Exploring the Experiences of Adults Who Have Been Exposed to Problematic Parental Substance Use During Childhood.

Hayley Ansell

Thesis submitted in partial fulfilment of the requirements of the University of Staffordshire for the degree of Doctorate in Clinical Psychology

July 2025

Total word count: 17871

(Excluding References and Appendices)

THESIS PORTFOLIO: CANDIDATE DECLARATION

Title of degree programme	**Professional Doctorate in Clinical Psychology**
Candidate name	**Hayley Ansell**
Registration number	**22042175**
Initial date of registration	**September 2022**

Declaration and signature of candidate
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work. I confirm that the decision to submit this thesis is my own. I confirm that except where explicitly stated, the work has not been submitted for another academic award. I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis. Signed: HAnsell Date: 04/07/2025

Acknowledgements

First and foremost, I would like to express my heartfelt thanks to the eight participants who so generously gave their time and shared their experiences with me. Your openness, honesty, and courage were the foundation of this research, and without you, this project would not have been possible.

A huge thank you to my research supervisor, Dr Nic Davies, for all your guidance, encouragement, and support over the last three years. To my cohort, thank you for bringing laughter and solidarity through training. I'm grateful to have shared this journey with such wonderful people.

To my friends and family, thank you for your constant encouragement and for always being there when I needed to step away and breathe. I'm so grateful for your constant love, laughter, and support you always give.

Finally, my wonderful fiancé, Joshua, thank you for your unwavering love, patience, and belief in me throughout not only this doctorate, but throughout life. Your support (and countless cups of tea) made even the most difficult days manageable. I truly couldn't have done this without you.

Contents

Contents

Thesis Abstract

Addiction, whether to substances or behaviours such as gambling, is a complex and often chronic condition that can profoundly affect not only the individual but also those around them, particularly children. When addiction occurs within a caregiving role, its impact can ripple across generations. Parental substance use (PSU) and problem gambling (PG) represent two distinct but related forms of addiction, often characterised by cycles of compulsion, impaired functioning, and emotional unavailability. These patterns often create environments marked by instability, neglect, and unmet emotional and physical needs. Children and adult children of parents with addiction difficulties commonly experience long-term psychological consequences, including trauma, role reversal, relationship difficulties, and increased vulnerability to addiction themselves. While PSU has been well documented, little research has explored adult children's experiences retrospectively, similarly, research into the impact of parental PG on children remains limited. This thesis aims to gain insights into how best to support those impacted by addiction and contribute to the growing evidence base.

Paper one is a literature review on the experiences of children and adult children of parents with PG. Drawing on eight studies, it highlights the significant emotional, psychological, and relational harm experienced by this often-overlooked group. Parental PG was associated with emotional neglect, poor supervision, and financial instability. These experiences can contribute to enduring distress and challenges into adulthood, including difficulties in relationships, continued financial responsibility for parents, and, for some, an increased risk of developing gambling problems themselves. While the impacts were largely negative, variation in outcomes suggest the presence of moderating factors warrant further investigation. Given the high prevalence of PG among parents, these findings underline the urgent need for greater attention, support, and targeted interventions for affected children.

Paper two is an empirical paper which explores the lived experiences of adults exposed to problematic PSU in childhood. Eight participants engaged in semi-structured interviews, which were analysed using Interpretative Phenomenological Analysis. Four Group Experiential Themes were identified: 1) "I Was the Parent"- Parentification, 2) I Saw Too Much Too Soon: Early Exposure and Its Impact, 3) When Normal Isn't Normal, and 4) Breaking the Silence, Breaking the Cycle. This empirical study highlights the need for trauma-informed, developmentally attuned psychological support that recognises hidden caregiving roles, intergenerational harm, and adaptive coping. The study contributes to clinical understanding and efforts to break stigma through the amplification of adult children's voices.

The final paper in this thesis is an executive summary that provides an accessible overview of the completed empirical paper, written in a style intended for a wider, interdisciplinary audience.

Paper One: Literature Review

What Is Known About the Experiences of Children and Adult Children of Parents with Problem Gambling? A Review of the Literature.

Hayley Ansell

Student ID: 22042175

Word count: 7848

(Excluding References and Appendices)

This Literature Review has been written in accordance with author guidelines for the Journal of Family Studies. The author guidelines are in Appendix A

Abstract

Background

The gambling industry has expanded rapidly over the past three decades, becoming increasingly accessible and normalised as a recreational activity. While gambling is harmless for most individuals, problem gambling (PG) can lead to substantial personal, family, and societal harm. The effects of PG extend far beyond the gamblers themselves, often impacting their children. Despite estimates suggesting that up to half of individuals with PG have dependent children, research on the experiences of children of PG parents remains limited, highlighting a need for further exploration.

Objective

This review synthesises research on children's and adult children's experiences of parental problem gambling, aiming to identify the nature and extent of these experiences.

Method

A systematic search was conducted across 20 databases through the University of Staffordshire's database, yielding eight studies that met the inclusion criteria. Studies were evaluated using the Mixed Methods Appraisal Tool (MMAT) and findings were synthesised using a narrative approach.

Results

The review found that experiences of parental PG significantly impact children, leading to emotional and psychological issues, as well as an increased risk of gambling problems. Ineffective parenting, including emotional neglect and lack of supervision, exacerbated these issues, with financial instability and poverty often reported. Long-term effects included difficulties forming healthy relationships, persistent psychological distress, and continued financial support to parents. However, variability in the severity of outcomes highlights the need for further exploration of moderating factors.

Key words

Problem gambling, children, adult children, parental problem gambling.

Introduction

Over the past three decades, the gambling industry has undergone rapid global expansion, becoming increasingly accessible and widely accepted as a mainstream form of recreation (Stucki & Rihs-Middel, 2007). Gambling is a prevalent social activity worldwide, and for most individuals, it remains an enjoyable and harmless activity. National surveys consistently indicate that there are more gamblers than non-gamblers (Calado & Griffiths, 2016; Meyer et al., 2009). However, for some, gambling can develop into problem gambling (PG). Growing research continues to support the link between gambling, various risk factors and adverse outcomes, contributing to a growing consensus that gambling is a public health issue requiring a comprehensive approach to prevent gambling-related harms (Johnstone & Regan, 2020).

PG, also known as gambling disorder in both the DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th Edition) and ICD-11 (International Classification of Diseases, 11th Revision), is defined as a behavioural addiction. It involves persistent patterns of gambling behaviours that disrupt family relationships and interfere with personal and recreational activities, leading to clinically significant impairment or distress (American Psychiatric Association, 2013; World Health Organisation, 2019). Globally, the lifetime prevalence rates of PG ranges from 0.7 to 6.5% and is not without significant risk factors and negative consequences (Calado & Griffiths, 2016; Meyer et al., 2009).

There are several harms experienced by those who gamble problematically, including substantial financial, physical, psychological, comorbid addictions and relational impacts (Petry et al., 2005). However, research has shown that PG also negatively impacts those close to the individual, with approximately six people directly affected for each person struggling with a gambling issue (Goodwin et al., 2017). Although the exact proportion of people with PG difficulties who are also parents remains unclear, estimates indicate that between one-quarter to one-half of individuals with PG have dependent children (Dowling et al., 2010). Despite growing awareness that the effects of PG extend beyond the individual, research that is specifically focused on the impact on family members, particularly children, remains limited (Tulloch et al., 2021). As gambling opportunities become more accessible, the prevalence of serious PG is likely to increase, putting significant others, particularly children, at higher risk of experiencing adverse effects (Darbyshire et al., 2001).

Current literature highlights the negative impact of parental PG on children, which can lead to a range of harmful consequences, including psychological, relational, behavioural, and physical health issues, as well as exposure to violence and financial difficulties (Suomi et al., 2022). Children may also experience negative effects due to the physical absence of their parent and the loss of care

from their primary caregiver, leading to shifts in family roles, with children sometimes assuming a 'parenting' role for their PG parent (Järvinen-Tassopoulos, 2020).

The primary aim of this literature review is to explore the experiences of children and adult children affected by parental PG. Currently, research on this topic is limited, with existing studies highlighting the need for a greater understanding and greater support offer for both families and children with PG parents. There is a need for conducting more systematic reviews to synthesise and analyse the prevalence of children's experiences with parental PG. The findings from this review could inform future practices, interventions and contribute to the evidence base, offering valuable insights for future research. Therefore, the review seeks to answer the following question: What is known about the experiences of children and adult children of parents with problem gambling?

Methodology

Scoping Searches

An initial scoping search of Google Scholar and the University of Staffordshire Library was conducted to assess the available literature for the review and to identify existing reviews on the topic. A recent review by Suomi et al. (2022) was identified, which focused on child well-being. Additionally, Kourgiantakis et al. (2016), completed a review on prevention programs for children. Lastly, Lane et al. (2016), conducted a review which explored adult problem gamblers' risk of abusing or neglecting their own children. As a result, the current review aims to address the gap in the literature by exploring children's experiences of parental problem gambling.

Search Strategy

Systematic searches were completed during August 2024, utilising the University of Staffordshire Library Database (USLD). Initially, the searches focused on children of parental problem gamblers who were under the age of 18. However, when these searches yielded an insufficient number of results, the age exclusion criterion was removed. The following search terms were used alongside Boolean operators: (Child* OR adolescen* OR youth OR "child* experience*") AND (experience* OR perspective* OR lived experience* OR narrative*) AND (parent* OR carer* OR guardian*) AND (problem gambl* OR gambl* addiction OR disord* gambl* OR gambl* disorder). Search terms were determined by exploring definitions currently used in the literature and through consultation with the university's librarian. The databases were searched electronically, which included searches in 20 collections (see Appendix B), with no date limiter applied. Reference lists of the included studies were manually searched, and citation searches were performed on Google Scholar to identify relevant research. Two additional studies were identified and included through this process.

Inclusion and Exclusion Criteria

To be included in the current literature review, studies were required to:

- Be published in English due to lack of translation resources
- Be published in a peer-reviewed journal
- Quantitative or qualitative data relating to children's experiences of parents who gamble problematically

Studies, which met the following criteria, were excluded:

- Studies which considered children's experiences of parental PG from the perspective of any other sample
- Studies which considered children's experiences of parental PG who also gambled problematically

Publication Bias

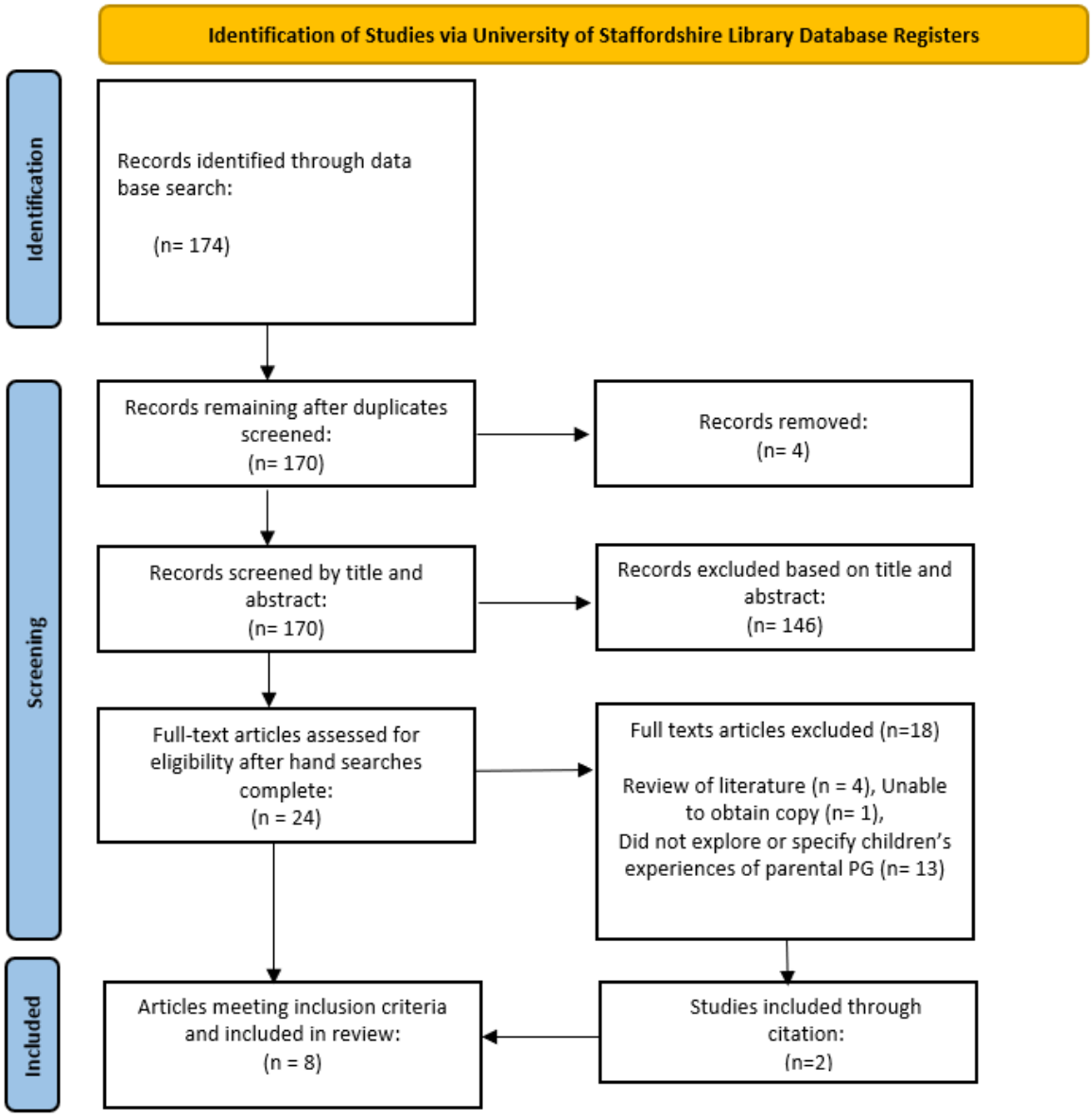
Due to the high standards and quality upheld by peer-review literature, this review exclusively included peer-reviewed studies (Weaver et al., 2022). However, research may still be subject to publication bias, which should be interpreted with caution. Publication bias refers to the selective publication of studies based on the nature of their findings, often referred to as 'dissemination bias' (Song et al., 2013). This bias can lead to a distorted and unreliable understanding of research evidence, as it may not represent the full spectrum of available data (Song et al., 2013). To minimise publication bias, a search of the grey literature was conducted by reviewing the first 200 results on Google Scholar, as recommended by Haddaway et al. (2015), but no additional studies were identified.

Data Extraction

The initial electronic database search retrieved 174 articles. Duplicates were removed, and following this, titles and abstracts were screened in line with the eligibility criteria. This resulted in 24 remaining full texts, which were examined further to assess for relevance, resulting in 6 papers being included in the literature review. To identify additional relevant papers, reference lists were manually searched, and citation searches were conducted in Google Scholar, leading to the inclusion of two additional studies. The Preferred Reporting Items for Systematic reviews and Meta-Analyses (PRISMA), outlines the results of this process (Figure 1).

Figure 1

PRISMA flow chart showing literature review strategy (Page et al., 2021)



Critical Appraisal Tool and Quality Assessment

Screening of full texts of eligible studies was conducted and data extracted into a standardised table (see Table 1). The information included consisted of authors, year of publication, country, sample, research design, key findings, methodological strengths and limitations and the Mixed Methods Appraisal Tool (MMAT) score. The MMAT (Hong et al., 2018) is a widely used instrument for assessing the quality of studies with diverse methodologies. The MMAT is a valuable tool for systematic reviews, due to its ability to evaluate multiple research designs in a straightforward and efficient manner, using a relatively small set of criteria. The MMAT also provides

a structured framework, promoting consistency and transparency across the quality assessment. The clarity of criteria and structured process supports the MMAT's inter-rater reliability. However, while its simplicity and breadth are strengths, they also limit the MMAT's ability to provide a nuanced appraisal. This can result in certain methodological issues being overlooked and may insufficiently address the depth of individual components. Additionally, the MMAT does not include a scoring threshold to categorise studies, which can lead to variability and subjectivity in its application, as reviewers are left to interpret the results on their own.

Of the eight papers included for review, four papers used qualitative research methods, with the remaining using quantitative methodologies. The MMAT uses a clear and structured scoring system, which includes reviewers marking against each criterion with 'Yes', 'No' or 'Can't tell', each with a numerical value (Yes=2, No=0, Can't tell=1). This structure was adopted to enable comparison across all eight studies. The MMAT scores are highlighted in Table 1 for each research paper. The scoring system had a maximum possible score of 10 (see appendices C, D and E). Scores from 0 to 4 were categorised as 'low', scores from 5 to 8 as 'medium', and scores from 9 to 10 as 'high'. As mentioned, there is no guidance of cut-off scores to suggest sound research, however, higher MMAT scores are generally considered to be of higher methodological quality and more reliable for drawing conclusions.

Synthesis

A narrative approach to synthesis guided by Popay et al. (2006) was utilised for reviewing the literature. Popay's et al.'s (2006) framework is a systematic approach for synthesising findings from diverse studies which use different methodologies including, quantitative, qualitative and mixed methods. It involves exploring relationships within and between studies while considering contextual differences across studies. This approach ensures transparency and rigour in the synthesis. Popay et al. (2006), narrative synthesis follows a four-step process: 1) developing a theoretical model, 2) developing a preliminary synthesis, 3) exploring relationships in the data and 4) assessing the robustness of the synthesis product. This process was used as a guideline for the review.

Results

Overview of Included Studies

This review included a total of eight papers published between 1989 and 2023 that explored the experiences of children and adult children of parents who gamble problematically. A summary of the papers is provided in the key study characteristics table (Table 1). The studies were conducted across four countries: Australia (four studies), the Unites States (two studies), and Canada (two

studies). The reviewed studies varied in sample size, from as few as eight participants in Ferland et al. (2021) to 844 participants in Jacobs et al. (1989). Recruitment strategies ranged from opportunity and volunteer sampling to more specific approaches like random, longitudinal, and purposive sampling.

A notable finding was the gender disparities observed across the studies, with most having higher female representation. The age range varied widely, encompassing both children and adults. Quality assessment, as assessed by MMAT scores, ranged from 4 to 10, with half of the studies scoring the highest possible score of 10, while Jacobs et al. (1989) received the lowest score of 4.

In terms of research design, there was an equal split between quantitative and qualitative research. Quantitative studies include Vitaro et al. (2008), who conducted a longitudinal study in Canada, comparing 42 children of problem gamblers with a control group. Though the overall sample size was large, the subset of children affected by PG was relatively small. In contrast, an Australian study conducted by Suomi et al. (2023) used a large sample of 211 participants in a cross-sectional survey to investigate the effects of parental PG on children. Lesieur et al. (1989) used self-report questionnaires with 105 children and adult children, assessing the impact of parental gambling, while Jacobs et al. (1989) conducted a similar self-report survey in the United States, examining the risks faced by children of problem gamblers.

Qualitative research added further insights into the experiences of those affected by parental PG. Suomi et al. (2023) also conducted semi-structured interviews with adults who had been exposed to parental PG in childhood, highlighting the significant harm these individuals experienced. Similarly, Ferland et al. (2021) used semi-structured interviews with significant others of problem gamblers, which included perspectives from eight adult children. In Australia, Patford (2007) explored late-onset parental gambling through interviews with 15 participants, while Darbyshire et al. (2001) used interviews to gather data from Australian children living with gambling parents.

Table 1:

Key Study Characteristics

Author(s), Year, Country	Aim	Sample	Research design	Key Findings	MMAT quality appraisal score (0-10)	Strengths	Limitations
Suomi et al. (2023) **Australia**	Understand gambling harm directly attributed to parental gambling.	N=211 Median age 36.1 years old 68% female and 32% male	Quantitative, cross-sectional survey design.	Parental gambling severely affects children's financial, psychological, and relational wellbeing, leading to long-term mental health difficulties and intergenerational gambling behaviour.	5	Clear aims. Large sample.	Non-validated measures, survey requires self-selection, which can limit representativeness.
Suomi et al. (2023) **Australia**	To explore the first-hand experiences of adults who were exposed to	20 Australian adults	Qualitative, semi-structured interviews,	Highlighted the significant and long-term harm experienced	10	Clear and transparent approach to ethical considerations.	Non-representative sample. Mainly retrospective.

	parental gambling during childhood.	80% female and 20% male Median age 33 years old	thematic analysis.	by children of gambling parents.		Researcher reflexivity.	
Ferland et al. (2021) **Quebec & Canada**	To compare the consequences experienced by the partners of gamblers with those experienced by close family members (including children).	8 adult children- however does not specify demographic for each sample group	Qualitative, semi-structured interviews, thematic analysis.	The extent and significance of harm experienced by children was influenced by the age of when their parent developed a gambling disorder and the degree of their emotional and financial involvement with the parent who gambled.	10	Clear research questions and procedure.	Limited consideration of cultural contexts. Although overall large total sample in the study, it may be a non-representative sample due to avenue of recruitment.
Patford (2007) **Australia**	To explore adult children's experiences and perspectives in	15 adult children; 11 female, 4 male	Qualitative, in-depth interviews,	Adult children reported several problems and dilemmas created by parental gambling.	10	Comprehensive recruitment methods and consideration of sample diversity.	Small sample, which may limit generalisability. Self-selected.

	regard to late onset parental gambling.		thematic analysis.	Including emotional distress, financial strain, and relationship difficulties.			
Vitaro et al. (2008) **Canada**	Comparing offspring of problem gamblers to offspring of parents without gambling problems with respect to depressive feelings and conduct/antisociality problems.	*N*=42 children of problem gamblers compared to *N*= 100 children without problem gambling parents. Final participation age and gender not shared.	Quantitative, Longitudinal Design.	Offspring of problem gamblers are at increased risk for emotional and behavioural problems, such as depression and conduct issues.	8	Community based sample. Longitudinal design. Established measures.	Self-report which may be subject to biases. Only two data points. Attrition.

Darbyshire et al. (2001) **Australia**	To explore the understandings and perspectives of Australian children who live in families where a parent or caregiver has a serious gambling problem.	N= 15 children and adolescents 73.33% males and 26.67% females Ages between 7-18 years old	Qualitative, interviews, interpretative analysis.	A central finding, the experience of 'pervasive loss', encompassed both physical and existential aspects of the child's life.	10	Well-grounded themes supported by quotes and examples.	Limited reflexivity. Wide developmental ages, thus, understanding may differ and is not addressed.
Lesieur & Rothschild (1989) **United States of America**	To investigate the impacts of acknowledged pathological gamblers on their children.	105 children and adult children (12-60) with a mean age	Quantitative, descriptive, self-report questionnaires.	Children of problematic gamblers exhibit higher levels of anxiety, depression, and behavioural difficulties compared to peers. Children experienced	5	Anonymity ensured more honest responses.	Self-report may induce bias. Participants only recruited through Gamblers Anonymous – restricted sample.

		of 17 years old 55% females and 45% males		inconsistent parenting and family disruptions.			
Jacobs et al. (1989) **United States of America**	To explore the effects of parental problem gambling on children's psychological well-being and behaviour.	844 randomly selected 9^{th}-12^{th} grade students- with 52 children reported one or both parents as 'problem gamblers'. Age and	Quantitative, survey design.	Children of parents who gambled problematically at greater risks than their peers. Including emotional distress and academic struggles.	4	Standardised questionnaires.	Self-report data introduces potential bias.

		gender not specified					

Study Quality

Table 1 provides an overview of the scores given for individual studies. A complete table of quality ratings can be found in the appendices (see Appendix C, D and E). All studies achieved a quality score of four or above (low-high), indicating mixed quality universally.

The review identified a range of strengths and weaknesses in the quality assessment process. Common strengths across the studies included a clear rationale and justification for the research. High-scoring qualitative studies, such as by Darbyshire et al. (2001), Patford (2007), and Suomi et al. (2023), were characterised by robust research designs, the use of reflexivity and strong ethical considerations. Reflexive statements are a critical component of qualitative research, as they enable researchers to transparently acknowledge and critically assess their potential biases and positionality, which can influence the study (Berger, 2013). Medium- quality scoring studies, such as Vitaro et al. (2008) scored moderately well due to their community sample and longitudinal design but were limited by a smaller subsample. All studies clearly reported their findings, demonstrating clinical value.

Lower scoring quality studies were constrained by their recruitment strategies and an overreliance on self-report data (Jacobs et al., 1989; Lesieur & Rothschild, 1989), which could introduce sample biases and affect reliability. Lower-scoring studies included 'can't tell' ratings, leaving uncertainty about whether quality assurance measures were included or simply not reported. Jacobs et al. (1989) was the lowest scoring paper with a rating of four.

Sample

The sample sizes in the reviewed studies varied significantly, ranging from a small group of eight participants in Ferland et al. (2021) to a much larger cohort of 844 participants in Jacobs et al. (1989), highlighting the diverse methodological approaches and study designs used. Across the studies, various recruitment methods were used, each contributing valuable insights into the experiences of individuals affected by parental gambling. The most common recruitment strategies were opportunity and volunteer sampling, which primarily involved advertisement and participants self-selecting through service access. However, other approaches were also used, including random sampling in Jacobs et al. (1989), longitudinal sampling in Vitaro et al. (2008) and Darbyshire et al. (2001), and purposive sampling, where participants were selected on specific characteristics related to the study's focus (Lesieur & Rothschild, 1989).

The variety in sampling methods influenced the ability to reach various populations. Some studies primarily accessed individuals who were already engaged in some way with treatment services (Lesieur & Rothschild, 1989; Ferland et al., 2021), whilst others aimed for broader,

community-based samples (Patford, 2007; Vitaro et al., 2008). However, the recruitment processes that relied on participants already accessing services, such as Gamblers Anonymous (GA), limit sample representativeness, as they only capture the experiences of individuals where parents are already seeking gambling-related support services. Notably, studies relying on self-reporting and voluntary participation are prone to sampling bias, as participants may self-select based on their willingness to share their experiences (Bauhoff, 2011). This is particularly relevant in studies with specific eligibility criteria, where respondents may underreport or misrepresent their difficulties. Furthermore, representative bias presents a significant limitation in many of these studies, as recruitment through individuals who are already engaged in treatment or seeking help, may be more open to discuss gambling-related issues. These challenges, combined with gambling disorder being among the most stigmatising mental health problems (Quigley, 2022), may result in difficulty in achieving a truly representative sample, thus limiting the generalisability of findings.

Across most studies, there was a female majority, with Ferland et al. (2021) and Suomi et al. (2023), showing notably higher female representation. In contrast, Darbyshire et al. (2001) and Vitaro et al., (2008) had a higher male representation, while Jacobs et al. (1989), did not specify the gender distribution. The gender disparity in the studies reflects broader patterns in research, where females may be more open to discussing their experiences (Kring & Gordon, 1998).

The studies included in the review encompassed a wide range of ages among participants, which demonstrates the diversity in the population of individuals affected by parental gambling across different life stages. The age range of participants varied from children as young as seven (Darbyshire et al., 2001) to adults in their late 40s (Suomi et al.,2023). This included adult children's retrospective accounts. This comes with challenges such as, recall bias and the accuracy of memory, which can be a limitation of the study as it may affect the validity and reliability of the data collected. Additionally, children may not have had the same capacity to process or understand the full impact of their parent's gambling, which may affect how they recall those experiences as adults.

Research Design

This review adopts a mixed-methods design, incorporating both qualitative and quantitative research methods. The included studies demonstrate a wide range of research methodologies, ranging from large-scale quantitative surveys to smaller qualitative interviews.

Several studies employed quantitative research methods, primarily using surveys and structured instruments to assess the experiences of children affected by parental gambling. Vitaro et al. (2008) employed a longitudinal design, utilising well-established measures such as the South Oaks Gambling Screen (SOGS), the South Oaks Gambling Screen for Adolescents (SOGS-RA) and DSM-III-R

criteria. These instruments were reported to have good internal consistency and validity. In addition, Vitaro et al. (2008), constructed two additional scales for the purpose of this study. While these scales showed satisfactory internal consistency, the lack of external validation raises concerns about their reliability and generalisability, suggesting that these tools may not capture the full scope of harms experienced by children. Suomi et al. (2023) similarly used a non-validated measure, adapting the US National Alcohol's Harm to Others Survey to assess gambling harm to children. Although they included other validated measures (CAST-6, Parenting Style Inventory, Emotional Responsiveness Subscale), the use of non-validated tools in both Suomi et al. (2023) and Lesieur & Rothschild (1989), introduces potential measurement biases, which could limit the accuracy of their findings. Jacobs et al. (1989) also used self-report surveys but lacked transparency in the details of the survey instrument, further complicating the reliability of the results. These issues with non-validated tools and lack of transparency likely influenced the MMAT scores for these studies.

On the qualitative side, several studies used in-depth interviews to provide deeper insights into the lived experiences of individuals impacted by parental gambling. Darbyshire et al. (2001), used semi-structured interviews with children, providing flexibility for participants to express their experiences. While this approach provided rich data, the retrospective nature of the interviews introduces the potential for recall bias, which may affect the accuracy and reliability of participants' accounts of past events. Patford (2007), also used semi-structured interviews, with a small sample, which, while providing valuable insights, limits the generalisability of the findings due to the sample size. Similarly, Suomi et al. (2023) and Ferland et al. (2021) also employed semi-structured interviews. Lesieur & Rothschild (1989), combined self-report questionnaires with qualitative responses, allowing for a deeper exploration of individual experiences.

The data analysis methods used in the designs were generally robust, with clear documentation of how themes were derived in qualitative studies (Patford, 2007; Suomi et al., 2023) and appropriate statistical tests employed in quantitative studies.

Synthesis of the Main Findings

Findings are presented using a narrative synthesis approach guided by Popay et al. (2006). The literature reveals a complex and multi-dimensional impact of parental PG on both children and adult children. The findings consistently highlight several themes related to psychological, behavioural and family outcomes, that are long-lasting. Despite these consistent patterns, the findings highlight that there is variability in the degree to which children of PG parents experience these difficulties.

Emotional and Psychological Outcomes

All studies highlight the significant emotional and psychological outcomes for children and adult children exposed to households where there is parental PG. This includes a range of negative experiences for children of parents with PG including emotional difficulties such as, anxiety, depression, worry and anger. Vitaro et al. (2008) found that children were at a risk for depressive symptoms and conduct disorders, whilst highlighting the emotional neglect experienced often resulted from parent's preoccupation with gambling. Notably, the study found that children of problem gamblers had significantly higher levels of depression compared to children from non-gambling families. Suomi et al. (2023) further expanded on these findings, highlighting those children of PG parents often experienced high levels of emotional distress including anxiety, depression and post-traumatic stress disorder (PTSD).

Lesieur and Rothchild (1989), continue to support these experiences, finding that this population exhibited higher levels of insecurity, anxiety and feelings of inadequacy. Furthermore, 68% of children with PG parents reported feeling sad. Qualitative insights from Darbyshire et al. (2001) highlight the emotional loss experienced by children of PG parents, including both existential and tangible aspects, such as loss of trust, security and family stability. This is further supported by Jacobs et al. (1989), who identified high levels of anxiety and depressive symptoms within this population, with suicide attempts being reported at twice the rate of their school peers. Patford (2007), found similar psychological experiences, with two thirds of the sample reporting stress and an impairment to their physical and mental health, with 40% of participants sourcing formal support for themselves.

Behavioural Outcomes

The literature suggests significant behavioural outcomes that arise as a direct consequence of growing up in a household affected by parental PG. One of the reported behavioural difficulties is the development of conduct problems, involving defiant, disruptive and antisocial behaviours. The study by Vitaro et al. (2008) found that children were more likely to exhibit conduct disorder symptoms, which persisted through adolescence into early adulthood, especially in boys. However, Ferland et al. (2021), commented on no criminal activity participation mentioned by children in their study.

Additionally, risk taking and health limiting behaviours were present across several studies and highlighted the prevalence among children of PG parents. For example, Jacobs et al. (1989), found that children of parental PG were much more likely to engage in alcohol, tobacco and drugs in addition to overeating behaviours. This included the use of stimulant-type drugs and excessive

alcohol use compared to children of non-gambling parents. Although this was a common theme, Lesieur & Rothschild (1989) compared their sample with that of Jacobs et al. (1989) and found that their participants more closely resembled Jacobs' control group than his children of compulsive gamblers in terms of certain behavioural outcomes, such as tobacco use and gambling frequency.

Furthermore, gambling behaviours in adulthood presented itself in several studies, including those by Suomi et al. (2023) and Lesieur & Rothschild (1989). Studies showed that children of PG parents are at higher risk of experiencing PG themselves with Vitaro et al. (2008) finding that children at mid-adolescence would report more gambling problems in comparison to their non gambling parents' peers. Similarly, it was found that children of parents with PG experienced an earlier onset of gambling, with 75% gambling before age 11-years-old, compared to 34% of their peers with non-PG parents (Jacobs et al, 1989).

Ineffective Parenting

The role of ineffective parenting is a key theme across the literature. Across multiple studies ineffective parenting exacerbated the negative effects of living in a gambling-affected home. This was often characterised by poor emotional support, lack of supervision and role reversal. Emotional and psychological impacts of ineffective parenting was presented throughout, whereby, children's emotional needs were often not met in households with parental PG. Studies such as those by Suomi et al. (2023) emphasised that children in these households would often experience emotional neglect due to the parent's preoccupation with gambling. As highlighted by Darbyshire et al. (2001) children in these households often felt a deep sense of loss, as the parental figure they need is absent, both emotionally and physically. Often, this would result in children parenting and looking after other siblings and, in some cases, becoming the parents' caregiver (Darbyshire et al., 2001; Patford, 2007; Suomi et al., 2023).

Another critical component of ineffective parenting across the studies was the lack of parental presence and supervision, whereby, children of problem gamblers often experienced periods of unsupervised time, which increased their exposure to risky behaviours. Suomi et al. (2023) note that, particularly in households with one or more parent struggling with PG, children are left alone for extended periods of time. Vitaro et al. (2008) also highlighted the impact of parental disengagement and its relationship with their children's behavioural difficulties.

Additionally, parental PG is deeply intertwined with socioeconomic challenges that further contribute to the negative experiences for children in these households, including financial instability, economic hardship and poverty. In Darbyshire et al. (2001) this was highlighted through financial difficulties, whereby children of parents with PG reported having less money for

necessities, including food. This was further supported by studies including Suomi et al. (2023) and Jacobs et al. (1989) who highlighted the children's experiences of living in poverty and other financial impacts such as missing out on educational activities as a result, with 42% of children of parents with PG reporting being 'poorer than most' compared to 27% in non-parental PG families.

The negative impacts of parental PG are, in part, explained by the quality of parenting within the household. Several studies identify ineffective parenting as a key mediator in the relationship between parental PG and adverse outcomes for children. For example, Suomi et al. (2023) found that ineffective parenting was commonly present in households affected by PG. However, Vitaro et al. (2008) reported variability within groups, indicating that other moderating factors may influence this relationship and warrant further investigation.

Long-term Implications

The long-term implications of parental PG on children are named throughout several studies, with negative experiences of parental PG not being limited to childhood but continuing to persist and intensify over time, impacting individuals through their life course.

Research from Suomi et al. (2023) reported that maternal PG had particularly long-term consequences for children's emotional and mental health, with this having a lasting impact on their experiences into adulthood with their ability to form healthy relationships. The findings also suggested that children of PG parents experienced higher rates of intimate partner violence in adulthood. Similarly, Patford (2007), found that some adult children of problem gamblers had difficulty forming healthy relationships due to the mistrust and emotional distance they developed as children. Additionally, Patford (2007), offered further insight into the long-term experiences of growing up with a PG parent, highlighting the financial implications. Despite being financially independent, adult children continued to feel the financial burden of their parents' gambling problems and found themselves providing financial support to their parents.

Furthermore, Jacobs et al. (1989) examined the long-term behavioural outcomes of individuals whose parents engaged in PG, revealing that these individuals were more likely to develop addictive behaviours and substance use problems when compared to their peers. Findings from Suomi et al. (2023) and Ferland (2021), also highlighted the intergenerational transmission of PG with individuals who had been exposed to PG in childhood, with them reporting that children of problem gamblers being more likely to develop gambling problems themselves. Moreover, Lesieur and Rothchild (1989), found that 48% of children of problem gamblers often felt they needed success, acceptance and approval and often faced disrupted family dynamics, affecting their long-term social and emotional functioning.

Discussion

This literature review examined eight papers which explored the experiences of children and adult children of parents with PG. Overall, these experiences consistently highlighted a range of negative psychological and behavioural outcomes, as well as the experiences of ineffective parenting and the long-term repercussions that affect individuals throughout their life course. Whilst the findings across the studies vary in terms of methodology and focus, several key themes have emerged that highlight the persistent and prevalent impact of parental PG on children.

One of the most consistent themes emerging from the studies reviewed is the emotional and psychological impact of growing up in a household affected by PG. Vitaro et al. (2008) found that children of PG parents had increased depressive symptoms during adolescence, which worsened into early adulthood. This aligns with the findings of Suomi et al. (2023) who identified a range of psychological issues including anxiety, depression and PTSD, particularly for those who were exposed to maternal PG. The negative psychological outcomes reported by these studies are profound and enduring and impact not only childhood but also adult mental health.

These findings are consistent with the broader literature on the impact of parental addiction on children, which highlights the prevalence of emotional neglect and psychological harm that often emerge in such contexts (Felitti et al., 2019). As noted by Darbyshire et al. (2001), children in these households frequently report feelings of abandonment and emotional insecurity, which can contribute to a range of long-term emotional difficulties. This aligns with Ferland's (2021) findings, which suggest that the severity of negative consequences experienced by children is closely linked to their level of involvement with the problem gambler. Specifically, children who were minors at the time of exposure to parental PG reported more intense and lasting consequences. These experiences can be understood through the lens of attachment theory, which suggests that inconsistent, emotionally unavailable caregiving can disrupt the formulation of secure attachments (Bowlby, 1988; Cassidy, 2008). Over time, this disruption may hinder emotional regulation and relational functioning, increasing vulnerability to mental health difficulties in adulthood.

In addition to emotional distress, children of PG parents also face significant behavioural difficulties. Studies such as those conducted by Jacobs et al. (1989) and Vitaro et al. (2008) highlight the increased levels of conduct problems, substance use and risky behaviours in children of PG parents. Findings from Jacobs et al. (1989), found that children were more likely to engage in early alcohol and drug use, with a particular tendency toward stimulant-type drugs. These behaviours can be understood through the lens of the Power Threat Meaning Framework (PTMF; Johnstone & Boyle, 2018) as meaningful coping strategies developed in response to psychological distress and

threats to safety within households affected by PG. Rather than viewing substance use as a symptom of dysfunction, the PTMF frames it as a survival response to overwhelming emotional environments. This interpretation is supported by Jacobs et al. (1989), who found that children of parents with PG were 20% more likely than their peers to report using substances to as a means of 'escape'.

A concerning theme across the reviewed studies was that of 'ineffective parenting', whereby, children of parents with PG often faced significant challenges related to their caregivers' presence, emotional availability, and supervision. A consistent finding, echoing research on Adverse Childhood Experiences (ACEs), is that parental PG can result in emotional and physical unavailability, placing considerable strain on a child's development and well-being. Studies, such as Suomi et al. (2023) and Ferland et al. (2021), provide evidence that ineffective parenting is a key mechanism through which gambling-related harm is transmitted to children. These studies noted increased instances of neglect, unsupervised children, and emotional disengagement, further exacerbating vulnerability to adverse outcomes. These findings align with ACEs literature, which shows that early exposure to neglect and caregiver inconsistency significantly increases the risk of poor psychological, relational, and health outcomes across the life course (Felitti et al., 1998).

However, some studies suggest that there is not always a clear distinction between children of problem gamblers and children from non-gambling control groups. For instance, findings from Vitaro et al. (2008), showed that although parental PG is related to negative outcomes in children, the variability within each group was substantial. Some children showed severe adjustment problems, while others did not, suggesting that additional variables need to be explored. Additionally, one possible explanation for this variability could be underreporting, a common issue in research involving gambling and addiction. The stigma surrounding PG could contribute to this and is supported by Ferland et al. (2021), and Lesieur Rothchild (1989) findings, which highlighted children of problem gamblers feelings of shame and fear of being stigmatised.

The long-term implications of parental PG on children's experiences are profound and highlighted across the studies in this review. A consistent finding is that children of problem gamblers often face significant emotional, behavioural and mental health challenges that extend into adulthood. These experiences result in depression, anxiety, substance use and the development of gambling problems themselves (Vitaro et al., 2008; Suomi et al., 2023).

Furthermore, research from Suomi et al. (2023) highlighted the long-lasting effects if maternal PG on children's emotional and mental health, resulting in difficult experiences in forming healthy relationships in adulthood, including intimate partner violence. Thus, illustrating the enduring impact of early exposure to gambling-related stress. This is further supported by Ferland et

al. (2021) and Suomi et al. (2023), who found that exposure to parental PG increases the likelihood of intergenerational transmission of gambling behaviours, not just because of exposure, but also due to emotional and psychological factors that shape their responses to stress, relationships and coping mechanisms (Lesieur & Rothchild, 1989).

Clinical Implications

Problem gambling has increasingly become a public health issue, with the impact of gambling harm being more substantial than previously understood and extending beyond the individual gambler (Wardle et al., 2024). The findings from this review highlight the complexity and the substantial emotional, psychological, behavioural and familial consequences of parental PG on both children and adult children. These effects not only persist throughout childhood but also extend into adulthood, highlighting the need for targeted clinical interventions to address the complex challenges faced by this population.

A critical consideration arising from the reviewed studies is the importance of early identification and prevention. Consistent with the findings in this review, existing research suggests that parental PG is often accompanied by stigma and shame, which may lead to underreporting. This highlights the need for clinicians to be aware of hidden harms and to develop targeted screening tools that can help identify PG in affected families. Early identification can facilitate timely intervention and improve long-term outcomes for children. This could involve incorporating prompts about parental gambling into clinical assessment tools and interview proformas, similar to current practices regarding parental mental health.

Furthermore, children and adult children of parents with PG are at an increased risk of a variety of emotional and psychological difficulties. Clinicians must remain vigilant in recognising signs of emotional distress and provide timely, targeted therapeutic interventions. In addition to supporting the individual with PG, it is crucial to extend this support to their children, who are often overlooked. Therefore, the development of specialised support services that address the needs of both the individual with PG and their family members should be prioritised and considered through models that account for systemic influences and early adversity.

In addition to providing support for individuals with PG, clinicians should consider the broader systemic implications, particularly if the individual is a parent. Adopting a more holistic approach that extends beyond the individual with PG can be beneficial. As highlighted in the review, ineffective parenting is closely linked to PG, so clinicians should prioritise interventions aimed at improving parent's emotional engagement, parenting skills and family dynamics. By addressing

these areas, clinicians can help mitigate the negative impact of PG on children and promote healthier family functioning.

Lastly, the long-term effects of growing up in a household affected by PG extend into adulthood, affecting individuals' ability to form healthy relationships, manage addictions and maintain social and emotional well-being. Therefore, when working with children of PG parents, it is important to adopt a long-term perspective, ensuring that support extends into adulthood if needed. Regular monitoring for the development of gambling problems in adulthood, along with ongoing interventions, may play a role in breaking the cycle of PG and mitigating its impact on future generations.

Research Implications

One key implication for future research is the need for a more comprehensive understanding of the long-term effects of growing up in a PG-affected household. While several studies highlight difficulties during childhood, with one study exploring both childhood and early adulthood, there is a gap in understanding how these challenges evolve across the life span. Further longitudinal research is needed to explore these long-term impacts. Additionally, replicating such studies within the UK population would enhance the generalisability and relevance of findings to this context

Furthermore, research involving the effectiveness of interventions aimed at reducing the impact of parental PG on children and families should be considered. Future studies could focus on evaluating and evolving the efficacy of family-centred interventions that address both the needs of children and the parent. Additionally, research into the integration of PG treatment with broader mental health and social contextual factors could provide insights into more holistic approaches that support the wider family.

While the negative experiences of parental PG are well-documented across the research studies, there is comparatively less research exploring the protective factors that may buffer children from harm. Investigating these factors could help identify the conditions or strategies that mitigate the detrimental effects of PG and support more adaptive outcomes. This aligns with post-traumatic growth theory (Tedeschi & Calhoun, 2004), which emphasises how adversity can become a catalyst for psychological resilience. Future research could use this lens to explore how some individuals navigate and grow through the challenges presented by parental PG.

Finally, research on screening and early intervention for identifying PG in parents is essential. Given the stigma surrounding addictions, specifically gambling behaviours, the development of reliable screening tools and assessments may facilitate early intervention, which is key in preventing

long-term negative outcomes for children. Research into the development, validation and implementation of such tools may be a fundamental next step in addressing this public health issue.

The clinical and research recommendations arising from this review should be considered tentative and interpreted with caution due to the limited generalisability of the findings and the following limitations below.

Strengths and Limitations of the Studies

The review included a balance of quantitative and qualitative studies across four countries, allowing for a broader understanding of the impact of parental PG across different cultural contexts. The studies included participants spanning a wide age range, from young children to adult children, providing valuable insights into both the short-term and long-term effects of parental PG. However, a limitation of several studies is that they relied on retrospective accounts which are prone to recall bias, potentially affecting the validity and reliability of the data.

A limitation of several quantitative studies was the reliance on non-validated measures or adapted addiction measures, rather than using validated tools specifically designed for assessing PG. This approach may have limited the accuracy and comprehensiveness with which PG was captured, potentially affecting the validity of the findings and their ability to measure the intended construct.

Additionally, several studies had methodological limitations that may affect the strength of the evidence. For example, Vitaro et al. (2008) reported significantly higher depression levels among children of problem gamblers, yet also showed a clustering of scores at zero, suggesting a potential floor effect. This may limit the sensitivity of the measure and affect the validity of the findings.

Furthermore, many of the studies had a much higher proportion of female participants, with one study not providing information on the gender distribution. This gender imbalance may limit the generalisability of the findings, as the experiences of male participants may not be adequately represented.

Lastly, several studies relied on self-report measures, which can introduce bias due to factors like social desirability, memory recall errors, or the respondent's own interpretation of questions. Moreover, recruitment processes that relied on participants already accessing services, such as GA, may limit the representativeness of the sample. There participants reflect experiences within families where the gambling parent was at least partially engaged in help-seeking, which may differ from families where problem gambling remains hidden or unacknowledged, limiting generalisability.

Strengths and Limitations of the Review

This systematic review was conducted by a single reviewer, which differs from the MMAT guidelines, which recommend the use of two independent reviewers for the critical appraisal of research papers (Hong et al., 2018). While the MMAT critical appraisal tool is widely recognised for evaluating mixed-method studies, it has limitations, particularly in its application to certain research designs and the potential for subjectivity in scoring.

Another limitation of this review is the relatively small number of studies included, which limits the generalisability of the findings. However, despite this limitation, the review contributes valuable insights to the current, albeit limited, body of literature. Additionally, a significant portion of the studies in this review included participants from Australia, the Unites States, and Canada, making it difficult to generalise the findings to other regions, such as the UK.

Conclusion

This literature review aimed to explore the experiences of children and adult children of parents with PG and to inform future research in this area. Findings consistently highlight the significant emotional, psychological, and behavioural impacts of parental PG. Parental PG have both short-term and long-term implications on children, including increased levels of anxiety, depression, conduct difficulties and an increased risk of developing gambling behaviours in adulthood. Furthermore, ineffective parenting, often exacerbated by PG, contributes to emotional neglect and role reversal within families, further intensifying the negative effects on children.

Despite the insights provided by this review, there are several limitations to consider. The small number of studies reviewed limits the generalisability of the findings. The overrepresentation of female participants and the reliance on self-report measures introduce potential biases, affecting the reliability and validity of the data.

Future research should aim to address these limitations by including more diverse samples and incorporating longitudinal designs to better capture the long-term effects of parental PG. Additionally, future research should focus not only on the long-term effects of growing up in a PG-affected household, but also on evaluating interventions, identifying protective factors and developing screening tools for early intervention. Lastly, exploring the integration of PG treatment with broader mental health support may help provide holistic family-centred approaches to mitigate the harmful experiences and impacts of parental PG.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

Bauhoff, S. (2011). Systematic self-report bias in health data: Impact on estimating cross-sectional and treatment effects. *Health Services and Outcomes Research Methodology*, *11*(1-2), 44-53. https://doi.org/10.1007/s10742-011-0069-3

Berger, R. (2013). Now I see it, now I don't: Researcher's position and reflexivity in qualitative research. *Qualitative Research*, *15*(2), 219-234. https://doi.org/10.1177/1468794112468475

Bowlby, J. (2005). *A secure base: Clinical applications of attachment theory*. Taylor & Francis.

Calado, F., & Griffiths, M. D. (2016). Problem gambling worldwide: An update and systematic review of empirical research (2000–2015). *Journal of Behavioral Addictions*, *5*(4), 592-613. https://doi.org/10.1556/2006.5.2016.073

Cassidy, J. (2008). The nature of the child's ties. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (2nd ed., pp.3-22). The Guilford Press.

Darbyshire, P., Oster, C., & Carrig, H. (2001). Children of parent(s) who have a gambling problem: A review of the literature and commentary on research approaches. *Health and Social Care in the Community*, *9*(4), 185-193. https://doi.org/10.1046/j.0966-0410.2001.00302.x

Darbyshire, P., Oster, C., & Carrig, H. (2001). The experience of pervasive loss: Children and young people living in a family where parental gambling is a problem. *Journal of Gambling Studies*, *17*(1), 23-45. https://doi.org/10.1023/a:1014536315167

Dowling, N. A., Jackson, A. C., Thomas, S. A., & Frydenberg, E. (2010). *Children at risk of developing problem gambling*.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (2019). Reprint OF: Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, *56*(6), 774-786. https://doi.org/10.1016/j.amepre.2019.04.001

Ferland, F., Blanchette-Martin, N., Côté, M., Tremblay, J., Kairouz, S., Nadeau, L., Savard, A., L'Espérance, N., & Dufour, M. (2021). Do the consequences experienced by the people in the life of a problem gambler differ based on the nature of their relationship with the gambler? *Journal of Gambling Studies*, *38*(3), 1075-1092. https://doi.org/10.1007/s10899-021-10058-7

Goodwin, B. C., Browne, M., Rockloff, M., & Rose, J. (2017). A typical problem gambler affects six others. *International Gambling Studies*, *17*(2), 276-289. https://doi.org/10.1080/14459795.2017.1331252

Haddaway, N. R., Collins, A. M., Coughlin, D., & Kirk, S. (2015). The role of Google scholar in evidence reviews and its applicability to grey literature searching. *PLOS ONE*, *10*(9), e0138237. https://doi.org/10.1371/journal.pone.0138237

Hong, Q. N., Fàbregues, S., Bartlett, G., Boardman, F., Cargo, M., Dagenais, P., Gagnon, M., Griffiths, F., Nicolau, B., O'Cathain, A., Rousseau, M., Vedel, I., & Pluye, P. (2018). The mixed methods appraisal tool (MMAT) version 2018 for information professionals and researchers. *Education for Information*, *34*(4), 285-291. https://doi.org/10.3233/efi-180221

Jacobs, D. F., Marston, A. R., Singer, R. D., Widaman, K., Little, T., & Veizades, J. (1989). Children of problem gamblers. *Journal of Gambling Behavior*, *5*(4), 261-268. https://doi.org/10.1007/bf01672427

Järvinen-Tassopoulos, J. (2020). The impact of problem gambling: Are there enough services available for families with children? *Public Health*, *184*, 28-32. https://doi.org/10.1016/j.puhe.2020.03.020

Johnstone, L., & Boyle, M., with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D., & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. British Psychological Society

Johnstone, P., & Regan, M. (2020). Gambling harm is everybody's business: A public health approach and call to action. *Public Health*, *184*, 63-66. https://doi.org/10.1016/j.puhe.2020.06.010

Kourgiantakis, T., Stark, S., Lobo, D. S., & Tepperman, L. (2016). Parent problem gambling: A systematic review of prevention programs for children. *Journal of Gambling Issues*, (33), 8. https://doi.org/10.4309/jgi.2016.33.2

Kring, A. M., & Gordon, A. H. (1998). Sex differences in emotion: Expression, experience, and physiology. *Journal of Personality and Social Psychology*, *74*(3), 686-703. https://doi.org/10.1037//0022-3514.74.3.686

Lane, W., Sacco, P., Downton, K., Ludeman, E., Levy, L., & Tracy, J. K. (2016). Child maltreatment and problem gambling: A systematic review. *Child Abuse & Neglect*, *58*, 24-38. https://doi.org/10.1016/j.chiabu.2016.06.003

Lesieur, H. R., & Rothschild, J. (1989). Children of gamblers Anonymous members. *Journal of Gambling Behavior*, *5*(4), 269-281. https://doi.org/10.1007/bf01672428

Meyer, G., Hayer, T., & Griffiths, M. (2009). *Problem gambling in Europe: Challenges, prevention, and interventions*. Springer Science & Business Media.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville, J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). The PRISMA 2020 statement: An updated guideline for reporting systematic reviews. *BMJ*, n71. https://doi.org/10.1136/bmj.n71

Patford, J. L. (2007). Linked lives: Adult children's experiences of late onset parental gambling problems. *International Journal of Mental Health and Addiction*, *5*(4), 367-380. https://doi.org/10.1007/s11469-007-9077-5

Petry, N. M., Stinson, F. S., & Grant, B. F. (2005). Comorbidity of DSM-IV pathological gambling and other psychiatric disorders. *The Journal of Clinical Psychiatry*, *66*(05), 564-574. https://doi.org/10.4088/jcp.v66n0504

Popay, J., Roberts, H., Sowden, A., Petticrew, M., Arai, L., Rodgers, M., ... & Duffy, S. (2006). Guidance on the conduct of narrative synthesis in systematic reviews. *A product from the ESRC methods programme Version*, *1*(1), b92. DOI:10.13140/2.1.1018.4643

Quigley, L. (2022). Gambling disorder and stigma: Opportunities for treatment and prevention. *Current Addiction Reports*, *9*(4), 410-419. https://doi.org/10.1007/s40429-022-00437-4

Song, F., Hooper, & Loke, Y. (2013). Publication bias: What is it? How do we measure it? How do we avoid it? *Open Access Journal of Clinical Trials*, 71. https://doi.org/10.2147/oajct.s34419

Stucki, S., & Rihs-Middel, M. (2007). Prevalence of adult problem and pathological gambling between 2000 and 2005: An update. *Journal of Gambling Studies*, *23*(3), 245-257. https://doi.org/10.1007/s10899-006-9031-7

Suomi, A., Bailey, M., Lucas, N., Dowling, N., & Delfabbro, P. (2023). "It's like you're not even there…": Gambling harm experienced by children of gambling parents. *Children and Youth Services Review*, *145*, 106800. https://doi.org/10.1016/j.childyouth.2022.106800

Suomi, A., Lucas, N., Dowling, N., & Delfabbro, P. (2022). Parental problem gambling and child wellbeing: Systematic review and synthesis of evidence. *Addictive Behaviors*, *126*, 107205. https://doi.org/10.1016/j.addbeh.2021.107205

Suomi, A., Lucas, N., Dowling, N., & Delfabbro, P. (2023). Gambling harm experienced by children exposed to parental gambling: An online survey of Australians. *Journal of Gambling Studies*, *40*(1), 181-200. https://doi.org/10.1007/s10899-023-10211-4

Tedeschi, R. G., & Calhoun, L. G. (2004). *Posttraumatic growth: Conceptual foundations and empirical evidence*. Psychological Inquiry, 15(1), 1–18.

Tulloch, C., Browne, M., Hing, N., Rockloff, M., & Hilbrecht, M. (2021). How gambling harms the wellbeing of family and others: A review. *International Gambling Studies*, *22*(3), 522-540. https://doi.org/10.1080/14459795.2021.2002384

Tulloch, C., Hing, N., Browne, M., Rockloff, M., & Hilbrecht, M. (2022). Parental gambling and the health and wellbeing of children derived from two nationally representative cohorts of Australian children. *Applied Research in Quality of Life*, *17*(5), 3049-3068. https://doi.org/10.1007/s11482-022-10052-0

Vitaro, F., Wanner, B., Brendgen, M., & Tremblay, R. E. (2008). Offspring of parents with gambling problems: Adjustment problems and explanatory mechanisms. *Journal of Gambling Studies*, *24*(4), 535-553. https://doi.org/10.1007/s10899-008-9096-6

Wardle, H., Degenhardt, L., Marionneau, V., Reith, G., Livingstone, C., Sparrow, M., Tran, L. T., Biggar, B., Bunn, C., Farrell, M., Kesaite, V., Poznyak, V., Quan, J., Rehm, J., Rintoul, A., Sharma, M., Shiffman, J., Siste, K., Ukhova, D., … Saxena, S. (2024). The Lancet public health Commission on gambling. *The Lancet Public Health*, *9*(11), e950-e994. https://doi.org/10.1016/s2468-2667(24)00167-1

Wardle, H., Reith, G., Langham, E., & Rogers, R. D. (2019). Gambling and public health: We need policy action to prevent harm. *BMJ*, l1807. https://doi.org/10.1136/bmj.l1807

Weaver, M. L., Sundland, R., Adams, A. M., Faria, I., Feldman, H. A., Gudmundsdottir, H., Marmor, H., Miles, V., Ochoa, B., Ruff, S. M., Tonelli, C., Altieri, M. S., Cannada, L., Dewan, K., Etkin, Y., Marmor, R., Plichta, J. K., Reyna, C., Tatebe, L., … Hicks, C. W. (2022). The art of peer review: Guidelines to become a credible and constructive peer reviewer. *Seminars in Vascular Surgery*, *35*(4), 470-478. https://doi.org/10.1053/j.semvascsurg.2022.10.002

World Health Organization. (2019). *International statistical classification of diseases and related health problems* (11th ed.). https://icd.who.int/

Appendices

Appendix A

Journal of Family Studies Submission Guidelines

Submit to Journal of Family Studies

Appendix B

Included Searches in 20 Collections from the University of Staffordshire Database

1	DOAJ Directory of Open Access Journals
2	EBSCOhost Business Source Complete
3	Elsevier ScienceDirect Journals
4	Gale Academic OneFile
5	Gale General OneFile
6	Health Research Premium Collection- UK edition
7	Ingenta Connection
8	IngentaConnect Journals
9	Journals@Ovid Complete
10	Publicity Available Content Database
11	PubMed Central
12	Scopus
13	Single Journals
14	Springer Nature- Complete Springer Journals
15	Springer Nature OA Free Journals
16	SpringerLink Contemporary
17	Taylor & Francis
18	Taylor & Francis Current Content Access
19	Wiley Online Library Full Collection 2020
20	Wiley Online Library Journals Frontfile Complete

Appendix C

MMAT Critical Appraisal of the Qualitative Research

Qualitative	Suomi et al., 2023	Ferland et al., 2021	Patford, 2007	Darbyshire et al., 2001
Is the qualitative approach appropriate to answer the research question?	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Are the qualitative data collection methods adequate to address the research question?	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Are the findings adequately derived from the data?	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Is the interpretation of results sufficiently substantiated by data?	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Is there coherence between qualitative data sources, collection, analysis and interpretation?	Yes (2)	Yes (2)	Yes (2)	Yes (2)
MMAT score	10	10	10	10

Appendix D

MMAT Critical Appraisal of Quantitative- Descriptive Studies

Quantitative – descriptive studies	**Lesieur & Rothschild, 1989**	**Jacobs et al, 1989**	**Suomi et al., 2023**
Is the sampling strategy relevant to address the research question?	Yes (2)	Yes (2)	Yes (2)
Is the sample representative of the target population?	Can't tell (1)	No (0)	No (0)
Are the measurements appropriate?	Can't tell (1)	Can't tell (1)	Can't tell (1)
Is the risk of nonresponse bias low?	No (0)	Can't tell (1)	No (0)
Is the statistical analysis appropriate to answer the research question?	Can't tell (1)	No (0)	Yes (2)
MMAT Score	**5**	**4**	**5**

Appendix E

MMAT Critical Appraisal of the Quantitative-Non-Randomised Studies

Quantitative – non-randomised studies	**Vitaro et al., 2008**
Are the participant's representative of the target population?	No (0)
Are measurements appropriate regarding both the outcome and intervention (or exposure)?	Yes (2)
Are there complete outcome data?	Yes (2)
Are the confounders accounted for in the design and analysis?	Yes (2)
During the study period, is the intervention administered (or exposure occurred) as intended?	Yes (2)
MMAT Score	**8**

Paper Two: Empirical Paper

Exploring the Experiences of Adults Who Have Been Exposed to Problematic Parental Substance Use During Childhood.

Hayley Ansell

Student ID: 22042175

Word Count: 7985

(Excluding References and Appendices)

This Empirical Paper has been written in accordance with author guidelines for the Journal of Family Studies. The author guidelines are in Appendix A

Abstract

Background: Problematic parental substance use (PSU) can have profound and enduring effects on children that persist into adulthood, including heightened vulnerability to mental and physical health difficulties and increased risk of problematic substance use. However, the perspectives of adults exposed to PSU in childhood, who are best placed to reflect on its long-term impacts, remain under-researched and overlooked. This study explored their lived experiences to address gaps in the literature, enhance understanding, and inform psychological practice.

Method: Eight participants were recruited through purposive sampling. Semi-structured interviews were conducted and analysed using Interpretative Phenomenological Analysis.

Results: Four Group Experiential Themes were identified including: 1) "I Was the Parent"-Parentification, 2) I Saw Too Much Too Soon: Early Exposure and Its Impact, 3) When Normal Isn't Normal, and 4) Breaking the Silence and Breaking the Cycles.

Conclusion: The findings underscore the lasting, and often hidden, impact of growing up with problematic PSU. They point to the need for trauma-informed, developmentally sensitive support and collaborative efforts to disrupt intergenerational cycles of harm and stigma.

Keywords: Problematic parental substance use, adult children, childhood adversity, experiences**.**

Introduction

The term “substance” refers to both illicit drugs (e.g., heroin, cocaine) and legal substances (e.g., alcohol, prescribed medication). “Problematic substance use” is understood as use causing social, physical, or psychological harm (SCODA, 1997). The term was intentionally left undefined for participants, as imposing diagnosis risked excluding those whose parents had not accessed services. This also acknowledges that individuals interpret their experiences in varied, personal ways, and that perceived harm may not align with clinical definitions.

The problematic use of alcohol and drugs remains a significant and growing public health challenge, yet research and resources in addiction remain disproportionately limited (Degenhardt et al., 2013). While patterns differ across regions, with many developing countries seeing rises in problematic use, high-income nations bear the greatest burden (WHO, 2014). Alcohol alone accounts for 4.7% of global deaths (WHO, 2024), and drug use prevalence remains high (United Nations publication, 2023). In the United Kingdom, alcohol-specific mortality has reached record highs (WHO, 2024), and drug-related deaths have more than doubled since 2012 (Office for National Statistics, 2021)[1].

The Global Burden of Disease study (2019) identified alcohol and drug use as leading risk factors for premature mortality among individuals aged 15-to 49-years-old, many of whom are parents. Over half (54%) of individuals entering substance use treatment in England have parental responsibilities, yet up to 80% receive no treatment, leaving a substantial gap in care and support (Public Health England, 2021). This has serious implications for children. According to the Children’s Commissioner for England (2023), an estimated 478,000 children lived with a parent experiencing problematic alcohol or drug use between 2019-20, though this is likely underestimated due to stigma and underreporting (Adamson & Templeton, 2012).

Problematic parental substance use (PSU) is widely recognised as a significant public health concern and a major threat to children’s rights and long-term well-being. Research shows that children in such households face heightened risks across emotional, psychological, behavioural, and educational outcomes (Cleaver, Unell & Aldgate, 2011; Fraser et al., 2008; Harwin et al., 2010; Torvik

[1] In 2023, alcohol-related deaths in the UK reached a record 10,473, while drug-poisoning deaths in England and Wales rose to 5,448, the highest since records began and at a rate more than double that of 2012.

et al., 2011). These children often live in environments characterised by instability, fear, neglect, and inconsistent caregiving, as parental attention is frequently consumed by substance use (Taylor & Kroll, 2001). Such environments can disrupt healthy attachments, impair coping, and contribute to adverse outcomes persisting into adulthood (Gance-Cleveland et al., 2007).

Problematic PSU is also identified as a key Adverse Childhood Experience (ACE), defined as stressful or traumatic events occurring before age 18, including abuse, neglect, and household dysfunction (Felitti et al., 2019). ACEs are consistently associated with a wide range of adverse outcomes into adulthood, including substance use disorders, poor mental and physical health, and socio-economic disadvantage (Bellis et al., 2014). A robust dose-response relationship shows that the greater the number of ACEs experienced, the higher the risk of long-term harm (Dube et al., 2001).

The UK government has acknowledged these risks in its evolving policy landscape. The 2017 Drug Strategy (Home Office, 2017) marked a shift from a primarily criminal justice approach to one that recognises the vulnerabilities of people who use substances problematically and, for the first time, explicitly addressed the needs of children affected by PSU. It highlighted the intergenerational nature of substance use and called for greater support for families to help break cycles of dependency. Despite growing recognition of the harms associated with problematic PSU, a significant gap remains in understanding how adult children make sense of these experiences later in life. While much of the existing research has focused on the adverse effects during childhood, fewer studies explore long-term meaning-making in adulthood. Emerging evidence highlights protective processes that may foster resilience in children growing up with PSU (Velleman & Templeton, 2016), yet how these are experienced or sustained in adulthood remains unclear.

Rationale

Problematic PSU is a well-established public health and social issue, with effects extending beyond the individual to the whole family. Research documents a wide range of short-and long-term risks faced by children growing up in such environments. While immediate consequences have been extensively studied, far less attention has been given to the longer-term impact, experiences, and perspectives of those children once they reach adulthood (Meulewaeter et al., 2022).

Emerging evidence suggests adult children exposed to PSU may experience a range of enduring and intergenerational impacts, including heightened risks of mental health difficulties, relational challenges, physical health problems, and increased vulnerability to substance use difficulties themselves (Taylor & Flood, 2020). However, little is known about how these adults interpret their experiences. This study addresses that gap by capturing their lived perspectives.

Understanding how early experiences of problematic PSU, often classified as ACEs, continue to shape adult lives is vital for informing trauma-informed, responsive interventions and support. Evidence suggests that the long-term needs of this group remain under-recognised within health and social care services, with most interventions focusing on children or on substance users themselves and limited guidance specifically addressing this population (Taylor & Flood, 2020). In addition, stigma associated with PSU frequently acts as a barrier to help seeking (Volkow, 2020). Deepening understanding of these individuals' developmental and relational contexts can therefore support psychological practice by informing nuanced formulations and intervention models that account for early adversity, systemic influences, and the long-term impact of PSU.

Research Question and Aims

This study asks: What are the lived experiences of adults who were exposed to problematic PSU during childhood? The research aims to deepen understanding of the long-term impacts of such exposure and to inform clinical and public health strategies to better support affected children and adult children.

Method

Ethics

Full ethical approval was granted by the University of Staffordshire Ethics Review Committee (Appendix B). Prior to participation, individuals received a Participant Information Sheet (Appendix C) and had the opportunity to ask questions before completing the Participant Consent Form (Appendix D) and Demographic Survey (Appendix E). Informed consent was obtained from all participants. To protect anonymity, pseudonyms were used, either self-chosen or assigned. Although the risk of distress was low, a Debrief Sheet with support contacts was provided after each interview (Appendix F).

Design

This study employed a qualitative design, using semi-structured interviews and Interpretative Phenomenological Analysis (IPA) to explore participants lived experiences. Semi-structured interviews balanced structure and flexibility, allowing the researcher to guide discussion while giving participants freedom to articulate perspectives in depth. IPA was selected to analyse interview transcripts, due to its suitability for understanding how individuals make sense of experiences. IPA's idiographic approach enabled a detailed, nuanced understanding of personal meaning-making, aligning with the study's exploratory aims (Smith, 2017). While alternative approaches such as

narrative analysis were considered, these place greater emphasis on the form and structure of stories rather than the interpretative exploration of lived experience. Given the study's focus, IPA was the most suitable approach.

Recruitment

Recruitment ran from August 2024 to March 2025. Purposive sampling was used, consistent with IPA research, to recruit individuals able to provide rich, first-hand accounts of the phenomenon under investigation (Smith et al., 2021). Recruitment occurred through multiple channels to maximise reach and diversity. Recruitment adverts (Appendix G) were disseminated online via a professional account, including posts on Facebook, Instagram, X, and LinkedIn. These were shareable, allowing others to circulate them within networks. Printed study advertisements were also displayed across University of Staffordshire campuses.

Interested individuals contacted the researcher via email. Those who expressed interest were sent a participant information sheet, followed by a consent form and demographic survey. Once signed consent and demographic details were received, the researcher arranged a mutually convenient time for the interview via Microsoft Teams (Teams). A Teams invitation and Interview Schedule (Appendix H) were then sent, which participants could review in advance.

Inclusion Criteria

To be eligible, individuals had to meet the following inclusion criteria: aged 18 years or older, currently residing in the UK, and experience of problematic substance use by at least one parent or primary carer during childhood. The parent or carer was required to be a primary caregiver in the family home, and their substance use beginning before the participant reached 18 years of age. Participants also needed to be fluent in English and have access to the necessary technology for a remote interview.

Current mental health difficulties or substance use were not exclusion criteria, recognising these may be part of the long-term impact of problematic PSU. Safeguarding measures were in place, including monitoring participant wellbeing throughout interviews and offering support or pausing the interview if distress arose.

Participants

Eight participants were recruited. Although six others expressed interest, only two returned consent forms and neither proceeded to interview, perhaps reflecting the sensitive and stigmatised nature of the topic, which can deter engagement in research (Appleseth et al., 2023). All participants identified as female and were from three age categories: 18-24, 25-34 and 45-54, with most in the

25-34 range. Most identified as White (English, Welsh, Scottish, Northern Irish, or British), and one as a Mixed or Multiple ethnic group. Employment status varied (full-time, part-time, and unemployed), as did educational qualifications (GCSE to degree-level or higher). Table 1 provides an overview of socio-demographic information.

There is no fixed sample size in IPA, though professional doctoral research typically includes four to ten participants (Smith et al., 2021). This study adhered to those guidelines, using a small, purposive sample to align with IPA's focus on in-depth exploration of individual lived experiences. The sample's adequacy is further supported by the concept of information power (Malterud et al., 2016), which suggests a smaller sample is sufficient when the study aim is focused, the sample specific, and the data rich.

Table 1

Participant Socio-Demographic Information

Participant	Gender	Age	Ethnicity	Current Employment Status	Highest Level of Education
Grace*	Female	18 - 24	White British	Part-time	A and AS level or equivalent
Amber*	Female	18 - 24	White British	Part-time	A and AS level or equivalent
Leah*	Female	25 - 34	White British	Full-time	Degree-level or higher
Elma*	Female	25 - 34	White British	Out of Work	A and AS level or equivalent
Poppy*	Female	25 - 34	White British	Other	Degree-level or higher
Mel*	Female	25 - 34	White British	Full-time	Degree-level or higher
Beth*	Female	45 – 54	White British	Full-time	NVQ or equivalent
Jan*	Female	45 - 54	Mixed or Multiple Ethnic Group	Full-time	GCSE or Equivalent

Note: Asterisks (*) denote pseudonyms. "White British" refers to "White: English, Welsh, Scottish, Northern Irish or British".

Procedure

Semi-structured interviews were conducted in accordance with IPA guidelines, with interview questions developed collaboratively with the research supervisor to ensure alignment with the study's aims. All interviews took place remotely via Teams, a secure, encrypted video-conferencing platform. With participants' consent, both audio and visual data were recorded, however, participants could keep their camera off, with one participant choosing to do so. Interviews ranged from 47 to 86 minutes, with an average length of approximately 63 minutes.

At the end of each interview, participants were invited to share any additional reflections they felt had not been covered. A verbal debrief was provided immediately after, followed by a written Debrief Sheet (Appendix F) sent via email, which included support service information. No participants reported any negative effects from taking part.

All interviews were transcribed verbatim using the Team's transcription function, with manual corrections made by the researcher to ensure accuracy. Participants were informed they could withdraw their data within four weeks of their interview, however, no participants requested withdrawal.

Analysis

Given the limited research in this area, a qualitative approach enabled in-depth exploration of adult children's lived experiences of problematic PSU. Data was analysed using IPA, following the six- step process by Smith et al. (2021), as outlined below. IPA was chosen for its idiographic and phenomenological commitment to understanding how individuals make sense of their lived experiences, making it well-suited for this study.

Interviews were transcribed using the Teams transcription feature and subsequently verified for accuracy through repeated listening, supporting immersion in the data. Analysis began at the individual level, consistent with IPA's idiographic approach. This initial stage involved making exploratory notes on each transcript (Appendix I), including descriptive observations, linguistic notes, and reflections on emerging meanings. Attention was paid to the participants' language and how they expressed and understood their experiences (Smith et al., 2021). Experiential statements were then developed by revisiting each transcript, interpreting, and consolidating exploratory notes and quotes. This served as a foundation for identifying emergent themes within each participant transcript.

The personal experiential statements were printed and physically cut out, allowing the researcher to cluster similar ideas and identify connections. As IPA participants often do not recount

experiences in a linear sequence, segmenting text supported alternative conceptual orderings and enabled more nuanced interpretation (Smith et al., 2021). Personal Experiential Themes (PETs) were then developed into emergent themes unique to each participant (Smith et al., 2021). The same procedure was repeated for all participants.

Finally, PETs were integrated across participants to identify shared and divergent features of experience (Appendix J). This cross-case analysis produced Group Experiential Themes (GETs), each with subthemes that reflected common experiential patterns while preserving individual meaning-making.

Epistemological Position and Reflexivity

The research adopts an interpretivist epistemological position, underpinned by the ontological view that multiple realities are shaped through individual's subjective experiences (Larkin & Thompson, 2011). From this perspective, knowledge is co-created through the interaction between researcher and participant. The interpretivist stance recognises that meaning is context-dependent, and that understanding someone's experience involves interpreting how they themselves make sense of it.

IPA was therefore employed, rooted in double hermeneutics, where the researcher interprets how participants make sense of their experiences (Smith, 2009). As Holloway and Todres (2003) highlight, qualitative researchers must make their epistemological and personal assumptions transparent, as these inevitably shape how knowledge is produced and understood.

Given the interpretivist nature of the study, the researcher's role in shaping the interpretation is acknowledged. Reflexivity was essential, involving ongoing reflection on how assumptions and experiences may influence analysis (Shaw, 2010; Smith et al., 2021). I bring both lived experience of growing up with problematic PSU and professional experience supporting affected young people, which informed my motivation to amplify marginalised voices. To remain critically aware of how positioning shaped interpretation, I used a reflective log, supervision, and peer discussions. For example, during analysis of participants discussing breaking the cycle, I noticed emotional parallels with my own experiences, which were explored in supervision to ensure interpretations remained grounded in the participant's narratives (See Appendix K).

Results

Results Overview

Analysis of the interview transcripts revealed four Group Experiential Themes (GETs) and 11 subthemes. The GETs were as follows: 1) "I Was the Parent"- Parentification, 2) I Saw Too Much Too

Soon: Early Exposure and Its Impact, 3) When Normal Isn't Normal, and 4) Breaking the Silence, Breaking the Cycle. Table 2 presents a summary; full details are provided in Appendix L. Each theme will be discussed in turn.

Table 2

GETs, Subthemes and Number of Contributing Participants

GET	Subtheme	Contributing Participants
1) "I Was the Parent" – Parentification	1.1: Emotional Burden of Growing Up Too Soon	7
	1.2: Becoming the Caregiver	7
	1.3: The Emotional Anchor: Caring For the Parent	6
2) I Saw Too Much Too Soon: Early Exposure and Its Impact	2.1: Premature Burdens	7
	2.2: "It Was Like a War Zone": Living and Witnessing Chaos	7
	2.3: Lasting Imprints	8
3) When Normal Isn't Normal	3.1: That Was Just Life	8
	3.2: Just Get On With It: Emotional Blunting and Survival	6
	3.3: Realising It Wasn't Normal	5
4) Breaking the Silence, Breaking the Cycle	4.1: "We Don't Talk About It": Silence, Secrecy and Shame	8
	4.2: This Ends With Me: Breaking the Cycle	8

Group Experiential Themes

1. "I Was the Parent" – Parentification

A striking pattern across most participants was parentification, being prematurely pushed into adult-like roles. Rather than receiving care, participants often became the primary source of emotional or practical support, attending to their parent's needs, managing household responsibilities, or intervening during crises.

1.1 Emotional Burden of Growing Up Too Soon

Participants described the emotional weight of adopting adult-like roles in childhood. As Poppy reflected, "I had to grow up. Way before my years", highlighting how this premature maturity was forced, not chosen. Many became acutely aware of the mismatch between their age and responsibilities: "…I'm supposed to be a child but acting like the parent, it's tough… I felt like everything had been weighed onto me" (Elma). Participants, including Elma, described feeling responsible for others, a sense that the heavy emotional burden of responsibilities that often persisted in adulthood, as some continued to adopt parental-like roles in their relationships.

Mel shared how this shift altered their relationship with their mother, no longer viewing her as a caregiver, but as someone who needed looking after: "I don't view her as like my mum… she's someone that I help. Like she's not even a friend, really. But she's just that, someone that needs help". Others spoke of the distress of loving someone in pain but feeling helpless, expressing a desire to make it better, as a parent might: "And it's also about seeing that person that you, you love dearly do that to themselves and again not being able to, to make it better" (Beth). This subtheme highlights the psychological strain of stepping into roles far beyond what childhood should require.

1.2. Becoming the Caregiver

Alongside the emotional burden, participants described the practical caregiving roles they were forced to adopt due to PSU. These often mirrored tasks typically carried out by parents: "Because what 12-year-old should be getting up and doing night feeds?" (Poppy).

Many also cared for younger siblings and took on protective responsibilities: "I was kind of the one who would look after my younger brother, to make sure like all the bottle lids were all off the floor…make sure that he was all right" (Amber). The role reversal was often stark and literal. Elma recounted:

> They got that bladdered, wasted, and to the point where like, I had to put my own mum and dad to bed kind of thing. And it's like I'm 13 or 12 at the time. Like you should be tucking me in at night, not the other way around.

1.3. The Emotional Anchor: Caring For the Parent

Participants described becoming emotionally responsible for their parents, acting as soothers, protectors, and confidants. This role was often internalised rather than explicitly assigned: "I reacted and said 'Mom, no, no, give me that'… and I tipped it down [the sink]" (Jan).

External figures, such as professionals and relatives, reinforced these expectations. Poppy described being positioned by social services as the responsible adult:

> …they let her do it [detox] at home and she had to have injections and everything and be weaned off it, and the social services said that I had to take care of everything in the house because I was the oldest.

Participants were also drawn into their parents' emotional world: "She confided a lot in me… I had to deal with the weight of hers as well as mine" (Amber). Leah recalled comforting her intoxicated mother, capturing the contradiction through the phrase "my grown parents", a powerful sign that, even as a child, she recognised the inversion of roles:

> "I've just gone and fetched my grown parents at the pub. I remember she tripped over… I hung back because she looked really vulnerable, and I felt really sorry for her. I was about eight or nine. And I remember going up to her like, 'come on mum'".

2. I Saw Too Much Too Soon: Early Exposure and Its Impact

Participants were forced into adult worlds of chaos, responsibility and danger long before they were ready. Childhood lacked protection, marked by adult realities, instability, and repeated exposure to traumatic events. These early exposures left lasting imprints, shaping participants' landscapes into adulthood.

2.1. Premature Burdens

Participants described being exposed to adult realities long before they were emotionally or developmentally ready. This sub-theme focuses on the practical and physical burdens of childhood exposure to PSU, including unmet basic needs, household instability and early responsibilities. Many recalled experiences such as homelessness, financial instability, or a lack of adequate clothing: "We lost our home. She lost her job" (Jan), "I think I had one blazer for the whole five years" (Amber). Food insecurity and physical neglect were also common: "…we never had food because Dad was drinking it all…" (Beth).

While these experiences were primarily practical, participants reflected on their emotional ramifications in adulthood, recognising that growing up in such conditions shaped their sense of

responsibility. Emotional neglect often accompanied these burdens, exacerbating feelings of pressure and parentification. Participants described a persistent sense of responsibility and the need to care for others, illustrating how practical hardships left lasting emotional and behavioural impacts into adulthood.

2.2. "It Was Like a War Zone": Living and Witnessing Chaos

For many, home was not a place of refuge but a battleground, marked by volatility, fear, and unpredictability. Childhoods were shaped by ongoing exposure to emotional and physical danger, where trauma unfolded not in isolated incidents but as a constant undercurrent of daily life: "It was like a war zone. That's how I can best describe it" (Poppy).

Participants recalled violence, breakdowns, and substance-related crises. What should have been ordinary family life was frequently interrupted by traumatic and overwhelming events, with substances being "the common denominator" (Leah). Leah remembered calling the police after her mother smashed a jewellery box over her father's head whilst intoxicated: "There was blood pouring out of his head…then she left the house in her underwear, and I was just left with my little brother". This experience illustrates how participants were forced into adult roles, having to manage crisis situations while caring for siblings.

Others shared similarly difficult memories of witnessing harm or suicidal behaviour. Mel recalled her mother threatening suicide in front of friends: "She was just like, in front of all my friends, 'I'm going to kill myself'", showing how trauma was public and unpredictable, compounding fear and anxiety. Elma described: "…being nine and thinking your dad's dead on your patio," reflecting a moment of fear and confusion, where her father was passed out from use of substances, creating an environment of uncertainly around family safety.

Crucially, participants were not merely observers. They were often enmeshed in the chaos, tasked with managing or surviving the very adults meant to protect them. Some spoke of sexual harm, such as one participant being sexually assaulted by a man her mother brought into the home while intoxicated. Others recalled being exposed to drug-related responsibilities within the family: "There'd be times where I'd have to go and pick up [drugs] or go to someone's house and get weed for my mum's partner" (Amber).

These accounts reveal both the extent of the chaos and the absence of emotional or physical safety in childhood, likely shaping later coping strategies, hyper-vigilance, and interpersonal patterns. Participants often oscillated between recognising the severity of their experiences and

seeing them as 'normal', reflecting ongoing meaning-making both during the interviews and into adulthood.

2.3. Lasting Imprints

The consequences of the chaos endured in childhood were far-reaching, leaving lasting imprints on participants' sense of safety, self-worth, and emotional wellbeing. As Beth reflected, "It changes you as a person forever…you can't unsee those things", capturing how traumatic memories and growing up with PSU remained active and shaped her view of the world. For many, trauma lived on in the body, through anxiety, low mood, and distress: "It kind of gave me panic attacks…it made me nervous to be around that sort of thing" (Amber), "I've experienced times in my life where I felt really low and highly anxious" (Leah).

Some described how the past remains alive in the present, triggered by sounds or everyday moments. Beth described reacting to the News theme tune with fear, linking an ordinary sound to anticipated violence: "Even now, when I hear the News at Ten tune, I go 'ooo'…because I know he was going to come in and start". These experiences also appeared to shape participants' self-image and relationships with others, surfacing feelings of being overlooked, emotionally unworthy, or fundamentally alone: "It was just thinking… that you're second best" (Grace), "I felt lonely a lot of the time" (Elma), both highlighting how neglect and instability were internalised as narratives of unworthiness and disconnection.

These early experiences appeared not to be left in the past, but were carried forward, shaping life into a constant reminder of what they have endured, illustrating the enduring weight of 'unseen' childhood trauma.

3. When Normal Isn't Normal

What once felt 'normal' to all participants in childhood, was later recognised as profoundly atypical. This distorted normality served as a psychological coping strategy, enabling participants to absorb their circumstances as everyday life.

3.1. That Was Just Life

All participants described growing up in environments where dysfunction was routine. What might seem chaotic to others was often experienced as "just normal life" (Beth). This normalisation blurred the line between safety and harm, shaping how participants understood childhood and family life. For Jan, her mother's alcoholism became part of everyday life: "She was drinking from early in the morning…till she was sick…and we just carried on our lives around her". Carrying on meant adjusting daily routines around her mother's substance use, continuing with school and

household routines. Others echoed this sense of uneasy familiarity: “I didn’t know my dad until I was 17 ½. I knew an alcoholic… because to me that was technically normal” (Beth). Here Beth conveyed that her father’s identity was defined through his alcohol use, rather than as a parent. In this sense, she felt she did not know him in the role of a father, only through the lens of his addiction.

Repeated exposure may suggest how participants desensitised to behaviours that, in retrospect, they recognised as far from typical: “…what we called red wine Sundays…” (Elma), “…heroin, or alcohol or cocaine and weed and fet[2], so it was always something different to be around…” (Amber).

Even amid chaos, violence, or being sent on “hunts for cash” (Mel), many struggled to name their experiences as anything but ordinary. For some, this normalisation extended to their own involvement with substances as a child, implying how such behaviours were normalised and adopted as part of growing up: “…about 9 I first got drunk…the time I was 12 I was drinking and smoking weed and smoking fags” (Poppy).

Substance use became a shared experience and internalised as just another element of growing up.

3.2. Just Get on with It: Emotional Blunting and Survival

Participants described developing emotional detachment as a survival strategy amidst ongoing chaos. For many, numbness or shutting down emotionally was not a conscious decision but a protective response to the unrelenting stress of living with problematic PSU: “I kind of feel numb to it all now” (Elma). Here Elma reflects on how repeated exposure dulled her emotional responses as a way of coping.

The emotional blunting often began in childhood, potentially serving to make unbearable experiences more manageable: “I think I just refused at that point to believe that what I was experiencing was out of the normal” (Mel), “I guess I couldn’t make any sense of it, so I just survived…just surviving” (Poppy), evoking an existence centred on endurance rather than living, where emotional processing was suspended in favour of getting through day by day.

Over time, detachment became deeply ingrained: “I think what scares me sometimes is how desensitised you become…because even though it was awful, I think there’s a protective element to it where my brain doesn’t really let me feel that as much” (Leah).

[2] Refers to amphetamines

The message to stay strong became internalised, even when it felt burdensome: “Maybe I don’t want to be strong, but I don’t have any other choice” (Poppy).

Beneath this resilience often lay unspoken pain. Suppression may have enabled participants to function within dysfunctional environments.

3.3. Realising It Wasn’t Normal

Although many participants initially spoke about their experiences as ‘normal’, a shift in understanding often came through comparison with others or reflection into adulthood. This growing awareness marked a turning point in how they understood their childhoods. Beth captured this when visiting friends’ homes: “I think that’s a realisation really. You know, I used to go to friends’ houses, and their dads wasn’t like that”.

Such glimpses into others’ family dynamics helped participants recognise their own experiences as different. For many, realisation deepened in adolescence or when starting their own families: “We always knew that… we were different, but we couldn’t describe that” (Grace), “It’s not until I really left house and had my own family and I realised that it’s not something you should be around as a kid” (Amber).

Amber’s use of the word “house”, rather than ‘home’, may suggest the absence of warmth or safety. Mel’s confusion as a child, when peers declined to visit her house, highlights the dissonance between her lived reality and emerging awareness of social norms: “I’d be like, why don’t you want to come to my house? I was so confused”.

4. Breaking the Silence, Breaking the Cycle

Participants described not only the silence and stigma that shaped their early experiences but also a powerful desire to speak out and create change.

4.1. “We Don’t Talk About It”: Silence, Secrecy and Shame

Across all participants, silence emerged as a recurring thread, shaping how PSU was understood, both within the family and in wider society. Speaking out was rarely encouraged, instead, secrecy appears to have become both a survival strategy and a source of shame: “It was all a taboo…you just don’t talk about it” (Beth). For Beth, silence allowed her to navigate daily life without drawing attention to her father’s drinking, avoid conflict and stigma, and maintain a fragile sense of safety and control in an unpredictable environment.

For some, silence was imposed through denial or gaslighting: “If I told my mum, she’d just say it must’ve been water” (Elma). Others internalised a message to keep quiet, driven by embarrassment, fear of judgement, or a desire to protect their parents: “I was always embarrassed of it” (Amber).

Stigma further reinforced silence as participants feared judgement or consequences such as family separation: “If I tell someone at school, they’ll tell the police, and she’ll get into trouble. Like the lens of substance use is so criminalised, that I think that prevents children or young people coming forward” (Leah).

The cost of this stigma was felt socially and emotionally. Mel described the social rejection that came with others knowing: “I’d like lost all my friends because obviously no one wanted to like, put their children around something like that”. For many, it felt safer to stay silent, even with friends, school or professionals: “…trying to hide it from people… school didn’t notice because I kind of made them excuses up” (Amber).

Participants also alluded to how others couldn’t truly understand the depth of what they have lived through: “You can’t explain those things to anybody unless they’ve been through it themselves” (Beth). Yet, despite this, many expressed a powerful desire to break the silence, for themselves and others: “That’s why I wanted to do this [interview]. It’s not something that’s spoken about” (Elma).

For some, the interview itself appeared to offer an opportunity to reclaim their story and begin to challenge past isolation, reinforce agency and reduced burden of secrecy.

4.2. This Ends with Me: Breaking the Cycle

While participants spoke of pain, chaos, and silence, they also shared a powerful determination to forge a different path, away from the cycles they grew up in. Across all accounts, transgenerational patterns of substance use emerged, “my nan was also an alcoholic” (Grace), yet these patterns were not passively inherited. Instead, participants spoke of a conscious refusal to repeat what they had grown up with.

For some, this meant rejecting substances entirely, building a different life, such as becoming the parent they never had, pursuing education, or distancing themselves from harmful environments: “I’m breaking that cycle of the shit I had to endure, so I’m not pushing it on my kids…it’s nice to know that they’re not going to have to endure the stuff that I’ve had to go through” (Elma).

Breaking the cycle involved a gradual process of reflection, learning from past experiences, and for some seeking support. This determination did not come easily, with many describing a journey through confusion, anger, and grief before arriving at clarity or, for some, compassion. Some feared they might be genetically or emotionally destined to repeat the past, but what emerged was an awareness of choice, agency, and responsibility: “You either learn by it or use it as an excuse” (Beth), “I was scared I would end up like her” (Jan).

Participants often described how their experiences shaped their values and boundaries, moving towards change: “It pushed me more not to drink” (Elma), “Told her I intended to break cycles and stuff” (Poppy). Another said, “…there’s always two ways you can either go and I think some people choose to go down the same path, but for me it was kind of not an option” (Amber).

Some found healing through reflection, therapy, or time, but many made it clear that it was also generational, deeply rooted in a desire to protect their own children from what they had endured: “I’m proud of how I turned out, as a mum in comparison to mine” (Poppy), “…and I’d never do the things that she’s done. And I hope to God that my children never do anything like that” (Jan).

Despite the enduring impact of their past, participants’ narratives revealed resilience, agency, and post-traumatic growth.

Discussion

This IPA study explored the lived experiences of adults who were exposed to problematic PSU during childhood. Four GETs were identified: 1) “I Was the Parent”- Parentification, 2) I Saw Too Much Too Soon: Early Exposure and Its Impact, 3) When Normal Isn’t Normal, and 4) Breaking the Silence, Breaking the Cycle. This discussion considers how the findings relate to existing literature and psychological theory and considers implications for clinical practice, future research, and methodological reflection. In line with IPA’s inductive nature, some literature was engaged with in response to experiential themes (Smith et al., 2021).

“I Was the Parent”- Parentification

Participants’ narratives highlighted a reversal of traditional parent-child roles. Many retrospectively identified as ‘parentified’, recognising they assumed emotional and practical responsibilities beyond their developmental age. This reflects Chase et al.’s (1998) definition of parentification, where a child takes on caregiving functions due to a parent’s inability or

unwillingness. In problematic PSU contexts, such dynamics are prevalent, as parental needs often take precedence over the child's (Kelley et al., 2007).

The emotional burden was profound. Childhoods were shaped by worry, emotional labour, and premature responsibility. While these roles may have served a stabilising function within the family system, they came at a significant psychological cost. Hooper (2007) describes emotional parentification as a form of neglect, where a child's developmental needs go unmet in favour of managing adult problems. Schorr and Goldner (2023) extend this, conceptualising parentification as a form of emotional abuse that fosters a 'split self', where children detach from their own needs to survive overwhelming responsibility.

From a developmental perspective, findings align with attachment theory. Bowlby (1988) and Cassidy (2008) emphasise the importance of emotionally available caregivers. In contrast, participants often described parents who were emotionally or physically unavailable, unpredictable, or impaired. Assuming a caregiving role may have created safety and emotional regulation, but led to identity confusion, boundary issues, and long-term relational challenges.

Caregiving sometimes extended to practical or even lifesaving responsibilities, such as caring for siblings, managing the household, or intervening during crises, echoing research on young carers and disrupted developmental trajectories (Becker et al., 1998). Brown (1988) conceptualises these patterns as co-dependence, where a child maintains family equilibrium amid parental dysfunctions. Some viewed this role as strength, but most reflected on the long-term emotional cost and loss of a 'normal' childhood. Consistent with Schorr and Goldner's (2023), the imprints of parentification endured into adulthood through hyper-responsibility, difficult recognising personal needs, and struggles in relationships. These accounts highlight the need to recognise hidden caregiving roles and ensure support structures affirm children's right to be cared for, rather than to care.

I Saw Too Much Too Soon- Early Exposure and Its Impact

Participants' narratives exposed childhoods shaped not by safety and nurture, but by instability, trauma, and emotional absence. They were exposed to adult worlds of fear, violence, and responsibility, aligning with ACE studies linking problematic PSU to multiple forms of child maltreatment, including emotional, physical, and sexual abuse (Kroll & Taylor, 2003; Barnard & Barlow, 2003). While some parents with PSU can parent effectively (Harbin & Murphy, 2000), this was often not reflected in participants' recollections.

Accounts revealed a dual absence, both of consistent caregiving and of the basic scaffolding needed for healthy development. Material deprivation, such as food insecurity, homelessness, and

lack of clothing, sat alongside emotional neglect. These experiences reflect what Maslow (1943) describes as a failure to meet foundational needs for safety and belonging, which are essential for psychological growth. Consistent with Kroll (2004), many participants recalled their needs becoming secondary to their parent's substance use. Some described extreme poverty, others emotionally unavailable caregivers.

Further compounding these experiences was the normalisation of trauma and chaos. Participants did not describe isolated incidents but persistent exposure to distress, what one likened to a 'war zone.' Such accounts echo trauma literature, which identifies cumulative adversity as particularly harmful to child development (van der Kolk, 2014). When problematic PSU is combined with co-occurring factors such as domestic abuse and parental mental illness, the capacity for safe caregiving is further compromised (Murphy & Rogers, 2019; Holland et al., 2014).

Crucially, these early experiences did not remain confined to childhood. Participants described lasting psychological and physiological effects, including anxiety, low mood, relational difficulties, and hypervigilance, consistent with developmental trauma. This aligns with ACEs research, which links household substance use with poorer emotional, relational, and physical outcomes in later life (Asmussen et al., 2020).

These insights highlight the need for trauma-informed, relational support that addresses the cumulative impact of adversity, with early and sustained interventions to support lasting change.

When Normal Isn't Normal

This theme explored how participants came to recognise the abnormality of their childhood experiences, initially internalised as ordinary. PSU, emotional neglect, and environmental chaos were not perceived as unusual at the time, but reflection in adolescence and adulthood revealed the extent of the dysfunction. This distortion of 'normal' may have served as a coping strategy, allowing adaption to otherwise intolerable circumstances.

Participants recalled incidents involving violence, neglect, and emotional volatility. These events were frequently described with minimal emotional expression or a detached tone, sometimes punctuated by laughter. This apparent emotional numbing was occasionally broken by visible emotion, suggesting earlier emotional blunting may have served as a protective mechanism. Moore et al.'s (2010) describe this capacity to remain outwardly composed as a form of 'emotional strength', a survival resource developed to withstand instability. In this study, such strength often involved caregiving or supressing personal needs. While protective in childhood, participants'

reflections suggest it also represents post-traumatic growth, fostering resilience and responsibility alongside ongoing emotional costs. Poppy's account of needing to be 'strong' exemplifies this.

The literature on trauma and resilience offers insight into these processes, particularly the subtheme 'Just Get on with It: Emotional Blunting and Survival'. Werner and Johnson (1999) highlight how children in threatening environments use emotional detachment and avoidance to protect themselves from overwhelm. These findings help explain participants' frequent references to feeling 'numb' or exhibiting desensitised responses that likely enabled them to function in unmanageable contexts.

Attachment theory also offers a helpful lens. When caregivers are emotionally unavailable or inconsistent, children may internalise a working model in which others are untrustworthy or powerless (Cleaver et al., 2011). Participants' normalisation of dysfunction reflects this internal working model, shaped by chronic instability where chaos is expected and safety is uncertain. Furthermore, such conditions increase the likelihood of insecure attachment development (Howe, 2005). Participants' descriptions of numbing and detachment suggest avoidant strategies, while others' accounts of constant worry and hyper-responsibility point to anxious attachment patterns. While these adaptations were protective in childhood, participants' accounts suggest they later contributed to relational and emotional wellbeing struggles.

Shifts in perspective often came later, through peer comparison or becoming parents, prompting retrospective re-evaluation of what had once felt routine. Delayed recognition of trauma is common, as participants processed their histories, they recognised unconscious coping strategies.

Taken together, these insights highlight the importance of recognising emotional blunting and the normalisation of dysfunction not as indifference, but as adaptive strategies developed in response to threat. Using the Power Threat Meaning Framework (PTMF; Johnstone and Boyle, 2018), such patterns are understood not as signs of disorder, but as meaningful survival responses. As these strategies often persist into adulthood, they should be seen not only as indicators of adversity, but as markers of psychological resilience and agency.

Breaking the Silence, Breaking the Cycle

This theme explored how participants navigated the silence and stigma that surrounded problematic PSU and their desire to create change. Silence functioned as both a coping strategy and an imposed burden, contributing to isolation, shame, and a reluctance to seek help.

Research highlights how family secrecy, often driven by denial or fear of judgement, fosters an atmosphere where substance use becomes the unspoken 'elephant in the room' (Kroll, 2004).

Children internalise this, viewing substance use as shameful and unspeakable (Muir et al., 2023; Barnard & Barlow, 2003), creating a self-perpetuating cycle of isolation (Groin, 2004).

The developmental implications are significant. As Orford et al. (2010) note, children often lack the cognitive or emotional tools to assess whether disclosure is safe, leading many to remain unseen by professionals or unsupported in their needs (Silent Voices, 2012). As seen through the participants' voices, secrecy is compounded by fears of family separation, judgement, consequences, or disloyalty to parents (Backett-Milburn et al., 2008; Houmølle et al., 2011).

Despite this, many participants expressed a clear wish to break the silence, aligning with Byng-Hall's (2008) concept of corrective family scripts, in which individuals consciously seek to rewrite intergenerational patterns. In doing so, participants exercised agency and resisted the narratives of secrecy that once shaped them. While this demonstrates resilience and agency, these capacities are context-dependent and other unmeasured variables, may also have contributed to their ability to break the cycle, highlighting the complexity of interpreting post-traumatic growth as solely resulting from personal coping.

Across all participants was the conscious effort to 'break the cycle' of substance use. While PSU often spans generations (Cattapan et al., 2008), this was a consistent pattern in the present study, with all participants referencing family histories of substance use. These intergenerational dynamics highlight how PSU can embed in family scripts unless actively challenged, with those seeking change often facing deeply entrenched patterns without support.

All participants referenced choosing a different path, rejecting substance use, redefining parenting roles, or pursuing personal growth. This aligns with post-traumatic growth theory, where adversity becomes a catalyst for change, clarity of values, and psychological resilience (Tedeschi & Calhoun, 2004).

These insights reinforce the importance of creating space for voice, meaning making, and agency, marking a shift from survival to self-authorship.

Strengths and Limitations

A key strength of this study is its focus on an underrepresented, marginalised population. By centring voices often excluded from dominant addiction discourses, it offers insights into long-term impact, coping, and resilience, building on Meulewaeter et al. (2022) by exploring those without substance use issues, broadening understanding of intergenerational outcomes.

IPA facilitated in-depth exploration of participants lived experiences. Its retrospective nature introduces the possibility of memory distortion, however, IPA recognises the interpretive nature of memory and treats such reflection as meaningful (Smith et al., 2022).

Self-selection bias may be present, as participants may have already begun processes of reflection or meaning making. This may underrepresent those in acute distress or less engaged with their histories, or facing barriers to participation. One potential barrier not explored is digital poverty, which may have limited access to online recruitment or interview participation. Additionally, although some participants referenced intergenerational substance use affecting wider family, only individual voices were captured.

Researcher subjectivity, a known consideration in IPA, was addressed through reflexivity and transparent documentation of analytic decisions. Nevertheless, interpretation was inevitably shaped by the researcher's positionality.

Furthermore, the sample lacked diversity, with all participants identifying as female and most White British. This reflects patterns in research on family and emotional experiences, where females are often more likely to participate, and aligns with parentification being considered a gendered phenomenon (Schorr & Goldner, 2023). Participants' positions within their families (e.g., older or younger sibling) were not collected, which may have shaped experiences. In addition, experts by experience were not involved in the design of the study, while their inclusion was intended, engagement proved challenging. These factors limit the transferability and highlight the need for future research with more diverse and co-produced samples.

Clinical Implications

This study contributes to a growing recognition of the long-term impact of problematic PSU and the need for support across the life span. The findings emphasise that the effects of growing up with PSU often persist into adulthood, shaping individuals' relationships, self-perception, and emotional wellbeing. This supports the need for psychological formulations and interventions that are trauma-informed, attachment-based and rooted in developmental and systemic understanding. Professionals must address the enduring imprints of early adversity, recognising strategies such as emotional numbing or over-functioning not as pathology, but as adaptive responses to threat, powerlessness and unmet needs, as conceptualised by the PTMF (Johnstone & Boyle, 2018).

Participants' experiences were often compounded by shame and silence, underscoring the importance of professionals working to reduce stigma by asking about PSU sensitively and routinely, as is now common with parental mental health. Despite growing awareness of PSU harms, research

highlights ongoing missed opportunities to identify, and support affected children (Forrester & Harwin, 2008). Early screening and open dialogue, particularly in schools and primary care, could facilitate earlier identification and disrupt intergenerational harm (Adamson & Templeton, 2012).

Findings demonstrate the importance of therapeutic space for adult children to reflect on their histories, challenge internalised shame, and explore identity formation beyond early caregiving roles. Clinicians must remain attuned to the complexity of family loyalty, fear of judgement, and difficult emotions in this population. Therapeutic approaches should build on individuals' determination to break cycles of dysfunction, valuing strengths-based, future-oriented interventions that foster agency and resilience.

Better recognition of this hidden population is essential with professionals across settings responding with timely, non-stigmatising, compassionate support.

Future Research

The findings of this study open avenues for future research. Given the homogeneity of the current sample, comprising all women who are predominantly White, future studies should explore the lived experiences of adult children from more diverse ethnic, cultural, gender, and socio-economic backgrounds. Substance use and its impacts are deeply embedded in cultural and structural contexts, therefore, intersectional approaches are essential to understanding how these experiences differ across populations.

Further research could build upon the experiences of those who have not yet begun a process of reflection or healing. This may include individuals who remain estranged from their families, currently struggling with substance use, or less willing or able to participate in qualitative interviews. Given the strong body of evidence linking ACEs to later substance disorders and psychological difficulties (Dube et al., 2001), this study may have excluded those facing the highest adversity and ongoing challenges. Including these voices is vital to fully capturing the long-term impact of PSU.

Finally, although not the aim of the study, many participants expressed a desire to "break the cycle", suggesting future research exploring how individuals navigate this process, such as developing new parenting identities, forming relationships, or making meaning from adversity. This could inform strengths-based, post-traumatic growth frameworks, including the role of peer support, across clinical and community contexts.

Conclusions

This study highlights the complex, often hidden, long-term psychological impact of growing up with problematic PSU. Using IPA, the voices of adult children revealed narratives shaped by silence, survival, and strength. The findings underscore the need to move beyond deficit-based understandings and toward trauma-informed, developmentally attuned approaches that honour the lived realities. By centring these experiences, this research contributes to closing the gap in the literature and advances efforts to break cycles of intergenerational harm and stigma. Continued research, policy development, and clinical innovation are essential to ensure these voices are meaningfully supported.

References

Adamson, J., & Templeton, L. (2012). Silent voices: Supporting children and young people affected by parental alcohol misuse. *London: The Office of the Children's Commissioner*

Appleseth, H. S., Moyers, S. A., Crockett-Barbera, E. K., Hartwell, M., Arndt, S., & Croff, J. M. (2023). Language considerations for children of parents with substance use disorders. *Substance Abuse Treatment, Prevention, and Policy*, *18*(1). https://doi.org/10.1186/s13011-023-00536-z

Asmussen, K., Fischer, F., Drayton, E., & McBride, T. (2020). *Adverse childhood experiences: What we know, what we don't know, and what should happen next*. Early Intervention Foundation. https://www.eif.org.uk/report/adverse-childhood-experiences-what-we-know-what-we-dont-know-and-what-should-happen-next

Backett-Milburn, K., Wilson, S., Bancroft, A., & Cunningham-Burley, S. (2008). Challenging childhoods: Young people's accounts of 'getting by' in families with substance use problems. *Children & Society*, *22*(6), 418–429. https://doi.org/10.1111/j.1099-0860.2007.00173.x

Barnard, M. (1999). Forbidden questions: Drug dependent parents and the welfare of their children. *Addiction, 94*(8), 1109–1111. https://doi.org/10.1046/j.1360-0443.1999.94811097.x

Barnard, M., & Barlow, J. (2003). Discovering parental drug dependence: Silence and disclosure. *Children & Society, 17*(1), 45–56. https://doi.org/10.1002/chi.727

Becker, S., Aldridge, J., & Dearden, C. (1998). *Young carers and their families.* Blackwell

Bellis, M. A., Hughes, K., Leckenby, N., Perkins, C., & Lowey, H. (2014). National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England. *BMC Medicine*, *12*(1). https://doi.org/10.1186/1741-7015-12-72

Bowlby, J. (2005). *A secure base: Clinical applications of attachment theory*. Taylor & Francis.

Byng-Hall, J. (2008). The significance of children fulfilling parental roles: Implications for family therapy. *Journal of Family Therapy, 30*(2), 147–162. https://doi.org/10.1111/j.1467-6427.2008.00423.x

Cassidy, J. (2008). The nature of the child's ties. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment: Theory, research, and clinical applications* (2nd ed., pp.3-22). The Guilford Press.

Cattapan, A., Thurston, W. E., & Totten, M. D. (2008). The intergenerational effects of substance use: Research and policy implications. In Canadian Centre on Substance Abuse (Ed.), *Changing the culture of substance use* (pp. 70–80). Canadian Centre on Substance Abuse.

Chase, N. D., Deming, M. P., & Wells, M. C. (1998). Parentification, parental alcoholism, and academic status among young adults. *The American Journal of Family Therapy*, *26*(2), 105-114. https://doi.org/10.1080/01926189808251091

Children's Commissioner for England. (2023, February 14). *CHLDRN - Local and national data on childhood vulnerability*. https://www.childrenscommissioner.gov.uk/chldrn/

Cleaver, H., Unell, I., & Aldgate, J. (2011). *Children's needs – parenting capacity: Child abuse, parental mental illness, learning disability, substance misuse, and domestic violence* (2nd ed.). The Stationery Office.

Colby, I. C. (1999). Young carers and their families by Saul Becker, Jo Aldridge and Chris Dearden London: Blackwell science Ltd, 1998, 128 pages ISBN 0-632-04966-9 (paperback). *Children & Society*, *13*(2), 149-150. https://doi.org/10.1002/(sici)1099-0860(199904)13:2<149::aid-chi537>3.0.co;2-u

Degenhardt, L., Whiteford, H. A., Ferrari, A. J., Baxter, A. J., Charlson, F. J., Hall, W. D., Freedman, G., Burstein, R., Johns, N., Engell, R. E., Flaxman, A., Murray, C. J., & Vos, T. (2013). Global burden of disease attributable to illicit drug use and dependence: Findings from the global burden of disease study 2010. *The Lancet*, *382*(9904), 1564-1574. https://doi.org/10.1016/s0140-6736(13)61530-5

Dube, S. R., Anda, R. F., Felitti, V. J., Chapman, D. P., Williamson, D. F., & Giles, W. H. (2001). Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span. *JAMA*, *286*(24), 3089. https://doi.org/10.1001/jama.286.24.3089

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (2019). Reprint OF: Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, *56*(6), 774-786. https://doi.org/10.1016/j.amepre.2019.04.001

Forrester, D., & Harwin, J. (2008). *Parental substance misuse and child welfare: A study of social work with families in which parents misuse drugs or alcohol*. Wiley-Blackwell.

Fraser, C., McIntyre, A., & Manby, M. (2008). Exploring the impact of parental drug/Alcohol problems on children and parents in a Midlands County in 2005/06. *British Journal of Social Work*, *39*(5), 846-866. https://doi.org/10.1093/bjsw/bcn016

Gance-Cleveland, B., Mays, M. Z., & Steffen, A. (2007). Association of adolescent physical and emotional health with perceived severity of parental substance abuse. *Journal for Specialists in Paediatric Nursing*, *13*(1), 15-25. https://doi.org/10.1111/j.1744-6155.2008.00130.x

Global burden of disease study 2019 (GBD 2019) reference life table. (n.d.). https://doi.org/10.6069/1D4Y-YQ37

Global status report on alcohol and health and treatment of substance use disorders. (2024, June 25). World Health Organization (WHO). https://www.who.int/publications/i/item/9789240096745

Global status report on alcohol and health, 2014. (2014). World Health Organization.

Gorin, S. (2004). *Understanding what children say: Children's experiences of domestic violence, parental substance misuse and parental mental health problems*. National Children's Bureau.

Harbin, F., & Murphy, M. (Eds.). (2000). *Substance misuse and child care: How to understand, assist and intervene when drugs affect parenting*. Russell House Publishing.

Harwin, J. P., Madge, N. P., & Heath, S. (2010). Children affected by parental alcohol problems (ChAPAPs).

Holland, S., Forrester, D., Williams, A., & Copello, A. (2014). Parenting and substance misuse: Understanding accounts and realities in child protection contexts. *British Journal of Social Work*, *44*(6), 1491-1507. https://doi.org/10.1093/bjsw/bcs197

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research*, *3*(3), 345-357. https://doi.org/10.1177/1468794103033004

Home Office. (2017) 2017 Drugs Strategy. [Online] [Accessed on 24th April 2025] https://assets.publishing.service.gov.uk/media/5a82b5a2e5274a2e87dc2966/Drug_strategy_2017.PDF

Hooper, L. M. (2007). The application of attachment theory and family systems theory to the phenomena of Parentification. *The Family Journal*, *15*(3), 217-223. https://doi.org/10.1177/1066480707301290

Houmøller, K., Bernays, S., Wilson, S., & Rhodes, T. (2011). *Juggling harms: Coping with parental substance misuse*. London: London School of Hygiene & Tropical Medicine.

Howe, D. (2005). Patterns of attachment. *Child Abuse and Neglect*, 27-45. https://doi.org/10.1007/978-0-230-80239-1_3

Johnstone, L., & Boyle, M., with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D., & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis*. British Psychological Society

Kelley, M. L., French, A., Bountress, K., Keefe, H. A., Schroeder, V., Steer, K., Fals-Stewart, W., & Gumienny, L. (2007). Parentification and family responsibility in the family of origin of adult children of alcoholics. *Addictive Behaviors*, *32*(4), 675-685.

Kroll, B. (2004). Living with an elephant: Growing up with parental substance misuse. *Child & Family Social Work, 9*(2), 129–140. https://doi.org/10.1111/j.1365-2206.2004.00325.x

Kroll, B., & Taylor, A. (2003). *Working with parental substance misuse: Dilemmas for practice.* Routledge.

Larkin, M., & Thompson, A. R. (2011). Interpretative phenomenological analysis in mental health and psychotherapy research. In D. Harper & A. R. Thompson (Eds.), *Qualitative research methods in mental health and psychotherapy: A guide for students and practitioners* (pp. 101–116). John Wiley & Sons.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: Guided by information power. *Qualitative Health Research, 26*(13), 1753–1760. https://doi.org/10.1177/1049732315617444

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50*(4), 370–396. https://doi.org/10.1037/h0054346

Meulewaeter, F., De Schauwer, E., De Pauw, S. S., & Vanderplasschen, W. (2022). "I grew up amidst alcohol and drugs:" a qualitative study on the lived experiences of parental substance use among adults who developed substance use disorders themselves. *Frontiers in Psychiatry*, *13*. https://doi.org/10.3389/fpsyt.2022.768802

Moore T, Noble-Carr D, McArthur M. (2010). Who cares? Young people with parents who use alcohol or other drugs talk about their experiences with services. *Family Matters*, 85 18–27.

Muir, C., Adams, E. A., Evans, V., Geijer-Simpson, E., Kaner, E., Phillips, S. M., Salonen, D., Smart, D., Winstone, L., & McGovern, R. (2023). A systematic review of qualitative studies exploring lived experiences, perceived impact, and coping strategies of children and young people whose parents use substances. *Drugs: Education, Prevention and Policy, 30*(2), 165–180. https://doi.org/10.1080/09687637.2023.2170477

Murphy, M., & Rogers, M. (2019). Working with adult-oriented issues: Parental substance misuse, mental ill health and domestic abuse. In J. Horwath & D. Platt (Eds.), *The child's world: The essential guide to assessing vulnerable children, young people and their families* (pp. 250–280). Jessica Kingsley Publishers.

Office for National Statistics. Deaths related to drug poisoning in England and Wales: 2020 registrations. 2021. Deaths related to drug poisoning in England and Wales - Office for National Statistics (ons.gov.uk) (24 February 2025, date last accessed).

Orford, J., Velleman, R., Copello, A., Templeton, L., & Ibanga, A. (2010). The experiences of affected family members: A summary of two decades of qualitative research. *Drugs: Education, Prevention and Policy, 17*(S1), 44–62. https://doi.org/10.3109/09687637.2010.514192

Public Health England. (2021). *Substance misuse treatment for adults: Statistics 2019 to 2020*. GOV.UK. https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2019-to-2020

Schorr, S., & Goldner, L. (2023). "Like stepping on glass": A theoretical model to understand the emotional experience of childhood parentification. *Family Relations*, *72*(5), 3029-3048. https://doi.org/10.1111/fare.12833

SCODA. (1997). *Drug-using parents: Policy guidelines for interagency working* (p. 10). LGA Publications.

Shaw, R. (2010). Embedding reflexivity within experiential qualitative psychology. Qualitative research in psychology, 7(3), 233-243. https://doi.org/10.1080/14780880802699092

Silent Voices. (2012). *Silent voices: Supporting children and young people affected by parental alcohol misuse*. Office of the Children's Commissioner. https://dera.ioe.ac.uk/16059/

Smith, J. A. (2017). Interpretative phenomenological analysis: Getting at lived experience. The Journal of Positive Psychology, 12(3), 303-304. https://doi.org/10.1080/17439760.2016.1262622

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative phenomenological analysis: theory, method and research. Sage Publications.

Smith, J. A., Flowers, P., & Larkin, M. (2021). Interpretative phenomenological analysis: Theory, method and research. SAG

Taylor, A., & Flood, S. (2020). *The impact of parental substance use on child development: Frontline briefing*. Research in Practice.

2688_fb_the_impact_of_problematic_parental_substance_use_on_child_development_v5.pdf

Taylor, A., & Kroll, B. (2001). *Parental substance misuse and child welfare*. Jessica Kingsley Publishers.

Tedeschi, R. G., & Calhoun, L. G. (2004). *Posttraumatic growth: Conceptual foundations and empirical evidence*. Psychological Inquiry, 15(1), 1–18.

Torvik, F. A., Rognmo, K., Ask, H., Røysamb, E., & Tambs, K. (2011). Parental alcohol use and adolescent school adjustment in the general population: Results from the HUNT study. *BMC Public Health*, *11*(1). https://doi.org/10.1186/1471-2458-11-706

UNODC, World Drug Report 2023 (United Nations publication, 2023)

van der Kolk, B. A. (2014). *The body keeps the score: Brain, mind, and body in the healing of trauma*. Viking.

Velleman, R., & Templeton, L. J. (2016). Impact of parents' substance misuse on children: An update. *BJPsych Advances*, *22*(2), 108-117. https://doi.org/10.1192/apt.bp.114.014449

Volkow, N. D. (2020). Stigma and the toll of addiction. *New England Journal of Medicine*, *382*(14), 1289-1290. https://doi.org/10.1056/nejmp1917360

Werner, E. E., & Johnson, J. L. (1999). Can we apply resilience? In M. D. Glantz & J. L. Johnson (Eds.), *Resilience and development: Positive life adaptations* (pp. 259–268). Springer. https://doi.org/10.1007/978-1-4615-4763-1_17

Appendices

Appendix A

Journal of Family Studies Submission Guidelines

Submit to Journal of Family Studies

Appendix B

University of Staffordshire Ethical Approval Feedback Form

School of Health, Education, Policing and Sciences

ETHICAL APPROVAL FEEDBACK

Researcher name:	**Hayley Ansell**
Title of Study:	**Exploring the experiences of adults who have been exposed to problematic parental substance use during childhood**
Status of approval:	**Amendment approved**

Thank you for your correspondence requesting approval of a minor amendment to add a demographic survey onto the consent form and update the information sheet

Your amended application is approved. We wish you well with your research.

Action now needed:

Your amendment has now been approved by the Ethics Panel.

You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel in writing of any significant divergence from this approved proposal. This approval is only valid for as long as you are registered as a student at the University.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics BlackBoard site

Signed:

Date: 06.09.2024

Dr Sarah Rose

Dr. Sarah Rose
Ethics Co-ordinator for HEPS

Appendix C

Participant Information Sheet

INFORMATION SHEET FOR PARTICIPANTS

University of Staffordshire

Title of study:

Exploring the experiences of adults who have been exposed to problematic parental substance use during childhood.

Invitation Paragraph:

My name is Hayley Ansell, I am a Trainee Clinical Psychologist at the University of Staffordshire. You are invited to take part in this research study which forms part of the requirement for Professional Doctorate in Clinical Psychology. It is important for you to understand why the research is being conducted and what is involved before you make your decision. Please, take time to read the following information carefully and ask if there is anything not clear or if you would like more information.

What is the purpose of the study?

The aim of this research is to explore the experiences of adults who experienced problematic parental substance use during childhood. Research in many areas of addiction is underdeveloped, despite the large number of individuals it impacts. Whilst there has been some movement around our understanding of substance use and the impact it has on children, there is little research to date understanding the perspectives of adult children who have been raised in the context of parental substance use.

Why have I been invited to take part?

You have been invited to take part because it is believed you may fit the criteria of someone who may be able to participate in this research. You can take part in the study if you are 18 years of age or older and live in the UK and had a parent/s or carer/s (a parent or carer who plays the role of guardian) who used substances problematically whilst you were in their care, prior to you turning 18 years of age.

What will happen if I take part?

If you are interested in taking part, you will be given this information sheet to keep and read, so you can decide whether you wish to take part. If I do not receive a response from you after 5 days, I will send a follow up email. If you decide to take part, you will be asked to sign a consent form to confirm your agreement to participate. This will also include demographic information for you to complete. You will be given a copy of this consent form to keep. After receiving your consent form, we will arrange a convenient time to complete a confidential remote interview using Microsoft (MS) Teams and you will be asked questions relating to your experience of growing up where there was problematic parental or carer substance use. The interview schedule will be sent to you with your MS Teams meeting invite, you may find it helpful to read this beforehand, so you are aware of the type of questions included in the interview.

Interviews will involve semi-structured interviews and are expected to last around 1 hour but may be shorter or longer than this. You will need to be able to access MS teams on an

electronic device and have access to the internet to be able to take part in this study. Interviews will be audio and visually recorded. It is not possible to record only audio, therefore video will also be recorded. If you do not wish to be recorded on video, you have the option to turn your camera off at the start of recording. There will be opportunity for you to ask questions throughout the research process.

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact me if you have any questions that will help you make a decision about taking part.

Incentives:

There are no incentives for taking part in this study.

What are the possible risks of taking part?

The research is not designed to cause you any harm and there are no dangers associated with taking part, although it is acknowledged that the research topic is sensitive and that talking about your experiences could feel difficult at times. There is also potential for adverse physical health consequences relating taking part in an online video (e.g. physical discomfort from using a screen for the required period). You can request to take a break from the interview or withdraw at any time. Following the interview, you will receive a debrief sheet with information on how to seek further support if needed.

What are the possible benefits of taking part?

There are no anticipated benefits for taking part in the study. However, there may be the potential for participants to contribute to the limited knowledge base on the topic with hope of informing both clinical and public health efforts.

Data handling and confidentiality:

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR). All the information we collect about you will be kept confidential and only accessed by members of the research team at Staffordshire University. Your data will be anonymised and a pseudonym used to protect your anonymity. You will be provided the opportunity to create your own pseudonym if you prefer. Consent forms will be destroyed after three months after study completion. Data will be retained for 10 years after it has been collected, aligning with university policy and GDPR. As this research uses a qualitative approach, verbatim extracts and quotes from your interview may appear in the results of the research or if published shared in the public domain. Quotes will be sensitively selected to minimise any possibility of participant identification and will be anonymised. Your demographic data may be presented in a table alongside your pseudonym and may be used as a general section in the data.

Data Protection Statement:

The data controller for this project will be the University of Staffordshire. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a ‘task in the public interest’. You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

What if I change my mind about taking part?

You are free to withdraw from the study, without having to give reason. You will be able to withdraw any data you have provided up to 4 weeks after your final interview. After which, withdrawal of your data will no longer be possible due to the interview being transcribed and fully anonymised. If you choose to withdraw from the study we will not retain any information that you have provided and all personal information will be deleted and will be excluded from any analysis and not included in any write up.

How is the project being funded?

This research is a student project as part of a Professional Doctorate in Clinical Psychology degree.

What will happen to the results of the study?

Results from the study will be disseminated within the University of Staffordshire as part of the professional doctorate in clinical psychology. The results will also be submitted for publication in peer reviewed journals which may be publicly available.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Principle Investigator: Hayley Ansell, Trainee Clinical Psychologist

Email: a042175m@student.staffs.ac.uk

Academic Supervisor: Dr Nic Davies, Research supervisor and Dr Kim Gordon, Research supervisor

Email: Nicholas.davies@staffs.ac.uk and kim.Gordon@staffs.ac.uk

What if I have further questions, or if something goes wrong?

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of Ethics Committee for further advice and information:

Email: ethics@staffs.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix D

Participant Consent Form

CONSENT FORM FOR PARTICIPANTS

Project Reference Number: SU_23_174

Project title: Exploring the experiences of adults who have been exposed to problematic parental substance use during childhood.

Principle Investigator: Hayley Ansell, Trainee Clinical Psychologist

Email: a042175m@student.staffs.ac.uk

Academic Supervisor: Dr Nic Davies, Research supervisor and Dr Kim Gordon, Research supervisor

Email: Nicholas.davies@staffs.ac.uk and kim.Gordon@staffs.ac.uk

Please tick the appropriate boxes	**Yes**	**No**
I confirm I have read and understood the information sheet provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.		
I understand that my taking part is voluntary and that I can withdraw from the study without giving any reason up to 4 weeks after completing the interview.		
I understand that the interview will be recorded via Microsoft Teams and will be kept confidential. I understand that the recording will be destroyed immediately following completion of the study.		
I wish to be contacted with a summary of the main findings upon completion of the research.		
I agree to take part in the above study.		

Name of participant [printed]	Signature	Date
Name of Researcher [printed]	Signature	Date

NB: – If this is being returned via email, the name of the participant is sufficient as a signature

Appendix E

Participant Demographic Survey

Demographic survey

We would like to ask some questions about you. If there are any questions you do not wish to answer, please, move on to the next.

1. What is your gender?

Male	
Female	
Transgender	
Nonbinary	
Prefer not to say	
Other (please give details)	

2. What is your age?

18 – 24	
25 – 34	
35 – 44	
45 – 54	
55 – 64	
65 – and over	

3. What is your ethnicity?

Asian, Asian British, Asian Welsh	
Black, Black British, Black Welsh, Caribbean or African	
Mixed or Multiple ethnic groups	
White: English, Welsh, Scottish, Northern Irish or British	
Other ethnic group	
Prefer not to say	

4. Current employment status?

Full-time	
Part-time	
Seeking opportunities currently	
Out of work	
Prefer not to say	
Other (please give details)	

5. Highest level of education?

Left school without qualifications	
GCSE or equivalent	

A and AS level or equivalent	
NVQ or equivalent	
Degree-level or higher	
Apprenticeships	

Appendix F

Participant Debrief Sheet

DEBRIEF SHEET FOR PARTICIPANTS

University of Staffordshire

Debriefing Sheet

Thank you so much for taking the time to share your experiences with me.

What happens next?

I will now type your interview into a transcript before analysing your transcript to generate themes within your interview and across the interviews with other interviewees who took part in the research. If you have selected on the consent form that you would like a copy of a summary of the main findings, I will send this to you upon completion. If you think of any questions, please don't hesitate to contact me at a042175m@student.staffs.ac.uk

Where can I get information and support?

I appreciate this interview may have brought up some difficult experiences for you. You might find that the interview has highlighted experiences that you would like to raise further, beyond the interview.

There are external organisations which can provide information or support:

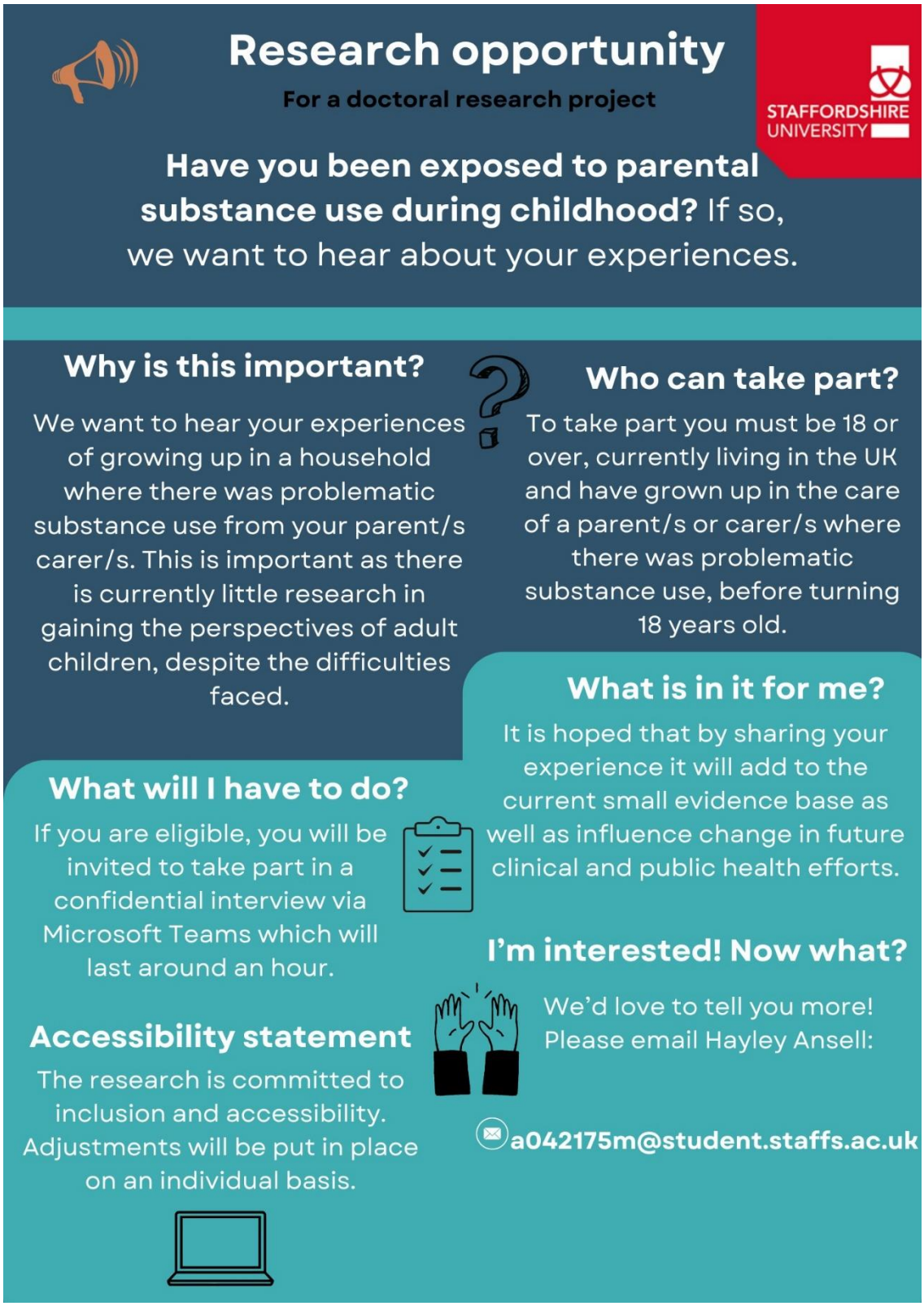
1. **Adfam-** *Adfam is a national charity tackling the negative effects of drugs and alcohol on family members and friends*. Accessed via: www.adfam.org.uk
2. **Al-Anon family groups**- *For people worried about some else's drinking*. Can contact them on: 0800 0086 811
3. **Cruse Bereavement care-** *For anyone who has suffered a bereavement*. Can contact them on: 0808 808 1677
4. **SupportLine –** *this service provides a confidential telephone helpline offering emotional support to any individual on any issue, as well as email support.* Accessed via: https://www.supportline.org.uk/ or by calling their helpline on 01708 765200
5. **Samaritans** - *Free and confidential emotional support via telephone.* Accessed via: https://www.samaritans.org/ or call their helpline on 116 123

You may also wish to consider speaking to your GP about any concerns.

Thank you again for taking part. Your contribution to the research is invaluable

Appendix G

Recruitment Advertisement



Appendix H

Interview Schedule

Interview schedule

"Exploring the experiences of adults who have been exposed to problematic parental substance use during childhood*."*

Researcher: Hayley Ansell

- How you heard about the study/reasons for participating
- What was life like for you growing up with your parent(s)/Carer(s)?
- Are there any particular experiences that stood out for you?
- What sense did you make of what was happening?
- Were you aware of your parents/carers difficulties?
- What were some of the challenges for you during this time?
- What was helpful for you during this time?
- What is life like for you now?
- What sense do you make of your experiences now? (Has this changed?)
- What would your hopes/wishes be for other children experiencing parental substance use?

Appendix I

An Excerpt of an Annotated Transcript with Exploratory Noting and Experiential Statements

Table A1

Table of Annotated Transcript with Exploratory Noting and Experiential Statements

2. Experiential Statements		Transcription	1. Exploratory Notes
	1		
	2		
	3	Researcher	
	4	OK. Yeah. We're good to go. So, yeah, how you heard about the study then, *name*,	
	5	and kind of your reasonings for wanting to take part?	
	6		
	7	Participant 8	
	8	So I saw a poster, and I remember like seeing it a few weeks	
	9	ago when I was going to a lecture and I was like a group of people. And I noticed	
Participant felt self-conscious about	10	actually I was going to stop and take a picture of your e-mail and I felt myself feeling	Pausing? Stigma?
being seen engaging with something	11	like, oh, I don't have to explain myself. So, I didn't. And then the following week,	
related to their experience	12	when I was alone, I took a picture of it. But then I reflect on that experience and…	What others think
	13		
	14	Researcher	
	15	Yeah.	
	16		
	17	Participant 8	
	18	…why was I ashamed of it? Like I was wondering, like would people ask questions?	Experiencing shame
	19	Because I'm quite open but, I suppose, like my reasoning is that I do think it's an	
	20	important topic, I haven't seen it before in research and I just wanted to contribute. I	Contribute to something
Insights of mixed experiences of parental PSU	21	think I have some insights both positive and negative, that might help shape future	

	22	research hopefully. But yeah, in terms of, seeing it was just a poster, yeah.	
	23		
	24	Researcher	
	25	Thank you and I'm glad it didn't get taken down too, I went to take them	
	26	down today and they were all still there but one., so I was happy about that.	
	27		
	28	Participant 8	
	29	Yeah, yeah, that's good	
	30		
	31	Researcher	
	32	Fab. So yeah, I guess it'd be really helpful to start with just kind of hearing about your	
	33	experiences of what life was like growing up. Yeah, with your parents or carers, I'm not	
	34	sure, who or it might be both who had the substance use difficulties or?	
	35		
	36	Participant 8	
	37	Yeah. Yeah, so, predominantly so both of my parents had experience. Yeah, they both	
	38	had experiences of substance use. Erm, so my mum is the predominant in my	Both parents use substances
Participant recalled both parents using	39	childhood that I can think of with alcohol. And my dad also drank, but I wouldn't	
substances during childhood with	40	have considered it problematic. He was just more social drinking. My dad did go	Problematic vs not problematic
Maternal alcohol use as the most	41	through…	
prominent.	42		
	43	Researcher	
Described father's cannabis use as	44	Yeah.	
happening at home and during early	45		
childhood.	46	Participant 8	
	47	…like a phase where I was quite young of smoking cannabis and he would do that in	
	48	the house with friends. So I kind of grew up around that and didn't think much of it. I	Cannabis use with friends
	49	know I didn't like it. I didn't like him smoking because as a child I learnt that he, you	Normalisation of cannabis use
Normalised the presence of	50	know, could get cancer and the usual stuff that you learn about as a child, that's	

substance use in the home.	51 52	smoking's bad and it kills your parents. I remember being really fearful that he's going to die young so that, that was kind of my exposure to that substance. But	Narratives of harm of substances
Feared her dad would die from smoking, having absorbed childhood messages that smoking kills.	53 54 55 56	alcohol. My mum started to drink in my later childhood. So, my dad was mostly the drinker, well just like socially drinking in my early childhood, and I didn't really feel the impact of that. It didn't feel problematic. But then when I was about 7-8 my, my mum's sister, so my auntie, she's got a really significant history of substance use, like	
Grew up aware of a family member's severe substance use and mental illness, seeing her as very unwell.	57 58 59 60	abuse, really. Erm, she's very unwell, so she has paranoid schizophrenia, bipolar. She she's really poorly. So, she had a child and was very negligent of that baby, so my mum adopted him and it was around that time that my mum started to drink and on reflection, I think it was just a very stressful time for her. So, when I think about my	Family patterns of substance use
Connected the start of her mum's drinking to the stress of adopting a neglected baby from within the family.	61 62 63 64	mum, when I was a child, she was always quite prudish to alcohol, like she was very I don't smoke, I don't drink. And, you know, I really, I really admired that. And you know, my values very much were, very much the same growing up until that point and then her whole view on that change and then she used to go to the pub quite	Why she drank
Admired her mum's early stance against alcohol, and felt the shift when her mum's values changed and she began drinking socially.	65 66 67 68	regularly and then she found like a bit of a community. And my dad used to go with her and it was more towards my later childhoods when I was about nine or ten, that I'd be left alone in the house quite a lot, and she would go to the pub, what feels like most nights now and yeah, like so, there was a lot of emotional neglect. Erm, she	Shift from non-drinker to drinker

Appendix J

Finding Connections Across Cases to Create Group Experiential Themes

Appendix K

Research Supervision Excerpt

Appendix L

Extended Participant Summary Results

Table A2

Extended Participant Summary Results Table

GET	Subtheme	Participants Contributing to Theme
1) "I Was the Parent" – Parentification	1.1: Emotional Burden of Growing Up Too Soon	Jan, Beth, Mel, Elma, Poppy, Amber, Leah
	1.2: Becoming the Caregiver	Jan, Beth, Mel, Elma, Poppy, Amber, Leah
	1.3: The Emotional Anchor: Caring For the Parent	Jan, Mel, Elma, Poppy, Amber, Leah
2) I Saw Too Much Too Soon: Early Exposure and Its Impact	2.1: Premature Burdens	Jan, Beth, Mel, Elma, Poppy, Amber, Leah
	2.2: "It Was Like a War Zone": Living and Witnessing Chaos	Jan, Beth, Mel, Elma, Poppy, Amber, Leah
	2.3: Lasting Imprints	All participants
3) When Normal Isn't Normal	3.1: That Was Just Life	All participants
	3.2: Just Get On With It: Emotional Blunting and Survival	Beth, Mel, Elma, Grace, Poppy, Leah
	3.3: Realising It Wasn't Normal	Beth, Mel, Elma, Grace, Amber
4) Breaking the Silence, Breaking the Cycle	4.1: "We Don't Talk About It": Silence, Secrecy and Shame	All participants
	4.2: This Ends With Me: Breaking the Cycle	All participants

Appendix M

Participant Personal Experiential Themes Excerpt

Table A3

Table of Participant Personal Experiential Themes

Participant 2	Personal Experiential Themes
	That Was Just Normal
	Always on Edge – Hypervigilance and Living with Fear
	'We Just Didn't Talk About It' – Silence, Secrecy, and Stigma
	'We Had to Stick Together' – Closeness, Survival, and Shared Burden
	The Switch Flipped – From Shielding to Exposure
	'You Can't Unsee That' – The Lasting Imprint of Trauma
	Caretaking, Chaos, and Crisis Response
	Distinguishing Parent from Addiction
	.'Breaking the Cycle' – Conscious Effort to Parent Differently
	'Why Aren't We Talking About This?' – Challenging Cultural Silence
	Enduring Psychological Effects in Adulthood
	'It Made Me Who I Am' – Resilience, Growth, and Double-Edged Meaning

Appendix N

An Excerpt of Group Experiential Themes (GETs)

Table A4

Table of Group Experiential Themes (GETs)

Group Experiential Theme	Subtheme	Quote
4) Breaking the Silence, Breaking the Cycle	"We Don't Talk About It": Silence, Secrecy and Shame	Jan (19-21) …So this is this is unusual for me to want to then tell someone that I don't know at all, especially like this. Beth (11-14) '…it just needs to be spoken because I think its just something that's not spoken about because a lot of people just file it… hard isn't it? Beth (126-127) and you can't explain those to anybody unless they've been through it themselves Beth (371-373) ...and I say you don't understand about what I went through as a child and what I'm trying to stop happen again because it's Beth (387-390) …but not many people talk about. But then I suppose in retrospect, not many, not many people. Although probably don't speak about it, I don't know, many people. Do many people have parents with addictions? I don't know. Is it something that's just not spoken about? Beth (396-399) I don't know, some of it's part stigma. I think some of it is like you know, that's 'we don't talk about that' sort of thing. And I think I just think some of it is just like people don't know how to cope with it. Whats your coping mechanism with it and I don't know if you've ever got a coping mechanism talking about it. Beth (518-524) ...was all a taboo, ...where in my days it was like you just don't talk about it Beth (816-818) So, I'm just praying and hoping that it's talked about more. And I think that's one of the reasons I wanted to do this because it's just not. But it is now. It's it's getting more and more

Mel (167-168) I'd like lost all my friends because obviously no one wanted to, like, put their children, like, around something like that

Mel (174) So yeah, she'd like, basically, I'd like driven my friends away at that point

Mel (171) like hearing like that they didn't want, like, their son to be, like, associated with me

Mel (192-193) and like oh like everything's fine because they only see like the surface level

Mel (530) I had a boyfriend… like he would be like scared to come to my house

Mel (559-562) I think that that was a big challenge, like having like a like a relationship like a normal like 15 year old like would and like all my friends and like he doesn't want to come anywhere near my family or like, like his family is saying like I'm not like any good…

Mel (793-794) I didn't even really talk about it at Uni because you're trying to make new friends like it's not really one to like, one to like talk about

Mel (1235-1238) I think probably like people like view, like people like with those kind of families like as like, like I would always say like that's why I didn't like think of myself in one of those families is because I would be like on the streets like begging like, do you know what I mean?

Mel (1278) I wish I would have told my school like I wish I would have, like seen like someone maybe earlier and like spoke it through like

Mel (1290) I hope someone like spots those signs like a little bit earlier

Mel (1326) I think something that's hidden

Elma (9) …trying to get a better awareness out there for younger people. We, we didn't have that.

Elma (526-528) like social services got involved, like child protection because of, like, the sexual abuse side of stuff. But, erm yeah, I I never wanted to go into detail about it because I felt embarrassed

Elma (1155-1157) I suppose, more resources or more places for people to go so they don't have to, like, seclude themselves and be alone

Grace (26-27) 'Cause, I think people still don't really talk about that sort of stuff, so just sort of to use it as really

Grace (460-463) I think that is quite, hard like, especially for other people to understand around you as well. That you know, if they haven't lived through it, it's quite hard for an outsider to sort of understand that.

Grace (484-485) It's just hard to be able to explain it in a way that they'll understand if they haven't lived through it.

Grace (495-496) If people, you know, just, yeah, when they don't understand it, really.

Grace (940-954) But apart from how I think, you know, I don't think I've really like people know, but not the extent of it, I think sometimes… I think they're probably in society. It's still quite, I don't know if stigmatised is the right word, but I think there is still, you know, ill taste around it.

Grace (1059-1061) and I feel like, yeah, as we mentioned, you know, sort of people still do look down upon that and I feel like you know now, having experienced that, I wouldn't do that to people.

Poppy (1115-1116) Nobody said, are you OK? Do you need some help? Do you need some support?

Amber (423-425) I think, ermm, trying to hide it from people. When I first met my partner, I was very adamant that I didn't want him knowing, I was embarrassed.

Amber (429) I think through my teenage years I was always embarrassed of it.

Amber (476-479) erm but no school didn't notice because I kind of made them excuses up. And apart from that, there was nothing where I was. I was going to school and showing anything, or those kinda signs. I think I kind of kept it hidden a lot with what I was going through at home.

Amber (631-633) I don't think no one kind of understands. No one knows about obviously everything that had gone on when I was younger.

Amber (890-891) That it's not a secret that you need to keep for your parents.

Amber (906-912) I think when it comes to drugs and alcohol, it's so infrequently talked about that it's such a negative thing that it does put you off ever talking about it. You obviously you'll hear all these stories about being taken away like children going into care and stuff like that. I think that one for me kind of made me nervous, because even though I understand now that it's not normal and that I shouldn't have gone through it, I didn't then so to, kind of, to keep it away from everybody meant that I was kind of keeping everybody safe in a way… I kind of felt like it was always a secret. In that obviously no one else should know about it.

Amber (912-915) And I think as well to not feel embarrassed, like I mentioned a lot about feeling embarrassed when it came to it, if people did find out about your situation that you shouldn't be embarrassed about it because it's not you in a way that's doing it

Leah (10-20) I was like a group of people. And I noticed actually I was going to stop and take a picture of your e-mail and I felt myself feeling like, oh, I don't have to explain myself. So, I didn't. And then the following week, when I was alone, I took a picture of it. But then I reflect on that experience and…why was I ashamed of it? Like I was wondering, like would people ask questions?

	Leah (607-610) Like, you've just embarrassed me in front of the whole class for not having my homework. You haven't even thought to ask if I'm OK or do I need support on anything? Leah (613-616) ...I didn't know how to ask for help, and I didn't really know what to say to teachers because I didn't want to, I didn't want to say oh my mum's an alcoholic and we got in a physical altercation, almost. It just didn't feel comfortable. It didn't feel right to say, it was embarrassing Leah (646-650) no one in my family really picked up on the problem. Erm, and it wasn't really spoken about. And I remember when my nan picked me up that one time it was a good example of I still didn't feel comfortable telling my nan, oh my mum drinks loads because no one brought it up with me or brought it up around me. Leah (650-652) I just thought I'm not going to tell anyone. I'm not going to, because the consequences will be so big. So, I just remember feeling like alone. Experiencing the brunt of it but feeling like I had to protect her as well. Leah (658-667) But just thinking about like even when I was telling you about the poster like, there's that protective element that's still there, where I just don't want to tell people and embarrass her… But at the time as a child, I thought I don't want to grass her up. Leah (923-934) as I've reflected with you when I was a child, I I would have found it very hard to admit to people that my mum is an abuse like an abuser of alcohol because…of the implications, like, I remember thinking, if I tell someone at school, they'll tell the police, and she'll get into trouble. Like the lens of substance use is so criminalised, that I think that prevents children or young people coming forward for support Leah (937-943) But I suppose having safe spaces that really remove the stigma in terms of like you know, removing the concern that people are going to get into trouble. Because I would have really benefited from any input from like my school, without it being about, I need to be removed from my mum's care like it needed to be shaped in a way that how can we support mum, to get better so she can support you? As opposed to, oh, my God, there's abuse of safeguarding, let's remove the child from the house Leah (943-945) I was so scared of that that I stayed in it. I stayed in the cycle because I didn't, I didn't see any other way.
This Ends With Me: Breaking the Cycle	Jan (56-58) listening to things from my brothers and my sister, and we're all sort of suffering with all of this for so many years and still suffering now… Jan (304) I was scared I'd end up like her

Beth (218) ...because I'm trying to stop that behaviour carrying on again

Beth (372-373) ...it's a cycle if you're not careful. And it can be a cycle.

Beth (701-705) ...But I've made that conscious decision. You either learn, you either learn by it or use it as an excuse.

Mel (874-875) I went to university, I decided to, to move as far away as possible

Mel (1068-1069) ...like, she's not doing on, like, on purpose

Mel (1448) So, it's just like it's not something I want to surround myself with

Elma (255-258) I didn't want to be around it anymore, I didn't want to have to have the, I didn't want to have to have the uproar of arguments and not being believed if I'd erm, seen something and got upset so I moved, I moved out.

Elma (347-348) I don't remember the last time I touched a drop of alcohol and I, I won't let my kids be in that same situation

Elma (372-374) I've been surrounded by Alcoholics my whole life, really. So it's, that's pushed me more to not drink, one because of the way that it might feel anyway

Elma (800) take control of yourself so you feel, like your owning that situation

Elma (900-902) Which I'm happy about because it's, I'm breaking that cycle of the, the shit that I had to endure, so I'm not pushing it on my kids because I've seeked the help

Elma (942) And it's nice to know that they're not going to have to endure the stuff that I've hd to go through.

Elma (964-966) I am able to give the life and a childhood that I didn't have. So it's nice because, it's it's mad because some of the things that we do with them, like I weren't able to do when I was a kid

Elma (1222-1223) But I suppose to just, I supposed to just know that it's not always going to be the same

Grace (735-738) I think I have more like forgiveness towards my dad… I've definitely had more forgiveness towards, you know, my dad and the dependency.

Grace (807-815) ...of you have control of it now because I think with dependency there's such a lack of control that you know you perhaps don't realise in the moment, but it's only then when you start to properly learn it and understand …that you have, you feel like you have more control of it.

Grace (1038-1039) .... It's what I have learned, it's important for them to do that for themselves

Grace (1055-1058) ...I'm definitely, you know, open and like more accepting to, you know, realising that people have these things that they have to deal with

Grace (1159-1163) it's that acceptance. And I think the resilience as well, a lot of that has come from that just being able to accept it and with the knowledge that's the greatest thing you can have to be able to, you know, just yeah, ride the wave with it, and you know, yeah, it's just the knowledge. It's it's really just definitely, I I don't know what we would have been like if we didn't have that.

Grace (1250-1251) it's definitely like hindered like my perception of alcohol, because even, yeah, just the worry of, you know, seeing it sort of, generationally, you sort of worry, like, is that going to happen to me?

Poppy (208-210) she has no interest in doing it, erm, because she said she wants a better life and doesn't want to end up like that. So, she's quite responsible and doesn't want to end up like that, so she's quite responsible.

Poppy (250) So, I think that a lot of the substance abuse comes from trauma.

Poppy (260-263) I'd love to just be able to get drunk and never have to worry about a thing again, it'd be great. But you can't do that. Not when you have become a mum. I have to be a responsible adult

Poppy (287-289) Because I think that I'm pretty good influence in the fact that I don't, I don't drink. And you know, I'm trying try and be, you know, live as healthy as I can and do the best that I can.

Poppy (591) Well, now I'm doing a law degree, so fuck them.

Poppy (670) I'm proud of how I turned out, as a mom in comparison to mine.

Poppy (750-751) Told her I intend to break cycles and stuff

Poppy (1308-1309) I think it needs to be more about breaking cycles and people getting their issues sorted before they have children

Poppy (1374-1382) I understand why she did what she did. But I don't understand why she took the path that she took. I understand that as a person. I don't understand that as a mom…. I don't understand how she could do it. I don't understand. I don't understand how she could not love the kids enough. To not make sure that they're fed

Amber (49-51) So I think for me, growing up around it, it kind of just made me know that I didn't want to do it myself. So it really put me off drinking, drugs, any sort of things. It completely put me off

Amber (67-68) Erm and I definitely knew it was something that I didn't want my son being around

Amber (68-70) So like, I don't do drugs. My partner doesn't drink or do drugs and nothing like that, so. So, I'm kinda very like thingy about making sure nothing like that's around for him

Amber (226) I don't really talk to my mum anymore

Amber (302-304) I think in a way I think that she hates that I've kind of not gone down her path in a way, I think that's what she wanted for me.

Amber (334-336) And obviously, it's like a cycle, I think with her, so, it kind of felt like that I needed to kind of leave that situation as quick as I can because it's not something I want to be in.

Amber (337-341) it became such, such a hate towards alcohol that I don't like it myself and drugs as well. I feel like I didn't get to experience anything. I wouldn't want to anyway, like drugs myself, but, I feel like I never got the chance to experience it or do anything because I was so scared of it, like the same with alcohol. I was always so scared of, if I drink alcohol I was going to get addicted to it straight away

Amber (361-367) Like I kind of took control of my life, so it didn't bother me as much. I knew I didn't want to do it and I knew that the life I was living was a bit crap…I started to really build something with my life is when kind of thought, no, you know, I don't want to be around this person anymore

Amber (375-377) And, I think that sort of stuff, kind of it's all like adds up of I don't want to be that person, I don't want to smoke and I don't want to drink and I don't want to do drugs, I don't want to be like her in a way

Amber (391-392) Because it's kind of like for me breaking that little cycle of I don't want him going through what I had to go through in a way

Amber (537-538) it just makes me feel so much better that I'm not around that anymore

Amber (708-716) So, I think for me to experience that half that little bit of life, let's see how much better it was for me, it's kind of pushed me to want to have a career myself… you know there's always two ways you can either go and I think some people choose to go down that same path, but for me it was kind of like not an option. Like felt like, I did not want to be that woman that that mother in a way.

Amber (730-733) So yeah, I have a lot of motivation because of her, so I am very thankful in a way I think that, I know that, not that I went through it, but I got to see, see it in a way because I don't think I'd be the person I am if it wasn't for that.

Amber (807-808) I think for me it's just breaking that cycle of parenting in a way.

Leah (97-99) I think my auntie still drives her to drink. I know it's not an excuse. She's got an addiction, but like any, any kind of stress

Leah (164-165) but I think she was quite stunted herself, like with her own upbringing and attachment style, if you like

Leah (185) I've been to therapy...

Leah (771-773) And so even when things felt rubbish, I think I've always had the mindset of it's not forever. I'll get out of here and I'll move to another city, or and I did that to be fair

Leah (780-781) I just always had hope, even if I didn't have faith in myself, I just thought it can't get worse. Really so, erm you know, I think I always just had some belief in myself.

Leah (817-826) I feel a lot better and I feel a lot able to manage any difficulties with my mum because, I don't live with her anymore and I don't, I don't, I can, I can clock out as bad as that sounds. I can and I give my permission. Like I give permission to do so…I'm allowed to do that, so life is a lot better.

Leah (905-909) I just think God like in some way in some weird way she has broken the pattern of how her mum was. At least I had those seven years with my mum, where I did feel like she wanted me. It was just the alcohol got in the way for the second part of my childhood

Appendix O

Risk Assessment

Likelihood	Consequence: Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
5 Almost certain	Moderate 5	High 10	Extreme 15	Extreme 20	Extreme 25
4 Likely	Moderate 4	High 8	High 12	Extreme 16	Extreme 20
3 Possible	Low 3	Moderate 6	High 9	High 12	Extreme 15
2 Unlikely	Low 2	Moderate 4	Moderate 6	High 8	High 10
1 Rare	Low 1	Low 2	Low 3	Moderate 4	Moderate 5

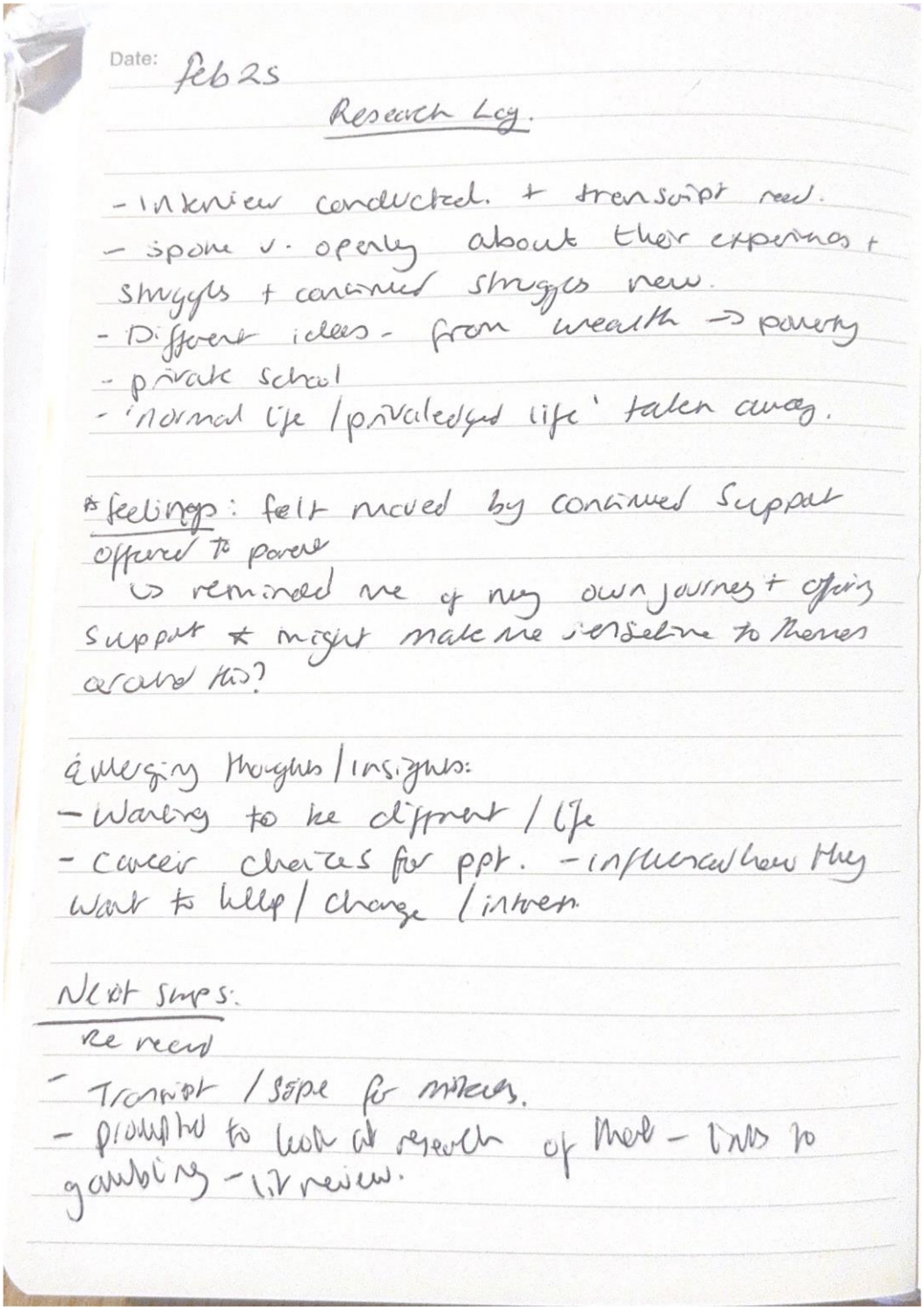
Key to Results: T = Trivial Risk A = Adequately Controlled N = Not Adequately Controlled U = Unable to decide (further information required)

	Activity/Process/Mechanism	Hazard	Persons at Risk	Measures/Comments	Consequence 1-5	Likelihood 1-5	Risk Rate	Result
1	Interviews with adult children who have experienced problematic parental substance use	Psychological distress or discomfort resulting from discussion of sensitive topics	Participants	- Participants will be made aware that sensitive topics may be discussed in the information sheet - Offer to cease interview if participant becomes distressed - Participants will be sent a debrief sheet which will include signposting to external sources of support - Participants will be sent the interview schedule the day before the interview	2	3	6	A
2	Interviews with adult children who have experienced problematic parental	Psychological distress or discomfort from discussion of sensitive topics	Researcher	- Researcher has access to support/supervision throughout the duration of the project - Researcher is responsible to actively look after their own wellbeing and is aware of how to access support through both the university and employer	2	2	4	A

	Activity/Process/Mechanism	Hazard	Persons at Risk	Measures/Comments	Consequence 1-5	Likelihood 1-5	Risk Rate	Result
	substance use			- Researcher will keep a reflective diary following interviews				
3	Interviews	Physical discomfort	Participants	- Participants needs will be discussed at the start of the interview - Participants are aware that interview will take place by Microsoft Teams and that they will last for around 1 hour - Participants may take breaks as needed	2	1	2	A
4	The use of Microsoft Teams	Data collection taking place remotely	Participants	- Participants will be made aware that interviews will take place via Microsoft teams - The researcher will suggest to participants being somewhere private and quiet prior to the interview - Participants will have a say when they take part in the interview to a time and date best suited for them	2	1	2	A
5	Participation in the study	Participant concerned about breaches to confidentiality	Participant	- Ensure all verbal and written information about research indicates remit of confidentiality and anonymity - Confidentiality will be maintained unless information is shared from participant that suggests risk of harm to themselves or others, whereby, the researcher as a duty of care to break confidentiality and follow NHS/HCPC guidance	2	2	4	A
Other special conditions specified as part of the permissions to carry out the work / activity / procedure and actions needed to minimise risk:								

Appendix P

Extract of Reflective Log



Date: feb 25

Research Log.

- interview conducted. + transcript read.
- spoke v. openly about their experiences + struggles + continued struggles now.
- Different ideas - from wealth → poverty
- private school
- 'normal life / privileged life' taken away.

*feelings: felt moved by continued support offered to parent
↳ reminded me of my own journey + ofcrs support * might make me sensitive to themes around this?

Emerging thoughts / insights:
- Wanting to be different / life
- Career choices for ppt. - influenced how they want to help / change / intervene

Next steps:
Re read
- Transcript / segments for themes.
- prompted to look at research of theft - DVS to gambling - lit review.

Paper Three: Executive Summary

Word count: 1607

(Excluding Title Page and References)

Exploring the Experiences of Adults Who Have Been Exposed to Problematic Parental Substance Use During Childhood.

Introduction

This report summarises a research project exploring the experiences of adult children who were exposed to problematic parental substance use during childhood. It is aimed at a range of audiences who may benefit from and apply the findings, including but not limited to:

- **Practitioners** working with children, families, and adults affected by parental substance use (e.g. social workers, teachers, addiction services, psychologists).
- **Policy makers and service commissioners** involved in shaping health, social care, and early intervention responses.
- **Academic and research communities** focused on addiction, Adverse Childhood Experiences (ACEs), trauma, and intergenerational patterns.
- **Individuals and organisations** with an interest in the wider substance use agenda.

Background

Problematic parental substance use (PSU) poses a serious and growing public health challenge, impacting not only individuals who use substances but also the children growing up in affected households. In the UK alone, nearly half a million children live with parents experiencing harmful alcohol or drug use, a figure likely to be underestimated due to stigma and underreporting (Children's Commissioner for England, 2023). Children exposed to PSU often face increased risks of emotional, psychological, and developmental harm, often living in unstable and neglectful environments that can have lasting effects (Cleaver et al., 2011).

PSU is a key component of Adverse Childhood Experiences (ACEs), which are strongly linked to long-term harm including substance use disorders and poor health outcomes (Felitti et al., 2019). Despite policy shifts acknowledging the needs of affected children within the substance use agenda (Home Office, 2017), there remains a gap in understanding how adult children perceive and make sense of these experiences.

Why do research in this area?

Despite substantial research showing how common and serious problematic PSU is, there remains a gap between what we know and what happens in practice, policy, and support services. While we understand the risks children face, less has been done to turn this knowledge into ongoing, trauma-informed support that reflects how children experience these challenges and their needs as they grow up. This study aims to address this gap by exploring the lived experiences of adults who grew up within environments where there was problematic PSU during childhood, offering unique insights into these early experiences and how they continue to affect individuals into adulthood. By capturing these voices, the research aims to promote a better understanding of the impact of problematic PSU and inform more effective and compassionate support.

Substance

Refers to both illicit drugs (e.g., heroin, cocaine) and legal substances (e.g., alcohol, prescribed medication). In this study problematic substance use is understood as substance use that results in social, physical, or psychological harm (SCODA, 1997)

Who could take part?

Participants were required to meet the following inclusion criteria:

- Experience of problematic parental or primary caregiver substance use during childhood
- Aged 18 years or older
- Currently residing in the UK
- Fluent in English

Who did take part?

- Total of 8 participants
- All participants identified as female
- Three age categories: 18-24, 25-34, and 45-54
- Most identified as White

The study

This study adopted a qualitative approach using Interpretative Phenomenological Analysis (IPA), a methodology that seeks to understand how individuals make sense of their lived experiences. Semi-structured interviews were carefully designed to align with the study's aims and were conducted remotely via Microsoft Teams. Data analysis followed the six-step process outlined by Smith et. (2021), allowing for a detailed exploration of each participant's account.

Main findings

Four main themes and 11 subthemes were found. The main themes identified were: 1) '"I Was the Parent"- Parentification', 2) 'I Saw Too Much Too Soon: Early Exposure and Its Impact', 3) When Normal Isn't Normal, and 4) Breaking the Silence, Breaking the Cycle. An overview of each theme will be shared.

"I Was the Parent"- Parentification

- **Role reversal/parentification**: Most participants experienced a reversal of traditional parent-child roles, taking on responsibilities beyond their years.
- **Emotional burden of growing up too soon**: Participants felt emotionally overwhelmed by adult-like responsibilities in childhood, often becoming emotionally attuned to and responsible for their parent's wellbeing.
- **Practical caregiving roles:** Many undertook tasks typically reserved for adults, including caring for siblings, managing household duties, and even responding in medical emergencies.
- **The emotional caregiver:** Participants functioned as protectors, confidants, and emotional regulators for their parents, roles that were at times encouraged or expected by family or professionals.

I Saw Too Much Too Soon: Early Exposure and Its Impact

- **Childhoods marked by chaos and instability:** Participants described early lives shaped not by care and safety, but by chronic instability, emotional neglect, and exposure to unsafe or traumatic environments caused by problematic PSU.

- **Living in unsafe and traumatising homes:** Home was often a source of fear and danger rather than protection. Participants recalled volatile, crisis-filled environments where they were not just witnesses but sometimes forced into risky situations themselves. This included exposure to substance use, physical, sexual and emotional abuse.
- **Long term impacts:** These early experiences had long-term psychological impact, including anxiety, depression, hypervigilance, and a lasting sense of loneliness, fear, and emotional disconnection.
-

When Normal Isn't Normal

- **Distorted normality:** Participants grew up viewing substance use, chaos, and neglect as normal. These experiences were internalised as everyday life with alcohol and drug use as a background feature of family life.
- **Later realisations:** Awareness that their experiences were not typical often came in adolescence or adulthood, especially through comparison with others or when starting their own families.
- **Desensitisation and survival:** Many participants described developing emotional numbness as a protective response to ongoing stress. This psychological detachment helped them endure overwhelming experiences in childhood, but often persisted into adulthood, affecting their self-worth, relationships, and mental health.
- **Pressure to be strong**: The idea of needing to 'just get on with it' or 'be strong' became a powerful message, often masking underlying emotional pain.

Breaking the Silence and Breaking the Cycles

- **Breaking intergenerational patterns:** All participants identified substance use within their family history but actively chose not to continue the cycle. This was a conscious, often deep-rooted decision in a desire to protect future generations.
- **Redefining the narrative:** Participants described rejecting substances, changing their parenting styles, pursuing education, and distancing from toxic environments as ways to rewrite their own stories.

- **Silence and secrecy:** Problematic PSU was rarely spoken about due to societal and family pressures, leading to shame and isolation. Participants reflected on how stigma and fear often prevented help-seeking during childhood.
- **Speaking out and resilience:** Many expressed a desire to speak about their experiences and to break the silence for themselves and others. Despite painful beginnings, participants found strength, insight, and transformation through their experiences. They moved beyond survival to create more hopeful futures for themselves and their children.

The key findings reveal that growing up in the context of problematic PSU often involves role reversals, early exposure to trauma, and the normalisation of dysfunction, all of which leave lasting emotional and psychological impacts into adulthood. Despite these adversities, participants demonstrated remarkable resilience and a strong desire to break intergenerational cycles. These findings highlight the complex interplay between survival strategies and later psychological outcomes. Importantly, they show that lived experience carries not only pain and lasting imprints, but also transformative potential, offering valuable insight into how services might better support both children and adult children affected by PSU.

Implications for Practice

- **Recognise hidden caregiving roles**

  Children affected by PSU often assume adult-like responsibilities, such as caregiving or managing household tasks. These roles can go unnoticed and carry lasting psychological effects into adulthood. Awareness of these often-hidden responsibilities is recommended.

- **Acknowledge long-term impact**

  The effects of growing up with PSU often persist beyond childhood, influencing mental health, relationships, and identity. Services should be sensitive to this enduring impact.

- **Challenge Stigma and silence**

  Stigma surrounding PSU can prevent disclosure. Creating open, non-judgemental spaces encourages help-seeking and reduces shame. Curiosity-led, routine conversations about family substance use can support early identification and understanding.

- **Adapt a whole-family, trauma- informed approach**

  Multi-agency collaboration (e.g. between mental health, social care, education, and addiction services) should consider not only the parent, but the broader family system when thinking about prevention and intervention, particularly children. Support should also look beyond the individual to consider family history and the ongoing transgenerational patterns.

- **Support meaning making and resilience**

  There is a need for therapeutic approaches to provide space to process lived experience, rebuild narratives, and foster agency. Strengths-based, future-orientated practices can support recovery and growth.

Strengths and limitations

This study offers new insight into the experiences and long-term impact of problematic PSU on adult children. IPA enabled rich, in-depth exploration of a typically underrepresented group. However, limitations include a lack of demographic diversity, potential recall bias, and self-selection. Findings reflect personal meaning-making but may not capture those in ongoing distress or wider family dynamics.

Future research

Future research should:

- Include voices we haven't reached yet, engaging those who may be facing adversity or themselves use substances.
- Diversify participant representation.
- Explore cycle-breaking in action, investigating post-traumatic growth approaches.

Summary

This study reveals the hidden, lasting psychological impact of growing up with parental substance use. Adult children's stories of silence, survival, and resilience demand a shift from deficit-based views to trauma-informed, developmentally aware approaches that truly reflect their lived experiences. By centring these voices, this research supports a current gap in the literature and supports efforts to break cycles of intergenerational harm and stigma. Continued focus on research, policy, and clinical innovation is essential to ensure these individuals are both heard and supported.

References

Children's Commissioner for England. (2023, February 14). *CHLDRN - Local and national data on childhood vulnerability*. https://www.childrenscommissioner.gov.uk/chldrn/

Cleaver, H., Unell, I., & Aldgate, J. (2011). *Children's needs – parenting capacity: Child abuse, parental mental illness, learning disability, substance misuse, and domestic violence* (2nd ed.). The Stationery Office.

Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., Koss, M. P., & Marks, J. S. (2019). Reprint OF: Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The adverse childhood experiences (ACE) study. *American Journal of Preventive Medicine*, *56*(6), 774-786. https://doi.org/10.1016/j.amepre.2019.04.001

Home Office. (2017) 2017 Drugs Strategy. [Online] [Accessed on 24th April 2025] https://assets.publishing.service.gov.uk/media/5a82b5a2e5274a2e87dc2966/Drug_strategy_2017.PDF

SCODA. (1997). *Drug-using parents: Policy guidelines for interagency working* (p. 10). LGA Publications.

Smith, J. A., Flowers, P., & Larkin, M. (2021). Interpretative phenomenological analysis: Theory, method and research. SAG