as we know, also have mixed feelings about anyone 'finding out' and yet desperately want someone to know. Disclosure, as a result, may often take some time and have a 'one step forward, two steps back' quality.

In this context sometimes straight talking is the most effective approach. This has much to do with getting over the barrier that the topic is 'taboo', or too terrible for an adult to approach directly. Because of

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the cloak of secrecy and denial that is often thrown over substance misuse, breaking through the wall of denial in a direct way can be very liberating. If the worker is able to validate the existence of the 'elephant in the living room' the relief can be enormous – 'Yes, someone else can see it! Maybe my perceptions are valid after all'. Most children want to be heard and to be believed, particularly if they are operating in a system where this is not happening. The way the child makes the worker feel may also provide an important layer of information about the child's world.

A critical task for the worker is the ability to 'enter the world of substance misusing families' and to start to know something of what it is like to be there both for the parents and also for the children (Aldridge 1999, p. 9). All parents will often have a highly subjective view of the way they operate as parents; substance misusing parents will be no exception. Observation of families could, then, be a useful way of gaining a different quality of information. Obviously there are a range of factors to consider here – worker objectivity and subjectivity, values, cultural differences and the fact that one observation alone might not provide a rounded or fair picture. Training, then, in this particular skill would seem to be essential. By the same token, decisions about which professionals in a network are best placed to undertake this element of assessment also need to be considered, as will the way that they operate as a team. If trust could be established sufficiently for workers to be allowed to actually see what is really going on, then more purposeful assessment and intervention might be possible. In addition, trust and communication between adult and child focused services needs to be improved to ensure that children do not fall through the net.

Effective assessment and intervention rest on an understanding of the dynamics of denial and resistance, as well as the impact of 'attachment' to the substance and its effect on parent/child relationships (Kroll & Taylor 2003). In this context, seeing the substance as a family member – the elephant in the living room – within a systems framework, can prove particularly useful. It also provides a graphic metaphor that relates to both family and professional systems.

SUMMARY

Children need to be seen, heard and engaged with on a real level if they are to feel confident about being helped. Communication between professionals needs to be made open and the child's perspective needs to be brought more firmly into the entire assessment process so that workers can gain a sense of what children's lives are really like. This needs to involve strategies that, rather than forcing them to 'tell tales', enable them to tell a story in a safe place. The use of observation and skills in communicating with children is clearly central to achieving this aim. Workers may need to increase their knowledge base in relation to parental substance misuse and child welfare and find different ways of engaging with difficult feelings via training and supervision.

Living with an elephant, as this analysis has shown, has implications for attachment, physical and emotional safety, self-esteem and being seen as an individual in one's own right, quite apart from the obvious financial and practical consequences which it has not been possible to explore here. Because the focus of intervention is often the elephant, on the basis that, if this can be managed more effectively or removed altogether, this will solve the problem, it is easy to miss anyone lurking in its shadow. To tackle the elephant without exploring what it has left in its wake is to ensure that children of substance misusing parents remain invisible.

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