

An Exploration of Adult Children's Experiences of Parental Alcohol Use

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Author's Declaration

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List of Abbreviations

AA Alcoholics Anonymous
ACMD Advisory Council on the Use of Drugs
ACoA Adult Child/ren of Alcoholic
ACoPD Adult Child/ren of Problem Drinkers
ACE Adverse Childhood Experiences
CoA Children of Alcoholics
CAPSM Children Affected by Parental Substance Use
DSM Diagnostic Statistical Manual
HE Higher Education
HMSO Her Majesty's Stationary Office
JRF Joseph Rowntree Foundation
LOC Locus of Control (internal or external)
NACOA National Association for Children of Alcoholics
NHS National Health Service
Non-PSU Did not undertake Problem Substance Use
ONS Office for National Statistics
PPAU Parent with Problem Alcohol Use
PPSU Parent with Problem Substance Use
PSU Problem Substance Use
SES Socioeconomic Status
WHO World Health Organisation

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Abstract

This thesis investigates the lived experiences of individuals born in Glasgow between 1956 and 1988 who grew up in households affected by parental alcohol use. Existing research on adult children [of alcoholics] has largely focused on negative outcomes, framed through a risk-focused lens, and dominated by quantitative studies from US populations, with little focus on the UK context. Alcohol use is often examined in isolation from broader life circumstances, neglecting the complex interplay of individual, familial, community, societal, and historical factors. Focusing on Glasgow further enables a context-specific understanding, reflecting the city's distinctive socioeconomic and cultural history of alcohol use. To explore these experiences, 20 narrative interviews were conducted, privileging participant voices. Data was analysed following Braun and Clarke's (2006) thematic analysis framework. Three core themes emerged. 'Normalising Dysfunction: Patterns of Harm and Gendered Roles' illustrates how violence, neglect, and gendered expectations shaped perceptions of normality across family and community contexts. 'Disappearing: Loss and the Erosion of Childhood' captures the erosion of childhood through bereavement, loss, and early responsibility and 'parentification'. 'Surviving: Coping and Active Agency' highlights coping strategies and agency, showing how education, mentorship, and community resources fostered resilience. The themes were then organised through the socioecological model, encompassing individual, familial, community, societal and historical/political levels. By situating these narratives within socioecological levels, the study underscores the need for consideration of adult children's broader experiences rather than simply in the context of parental alcohol use. The thesis contributes theoretical, empirical, and policy insights, advocating for holistic responses to alcohol-related harm that take account of the interplay of individual, familial, societal, and historical factors in shaping adult children's lives.

Chapter 1: Introduction

1.1 Introduction

This thesis is an investigation into the childhood experiences of adults (born 1956-1988) who grew up in Glasgow, affected by a parent's alcohol use. It describes and puts into context how these individuals were affected by differing experiences during their childhoods and how they consider these experiences to have been influenced by a range of factors. This initial chapter first defines the subject specific language used in this study and the need to be considerate when researching and writing about adult children's experiences of parental alcohol use. The background to the study is then introduced, followed by a discussion on the research aims and questions that shaped this project. Finally, this chapter ends with an overview of the structure of this thesis and a summary of significance of this study.

1.2 Language concerning Alcohol Use

As discussed above, this research focuses on the experiences of adults affected by their parent's alcohol use during childhood. There is some contention around which language is most appropriate to use when discussing the experiences of alcohol use due to the stigma surrounding using certain terminology, particularly 'alcoholic'. There are in fact, a range of different opinions on appropriate language to use when discussing alcohol use, with guides published on 'How to talk about alcohol' to address this issue (Castellina et al., 2024). Despite such information, there is not one agreed term, with different organisations and individuals having differing viewpoints on acceptable language.

There are some terms which are used in research that are not appropriate to use with participants. Terms such as 'alcoholic' or 'alcohol dependent' are concerned with diagnosable conditions. For example, the Diagnostic Statistical Manual of Mental Disorders (DSM) IV defines 'alcohol abusers', 'alcoholics' or people who are 'alcohol dependent' as "*individuals who drink despite recurrent social, interpersonal, and legal problems*" (National Institute on Alcohol Abuse and Alcoholism, 2020: n.p). As this study was concerned with adult children's experiences of growing up with parents who used alcohol, potential participants may not know the extent of their parents' drinking and/or any associated diagnosis, and these terms are therefore restricting. Moreover, the terms 'alcoholic' and 'alcohol dependent' have stigma attached to them, which may evoke biases to the individuals (Appleseth et al., 2023;

Kelly et al., 2016; Shi et al., 2022). Additionally, *“whilst arguably not as problematic, terms like ‘excessive’ or ‘binge’ drinking’ or ‘alcohol misuse’ are also probably best avoided altogether given the availability of more neutral and precise terms.”* (Morris, 2025: n.p).

Research suggests that ‘problem drinkers’ is the term most frequently used by children and young people to describe their parents’ alcohol use (Tunnard 2022), it also is a term that is used to refer to the point at which alcohol use affects work, domestic or social life, rather than a diagnosable addiction (Lancaster and Dudleston 2002). Kelly and colleagues (2016) argue that ‘person with problem drinking’ aligns with a person-centred approach by moving away from a labelling an individual to focusing on the behaviour. Such an approach was central to recruitment for this study, which sought to situate participant experiences at the centre and in doing so use language that avoids stigmatisation (Appleseth et al., 2023; Kelly et al., 2016). In order to be person-centred and avoid labelling, participants were recruited based on those who self-identified as having parent’s whose use of alcohol as problematic therefore these terms were used in the recruitment strategy. However, recent charitable organisations and research has suggested that the word ‘problem’ still has stigma attached (Alcohol Change UK, N.D.; Morris et al., 2025) . This is still more so where there is a lack of person-centred language such as ‘problem drinkers’ rather than ‘person with problem alcohol use’. However, it is a difficult area to navigate and after some thought I decided to steer clear of the word ‘problem’ in this thesis, after improving my knowledge of appropriate language post-recruitment.

1.3 Language concerning ‘Adult Children of Alcoholics’

As discussed above, the differences around language used for alcohol use can be contentious. In this study all participants self-identified as having a parent who had a problem with alcohol use when they were children, and often into adulthood. There is no one word for this group of individuals and ‘adult children of alcoholics’ (ACoA) is the term most commonly used in the academic literature (Hall and Webster, 2007; Haverfield and Theiss, 2014; Werner and Johnson, 2004; Woititz, 1990). The term ‘adult children of alcoholics’ (ACoA) originated from Alcoholics Anonymous (AA) to define anyone over the age of 18 who identifies as having had a parent who used or is currently misusing alcohol (Al-anon, 2014). As this term originates from AA, several participants in this thesis already used this term to identify themselves due

to their involvement with the service. Although this term is problematic in its use of the word 'alcoholics'. A more recent term is 'adult children of problem drinkers' (ACoPD). This term is used by al-anon, a group for family members of alcoholics, ACA, a group specifically for adult children of alcoholics (see: adultchildrenofalcoholics.co.uk), and recovery centres. Despite 'adult children of alcoholics' and 'adult children of problem drinkers' potentially having the same negative connotations due to their use of the word 'alcoholics' and 'problem drinkers', both are recognised terms in research. However, in this thesis I generally use the term 'adult children' for three key reasons. Firstly, the use of the term 'adult children' remains sensitive to issues of terminology relating to alcoholic and problem drinking discussed above. Secondly, I found that when writing this thesis the terms 'adult children of alcoholics' and 'adult children of problem drinkers' became overly wordy or, conversely involved repeatedly using acronyms (ACoA or ACoPD) which distracted from key points. Lastly, the term 'adult children' maintains clarity as to who is being referred to, differentiating between children's experiences and adult's experiences of growing up with a parent how as 'problem' with alcohol. Taken literally, the term 'adult children' could refer to all adults, however in this context it is helpful to differentiate between children's experiences and adult children's experiences of growing up with a parent who has a 'problem' with alcohol.

In general, I opted to use the term 'adult children', 'parents who drank' or 'parental alcohol use' throughout this thesis. There are some exceptions to this, such as in Section 2.2 for clarity and in my Findings chapters, I use other terms to reflect how participants define their parents use of alcohol, for example, when participants explicitly mention the term 'alcoholic'. Whilst the participants in this study used a variety of terms interchangeably to discuss their parents' alcohol use, they also clearly stated that it was not for them to label their parents as alcoholics. Instead, they believed their parent had some form of problematic and negative relationship with alcohol.

1.4 Background to the study

The initial iteration of this project was as part of an interdisciplinary research team working on the biology, behaviour, and social implications of living in 'chaotic circumstances'. This research aimed to use data from four doctoral studies to create a model to identify families living in these circumstances and how to support them. The funding for this project came

from the Hunter Foundation and Beatson Cancer Research Fund. The Hunter Foundation invests *“in determining model solutions...to troubling systemic issues relating to poverty eradication and educational enablement”* (The Hunter Foundation, 2025:n.p), whereas the Beatson Institute is designed to create *“a relaxing and therapeutic experience”* and treatment for people with cancer and their families (The Beatson Institute, 2025: n.p). Therefore, there was an implied focus on these areas, although cancer was not a specific focus. My particular project was entitled ‘improvement science and families in chaotic circumstances’ and aimed to answer the following questions:

1. How can we develop an academically robust model of complex interventions that take account of behavioural research?
2. How can complex interventions inform, and help develop, interventions in the lives of families in chaotic contexts?
3. What can we learn through the application of complex models to the case of families in chaotic contexts in Scotland?

I applied for and was successfully recruited to complete this project; however, since this initial brief the project changed significantly. This was primarily due to the discrepancies on the perceived expectations of PhD research and the realisation from my original supervisors and myself that the intended project was not feasible within the requirements of a PhD in Social Policy. As such, the project moved away from exploring complex interventions and was instead led by an initial scoping I had completed as part of the original study, which, at the direction of my supervisors, had involved exploring alcohol culture in Glasgow.

The new iteration of this project began at an Al-anon meeting I attended at the beginning of my project. As the meeting progressed, individuals were sharing their experiences, and one woman started to cry. She mentioned that no-one had ever asked for her opinion before; no researcher had ever wanted to know what she went through. The focus had generally been on her father and partners’ drinking. She was glad that someone outside of the group wanted to know what her experiences were and many in the room agreed. The group were predominantly female members of families whose parents, mainly fathers, had alcohol use problems. Although the initial idea for focusing on adult children was sparked by this meeting, it was also informed by my increasing familiarity with the literature which will be discussed

below and in the next chapter. This made me interested in researching the experiences of adult children in Glasgow and doing whatever I could to help, empirically, theoretically and practically.

Woititz (1990) was one of the earliest scholars to study adult children extensively, in her book, which looked at male and female individuals over 23 years old (Woititz, 1990). At the time, she believed that adult children's experiences had been grouped in with other individuals with similar experiences, which included traumatic events, due to a lack of accurate classification. From her work and research with adult children she created 13 'generalisations' about their experiences which included:

...difficulties in establishing 'normal' behaviour; difficulties following a project through; lying; judging themselves harshly; difficulties having fun; constantly seeking approval; a need for control; feeling different; highly irresponsible or responsible; extremely loyal; and impulsivity which could lead to self-loathing and a loss of control (Woititz, 1990: xxi-xxiv).

Although not comprehensive, these 'generalisations' were based on objectively negative behaviours which could have been exhibited by adult children due to the trauma they experienced as children. Her work has since been critiqued for: over-generalisations regarding her categories, with some studies finding them only relating to males and not females; for only looking at individuals who were 'psychoactive addicts'; and for a lack of inclusion of healthy people with alcohol-addicted parents (Shemwell et al., 1995; Spivakovskaya and Lutsenko, 2021). These critiques underscored the need for greater methodological rigor and inclusivity in research on adult children. For example, overgeneralisations based on narrow or gender-specific samples, as well as a focus solely on clinically diagnosed individuals, risk perpetuating incomplete or biased understandings of this population. This has significant implications for future research, as it could lead to inaccurate assumptions and ineffective support for individuals with varied experiences of parental alcoholism.

Previous attempts to research the experience of parental alcohol use have often lacked a focus on alcohol due to combining substances, frequently correlating the impacts of drug use to that of alcohol (Manning et al., 2009). As Kelley and colleagues (2016) note, there is no

consensus on what is covered by the term 'substance use'; it can be used to describe all substances including alcohol, drugs and tobacco or to describe substances other than alcohol (Kelly et al., 2016). Often, when substances are grouped together their usage is combined such as both alcohol and cannabis use (Manning et al., 2009). Polysubstance use refers to the consumption of more than one psychoactive substance, whether within the same occasion or across overlapping periods of time (Tomczyk et al., 2016). The rates of polysubstance use can be considered fairly low; in the UK during 2023-2024 14% of individuals "in contact with drug and treatment services" were there for 'non-opiate and alcohol' and 30% for alcohol only (UK Government, 2024: n.p). Similar figures were found in Scotland during 2025; 48.1% referred for alcohol, 37.5% for drugs, and 14.4% for polysubstance use (Public Health Scotland, 2025a). Poly-substance use, and mental health are addressed by Manning and his colleagues (2009) in his quantitative synthesis of 'problem' parental substance use. Data from five UK national household surveys were used and it was found that problem drug and problem alcohol use often intersect with mental distress (Manning et al., 2009). However, Bancroft and colleagues (2004) in their Joseph Rowntree Foundation (JRF) report, found that children believed living in households with alcohol use was different from that of drug use. For example, parents who used alcohol were more likely to "cause problems in public and spend less time at home", causing a less stable home environment for children, compared to parents who did not use alcohol (Bancroft et al., 2004). Likewise, research suggests that when in the home, families impacted by alcohol use are more likely to be affected by 'disharmony.' (Järvinen, 2015; Velleman and Orford, 1999; Velleman and Templeton, 2016, p. 201). These previous studies show that having a parent who drinks provides a specific experience which can increase the child's risk of various harms well into adulthood. Therefore, there is a need to look more closely at the experience of those impacted by alcohol use specifically.

The lack of knowledge around adult children is highlighted by the absence of accurate estimates of their prevalence or incidence. Estimates of parental problem alcohol use vary over time and by the measures used, which further complicates understanding the problem. These studies differ in their definitions of what constitutes 'problem' drinking, the methodologies employed, and the points in time when data were collected. For example, Shenker (2008) used national survey data and administrative records to estimate that one million children were affected by parental alcohol use across the UK (Shenker, 2008). In

contrast, the National Psychiatric Morbidity Survey combined self-reported household surveys with clinical assessments to estimate that 2.6 million children lived with a hazardous drinker and 705,000 with a dependent drinker (Manning et al., 2009). Other estimates from England, derived from administrative datasets and population-level surveys, suggest that 478,000 children live with a parent who uses alcohol (Children's Commissioner for England, 2022). These differences in data sources, definitions, and methodologies highlight why understanding the scope of the problem is difficult and emphasise the importance of considering local context when interpreting such estimates.

Despite extensive research on parental alcohol use, most studies focus on the perspective of the problem drinker, with relatively few examining children's experiences and even fewer exploring adult children's perspectives (Kroll, 2004; Laybourn et al., 1996; Velleman and Templeton, 2016; Bancroft et al., 2004). Existing work tends to emphasise negative outcomes and risk, rather than children's resilience. For example, Velleman and Orford (1999) highlighted the predominance of risk-focused analyses, a finding echoed by Bancroft et al. (2004). Kroll's (2004) systematic review of seven studies, found most relied on clinical samples, portraying childhoods marked by denial, secrecy, family breakdown, conflict, violence, and fear. These studies largely frame interventions around childhood, overlooking longer-term trajectories. Furthermore, research indicates substantial variability in family experiences. Haugland (2005) identified family profiles ranging from 'protecting' to 'chaotic' families, demonstrating that parental drinking impacts children differently depending on family dynamics (Haugland, 2005). This diversity underscores that adult children's experiences cannot be fully understood by focusing solely on childhood or clinical samples. Taken together, the limited attention to adult children, combined with the heterogeneity of family experiences, clearly justifies the need for research that directly examines adult children's perspectives of their lives.

Glasgow provides a particularly relevant context for studying adult children of parents with alcohol problems. From the 1970s onwards, the city experienced profound deindustrialisation, with the collapse of shipbuilding, steel, and manufacturing industries leading to widespread unemployment, poverty, and intergenerational deprivation (Pacione, 2004; Walsh et al., 2017). These structural changes disproportionately affected working-class

communities, disrupting family stability and contributing to high rates of alcohol use, mental health disorders, and social fragmentation (Hanlon et al., 2006; Hughes, 2007; Shipton, 2014). Housing policies, including large-scale high-rise estates in areas such as Easterhouse, Castlemilk, and Drumchapel, often reinforced social isolation and weakened community cohesion (McKee, 2010; Richardson et al., 2015; Thompson-Fawcett, 2004). As a result, Glasgow exhibits some of the highest alcohol-related mortality rates and health inequalities in the UK, with premature deaths far exceeding those in comparable cities (Ellaway et al., 2010; Walsh et al., 2017).

Within the context of the lack of research on adult children in Glasgow born between 1965-1990, theories concerning adult children become particularly important. Traditionally, these theories have focused on the long-term psychological and behavioural effects of growing up in a home affected by parental alcoholism (Arcaya et al., 2015; Christensen and Bilenberg, 2000; Velleman and Templeton, 2016). Early models, often rooted in clinical or addiction-focused perspectives, emphasised dysfunction and trauma, shaping public and institutional understandings of adult children as a high-risk group (Dube et al., 2003; Sher et al., 1991; Velleman and Orford, 1999). While these models brought important visibility to the issue, they largely focused on negative aspects of these individuals' lives. This deficit-focused framing can lead to policies and interventions that overlook the varied experiences of this population, for example, by prioritising risk over resilience, or by failing to engage individuals who do not seek formal support. Consequently, there is a clear need for research that moves beyond deficit-based approaches that more fully capture adult children's experiences. One promising avenue is the socioecological model (SEM), which examines multiple levels of influence, including individual, familial, community, and broader environmental factors (Golden and Wendel, 2020). By highlighting the differing levels that shape adult children's lives, this model provides an explanatory framework to understand how parental alcohol use interacts with individual, family, community and societal contexts. Importantly, the socioecological model is distinct from the choice between asset- and deficit-based approaches: the former provides a way to conceptualise and analyse influences across different levels, while the latter concerns whether research emphasises risks and problems. Using this framework allows for a more nuanced understanding of adult children's experiences and situates them within the wider social and structural context of Glasgow.

Despite the visibility of parental alcohol use in Glasgow, research specifically examining adult children's experiences within this complex social and structural context remains sparse. The lack of empirically and theoretically grounded work highlights the need for research that addresses both individual experiences and multi-level influences, reinforcing the importance of focusing on this population in this unique setting.

1.5 Research Questions and Aims

As discussed above there is lack of empirically and theoretically grounded research on adult children's experiences of growing up with parental alcohol use and this has significant implications for how we both understand and support this group. This research therefore aimed to explore how adult children in Glasgow understand the impact of their parents drinking on their own childhood experiences and how they believe this influenced their lives growing up between 1965-1990. This knowledge of experiences will then provide a better understanding of the problems associated with alcohol abuse in relation to other social and economic issues. Due to this categorisation, and previous research the research questions, given the Glaswegian context and time period, are as follows:

RQ1: How do adult children perceive parental alcohol use to have shaped their childhood experiences?

RQ2: What factors enable adult children to cope with having grown up with parental alcohol use?

RQ3: How do these factors map onto the socioecological model?

RQ4: What are the policy implications of the research findings?

1.6 Significance of Study

Experiences of adult children can range widely according to their unique circumstances and current research suggests that these are often negative, regarding abuse, education and employment (Balsa, 2008; Dube et al., 2003; Forrester and Harwin, 2008; Velleman and Orford, 1999). Despite this, there has not been much research on adult children and that most of the research undertaken has been quantitative in nature. (Harter, 2000; Velleman, 2010; Velleman and Templeton, 2016). Although this quantitative research has been important in

highlighting the problem, it fails to fully account for the lived experiences of adult children from their own perspectives. Whilst there is some qualitative research on the lived experiences of adult children (See Chapter 2, Section 2) such research is limited due to the focus on children. This thesis expands research by exploring the lived experience of adult children's lives through their retrospective understandings.

This thesis addresses the above gaps by adopting a qualitative, inductive approach that foregrounds adult children's own perspectives. Empirically, it expands the field by providing rich, contextualised accounts of adult children's experiences in Glasgow. Theoretically, the research contributes to the development of frameworks such as the socioecological model, offering a multi-level understanding of the interplay between individual, family, community, and societal influences on adult children. Methodologically, this study demonstrates the value of qualitative inquiry for capturing nuance and diversity in experiences that quantitative studies may not fully reveal, highlighting the importance of using qualitative methodologies in this field.

1.7 Thesis Structure

This thesis is structured across nine further chapters, this thesis employs a qualitative methodology to engage with complex and layered narratives of childhood adversity, alcohol use, and adult outcomes. The structure is as follows:

Chapter Two: Literature Review – In this chapter I provide a comprehensive analysis of existing literature on adult children, identifying key conceptual, empirical, and methodological gaps. I begin by establishing the importance of research into the lives of adult children affected by parental alcohol use, noting that these individuals often experience distinct developmental trajectories shaped by early adversity (Velleman and Templeton, 2016). Despite clear findings on the potential link between parental alcohol use and adverse childhood experiences, I argue that this population remains under-researched and poorly understood.

In Section 2.2 I explore the evolving definition of 'Adult Children of Alcoholics,' tracing its use across clinical, psychological, and popular discourses. In Section 2.3 I discuss the incidence and prevalence of 'adult children of alcoholics' within the population, emphasising the

challenges of measurement and the consequences of data scarcity, which contribute to their continued marginalisation in research and policy. I then turn to the intersection between parental alcoholism and childhood adversity in Section 2.4, drawing on the Adverse Childhood Experiences (ACEs) framework to examine how cumulative harm, trauma, and psychological stress shape the lives of affected children. Subsequent sub-sections allow me to explore trauma more deeply and assess both risk and protective factors, considering the roles of individual resilience, familial support, and broader social influences.

My analysis also highlights that much of the alcohol-based literature is shaped by American research, with limited applicability to UK-specific social, economic, and cultural contexts. I show how the dominance of quantitative research has contributed to an incomplete understanding of adult child experiences, often overlooking the complexity and nuance captured through qualitative approaches (Velleman and Templeton, 2016). This gap is particularly evident in the scarcity of UK-based studies that incorporate personal narratives or account for variables such as class, geography, and access to support. I therefore argue that the experiences of adult children must be understood not only through individual psychological impacts that focus on risk but also in relation to broader societal forces, including protective experiences and the potential invisibility of family members within alcohol policy discourse. By addressing these factors, I lay the groundwork for a more contextually nuanced and theoretically robust investigation into the experiences of children growing up with parental alcohol use.

Chapter Three: Glasgow as a Setting for Research provides a contextual foundation for my study by situating it within Glasgow's distinct social and historical landscape. From the 1970s through the early 2000s, the city underwent dramatic socioeconomic changes resulting from rapid deindustrialisation, the collapse of heavy industries, and shifts toward a service-based economy (Walsh et al., 2017; Pacione, 2004). These structural changes led to widespread unemployment, particularly among working-class men, and contributed to enduring patterns of poverty and social marginalisation. Housing policies, including the demolition of tenement buildings and the construction of peripheral high-rise estates, further eroded community cohesion and intensified social isolation (Thompson-Fawcett, 2004; McKee, 2010). Glasgow has consistently recorded some of the highest alcohol-related mortality rates in Scotland,

with deaths disproportionately concentrated in the most deprived areas (Understanding Glasgow, 2016; Leyland et al., 2007; National Records of Scotland, 2020b). Although public health interventions, such as Minimum Unit Pricing, have shown early promise, alcohol-related harms remain a major contributor to health inequalities in the city (Giles and Robinson, 2017; National Records of Scotland, 2020b).

Here I also connect Glasgow's enduring relationship with alcohol to the high prevalence of adverse childhood experiences (ACEs), particularly in communities marked by long-term deprivation. Children growing up in environments affected by parental alcohol use often experience neglect, domestic violence, and parental mental illness, core components of the ACE framework (Dube et al., 2003; Scottish Government, 2020). These intergenerational patterns of trauma, substance use, and poor health are further exacerbated by economic inequality and limited access to support. Studies also show that many individuals most affected by alcohol-related illness today were children during periods of high parental alcohol consumption, particularly in the 1980s and 1990s (Shipton et al., 2013; Tweed et al., 2018). Following Walsh et al. (2017), I argue that Glasgow's excess mortality can be attributed not only to contemporary deprivation, but also to a legacy of historical policy decisions and structural disempowerment. This chapter therefore highlights Glasgow's significance as a research setting, offering a vital context for understanding the lived experiences of adult children.

Chapter Four: Methodology – In this chapter I outline the theoretical and methodological foundations of my study, which is rooted in a constructionist, interpretivist, and inductive framework. These philosophical assumptions informed my use of narrative interviews as the primary data collection method, selected for their ability to privilege participant voice and offer insight into complex, lived experiences (Fehér, 2011). My research aimed to explore adult children's experiences and how they interpret the impact of parental drinking on their childhood. I justify my recruitment and data collection methods, discussing the associated challenges and how I overcame them. Recruitment required a flexible, multi-method approach due to the sensitivity of the topic and the potential vulnerability of the participant group. I argue that narrative interviewing was the most appropriate method to allow participants to guide their own storytelling, facilitating an open exploration of their

experiences within a safe, participant-led structure. I also examine the characteristics of the sample I recruited.

I analysed the data using Braun and Clarke's (2016) six steps of reflexive thematic analysis (see Section 4.7), chosen for its adaptability and alignment with the study's epistemological stance. This method enabled me to integrate theory and literature while preserving the individuality of participant narratives. Three key themes emerged from my analysis, which I explore in subsequent findings chapters. Ethical considerations were central to my research design, given the potentially distressing nature of revisiting childhood adversity. I embedded trauma-informed practices throughout the process to ensure the safety and well-being of both participants and myself as the researcher, particularly when sensitive memories surfaced during interviews. In this chapter I ultimately defend my methodological choices as best suited to answer my research questions with both rigour and empathy.

Chapter Five: Understanding the Experiences of Adult Children – In this chapter I present a detailed analysis of differing theories that could be used to understand and structure the thematic themes obtained from participant narratives. While the literature predominantly focuses on models that rely on deterministic interpretations, emphasising individual pathology or fixed psychological mechanisms such as attachment styles and locus of control, I challenge those limitations by situating personal experiences within broader ecological systems.

The Adverse Childhood Experiences (ACEs) framework has expanded the understanding of childhood trauma, but I argue that it remains constrained by its reliance on a predefined list of adversities. The ACE adversities may not capture the full spectrum of harm experienced by adult children from external factors. To address this, I argue that the socioecological model (Bronfenbrenner, 1977; Kilanowski, 2017) is an appropriate tool for highlighting how experiences can be understood across individual, familial, community, and societal levels.

In Section 5.2 I examine relevant biopsychological constructs such as attachment theory, locus of control, and the social determinants of health. In Section 5.3 I integrate these findings into the socioecological framework, highlighting the interconnections between trauma, structural conditions, and individual development. Finally, in Section 5.4 I apply the model to categorise

various influences, from genetic predispositions to environmental pressures, illustrating how adult children navigate complex and often adverse life trajectories. This layered analysis provides a comprehensive foundation for exploring how adult children understand, respond to, and are shaped by their early life environments.

Chapter Six: Normalising Dysfunction: Patterns of Harm and Gendered Roles – In this chapter I explore how deeply ingrained gendered and familial expectations shape children’s experiences in violent or neglectful households. At an individual and societal level, boys are often expected to be “hard men,” suppressing emotion, while girls are pushed into domestic roles, internalising subservience and emotional labour. Within families, violence, neglect, and emotional suppression are normalised, leading children to see dysfunction as standard. These patterns are further reinforced by broader community behaviours, such as heavy drinking and peer acceptance of aggression, which mirror and validate home life.

Beyond the household, cultural and historical factors perpetuate these norms. Communities often reinforce these behaviours, and society at large has historically promoted gendered roles, shaping expectations through policy and tradition. Alcohol consumption, particularly among men, is culturally sanctioned, creating environments where violent or neglectful behaviour is excused. The chapter highlights the interplay between individual, familial, community, and societal levels, showing how historical policies and gender norms collectively entrench cycles of dysfunction.

Chapter Seven: Disappearing: Loss and the Erosion of Childhood – In this chapter I examine the profound impact of loss on young people with parents who drank, particularly through bereavement, such as parental suicide and the deaths of peers, related in some ways to their alcohol use and tangentially their traumatic experiences. These experiences accelerate the responsibilities placed on children, eroding the innocence of childhood and thrusting them into caregiving roles or emotionally burdensome situations. Experiences of bullying, shame, and isolation compound this erosion, limiting friendships and support networks and intensifying feelings of vulnerability and precocious maturity.

I also situate these individual and familial struggles within a broader socioeconomic and environmental context. Children growing up in low-income neighbourhoods face poor

housing, environmental instability, and widespread deprivation, especially in areas like Glasgow. Historical policies that neglected these communities have left long-lasting impacts, creating environments where childhood is truncated, and deprivation is normalised. In this chapter I underscore how personal loss and structural inequities intersect to shape the lived realities of adult children.

Chapter Eight: Surviving: Coping and Active Agency – In this chapter I explore the strategies young people employ to navigate trauma, including substance use, self-harm, or suicidal behaviour, which can serve as turning points in their lives. At an individual level education and access to supportive resources emerge as vital mechanisms of active agency, allowing individuals to seek help, build coping skills, and reconstruct a sense of safety and control. Positive mentorship and relationships with at least one supportive adult can provide crucial guidance, counteracting the destabilising effects of early adversity.

I identify from participant data the importance of community support structures, such as youth centres, safe spaces, and community therapy, in fostering recovery and agency. Recovery centres and educational programs play a key role in helping young people navigate complex challenges, providing both practical and emotional resources. Lastly, at a societal and policy level, education can lead to a ‘sense of hope’ and ‘way out of poverty’ for adult children. By highlighting these pathways, I illustrate how individuals and communities can actively counteract the harmful legacies of violence, loss, and deprivation, demonstrating the potential for agency even in contexts shaped by historical and societal adversity.

Chapter Nine: Policy Implications – In this chapter I delve into the policy implications stemming from the study’s thematic findings, particularly the intersections between alcohol use, familial structures, and broader public health frameworks. One of the core themes of the research is the profound impact of alcohol use on family members and the long-term emotional, psychological, and social consequences they face. I highlight how existing alcohol policies in the UK and Scotland often fail to address the unique needs of these individuals, despite the increasing recognition of Adverse Childhood Experiences (ACEs) as a critical factor in public health. In light of this, in Section 9.2 I examine how neoliberal ideologies shape current alcohol policies, focusing on the individualistic framing of addiction. I highlight how neoliberalism often overlooks the role of socioeconomic factors, such as poverty and

inequality, in contributing to alcohol use and its impacts on family dynamics. I critique the lack of systemic support for families dealing with alcohol abuse, emphasising that current policy frameworks do not adequately address the broader, intergenerational effects of alcohol use.

Building on the thematic findings that alcohol use is not merely an individual problem but a family and community issue, the chapter discusses the limitations of global alcohol policies and their implications for public health. Section 9.3 reveals how alcohol policy across the globe varies, with some countries adopting harm-reduction approaches while others still focus on punitive measures. This resonates with the findings in the UK and Scotland, where the research highlights a gap in policy frameworks regarding adult children. In Section 9.5 I critically examine the policies related to family members affected by alcohol use, particularly in the context of ACEs. I call for a shift towards policies that are inclusive of the long-term needs of adult children, advocating for trauma-informed frameworks that consider the cumulative effects of growing up in environments where alcohol use is prevalent. The thematic findings suggest that policies need to adopt a more comprehensive, community-centered approach, offering resources not just for individuals suffering from addiction, but for entire families coping with the emotional and psychological burdens of alcohol use. In light of these observations, in Section 9.6 I outline policy, practice, and research recommendations. These recommendations emphasise the need for policies that address the root causes of alcohol use, including socioeconomic factors and the psychological needs of families.

Chapter Ten: Conclusion – In this chapter I synthesise the study's thematic findings and their implications for the broader context of alcohol policy and public health, offering empirical, theoretical, and methodological insights. In Section 10.2 I situate the empirical findings within the existing literature. In Section 10.3 I highlight the theoretical contributions of the study, particularly the application of the socioecological model to understand the multi-layered impacts of alcohol use. The socioecological model allows for a deeper understanding of how alcohol use is shaped by individual, familial, and societal factors, and it offers a framework for developing policies that address these interconnections. In Section 10.4 I address the methodological contributions of the study, particularly the richness of the qualitative data, which allows for a deeper understanding of the lived experiences of individuals and families

affected by alcohol use. In Section 10.5 I consider the limitations of the research, particularly in terms of participant selection and the challenges of conducting research on sensitive topics during the COVID-19 pandemic. In the conclusion I reiterate the study's contributions to the field, offering a foundation for future research that can further explore the intersections between alcohol use, family dynamics, and social policy, with a focus on addressing the socioecological factors that shape alcohol use and its consequences.

Chapter 2: Literature Review

2.1 Introduction

In this chapter, I present an in-depth and critical review of the literature on adult children of parents who drank. While research on this group exists, it remains fragmented and underdeveloped, often positioning adult children as a 'hidden' or 'invisible' population (Advisory Council on the Use of Drugs, 2003; Haverfield and Theiss, 2016). Much of the existing work adopts a narrow, risk-focused lens, neglecting the wider social, cultural, and economic contexts that shape children's experiences (Kroll, 2004; Velleman and Templeton, 2016). This approach has left important gaps in understanding: the limited prevalence data (Manning et al., 2009), the predominance of quantitative accounts, and a tendency to overlook protective factors or more nuanced experiences of growing up in these circumstances. These omissions are not simply academic, they influence how individuals and families affected by alcohol use are understood and supported in research, policy, and practice. In particular, much of the literature isolates alcohol use from broader structural and community conditions, failing to recognise how experiences are mediated by individual characteristics, family relationships, and wider social environments. This study seeks to address this gap by reframing the focus: in doing so, it situates alcohol-related harms within the wider social and economic environment, offering a more comprehensive account of how alcohol interacts with other factors shaping childhood and adult life.

The literature review was undertaken semi-systematically, due to the broader topic under investigation being conceptualised and studied differently within diverse disciplines, ruling out a systematic review (Snyder, 2019). A semi-systematic review allows for an in-depth overview of the field of adult children that follows a structured approach but may not include all available studies. A semi-systematic review approach was undertaken to map themes as well as identify knowledge gaps within the literature relevant to the UK (Snyder, 2019). Key terms such as 'adult children' and 'adult children of problem drinkers', 'parental alcohol use', 'trauma and alcohol use' as well as 'adverse childhood experiences' were searched in relevant databases such as SCOPUS, Web of Science and Google Scholar and in journals such as 'Sociology of Health and Illness' and 'Public Health', to not miss any reports that are relevant. This literature review utilises English language academic articles as well as government reports and some grey literature, from 1978 (from when the terminology for adult children

was established) onwards, to understand the literature around the topic. Much of this literature was psychological in nature and predominantly undertaken around 1990s to early 2000s. Although, there has been some recent studies which provide vital information on current knowledge of adult children.

The chapter is structured as follows. Section 2.2 clarifies the recognition of ‘adult children’ and outlines how the group has been categorised in the literature. Section 2.3 reviews what is known about adult children’s prevalence, before turning in section 2.4 to consider children’s experiences in relation to risk factors. Section 2.5 focuses on how the aforementioned risk factors can be mediated by protective factors, coping mechanisms and resilience. Section 2.6 then examines what is known about adult children’s lives in adulthood. This structure reflects both the existing focus of the literature and its key limitations, setting the stage for the methodological approach adopted in this study.

2.2 Recognition of ‘Adult Children of Alcoholics’¹

As discussed in the introduction chapter, ‘adult children of alcoholics’ are the focus demographic for this study (see Section 1.2, 1.3 and 1.4). Here, I argued that there is no one word for this group of individuals and ‘adult children of alcoholics’ is the term most used in the academic literature (Hall and Webster, 2007; Haverfield and Theiss, 2016; Park, 2007; Werner and Johnson, 2004; Woititz, 1990). However, it is also important to understand how ‘adult children of alcoholics’ emerged as a distinct group and the associated implications for how we currently understand the experiences of adult children.

The term ‘adult children of alcoholics’ (ACoA) originated from Alcoholics Anonymous (AA) to define anyone over the age of 18 who identifies as having had a parent who used or is currently misusing alcohol² (Al-anon, 2014). There is not a pre-requisite for the parent to have been officially diagnosed as an alcoholic³, simply for them to have used or have a problem with alcohol or for their children to perceive their alcohol use as problematic. The name for

¹ Section 2.2 is the only section written referring to ‘adult children of alcoholics’ to provide clarity, to avoid stigmatising language, ‘adult children’ will be used in the rest of the thesis

² Alcohol use is defined as “when you drink in a way that’s harmful, or when you’re dependent on alcohol” (NHS, 2017:n.p)

³ Alcoholism is defined as “a compulsion...loss of control in limiting intake, and the emergence of a negative emotional state when access to the drug is prevented.” (Koob, 2013, p. 3)

this group of individuals appears to first be found in Tony A's pamphlet (A, 1978) and later (1990) book 'The Laundry List: The ACOA Experience' (A and F, 1990), where he lists 14 'characteristics' (see Appendix 1) and in fact the terminology of 'adult children of alcoholics' is still used in AA and al-anon groups. The group were later referred to in Black's (1981) work as 'children of alcoholics' when they are children. However, the term is often attributed to Woititz (1983) book 'Adult children of Alcoholics'. She has a 13-point list of 'characteristics' of adult children (see Appendix 2). Although this term is critiqued in more current academic literature (Kelly et al., 2016), it is still used throughout the AA sphere.

Even before this terminology was in place, 'adult children of alcoholics' were considered a clear group with distinct experience and needs in Black's (1981) work. In her book she examined the experiences of 'children of alcoholics', both when they were children and as adults and then goes on to discuss 'self-help' topics. She has vignettes of how 'adult children of alcoholics' perceive their childhood experiences and categorises these individuals based on three 'rules'; 'don't talk', 'don't trust', and 'don't feel' (Black, 1981). Black (1981) argued that children of alcoholics are worried about not being believed and do not trust others and themselves. As a group, she argued that by age nine they attempt not to 'feel' and experience denial over their perceptions and feelings in order to survive their circumstances (Black, 1981). She believed that this often causes 'adult children of alcoholics' to repeat dysfunctional behaviours such as alcohol use in their own adult lives. This work is based upon Black's (1981) own psychological practice and her own perceptions as a psychologist of 'adult children of alcoholics' rather than on peer reviewed research, therefore this cannot be given as much weight as later studies but does provide a starting argument for 'adult children of alcoholics' as distinct from other individuals who have experienced traumatic childhoods.

Both the Al-anon self-help groups and Black's (1981) work centre 'adult children of alcoholics' as a specific group, although there has been debate as to their uniqueness. Older psychosocial research included arguments for either a new diagnostic category of this group or that the group is no different from other groups which experience traumatic childhoods (Cermak, 1984; Charland and Côté, 1998). Despite this, there is much to argue for the identification of 'adult children of alcoholics' as a specific group. To try and categorise this group and assess psychosocial characteristics, studies have tried to develop a screening tool for 'adult children

of alcoholics' (Gondolf and Ackerman, 1993; Hawkins and Hawkins, 1995; Park, 2007). Park (2007) in his paper updating a screening tool for 'adult children of alcoholics' in the cultural context of Seoul states:

The term 'ACOA' refers not only to those who have alcoholic parents, but also those with specific psychosocial characteristics or syndromes as a result of parental alcohol problems (p. 75).

Initially, in the 1980s, a tool was developed to identify children who were living with parents who used alcohol, the Children of Alcoholics Screening Test (CAST) (see Appendix 3) (Jones, 1981). This tool was designed for children, with a 30-item questionnaire to identify children who are either living with or have lived with 'alcoholic parents' (Hodgins et al., 1993). It focused on the severity of parental alcoholism and less on the characteristics of the child of alcoholics and did not mention 'adult children of alcoholics'. Gondolf and Ackerman (1993) built on this and produced a tool for adult children entitled the 'adult children of alcoholics index' with four areas: rejection, impulsiveness, inconsistency, and deliberation. This study was the first to assess 'adult children of alcoholics' through a 21-item questionnaire (see Appendix 4). Hawkins and Hawkins (1995) developed a similar 25-item 'adult children alcoholics tool' (ACAT) and compared this against Gondolf and Ackerman's (1993) work (See Appendix 5). Both of these tools rely on clinical mental health issues for their assessment of adult children and are largely psychological measures. These measures have since been critiqued for ignoring the cultural context, such as cultural norms and values as well as cultural beliefs and behaviours (Park, 2007). They have also been critiqued as they can be considered personal attributes and not due to growing up as an adult child of alcoholics (Hawkins and Hawkins, 1995). The measures are also deficit rather than strengths based and focus on the problems associated with being raised in a home with parents who drank. Additionally, the measures and statements within them are often contradictory, which makes it difficult to be clear on who an 'adult child of alcoholics' is, in addition to reducing the experiences of these individuals down to 20-30 statements. Hawkins and Hawkins (1995) even warn in their paper on the screening tool they created (ACAT), that the tool is simply one way to measure "*the continuum of individual vulnerability, in interaction with risk and resilience factors in the environment*" (p. 336). This highlights that at the time there needed to be more attention

within research on resilience and the environment, as seen below with more recent literature this is still true today.

There have been other attempts to categorise 'children of alcoholics' as a distinct group based on their roles within the family, open to the same critique of the focus being on individuals in the context of their families and not the wider social or cultural factors. Research based in the United States of America (USA) on children who have parents who drink has shown that parental alcohol use impacts the child's behaviour traits (Veronie and Fruehstorfer, 2001; Wegscheider, 1981). Scholars have summarised four roles of children within the family, taken from Wegscheider's (1981) research: Hero, Scapegoat, Mascot or Lost Child (Veronie and Fruehstorfer, 2001; Wegscheider, 1981). The *hero* is typically an overachiever but also struggles with feelings of inadequacy, as a result, they often take on additional responsibilities. The *scapegoat* is disobedient and often blamed for actions not their own. The *lost child* has difficulty with social skills, while the *mascot* relies on comedy and people-pleasing behaviours to cope. These roles can also vary by gender: females are more likely to identify with the lost child role, whereas males more often align with the mascot role (Veronie and Fruehstorfer, 2001). Scholars such as Brisbane (1989) and Alford (1994) have further associated the *hero* role with daughters, particularly due to their involvement in nurturing younger siblings (Alford, 1994; Brisbane, 1989). This ties into research which focuses on female adult children taking on caregiving roles during childhood (Kelley et al., 2007).

In more recent work, Park and Schepp (2015) underscore the significance of treating 'children of alcoholics' as a distinct group, given their increased risk of psychological, behavioural, and social problems compared to children from non-alcoholic households (Park and Schepp, 2015). Their review reveals that 'children of alcoholics' are more likely to experience 'anxiety and depression', as well as having a higher likelihood of 'aggressive and behavioural problems', alongside difficulties in academia and cognitive performance (El-Sheikh and Flanagan, 2001; Molina et al., 2010; Park and Schepp, 2015). At the same time, Park and Schepp (2014) stress that recognising 'children of alcoholics' as a distinct group does not imply homogeneity. Many children in this category exhibit resilience, successfully adapting despite high-risk circumstances. Factors such as a strong bond with a non-alcoholic parent, cohesive family relationships, supportive friendships, and community involvement can buffer against

negative outcomes (Park and Schepp, 2015). This highlights how 'children of alcoholics' are a specific group with unique experiences and protective and risk factors. The different categories examined in this section are all argued to be specific to adult children. This demographic can be viewed as a distinct group due to the unique experiences and impact of growing up with parental alcohol use.

2.3 Prevalence of Adult children

There are many different estimates of the incidence and/or prevalence of adult children, none of which can be considered completely flawless (see table 1). Table 1 shows the different ways in which estimates relating to the prevalence of adult children have been studied in the UK, summarising where the studies were undertaken, the year the data was collected, the sample size and estimated prevalence taken directly from the sources listed. As can be seen from this table, over the years, these figures have been drawn from a variety of sources and are largely based on looking at substance use as a whole rather than alcohol use specifically. A key issue underpinning this variation is the lack of consistency in how 'parental drinking' is defined across studies. Definitions range from subjective descriptions such as parents who 'drink too much' to clinical categories including hazardous, binge, or dependent drinking, each capturing different populations and levels of severity. This presents a problem in knowing the prevalence of children and adult children affected by parental drinking. This is key in acknowledging and knowing the extent of the individuals affected and in providing appropriate services, such as specific counselling and support groups, for those who require it (Haverfield and Theiss, 2016).

There are often complications with determining prevalence due to parental drinking being hidden within the family (Forrester and Harwin, 2008). This leads to underreporting of the problem, especially where self-disclosure is required (Forrester and Harwin, 2008). In addition, studies relying on treatment or administrative data may underestimate prevalence by excluding individuals not in contact with services, while retrospective studies of adult children may be affected by recall bias. Most data is based on what we know about childhood experiences of living with someone who uses alcohol, rather than asking these children as adults. Additionally, estimates are taken from different sub-sections of the population, so it is difficult to compare. This lack of comparability is further intensified by methodological

variation, including differences in sampling strategies, datasets, and time periods. The figures of estimates of children living with parents who use alcohol in Scotland, range from 36,000 (Scottish Executive, 2002) to 100,000 (Scottish Government, 2020). Although there is a large gap in dates these studies were undertaken, the figures range hugely. This variation is likely to reflect differences in definitions and data sources rather than actual changes in prevalence. This wide difference in estimates of adult children is especially clear throughout the UK with the Advisory Council on the Misuse of Drugs (2003) estimating a UK prevalence of 250,000 whereas Manning et al (2009) estimate 3.5 million, with the latter including broader categories such as binge drinking, which significantly increases the size of the population captured. In the Manning et al (2009) study it does depend on the data they are using as they use multiple datasets which highlights the huge discrepancies in estimates (see table 1). Another challenge in interpreting these figures is the use of absolute numbers rather than proportions when comparing England and Scotland. Given the substantially larger population of England, higher numerical estimates do not necessarily indicate higher prevalence rates. However, many of the original studies report findings in absolute terms, limiting the ability to standardise comparisons across regions. As such, these figures should be interpreted with caution.

Table 1: Summary of Estimates of Parental Substance Use in UK and Scotland, organised by location and then year of data collection

Location	Year data collected	Author	Year of Publication	Sample Source and Size	Estimated prevalence
UK	1992	National Association for Children of Alcoholics (NACoA)	1992	1000 representative sample of UK	4.7% of individuals were brought up in a family where ≥ 1 parents 'drank too much'. This equated to 2.05 million adults in the UK
UK	1996-2001	ACMD	2003	Combined datasets from ACMD England, Wales and Scotland (see rows below)	250,000 - 350,000 children of problem drug users
UK	1998	National Association for Children of Alcoholics (NACoA)	1998	face-to-face interviews were conducted with a nationally representative sample of 23,378 British adults and a survey of 9,789 people	6.2% of participants reported they had grown up in a home in which one or both of their parents drank too much. This equated to 920,000 children and young people were living with parental alcoholism in the UK
UK	2000	Manning and colleagues	2009	National Psychiatric Morbidity Survey (NPMS)	22% (2.6 million) children lived with a hazardous drinker and 6% (705,000) children with a dependent drinker ⁴
UK	January 2000-April 2001	Forrester and Harwin	2008	All case files for families allocated for long-term work where there was a concern about parental use of drugs or alcohol in the whole of three London local authorities and one district covering half of a fourth	Out of 100 case files with 186 children, almost half of children still at home were living with a parent with a serious drug or alcohol problem (47 per cent) after follow-up

⁴ Manning et al., (2000:4) "Hazardous drinking (a pattern of alcohol consumption that increases the risk of harmful consequences for the user or others) was defined as a score on the Alcohol Use disorders Identification Test of 8 or more...The Severity of Alcohol Dependence Questionnaire was used to identify alcohol dependence in this survey."

				authority had information collected from them shortly after allocation	
UK	2000-2004	Manning and colleagues	2009	British Crime Survey (2004) and NPMS (2000)	8% (up to 978,000) of children lived with an adult who had used illicit drugs. Around 335,000 children lived with a drug dependent user, 72,000 with an injecting drug user, 72,000 with a drug user in treatment and 108,000 with an adult who had overdosed.
UK	2004	Manning and colleagues	2009	Secondary analysis of five UK national household surveys, only two were used for the estimate of parental alcohol use: the General Household Survey (GHS), 2004 (6704 adults); the Household Survey for England, (HSfE) 2004 (16,715 adults)	around 30% of children under-16 years (3.3 - 3.5 million) in the UK lived with at least one binge drinking parent, 8% with at least two binge drinkers and 4% with a lone (binge drinking) parent
England	Unknown – prior to 2004	Prime Ministers Strategy Unit	2004	Part of the Alcohol Harm Reduction Strategy England (AHRSE)	780,000 - 1.3 million children of adults with an alcohol problem
England	2018	Parental Alcohol Use and Children (POST)	2018	Public Health England and the Office for National Statistics	189,119 to 207,617 children live with an alcohol-dependent adult, while 15,500 children live with an adult receiving treatment for alcohol dependence
England	2018/19	UK Government	2023	Data from the National Drug Treatment Monitoring System (NDTMS) is used alongside the estimates of national and local prevalence for alcohol dependence to provide estimates of the extent to which treatment need is unmet.	120,552 alcohol dependent adults living with children

England	2019/2020	UK Government	2023	Children's Commissioner for England's data on childhood vulnerability	478,000 children living with an alcohol or drug dependent parent in 2019 to 2020.
England	2023	NSPCC	2024	Child in Need assessment	71,580 children living with a parent who uses alcohol
Scotland	1996-2001	ACMD	2003	<p>Scottish Drug Use Database (SDMD): data on new attenders at drug agencies and new treatment episodes with general practitioners - 47,488 users</p> <p>Estimating the National and Local Prevalence of Problem Drug Use in Scotland Report</p> <p>Drug Outcome Research in Scotland (DORIS): 1,033 drug users beginning a new episode of drug treatment were recruited to the study in 2001/02. Calculations based on dataset with 57% of the males and 60% of females are parents. On average, fathers had 1.83 children and mothers 1.77 applied to national average numbers</p>	<p>SDMD: 20% reported living with one or more dependent children</p> <p>DORIS: 17,900 children with a problem drug-using mother. 40,800 children with a problem drug-using father</p> <p>Both: 40,800 - 58,700 children in Scotland have a parent who is a problem drug user. Based on population estimates for 2000, this represents about 4–6% of the 1 million children under 16 in Scotland</p>
Scotland	2001/2002	Public Health Scotland	2002	10,798 adults reported to the Scottish Drug Use Database	40,000-60,000 children affected by parental drug use
Scotland	2001/2002	Scottish Executive "It's everyone's job to make sure I'm alright"	2002a	"The statistics and information presented in this chapter come from the following sources: General Register Office Scotland; Scottish Executive; Scottish Children's Reporter Administration; ChildLine	40,594 and 58,916 children with a drug-using parent in Scotland 9,391 and 19,553 children appear to be living with a drug-using parent

				Scotland; Information and Statistics Division Scotland; Department for Work and Pensions; Department of Health; Scottish Women's Aid; Centre for Drug Use Research, University of Glasgow." Pg. 37	
Scotland	Unknown – prior to 2002	Plan for Action on Alcohol Problems/Scottish Executive	2002b	Unknown	80-100,000 children
Scotland	2003	Scottish Government	2009	Scottish Health Surveys (SHeS)	65,000 children under the age of 16 have a parent with an alcohol problem
Scotland	2006	Scottish Government 'Getting our Priorities Right'	2013	Non-specific "From the Estimates of Problem Drug Use in Scotland" pg. 17	40,000-60,000 children in Scotland may be affected by parental problematic drug use and that, of these, 10,000-20,000 may be living with that parent
Scotland	2008-10	Scottish Government	2012	Scottish Health Surveys (SHeS)	10.4 per cent of young people under the age of 16 in Scotland are vulnerable to emotional, physical and verbal abuse because of their parents' "problematic use" of alcohol. This equates to 93,000 children
c	2015-2017	Russell et al.	2023	Random selection of caseloads Alcohol and Drug Recovery Service records resulting in of 8 nurses and 12 social care workers (736 service users)	462 (62.8%) service users were parents to children; including adult children. 38.3% of those being parents of children aged 16 years and under
Scotland	2018	Scottish Government	2020	Scottish Health Surveys (SHeS)	36,000 and 51,000 children are living with parents (or guardians) whose alcohol use is potentially problematic

The Borders	2002-2003	Murray and Hogarth	2003	33 questionnaires from assessment agencies in drug/alcohol addictions services, and children and families services	1,306 children and young people affected by substance use within the family (1.2% of the overall population of 109,270)
Glasgow	2005	Hay, Gannon & McKeganey	2005	A hidden population model to attempt to estimate the people not in touch with services. Data sources were treatment contacts (SDMD), drug related hospital admissions, police contacts and social work/social enquiry records and were identified by Council area or by postcode	6,142 children affected by parental substance use. (5.5% of the under 16 population), with slightly more living with at least one parent with an alcohol problem than with a drug problem

The National Association for Children of Alcoholics (NACOA) has the largest UK survey to date on the prevalence of children who live with parents with alcohol problems and the impact on the family, despite being undertaken in the 1990s (National Association for Children of alcoholics, 1992, 1998). In the 1992 study, NACOA conducted telephone interviews with 1000 UK adults in a “nationally representative sample of UK adults” (National Association for Children of alcoholics, 1992:1). They found that 4.7% of individuals were brought up in a family where one or both parents ‘drank too much’⁵, from their own calculations this is 2.05 million adults in the UK (National Association for Children of alcoholics, 1992). Following this, in 1998, researchers conducted face-to-face interviews with a nationally representative sample of 23,378 adults in Britain. Among the participants, 6.2% reported that they had been raised in a household where one or both parents drank excessively (National Association for Children of Alcoholics, 1998). In 1998 NACOA also undertook 9789 questionnaires with adults that focused-on prevalence of parental alcohol use. The combination of the 1998 face-to-face interviews and survey measures created an estimate of ‘920,000 children and young people living with parental alcohol problems’ in 1998 (National Association for Children of alcoholics, 1992, 1998). This is quite a difference in figures and shows how attempting to use representative data and scaling up estimates can be problematic. Although, arguably, this study could be used to understand the number of adult children as it is retrospective due to the sample being adults reporting on their experiences as children, it is problematic, the population will have increased between 1992 and 1998 however, the estimates of children living with parents who drank has changed, as discussed below.

The Plan for Action on Alcohol Problems (2002) estimated that “80,000-100,000 children in Scotland are affected by parental alcohol problems” (Scottish Executive, 2002b:n.p). This estimate was based on numbers from European studies which have many flaws. For example, the lower estimate is based on adolescents reporting hospitalisation of parents in Denmark in the 1990's (Eurocare and Coface, 1998). However, it does not count parents who may not have been hospitalised or where alcoholism may not be identified as the problem. More recent studies by Manning and his colleagues, (2009) estimated that in England 28-30% of the

⁵ In the context of the NACOA research ‘drank too much’ meant a parent had alcoholism

2.4 million children in the UK live with at least one binge drinking parent⁶(Manning et al., 2009). This estimate is substantially higher than others, largely because “binge drinking” represents a broader and more inclusive category than alcohol dependence, demonstrating how definitional differences can significantly influence prevalence figures. This is a huge difference in estimates; without accurate estimates of adult children or parents who use alcohol in the UK and Scotland, the true scale of the problem remains hidden, leading to underfunded and poorly planned services. This gap in data undermines prevention efforts, research quality, and effective policymaking. It also reinforces the invisibility and stigma of those affected, making it harder for them to access support.

In Scotland specifically, The Hidden Harm report tried to bring to light issues with invisibility and stigma. The report estimated that there were almost 60,000 children under 16 years old, living with a parent with a substance use problem (Advisory Council on the Misuse of Drugs, 2003). The figures presented in the *Hidden Harm* report are regarded as the most accurate—though now outdated—estimates, as they were derived from the integration of three key data sources: *Estimating the National and Local Prevalence of Problem Drug Use in Scotland*, the *Drug Outcome Research in Scotland (DORIS)*, and the *Scottish Drug Misuse Database (SDMD)*. Among these, only the DORIS study contained specific information on the proportion of individuals who both used substances and had children (Advisory Council on the Misuse of Drugs, 2003). Furthermore, although the SDMD collects data exclusively from individuals engaged with treatment services, it remains the most extensive source of information, documenting 47,488 ‘substance users’ living with a child and providing valuable insight into the nature of substance use in Scotland (Advisory Council on the Misuse of Drugs, 2003). These datasets were combined and produced estimates for 2000 using the percentages of individuals who were ‘living with at least one dependent child’. These figures are somewhat similar to those determined by other reports which estimate around 40,000 children who live with an alcohol using parent (Scottish Executive, 2002b; Public Health Scotland, 2002; Scottish Executive, 2013; Scottish Government, 2020). Although, given alcohol use in Scotland has decreased since 2002-2024, it appears incongruous that the estimated number of children whose parents who use alcohol has not decreased also (Scottish Government, 2024a).

⁶ Binge drinking is defined as “drinking heavily over a short space of time” (NHS, 2017)

The data is further problematic when trying to address more local estimates, particularly important for this thesis. There is only one study found which focuses on Glasgow. While Hay, Gannon & McKeganey's (2005) study offers valuable early insight into the scale of parental substance use in Glasgow, it has notable limitations. The use of a hidden population model relying on administrative sources (SDMD, hospital admissions, police contacts, and social work records) risks underestimating prevalence, as it excludes families not in contact with services and may overrepresent more severe cases. Furthermore, the combination of alcohol and drug use into broad categories obscures nuanced patterns of harm. As the sole Glasgow-specific estimate, its findings should be treated cautiously and not assumed to reflect current or comprehensive realities.

Although estimates of adult children range widely, and often combine drug and alcohol use, all papers around prevalence of the problem of parental drinking agree it is large, and the problem is not often addressed directly. Unfortunately, most of these estimates focus on substance use and not specifically alcohol use and the estimates are based on children living in these circumstances and not the population of adult children. Despite these figures being inconsistent, they suggest that there is a high prevalence in communities and, as shown below, this is significant given the impact this may have on children both during childhood and beyond.

2.4 A Childhood 'At Risk'

Children in families where parents drink are especially at risk of harmful factors (Eiden et al., 2010; Leonard, 2002). Parental alcohol use can directly lead to additional adversities, creating complex trauma. Evidence shows that young adults with parents who drank report higher numbers of traumatic events (Hall and Webster, 2007), and adult children often describe stressful home environments characterised by financial difficulties, frequent arguments, violence, and social problems (Callingham, 2004). Protective and risk factors mediate these outcomes, demonstrating that parental alcohol use does not inevitably lead to negative effects. Parental alcohol use also frequently co-occurs with other pre-existing or wider contextual adversities, rather than being the sole cause of them. Household hardships, social inequalities, or community-level challenges may coincide with parental alcohol use, or in some cases contribute to it, creating a complex interplay of risk factors. Research indicates

variability in experiences: for example, the National Association of Children of Alcoholics (1992) found that only 62% of participants in their study on parental alcohol use reported problems, highlighting that experiences are not uniform. Recognising that parental alcohol use can both generate additional adversities and exist alongside other adversities is essential for understanding adult children's experiences and the broader social, familial, and economic contexts that shape them.

2.4.1 Risk Factors

Research on the experiences of children raised in families affected by parental alcohol use highlights a range of social, economic, and psychological challenges that act as significant risk factors. These risks encompass greater exposure to financial instability, disrupted family dynamics, and limited access to supportive resources, alongside heightened susceptibility to emotional distress, behavioural difficulties, and challenges in educational achievement (Balsa, 2008; Braitman et al., 2009; Solis et al., 2012; Mahedy et al., 2017; Veronie and Fruehstorfer, 2001; Werner and Johnson, 2004). Collectively, these studies illustrate that the effects of parental alcohol use extend far beyond the household.

Qualitative studies provide important insight into the risk factors associated with growing up in families with alcohol use, highlighting how vulnerability manifests in the day to day experiences of children (Hagström and Forinder, 2022; Ross and Hill, 2001; Velleman and Templeton, 2016). Ross and Hill (2001) explored the narratives of 50 adult children in the U.S., documenting recurring themes of low self-esteem, trust difficulties, and relational challenges, often compounded by secrecy and shame surrounding familial circumstances. These findings underscore the emotional and social risks that persist beyond childhood, illustrating how early exposure to parental alcohol use can disrupt the development of adult children. Similarly, Velleman and Templeton (2016), through interviews with 30 adults in the U.K. about their childhoods, identified pervasive feelings of guilt and anger directed toward parents with alcohol use, reflecting the internalisation of familial dysfunction and the psychological burden associated with navigating chaotic or neglectful households. Hagström and Forinder (2019) further highlight how risk factors operate dynamically over time, with children aged 6–11 initially struggling to articulate their emotions about parental alcohol dependency, reflecting communication barriers and emotional suppression. These children often assumed caregiving

roles within their families, which, while sometimes fostering adaptive coping, simultaneously exposed them to heightened stress and emotional responsibility beyond their developmental capacity.

The gender of the parent with alcohol use also significantly influences the risk factors faced by their children. Research by Adamson and Templeton (2012) indicates that children whose mothers are the primary individuals struggling with alcohol face notably worse developmental and emotional outcomes than those whose fathers hold this role. Supporting this, Corte and Becherer (2007) explored the distinct consequences of maternal and paternal alcoholism on various outcomes, such as drinking behaviours, self-cognition related to alcohol, and mental health issues. Their findings reveal that paternal alcohol use serves as a risk factor for drinking behaviour in children (Corte and Becherer, 2007). This highlights the need to consider family dynamics and parental roles in research on the intergenerational effects of alcohol use.

Studies often focus on the risk factors with an emphasis on adult outcomes, such as anxiety, relational instability, and low self-worth, rather than the detailed, day to day mechanisms of risk exposure during childhood. Balsa et al. (2009), using a sample of 1,900 children, found that parental alcohol use caused children to take on a parental role. This early 'parentification' placed emotional strain on children. Veronie and Fruehstorfer's (2001) qualitative work further illustrates how children internalise family dysfunction, often taking on caregiving roles for their parents with alcohol use, leading to feelings of inadequacy and neglect of their own needs. The Kauai Longitudinal Study (Werner and Johnson, 2004) adds to this body of evidence, revealing turbulent home environments characterised by neglect and emotional chaos. However, as a survey-based study, it lacked the depth needed to fully capture the nuances of children's lived experiences. Collectively, these studies demonstrate that the lived experiences of children with parents who use alcohol are marked by overlapping psychological, relational, and social risk factors, which can shape long term vulnerabilities. However, limitations in sample size, cultural context, and retrospective reporting highlight the need for broader research to fully understand the diverse range of risks faced by adult children.

Familial and social contexts further influence the scale and severity of these risks (Hall and Webster, 2007; Herman, 2015; Järvinen, 2015; McEwen et al., 2015; Templeton et al., 2006; Velleman and Templeton, 2016). Dysfunctional family structures, parental neglect, and inconsistent caregiving are recurring features in households affected by alcohol use, creating environments where children must navigate complex emotional landscapes without adequate support (Hall and Webster, 2007, Velleman and Templeton, 2016). While strong external networks, such as extended family members, teachers, or supportive peers, can serve as protective buffers (McEwen et al., 2015), children with parents who drank are often isolated by secrecy, stigma, or shame (Templeton et al., 2006). This isolation compounds risk, limiting opportunities for emotional disclosure and help seeking. Broader social factors, including socioeconomic disadvantage, cultural attitudes toward alcohol, and the availability of community resources, also play a significant role (Järvinen, 2015, Herman, 2015). In lower income households, financial instability can magnify stress and insecurity, while societal stigma surrounding alcoholism may result in marginalisation and reduced access to support services (Templeton et al., 2006). The interplay of these familial and societal factors means that risk is rarely the result of a single element but emerges from the cumulative and interacting effects of multiple adversities, sustained over time.

2.4.1 Adverse Childhood Experiences (ACEs)

Parental drinking is widely recognised as one of the most prevalent adverse childhood experiences (ACEs), defined as potentially traumatic and likely to include abuse, neglect, and household dysfunction, which can have cumulative effects on long-term well-being (Anda et al., 2002; Bellis et al., 2018, 2019). Adverse childhood experiences (ACEs) are broadly defined as stressful or traumatic events occurring before the age of 18 that have the potential to disrupt healthy development and increase the likelihood of negative social, psychological, and health outcomes across the life course (Boullier and Blair, 2018; Felitti et al., 1998; UCL Institute of Health Equity, 2015). These experiences encompass: maltreatment and family or household dysfunction, including emotional, physical, and sexual abuse, parental substance use, mental illness, criminality, domestic violence, and parental separation (Burke Harris, 2018; Kelly-Irving et al., 2013). While ACE research has been influential in highlighting the predictive relationship between early adversity and outcomes such as substance use, depression, chronic illness, and premature mortality (Felitti et al., 1998; Burke-Harris, 2018),

it has faced criticism for several reasons. A biological and risk-focused lens found in much of the ACEs research may oversimplify the complex interplay of environmental, social, and psychological factors that influence development, often underestimating resilience, agency, and protective influences that can mitigate the impact of adversity (Kelly-Irving and Delpierre, 2019).

Anda and colleagues (2002) conducted a comprehensive study demonstrating a significant relationship between ACEs and parental alcoholism. The study involved a survey of 9,346 adults and found that individuals reporting parental alcohol abuse had a higher likelihood of experiencing all nine ACEs. Additionally, those with a history of parental alcohol use were statistically more likely to develop alcohol use and mental health issues as adults. The number of ACEs an individual has reflects an increased risk of negative outcomes. Evidence indicates a strong association between adverse childhood experiences (ACEs) and later-life substance use and mental health outcomes (Bethell et al., 2019). Individuals with an ACE score of four or more are more likely to have attempted suicide, engaged in injection drug use, and experienced depressive episodes compared to those reporting no ACEs (Bethell et al., 2019). Moreover, adults with an ACE score of two or more demonstrate a fourfold increase in the likelihood of identifying as having an alcohol dependency relative to those without ACEs (Bethell et al., 2019). Corroborating these findings, a large-scale longitudinal study conducted in Norway revealed a clear relationship, wherein higher ACE scores were consistently associated with elevated risks of substance use (Broekhof et al., 2023). Collectively, the evidence suggests that individuals with any history of ACEs possess a 4.3-fold greater likelihood of developing a substance use disorder compared to those with no such experiences (Broekhof et al., 2023). This connection highlights the critical importance of addressing childhood trauma in efforts to mitigate substance use issues in adulthood.

Research suggests that adult children of parents with alcohol use are particularly vulnerable to experiencing multiple ACEs, given that parental alcohol use often co-occurs with household dysfunction, neglect, and exposure to domestic violence (Anda et al., 2002; Dube et al., 2003; Meulewaeter et al., 2022; Velleman and Templeton, 2016). Large-scale quantitative studies provide compelling evidence for this heightened risk. Haugland et al. (2021), for example, analysed data from over 28,000 adults and found that parental alcohol use was associated

with perceptions of a difficult childhood, lack of support from trusted adults, and broader household dysfunction. These effects were evident well into adulthood, suggesting that the consequences of parental alcohol use are enduring. They further demonstrated that even occasional exposure to parental drinking increased the odds of experiencing ACEs and psychological difficulties during adolescence, while frequent exposure was linked to a wider array of adverse outcomes in young adulthood (Haugland et al., 2021). Although this study benefits from large sample sizes and robust statistical approaches, they are limited by the scope for what is considered an ACE which often lacks nuance, potentially obscuring the variability in severity, duration, and context of exposure.

While quantitative studies establish the heightened vulnerability of adult children, qualitative research provides a more nuanced understanding of how these individuals navigate their developmental trajectories. Bickelhaupt et al. (2019) conducted a qualitative study of young adult children and found that distancing themselves from a parent's alcohol use behaviours enabled greater control over their environment and fostered healthier outcomes (Bickelhaupt et al., 2019). This underscores the capacity for agency, resilience, and adaptive coping in mitigating the long-term impact of parental alcohol use. These studies are crucial for moving beyond risk-focused frameworks, highlighting the complex interplay between adversity, resilience, and personal agency in the lives of adult children.

Kelly-Irving and Delpierre (2019) have argued that the Adverse Childhood Experiences (ACEs) model has gained widespread recognition due to its simplicity and perceived originality in quantifying trauma. However, while the model was originally designed as a framework to explain the consequences of childhood adversity, it has since been adapted across various research and policy contexts (Kelly-Irving and Delpierre, 2019). This has led to an expansion of the concept, incorporating a broader range of traumatic experiences beyond the original categories. The ACEs model has been instrumental in highlighting the long-term impact of early adversity, reinforcing the link between childhood trauma and later-life health and behavioural outcomes (Anda et al., 2002; Felitti et al., 1998). Furthermore, studies have consistently demonstrated that individuals with a higher number of ACEs face significantly increased risks of developing mental health disorders, engaging in high-risk behaviours, and

experiencing chronic illnesses such as cardiovascular disease and diabetes (Anda et al., 2010, 2002).

The neurological impact of ACEs and trauma is a crucial area of study, as childhood represents a period of heightened neuroplasticity, during which brain development is particularly vulnerable to chronic stress (Burke Harris, 2018; Goddard, 2021, See Appendix 6). Chronic exposure to stressors—including parental substance use, domestic violence, or neglect—triggers sustained activation of the hypothalamic-pituitary-adrenal (HPA) axis, culminating in elevated cortisol levels (Burke Harris, 2018). Elevated cortisol levels over time contribute to structural and functional impairments in key brain regions, including the hippocampus, which plays a vital role in memory; the amygdala, responsible for emotional regulation; and the prefrontal cortex, which governs executive functioning and decision-making (Perry and Pollard, 1998; Shonkoff et al., 2012). These neurobiological disruptions can manifest as heightened anxiety, impulsivity, and difficulty regulating emotions, predisposing affected individuals to further risk-taking behaviours and mental health challenges (Burke Harris, 2018; Kelly-Irving and Delpierre, 2019; Shonkoff et al., 2012). Additionally, chronic trauma often results in hypervigilance, a state of persistent alertness to perceived threats, which may lead to social withdrawal or difficulties forming trusting relationships (Shonkoff et al., 2012).

The intergenerational transmission of trauma remains a significant concern, particularly in the context of parental alcohol use. Children of parents with alcohol use frequently experience multiple traumatic events within a single household, increasing their risk of encountering complex trauma (Anda et al., 2002). Furthermore, research suggests that individuals exposed to high levels of childhood trauma are more likely to struggle with emotional regulation, engage in maladaptive coping mechanisms, and inadvertently perpetuate cycles of adversity in their own parenting practices (Anda et al., 2010). Within this context, adult children are a particularly vulnerable group (Goddard, 2021; Bellis et al., 2015). Overall, while the literature consistently frames adult children within a risk narrative, emphasising vulnerability to emotional, behavioural, and relational difficulties, this focus may inadvertently limit attention to resilience, adaptive coping, and other positive developmental outcomes within this population.

Despite growing recognition of risk and resilience, the ACEs literature regarding parental drinking continues to be dominated by studies conducted in the USA and Europe, with relatively few examining Scottish or other UK-specific contexts, despite high levels of alcohol-related harm (Scottish Government, 2024a; Walsh et al., 2021). Most ACE research on parental drinking emphasises negative outcomes, often neglecting the strategies adult children employ to navigate, resist, and adapt to adversity. This limits the understanding of how protective factors such as supportive relationships, community engagement, and individual coping strategies interact with exposure to parental alcohol problems. Moreover, the social, cultural, and policy contexts, such as access to mental health services, educational support, and community interventions, remain underexplored, yet they are likely to shape both risk and resilience trajectories.

2.5 Protective Factors and Resilience

Understanding the dynamics of protective factors and resilience can help understand childhood experiences involving parental alcohol use. Adult children are more likely to be exposed to more risk factors as children compared to the general population and have fewer protective factors (Braitman et al., 2009; Christoffersen and Sothill, 2003; Ross and Hill, 2001; Templeton et al., 2006). Protective factors are attributes, relationships, or environmental conditions that help mitigate these risks and promote resilience in children (Velleman and Templeton, 2016; see Appendix 7). According to Adamson and Templeton (2012), protective factors can enhance coping mechanisms, enabling children to navigate the challenges presented by their family environments (see Appendix 8). Recognising these factors provides a framework for understanding how some children are better equipped to cope with the adverse effects of growing up in families where parental alcohol use is prevalent. However, quantitative and qualitative research has primarily focused on psychological risk factors and the familial transmission of alcohol use rather than on protective factors and coping mechanisms, the preceding section providing examples of this (Balsa, 2008; Balsa et al., 2009; Braitman et al., 2009; Newcomb and Rickards, 1995; Park and Schepp, 2015; Sher et al., 1991; Tweed and Ryff, 1991; Veronie and Fruehstorfer, 2001; Wegscheider, 1981; Wlodarczyk et al., 2017).

2.5.1 Protective Factors

Protective factors play a crucial role in shaping the experiences and outcomes of adult children, but their effectiveness can vary significantly based on individual and contextual variables. Velleman and Templeton (2016) offer a comprehensive list of protective factors, including individual, familial, and community dimensions. Individual factors encompass emotional regulation and proactive coping strategies, while family factors stress the significance of stable relationships with non-substance-using adults, consistent family life, and effective communication. Community factors, including social networks, positive school experiences, and active community engagement, are equally vital. A systematic review by Wlodarczyk et al. (2017) supported this and found several protective factors associated with positive mental health outcomes in children of parents with alcohol and drug use disorders, including secure parent-child attachment, family cohesion, and social support, which collectively contribute to resilience in this population (Wlodarczyk et al., 2017). However, it is essential to recognise that these protective factors do more than just reduce risk; they interact with social and environmental influences, shaping coping skills that can help or hinder a child's ability to adapt and thrive. Thus, while protective factors hold potential, they do not encompass the wide range of experiences of adult children; positive, negative and neutral, highlighting the need for more nuanced understanding and intervention strategies tailored to the unique circumstances of children with parents who drank.

The Ask The Family Report (2021) underscores the significance of protective factors that can lead to more positive outcomes for adult children in Scotland (Scottish Families Affected by Alcohol and Drugs, 2021). However, it is essential to critically evaluate the implications and the broader context in which protective factors operate. For instance, the existence of a supportive adult who abstains from drinking can indeed mitigate some negative outcomes for children, but there are many cases in which both parents drink alcohol. The *My World: National Study of Youth Mental Health in Ireland*, led by Dooley and Fitzgerald (2012), illustrates the critical role of 'one good adult' in bolstering the mental well-being of young people in alcohol-affected households. The finding that over 70% of participants benefitted from this support highlights a significant relationship (Dooley and Fitzgerald, 2012); however, it also raises questions about the implications for those who lack such support, suggesting that reliance on a single protective figure may not be sufficient for all children. The factors

contributing to positive outcomes often include support from parents or family members, as confirmed by research (Werner and Johnson, 2004). Yet, the emphasis on familial support must be contextualised within the complex dynamics of families affected by alcohol use. Focusing on one protective factor may inadvertently downplay the systemic issues that can render such support inconsistent or unavailable in many households.

Parental alcohol use significantly influences children's psychology and behaviour, with gender playing a pivotal role in how these effects manifest. Kelly et al. (2011) found that positive family environments serve as protective factors against adolescent alcohol use. However, these protective effects differ between genders. For instance, emotional closeness with mothers is a significant influence on daughters' drinking behaviours, especially in contexts where they are exposed to high-risk peer networks. In contrast, for sons, the quality of the father-son relationship and the father's alcohol use behaviours are more strongly associated with the son's alcohol use (Kelly et al., 2011). Additionally, gender differences extend to coping mechanisms. Adolescent girls are more likely to initiate alcohol use due to psychosocial factors such as lack of family social support and peer influences, whereas these factors have a lesser impact on boys (Sipilä et al., 2023). Furthermore, maternal alcohol use has been found to significantly affect sons' later drinking behaviours, while paternal alcohol use has a more substantial impact on daughters (Sipilä et al., 2023). The interplay between the risks posed by parental alcohol use and the protective factors arising from family dynamics highlights the necessity of a nuanced understanding of how these elements affect children at differing levels.

Personal qualities such as emotional intelligence and coping skills are often cited as key protective factors; however, the mere presence of these attributes does not guarantee resilience (Velleman and Templeton, 2016). For instance, a child with parents who drank who possesses a strong belief in their active agency may attempt to manage toxic stress proactively, but this coping strategy is contingent on the availability of supportive environments and resources (Adamson and Templeton, 2012; Velleman and Templeton, 2016). Templeton et al. (2006) broadened the discussion surrounding protective factors by incorporating a diverse range of influences that affect adult children. They demonstrated that individual protective factors, like self-control, effective coping strategies, and positive

relationships, do not operate in isolation but are intricately linked to family dynamics and community resources (Templeton et al, 2006). This underscores a critical point: individual protective factors such as self-control and self-efficacy may be rendered ineffective in the absence of a supportive family or community context.

2.5.2 Resilience and Coping Mechanisms

Resilience, defined as the ability to adapt to and recover from stress and adversity, is crucial for understanding the varied experiences of children with parents who drank (Masten, 1994). Numerous studies highlight that protective factors significantly influence resilience, shedding light on why some individuals cope more effectively than others when confronted with adverse experiences (Bancroft et al., 2004; Velleman and Orford, 1999). While resilience is recognised as essential for managing adversity (Rutter, 1985), its definition is not uniformly agreed upon, leading to differing interpretations in the literature (van Breda, 2018). It encompasses a range of beliefs and attitudes, such as the conviction that challenges can be overcome (Werner, 1995), a learned sense of optimism (Seligman and Kidman, 1992), and a feeling of personal control and hopefulness (Walsh, 1996).

In the context of adult children, resilience is profoundly shaped by family dynamics. Gaşior (2014) explored the varying childhood experiences of these individuals and found that protective factors, including the presence of a non-drinking parent and supportive sibling relationships, were critical in fostering resilience. The study classified adult children according to their family environments, revealing that those with fewer risk factors exhibited greater resilience, thereby underscoring the importance of positive familial interactions in mitigating the adverse effects of childhood experiences. Further research by Coyle et al. (2006) supports the role of family relationships in developing resilience among adult children. Their study examined the functionality of families affected by alcohol-related issues and identified three distinct family types concerning resilience: high, middle, and low intensity (Coyle et al., 2009). This classification highlights a spectrum of resilience among families dealing with alcoholism, suggesting that while many may demonstrate lower resilience, they can still cultivate adaptive capacities through effective communication and problem-solving skills (Coyle et al., 2006). The literature indicates that the pathways to resilience vary significantly across individuals and contexts (Brisby et al., 1997; Coyle et al., 2009; Park and Schepp, 2015) and that not all

families impacted by alcoholism share the same dynamics, and understanding their unique characteristics is crucial for fostering resilience.

Coping mechanisms refer to the strategies and behaviours that individuals utilise to manage stressors and adverse experiences. Adamson and Templeton (2012) argue that specific coping behaviours, such as avoiding the home during parental intoxication or seeking out supportive adult relationships, significantly impact outcomes for adult children. However, a coping strategy that proves beneficial in one situation might become detrimental in another. For example, focusing intensely on education can serve as a positive coping mechanism for children by providing structure and a sense of control, but it can turn negative if it develops into perfectionism or workaholism that masks underlying emotional needs. Some children may view their parents' substance use as a deterrent, while others might emulate similar behaviours to manage emotional turmoil (Kroll, 2004). The effectiveness of these coping mechanisms is often contingent upon contextual factors, including family dynamics and individual differences, and they are intricately linked to the development of resilience (Velleman and Templeton, 2016). For instance, children who employ effective coping strategies can cultivate resilience, enabling them to better adapt to their circumstances and recover from challenges. The roles that children assume based on their birth order can also play a crucial role in shaping their coping abilities and, consequently, their resilience. For instance, later-born children who develop strong problem-solving skills and actively seek support may demonstrate greater resilience than first-born siblings who adopt caretaker roles, often at the expense of their own needs (Veronie and Fruehstorfer, 2001).

Children with parents who drank undoubtedly have more traumatic or adverse childhood experiences compared to children who did not (Anda et al., 2002; Eiden et al., 2010; Leonard, 2002). While research on protective factors, risk factors, resilience, and coping mechanisms provides some explanations for the diverse experiences of children with parents who drank, these factors alone do not fully capture the complexity of their situations. Velleman and Templeton (2016) suggest that resilience cannot be generalised; it is influenced by a myriad of factors that may manifest differently in individuals. This complexity necessitates a deeper exploration of the interplay between protective factors and resilience to gain a clearer understanding of how children with parents who drank can not only survive but thrive despite

their challenging backgrounds, looking for commonalities in individuals which may be replicated. By examining these studies and their findings, we gain a better understanding of protective factors such as social support, positive familial relationships, and effective strategies contribute to resilience despite the adverse circumstances these individuals may encounter. Continued research in this area, including how adult children view their own experiences as either protective or not, is essential to enhance our understanding of adult children in navigating their experiences and promoting healthier outcomes in their lives.

2.6 Experiences of Adult children as Adults

The experiences of adult children are deeply influenced by their childhood environments, but these impacts often manifest in complex ways during adulthood. Graeber et al. (2017) emphasise that regardless of the variety of adverse experiences encountered in childhood, it is the perceived impact of these events that significantly shapes an individual's health and well-being in adulthood (Graeber et al., 2017). The psychological impact of growing up in such environments can manifest in low self-esteem, social isolation, and maladaptive coping mechanisms (Velleman and Templeton, 2016). Studies by Balsa et al. (2009) and Sher et al. (1991) reinforce the idea that adult children face a range of negative outcomes, including higher risks of substance use, mental health problems, and unemployment. However, it is critical to note that the specific experiences of adult children play a significant role in shaping their life trajectories (Braitman et al., 2009; Nation and Heflinger, 2006; Ross and Hill, 2001). Braitman et al. (2009), in a quantitative U.S. study of 1,207 adults, identified marked emotional distress rooted in childhood experiences, with participants reporting feelings of neglect, anxiety, and insecurity. These emotional difficulties often persisted into adulthood, influencing self-perceptions and the ability to form stable relationships (Braitman et al., 2009). Importantly, despite the documented risks, many adult children manage to lead fulfilling and productive lives. This complexity makes it difficult to uniformly view the narratives of adult children, as the impact of experiences can fluctuate based on individual circumstances and life stages.

This section provides an overview of the main themes common in the literature on experiences of adult children as adults. There is a consideration of the increased risk of substance use and mental health problems among adult children, which has often been the

focus of studies, ignoring wider experiences of adult children (see Section 2.6.1), providing a gap in research in which more in-depth qualitative work is needed. There is then a consideration of broader socioeconomic influences on adult children's lives (section 2.6.2). The impact their experiences have on relationships and attachment is then considered (section 2.6.3). Much existing research on adult children focuses narrowly on measurable outcomes, such as substance use, mental health issues, or employment difficulties, often using survey-based designs. While these studies provide valuable data, they do not capture how individuals experience and interpret parental alcohol use, or how coping, resilience, and identity development unfold over time. Consequently, there remains a gap in understanding the nuanced social, familial, and cultural contexts of adult children, highlighting the need for qualitative, retrospective accounts that explore the processes underlying the full range of experiences.

2.6.1 Substance Use and Mental Health

The outcomes experienced by adult children can significantly diverge from those of individuals not raised in environments characterised by parental alcohol use (Balsa, 2008; Forrester and Harwin, 2008). Research indicates a spectrum of adverse consequences, including heightened risks for mental health disorders, unemployment, and substance use (Balsa, 2008; Braitman et al., 2009; Forrester and Harwin, 2008; Nation and Heflinger, 2006; Ross and Hill, 2001). Research by Dillon et al. (2007) has shown that the number of risk factors to which an individual is exposed is predictive of substance use⁷ (Dillon et al., 2007). Supporting this research, the Home Office's literature review on risk factors and drug use in the UK identified various factors associated with increased substance use, including parental discipline, family cohesion, peer drug use, and genetic predispositions (Fisher et al., 2007). Numerous studies indicate that adult children are significantly more likely to engage in substance use themselves (Braitman et al., 2009; Christoffersen and Soothill, 2003; Epstein et al., 2020; Gilvarry, 2005; Kerr et al., 2020; Landberg et al., 2018; Ross and Hill, 2001; Sher et al., 1991).

Research linking adult children to substance use encompasses a range of studies across different countries and populations, highlighting significant negative outcomes associated

⁷ Defined as using drugs, including alcohol.

with growing up with parental alcohol use. Sher et al. (1991) examined U.S. adults to investigate the long-term relationship between parental alcohol use and drug-related problems, finding that adult children experienced higher rates of substance use. Balsa et al. (2009) used a large-scale survey to explore mental health outcomes among adult children with parents who drank, showing elevated risks of depression and anxiety, while an earlier study by Balsa (2008) focused on employment patterns and identified higher rates of unemployment in this population. In the UK, Gilvarry (2005) conducted a retrospective questionnaire with 746 adults raised in households affected by alcohol use or parental mental health issues, examining mental health and substance outcomes, and demonstrating increased likelihoods of substance dependence, suicidal ideation, and eating disorders compared to controls. Braitman et al. (2009) explored patterns of intergenerational substance use among college students, supporting findings by Christoffersen and Soothill (2003), who examined broader survey data on the social and behavioural consequences of parental substance use. Epstein et al. (2020) carried out a longitudinal study tracking children of parents with chronic alcohol and marijuana use, showing that these individuals remained at elevated risk of substance use even years after parental use ceased. Similarly, Kerr et al. (2013), Landberg et al. (2018), and Ross and Hill (2001) investigated the association between family histories of alcohol use and adult children's drinking behaviours using community and population-based samples. Collectively, these studies, spanning retrospective, cross-sectional, and longitudinal designs, highlight consistent patterns of substance use and related difficulties among adult children (Nation and Heflinger, 2006; Braitman et al., 2009).

Research by Kerr and colleagues (2013) further elaborates on this, they found that children with parents who drank are often caught in a cycle of unhealthy relationships and poor coping strategies, which can perpetuate the risk of substance use in adulthood. This perspective is complemented by the findings of Braitman et al. (2009) and Christoffersen and Soothill (2003), which indicate that adult children are at an increased risk of engaging in substance use themselves. There is compelling evidence that individuals with a history of parental alcohol use are more likely to use alcohol in adulthood (Landberg et al., 2018; Rossow et al., 2016; Yap et al., 2017). Potential explanations for this intergenerational use include genetic predispositions and environmental influences (Hawkins et al., 1992). For example, Braitman and colleagues (2009) found that college-aged adult children were more likely to use alcohol

at a younger age compared to 'non-adult children'. This earlier initiation is significant, as it is associated with an increased risk of developing problematic drinking patterns later in life, suggesting that parental alcohol use may influence not only whether individuals drink, but also how and when drinking behaviours begin. Similarly, Ross and Hill (2001) found that family histories of alcohol use were linked to increased drinking. This relationship may reflect both learned behaviours within the family environment and potential genetic vulnerability, making it difficult to disentangle the relative contribution of each factor. Additionally, research by Epstein et al. (2020) found that children of parents who engaged in substance use were more likely to adopt similar behaviours. However, it is important to recognise that not all children exposed to parental alcohol use go on to develop similar patterns, highlighting the role of protective factors.

Meulewaeter et al. (2022) conducted a qualitative study examining the experiences of adult children of parents with substance use disorders in Flanders, Belgium, focusing on the risks associated with substance use within this demographic. Through in-depth interviews, the researchers aimed to illuminate how growing up in an environment marked by parental substance use can increase the likelihood of these individuals engaging in substance use themselves (Meulewaeter et al., 2022). The findings revealed themes of loneliness and neglect during childhood, the stigma linked to having a parent with substance issues, and the influence of social connections on substance use behaviours. Participants frequently reported emotional neglect and a lack of parental support, which contributed to feelings of isolation and distress. This emotional vulnerability was compounded by the stigma surrounding their upbringing, creating barriers to seeking help and increasing the risk of developing maladaptive coping strategies, including substance use (Meulewaeter et al., 2022). Additionally, the study highlighted how peer pressure and a desire for belonging led many participants to experiment with substances, often as a means of coping with emotional pain, further exacerbated by the normalisation of substance use in their social circles. However, while the study underscores these risks, it falls short of sufficiently exploring how protective factors, such as supportive relationships, might mitigate these challenges. By emphasising emotional pain and stigma without addressing resilience and coping strategies, the research risks perpetuating a one-dimensional narrative that positions adult children solely as victims, neglecting the complexities of their adaptive responses and the potential for healthier

outcomes (Eiden et al., 2010; Jaccard et al., 2005; Meulewaeter et al., 2022). A more balanced exploration of both risk factors and resilience would provide a comprehensive understanding of the challenges faced by this population.

Gender also plays a critical role in shaping the experiences of adult children, influencing not only their personal circumstances but also the dynamics associated with the drinking parent (Adamson and Templeton, 2012; Laycock and Ryan, 2024; Veronie and Fruehstorfer, 2001). The literature highlights how social perceptions of drinking behaviours differ between genders, as individuals who believe that others drink heavily and approve of such behaviour are more likely to increase their own consumption to fit in and avoid social disapproval (Halim et al., 2012). In certain contexts, such as sports, alcohol consumption becomes a male bonding activity, often embedded in patterns of sexism, racism, and homophobia (de Visser and Smith, 2007; Gough and Edwards, 1998). This reinforces traditional notions of masculinity, where men may use drinking as a means to assert their identity and engage in risk-taking behaviours that negatively impact health outcomes (Thom, 2003). Conversely, for women, alcohol can serve as a respite from the pressures of both paid and unpaid labour, offering a chance to relax. However, women often navigate their drinking within the confines of 'respectable' societal roles, typically drinking only after fulfilling their responsibilities as employees, partners, and mothers (Emslie et al., 2015, 2013). Although studies indicate that rates of substance use and alcohol-related mortality are generally higher among men (Cotto et al., 2010; Emslie and Mitchell, 2009), recent findings reveal that binge drinking is also prevalent among women, challenging traditional gender norms (Emslie et al., 2015). This highlights how individual differences in drinking behaviour may differ based upon gender but for reasons broader than traditional gender-based distinctions.

While existing studies provide valuable insights into the intergenerational impact of parental alcohol use, they also present specific strengths and limitations. Retrospective studies, such as Gilvarry (2005), are particularly useful for identifying long-term patterns and associations between childhood experiences and adult outcomes, allowing participants to reflect on their experiences after processing them. Cross-sectional research, including Sher et al. (1991) and Balsa et al. (2009), provides a snapshot of associations between parental alcohol use and later substance use but cannot establish causality or fully account for other influencing factors,

such as socioeconomic status or genetic predisposition. In contrast, longitudinal studies, like Epstein et al. (2020), track individuals over time and offer stronger evidence of long-term effects. Nevertheless, they are often constrained by sample attrition, which can skew results if participants drop out.

Another limitation across much of the literature is a predominant focus on negative outcomes, with less attention paid to resilience and protective factors, such as supportive relationships, coping strategies, and access to early interventions. Braitman et al. (2009) note that while adult children may initiate substance use earlier than peers, this does not necessarily lead to addiction; many develop effective coping mechanisms that mitigate risk. Similarly, Ross and Hill (2001) highlight that some adult children successfully avoid significant substance use problems through adaptive strategies. Sampling methods also influence findings. Studies often rely on participants from support groups or clinical settings, which may overrepresent those experiencing difficulties, while underrepresenting adult children who have navigated their challenges successfully (Alford, 1994). A more representative sample, including both support-seeking and non-support-seeking adult children, could provide a fuller understanding of their experiences. Taken together, these observations underscore the importance of considering both risk and protective factors and suggest that future research would benefit from qualitative approaches that explore the full spectrum of childhood experiences among adult children. As Velleman and Templeton (2016) point out, many adult children can lead healthy, productive lives, challenging the assumption that all individuals from such backgrounds will inevitably struggle with substance use. Therefore, it is crucial to adopt a more nuanced understanding of the complexities surrounding substance use among adult children, acknowledging both their vulnerabilities and strengths.

2.6.2 Education, Income, Housing and Employment

Adult children often face significant challenges in educational attainment, housing stability, income, and employment, all of which are closely intertwined with their upbringing in environments marked by substance use. Research indicates that these individuals may struggle academically due to the emotional and psychological burdens stemming from their childhood experiences (Braitman et al., 2009; Velleman and Templeton, 2016; Gilvarry, 2005). For instance, Braitman et al. (2009) found that college students from alcohol use backgrounds

often demonstrate lower academic performance and higher dropout rates compared to their peers. The emotional turmoil and instability associated with growing up in an alcohol use household can impair cognitive functioning and focus, hindering academic achievement (Braitman et al., 2009). Additionally, the lack of parental support and involvement typically seen in families with substance use can further exacerbate these educational challenges, leaving adult children feeling unprepared for the demands of higher education. Velleman and Templeton (2016) also emphasise that adult children frequently face emotional and behavioural issues that can contribute to academic difficulties, as they may struggle with low self-esteem and anxiety, further impacting their educational trajectories.

The repercussions of growing up in a household with alcohol use can extend into housing outcomes as well. Gilvarry (2005) identified that adult children are more likely to experience housing instability and face difficulties in securing stable living arrangements. This instability can manifest in frequent moves, living with multiple families, or relying on temporary accommodations, all of which can disrupt their sense of security and belonging (Gilvarry, 2005). The inability to establish stable housing is often linked to financial difficulties, which may stem from the lack of a solid educational foundation. As previously shown, childhood social insecurity, such as the lack of financial support from parents during the transition to adulthood, can have significant implications for later development. Balsa (2008) noted that adult children have an increased likelihood of unemployment or underemployment, limiting their financial resources and ability to secure stable housing. The resulting financial instability further exacerbates their educational challenges and can lead to a cycle of poverty that is difficult to break.

In addition to educational and housing challenges, employment outcomes are particularly concerning for adult children. Research has shown that these individuals often face barriers to obtaining and maintaining stable employment, which is often linked to their educational struggles and psychological challenges (Velleman and Templeton, 2016). For example, Velleman and Templeton (2016) highlight that adult children may have difficulty in professional environments due to low self-esteem, anxiety, and issues related to emotional regulation. Furthermore, Balsa (2008) found that these individuals are more likely to experience unemployment or job instability, which directly affects their financial situation

and overall well-being. The inability to secure steady employment not only limits their income but also perpetuates a cycle of instability that can affect their housing situation. Gilvarry (2005) pointed out that adult children often found themselves in precarious job situations, further complicating their ability to achieve financial independence. The cumulative effects of these factors illustrate the interconnected nature of educational outcomes, housing stability, income, and employment for adult children, emphasising the long-lasting impact of their upbringing on their ability to achieve stability and success in adulthood.

2.6.3 Relationships and Attachment

Adult children often experience difficulties in their attachment styles and interpersonal relationships, stemming from the emotional neglect and instability prevalent in their childhood environments (Velleman and Templeton, 2016; Braitman et al., 2009). Research has shown that these individuals frequently develop insecure attachment styles, manifesting as either anxious or avoidant behaviours in their adult relationships (Beesley and Stoltenberg, 2002; Kroll and Taylor, 2000; Newcomb and Rickards, 1995). Living in a substance using household can negatively impact the emotional support necessary for children to develop secure attachments (Gilvarry, 2005; Windle and Searles, 1990). As a result, adult children may struggle with trust issues, fear of abandonment, and difficulty expressing their emotions or needs within relationships (Walsh and Shapiro, 2006). Velleman and Templeton (2016) emphasise that these attachment challenges can hinder their ability to form healthy and stable relationships, leading them to either cling excessively to partners out of fear of being alone or withdraw emotionally to protect themselves from potential hurt. Additionally, Beesley and Stoltenberg (2002) found that adult children often exhibit a heightened need for control, complicating their relationship dynamics and contributing to lower overall relationship satisfaction. Research by Braitman et al. (2009) further supports the notion that adult children often enter into relationships characterised by volatility, codependency, or emotional unavailability.

Furthermore, adult children frequently grapple with emotional regulation issues within their relationships. Due to the emotional neglect experienced in childhood, they may struggle to identify and articulate their feelings, leading to misunderstandings and conflict with partners. Research by Christoffersen and Soothill (2003) highlights the difficulties some these

individuals face in managing their emotions, often oscillating between emotional extremes or resorting to maladaptive coping strategies, such as substance use or withdrawal, to handle relational stress. While these findings are critical for understanding the challenges faced by adult children, they often lack exploration into the internal thinking of adult children based on their experiences (Kolk et al., 2009). This emotional dysregulation can further strain their relationships, contributing to a cycle of instability and disappointment. As Velleman and Templeton (2016) note, the pervasive effects of growing up in a household with alcohol use not only shape attachment styles but also influence the overall quality and stability of adult relationships, underscoring the long-term emotional ramifications of such experiences. Additionally, a review by Harter (1998) indicates that adult children face heightened risks for various negative psychosocial outcomes, including difficulties in family relationships, low self-esteem, and generalised distress.

While these studies provide valuable insights into the attachment styles of adult children, the focus on insecure attachment and negative outcomes can create a deterministic view of their relationships, neglecting the adaptive strategies some individuals develop in response to their challenging backgrounds (highlighted by Beesley and Stoltenberg, 2002; Kelley et al., 2005). This one-dimensional perspective risks reinforcing stigma, suggesting that adult children are inherently predisposed to dysfunction without recognising the potential for growth and positive change (Haverfield and Theiss, 2016). Windle and Searles (1990) point out that the emphasis on negative outcomes in existing studies contributes to a deterministic narrative, overlooking the potential for resilience and positive adaptation (Hutchinson et al., 2014; Windle and Searles, 1990). A research design that explores both the positive and negative experiences of adult children can provide a richer, more nuanced understanding of childhood life in households affected by parental drinking.

2.7 Conclusion

The literature review highlights the difficulties involved in viewing alcohol use in isolation from other factors and the importance of placing it in a wider context. Adult children are more likely to experience traumatic or adverse childhood experiences than those without such backgrounds (Anda et al., 2002; Eiden et al., 2010; Leonard, 2002). However, the reasons for the diversity of outcomes within this group remain insufficiently understood. While research

on protective factors, risk factors, resilience, and coping mechanisms provides partial explanations, these concepts alone do not account for the varied levels of influence that can shape adult children's lives.

As discussed, the existing literature on adult children has largely prioritised the negative impacts of growing up in an alcohol using household, often framed within a risk narrative and conducted predominantly through quantitative methods leaving little room for adult children's 'voices' (Velleman and Templeton, 2016). Common issues identified include insecure attachment, emotional dysregulation, and tendencies toward codependent or volatile relationships (Beesley and Stoltenberg, 2002; Velleman and Templeton, 2016). While these findings have value, they disproportionately emphasise dysfunction and underplay the potential for resilience, growth, and adaptive coping strategies. Furthermore, much of the current literature draws on quantitative self-report measures from US populations (Balsa, 2008; Balsa et al., 2009; Braitman et al., 2009; Newcomb and Rickards, 1995; Sher et al., 1991; Tweed and Ryff, 1991; Veronie and Fruehstorfer, 2001; Wegscheider, 1981), which limits the exploration of personal, qualitative accounts and fails to capture the complex interplay between individual, familial, community, and societal factors. This narrow focus reinforces an overemphasis on substance use, which overlooks the unique experiences relating to parental drinking, and dysfunctional outcomes, leaving other important dimensions of adult children's lives underexplored.

What is clear from the literature is that a variety of factors, individual, familial/relationship, community, societal and political and historical conditions provide a means to understand children's experiences of parental alcoholism. Yet research to date has tended to prioritise the individual and familial dimensions first, with the wider structural environment treated as secondary. This study intentionally reframes that approach, placing the wider social, economic, and cultural environment at the centre of analysis. The literature review underscores the difficulty of viewing alcohol use in isolation from other life circumstances and highlights the importance of situating it within its broader context. This provides the rationale for a locally focused study, particularly within Glasgow, a city with a distinctive socioeconomic and cultural history of alcohol use and use. This reflexive approach positions participants' experiences within the larger context of place. By doing so, this study seeks to develop a more

nuanced and context-specific understanding of how adult children interpret the impact of their parent's drinking on their childhoods, and how they believe these experiences have influenced their adult lives.

Chapter 3: Glasgow as a Setting for this Research

3.1 Introduction

The literature review showed that parental alcohol use cannot be fully understood in isolation from the broader conditions in which it occurs. This thesis therefore reframes parental drinking as part of a nexus of inter-related factors, embedded in wider social, economic, and cultural circumstances. Glasgow provides a particularly valuable context for such an approach because of its distinctive historical relationship with alcohol and the ways this has intersected with family life and community experience. Participants in this study were born in 1966-1988 (with the exception of one participant born 1956). From the 1950s onwards, Glasgow became associated with heavy drinking and alcohol-related harm (Shipton, 2014; Walsh et al., 2017). Compared to the rest of Scotland, the city had the highest rate of alcohol deaths per 100,000 population from 1979–1983 (Understanding Glasgow, 2016). This period coincided with profound social and economic change in the city, as industrial decline, unemployment, and poverty shaped the lives of many families. Alcohol was not only a health concern but also linked to deindustrialisation, urban policy changes and social fragmentation creating complex environments in which children grew up. These challenging environments are compounded by the high prevalence of adverse childhood experiences (ACEs) in communities affected by alcohol and drug use, which intensified existing inequalities (Ellaway et al., 2010; Scottish Government, 2020). By tracing Glasgow's history of alcohol use from the 1960s through to the 2000s, this chapter situates parental drinking within its wider context, showing how it interacted with broader adversities such as economic insecurity, family disruption, and intergenerational hardship. In doing so, Glasgow is positioned not merely as a backdrop, but as a central lens through which to understand participants' experiences of parental alcohol use.

The chapter will first outline Glasgow's socioeconomic and cultural history during this period, then the city's experience with alcohol, before considering how these wider conditions shaped the environments in which children encountered parental drinking. This provides the foundation for exploring how participants interpret these experiences.

3.2 Glasgow, 1960s-2000s

From the 1970s onwards, Glasgow experienced profound socioeconomic transformations that have had long-lasting impacts on its population (Walsh et al., 2017). The decline of

traditional industries, such as shipbuilding and manufacturing, caused widespread job losses, economic instability, and increasing poverty. Deindustrialisation, from the 1950s to present day, particularly affected working-class communities, creating cycles of unemployment and deprivation that persisted across generations. Alongside these high levels of deprivation, there were also issues with increasing levels of social housing. Many families continued to face inadequate housing standards and broader social exclusion, illustrating the limits of rehousing policies in addressing structural disadvantage (Walsh et al., 2017). These overlapping processes of industrial decline and mass rehousing shaped the environments in which Glaswegians lived, embedding disadvantage in both work and home life, and leaving many households increasingly vulnerable to the social harms associated with alcohol use.

3.2.1 Deindustrialisation

The rapid deindustrialisation that took place deeply affected Glasgow's employment and social structures. Heavy industries such as shipbuilding, steelworks, and engineering, which had long been the city's economic backbone, collapsed, leading to significant job losses, especially among working-class men (Pacione, 2004). This structural shift resulted in widespread unemployment and economic instability; factors which have been found to impact the prevalence of alcohol use. Research has shown that the loss of stable, well-paid employment led to an increase in mental health disorders, including depression and anxiety, particularly among former industrial workers and their families (Hanlon et al., 2006). As a result, Glasgow began to experience some of the highest rates of health inequalities in the UK, which were often linked to social and economic deprivation.

Walsh and colleagues (2010) compared Glasgow with Manchester and Liverpool, cities that share similar levels of deprivation and industrial histories, to understand why Glasgow experiences significantly poorer health outcomes, a phenomenon sometimes erroneously termed the 'Glasgow Effect'. While all three cities were shaped by rapid deindustrialisation, Walsh and colleagues (2010) argue that Glasgow's experience was particularly acute and destabilising, with earlier and more severe industrial decline, large-scale housing clearances, and associated patterns of population dispersal. These processes not only undermined economic stability but also disrupted social cohesion and community structures to a greater degree than in the English comparator cities. Such historical and structural differences help

but do not completely explain why, despite comparable socioeconomic conditions, Glasgow exhibits persistently higher rates of premature mortality and chronic ill health (Walsh et al., 2010).

3.2.2 Urban Policy Changes

Housing policies played a crucial role in shaping Glasgow's socioeconomic landscape during this period. From the 1950s to the 1980s, large-scale housing redevelopment programs were launched in response to overcrowding and poor living conditions in Glasgow's tenements (Thompson-Fawcett, 2004). From the 1950s through to the 1970s, tens of thousands of residents were moved out of overcrowded tenements into newly built estates on the city's periphery, including Easterhouse, Castlemilk, and Drumchapel, as well as into large numbers of tower blocks whilst many traditional buildings were demolished (Abrams et al., 2020; Damer, 2018). By the early 1970s, Glasgow stood out for the extent of its municipal housing, with around 66% of households renting from the council, this became 70% by the mid-1970s; the highest proportion recorded in the UK at that time (Damer, 2018; Kearns et al., 2019). However, the scale of provision did not necessarily translate into improved living conditions. While these developments were intended to provide modern housing solutions, they often led to social isolation, poor infrastructure, and a lack of local amenities (McKee, 2010).

3.2.3 Social Fragmentation

The consequences of these housing policies extended beyond the physical environment, influencing social behaviour across Glasgow. The relocation of communities often fractured established social networks, weakening the informal support systems that had previously helped during economic and social stress (Egan et al., 2015). The peripheral estates frequently lacked accessible public transport, shops, and community centres, reinforcing social isolation, particularly among the elderly and unemployed (Thompson-Fawcett, 2004). Research has shown that such urban restructuring contributed to elevated levels of mental health issues, substance use, and youth delinquency in affected neighbourhoods (Macintyre et al., 2002). Additionally, the separation of low-income individuals and families into concentrated estates intensified patterns of deprivation and inequality (Walsh et al., 2017). This decline in community cohesion, coupled with economic hardship, further exacerbated social problems, including alcohol and drug dependency (Richardson et al., 2015).

3.2.4 Glasgow City of Culture and Cultural Resurgence

From the late 1980s onwards, Glasgow underwent a deliberate process of cultural revitalisation that significantly altered both its image and civic identity. Initiatives such as the Glasgow Eastern Area Renewal (GEAR) project (1976–1987), Further and Higher Education Act 1992, Glasgow’s designation as European City of Culture 1990 and Sure Start 1998 all contributed to Glasgow’s changing culture.

At the community level, housing associations played a key role in urban regeneration by improving living conditions and promoting local engagement (Robertson, 1998), while earlier initiatives such as the Glasgow Eastern Area Renewal (GEAR) project (1976–1987) had already attempted to tackle deprivation through coordinated support services and community participation (Nairn, 1983; Wannop, 1990). These efforts were complemented by wider policy reforms aimed at expanding educational and employment opportunities, particularly for those from disadvantaged backgrounds. From the 1980s onwards, competency-based vocational education and training (VET) and school leaver programmes were introduced to address youth unemployment and enhance practical skills, with their scope and quality improving over time (Mulder, 2019; Paterson, 2022). The Further and Higher Education Act 1992 marked a significant shift by removing institutional divisions between colleges and universities, contributing to the establishment of new universities such as Glasgow Caledonian and the University of Paisley, and widening access to higher education. Additional targeted initiatives, including summer schools and the Greater Opportunity of Access and Learning within Schools (GOALS) project, aimed to increase participation among young people from low-attainment areas by providing early exposure to university pathways (Paterson, 2022).

A pivotal moment in this transformation was Glasgow’s designation as European City of Culture 1990, which marked the first time a post-industrial British city had been awarded this title. The City of Culture year was used strategically by local authorities and cultural organisations to challenge longstanding negative perceptions of Glasgow as a declining industrial centre and to promote the city as a place of creativity, heritage, and civic pride (García, 2005). The legacy of the City of Culture status was not limited to the one year itself; rather, it catalysed sustained cultural policy innovation through the 1990s and beyond,

embedding investment in the arts, festivals, museums, and cultural venues into the fabric of urban planning. This shift contributed to the redevelopment of cultural infrastructure, helped attract tourism and external investment, and repositioned Glasgow on the international stage (Brennan, 2024). However, scholars emphasise that while cultural regeneration enhanced the city's profile and provided new opportunities for participation in creative and educational activities, it did not automatically translate into equitable improvements in social conditions across all communities (Mooney, 2004). In particular, many peripheral housing estates, where a number of this study's participants grew up, continued to experience entrenched disadvantage, suggesting that cultural resurgence and material improvement were not evenly distributed across the urban landscape.

Following its cultural renaissance, Glasgow pursued a range of urban policies aimed at addressing deprivation, aimed at expanding access to education and support services. These reforms occurred against the backdrop of wider social change in Glasgow, including significant shifts in the labour market, rising educational attainment, and the gradual diversification of the urban economy beyond its industrial foundations. Initiatives such as Sure Start, introduced in 1998, sought to enhance early childhood services, parental support, and community outreach in disadvantaged neighbourhoods for children under 4, reflecting a broader policy emphasis on early intervention and preventive care (Glass, 1999). Long term school leaver surveys show that overall participation in higher education in Scotland increased from approximately one in eight school leavers in the early part of the twentieth century to over one third by the end of the century, reflecting substantial expansion across the period (Paterson, 2021). Furthermore, research analysing Scottish School Leavers Survey data from the late 1980s to the early 2000s concludes that enrolment in higher education expanded substantially, accompanied by declines in social inequality in participation over time (Iannelli, Paterson and Gamoran, 2011).

3.3 Alcohol Consumption in Glasgow

Alcohol consumption has been a significant aspect of Glasgow's social and cultural life. Patterns of alcohol use and the associated harms have been visible since at least the 1980s, with Glasgow recording the highest rates of alcohol-related deaths per 100,000 population in Scotland during this period (Shipton, 2014; Understanding Glasgow, 2016; Walsh et al., 2017).

This pattern has continued into the 1990s and early 2000s, reflecting entrenched social inequalities (Walsh et al., 2017). Although self-reported alcohol consumption has decreased in recent years, the city continues to experience disproportionately high alcohol-related mortality.

Alcohol-related mortality in Glasgow reflects broader Scottish trends, with deaths rising through the 1990s and falling in the mid-2000s, before recent increases in certain areas (Understanding Glasgow, 2016). Between 1981 and 2001, alcohol-related mortality increased by 177% among individuals in the most deprived quintile, compared with an 81% rise in the least deprived quintile (Understanding Glasgow, 2016). Scotland experienced sharp increases in alcohol-related mortality during the late 1980s and 1990s (Walsh et al., 2021). Hospitalisations mirrored these patterns, rising in the 1990s and plateauing before declining post-2008, yet remaining well above 1980s levels (Wyper et al., 2023). Adults aged 40–70 during the 1990s and 2000s, largely the parents and grandparents of today’s adult children, were the group most affected by these rises in alcohol-related harm, including deaths, hospitalisations, and alcohol-related crime. This historic peak in alcohol consumption and harm created family environments where parental alcohol use was more prevalent, particularly in deprived communities, shaping the childhood experiences of many who are now adult children.

Leyland et al. (2007) highlight the strong socioeconomic gradient in alcohol-related mortality, demonstrating how structural inequalities shaped patterns of alcohol-related harm. Using death records from 1980–2001, they show that rising deaths among men aged 15–44 were largely attributable to alcohol, drug use, and suicide (Leyland et al., 2007). For men under 65, mortality fell by 49% in the least deprived areas but only 2% in the most deprived, illustrating a link between deprivation and alcohol-related risks (Leyland et al., 2007). These historic patterns are particularly relevant for understanding parental alcohol use in Glasgow during the 1980s–2000s, as they indicate the wider social and economic conditions in which heavy drinking occurred and the potential exposure of children to harmful drinking environments.

By situating parental alcohol use within Glasgow’s historical and structural context, characterised by deprivation, urban policy changes, and persistent inequalities, this research moves beyond viewing alcohol problems in isolation. It justifies asking participants about their

broader childhood experiences in Glasgow, enabling a more holistic understanding of how historical patterns of alcohol use intersected with social, familial, and economic factors to shape adult children's lives.

3.4 Wider Aspects of Adverse Childhood Experiences in Glasgow

The prevalence of adverse childhood experiences (ACEs) in Glasgow is strongly influenced by the city's economic and social conditions. While this thesis presents data on ACEs within Glasgow, similar patterns are evident across the UK. Research by Bellis et al. (2014) estimated that almost half of adults in England reported experiencing at least one ACE, with around 8–9% reporting four or more. Higher ACE exposure was strongly associated with a range of negative outcomes, including harmful alcohol use, smoking, poor mental health, and involvement in violence. Comparable findings reported by Public Health Wales in Bellis et al. (2016) demonstrated that individuals with four or more ACEs were significantly more likely to engage in high-risk drinking and other health-harming behaviours. Research highlights that individuals exposed to multiple ACEs are more likely to develop substance use disorders, mental health problems, and engage in criminal activities later in life (Dube et al., 2003). In Glasgow, where deprivation is often passed down through generations, many individuals who experienced ACEs encounter addiction, unemployment, and chronic health conditions as adults (Walsh et al., 2017).

Until 2019, much of the research on ACEs in Scotland relied on data from England and Wales (Couper and Mackie, 2016), leading to limited insights into Scotland's unique challenges. However, a 2019 Scottish government survey revealed significant findings. Over 70% of adults reported having experienced at least one ACE, with 15% reporting four or more (Scottish Government, 2020). Prevalence of multiple ACEs was higher among those aged 18-64, with 15-19% reporting four or more ACEs, compared to just 8% among those aged 65-74 and 5% among those aged 75 and over (Scottish Government, 2020). Among adults aged 18 and older, household mental illness and household alcohol abuse were also common, reported by 19% and 16%, respectively (Scottish Government, 2020). This shows that parental alcohol use is quite prevalent amongst the population who completed the Scottish Household Survey in 2019. While unfortunately not during the relevant time period, this does give some understanding of ACEs in Scotland. Additionally, while this data incorporates Glasgow, there

are limited studies on ACEs in Glasgow. Research by Taulbut, McCartney, and Collins (2014), which compared early childhood health, cognitive, and social outcomes in Scotland and Glasgow during the 1960s and 1970s with those in comparable English regions, suggests that, overall, early years' experiences were not markedly worse in Glasgow. However, they do state that it is not known if Glasgow had more "extreme aspects of family dysfunction (such as abuse, neglect or parental substance use)", which could have shaped childhood adversity beyond what their measures captured (Taulbut et al., 2014: 8). This gap highlights the relevance of focusing specifically on adult children in Glasgow between the 1970s and 1990s. While broader Scottish data indicate that parental alcohol use was a common ACE, limited city-level research means the unique social, economic, and cultural context of Glasgow during this period, and its potential impact on childhood experiences, remains underexplored.

3.5 Conclusion

This chapter has demonstrated that Glasgow during the 1970s-1990s offers a particularly significant context for investigating the experiences of adult children. The city's post-industrial legacy, combined with historical patterns of deindustrialisation, poor housing policy, and cultural normalisation of alcohol, may have created an environment in which parental alcohol use and associated dysfunction from this is prevalent (Walsh et al., 2017; Leyland et al., 2007; Understanding Glasgow, 2016; Taulbut et al., 2014). These structural and social factors, compounded by high levels of deprivation, have potentially contributed to elevated alcohol-related mortality in the city, disproportionately affecting the most disadvantaged communities (Giles and Robinson, 2017; National Records of Scotland, 2020b).

By focusing on Glasgow, this study addresses a notable gap in the literature, which has predominantly emphasised quantitative research on alcohol-related harms and has often overlooked the localised, lived experiences of adult children (Balsa, 2008; Velleman and Templeton, 2016). Examining the historical and sociocultural context of parental alcohol use in Glasgow, particularly during the 1970s–1990s when alcohol consumption and related harms peaked, enables a deeper understanding of how wider environmental, economic, and social factors intersect with individual and familial experiences to shape outcomes for children (Leyland et al., 2009; ISD, 2017). Ultimately, this Glasgow-focused investigation contributes to the literature by providing a qualitative, contextually grounded perspective on

adult children, highlighting not only the challenges they faced but also the protective and coping mechanisms that may mitigate the impact of parental alcohol use. Localised studies such as this are essential to move beyond generic or nationally aggregated data, offering insights into how urban, post-industrial contexts uniquely influence family life, childhood adversity, and experiences for adult children.

Chapter 4: Methodology

4.1 Introduction

In the previous chapters I explored how adult children have unique childhoods, especially when growing up in Glasgow. I argued that parental alcohol use is a prevalent issue that is under researched, and the experiences of adult children are not well known. This lack of research has important implications for how we holistically understand such experiences. Moreover, the needs of children and substance use have been historically absent from UK and global policy making, despite evidence suggesting that exposure to a parent who is drinking can result in negative outcomes. More recently, national policy has drawn attention to the needs of children; however the focus has often been on drugs rather than alcohol, and there is limited evidence regarding the number of adult children affected by parental drinking (Finch et al., 2023; UK Government, 2022a). There is thus a need for further research that explores the experiences of adult children.

This chapter will begin by reviewing the specific research aim and questions that the study intends to address. It will then outline the ontological considerations (Section 4.3) that informed the research approach, going on to discuss the research context and my approach to selecting and recruiting participants (section 4.4, 4.5 and 4.6). The methods for data collection and analysis will be justified, including why interviews and thematic analysis were undertaken (section 4.7 and 4.8). Section 4.9 includes a discussion of the ethical considerations which were undertaken on such a sensitive topic of research.

4.2 Research Questions and Aims

The literature review identified that the childhood experiences of adult children can range widely according to their unique circumstances, which includes the range of protective and risk factors. As discussed in the previous chapter, quantitative research has often been used to measure and quantify factors regarding adult children (Harter, 2000). Although previous research has been important in identifying the importance of adult child experiences, it fails to fully consider the breadth of adult children's experiences and the wider sociocultural impacts on individual behaviour. Whilst there is some qualitative research on the lived experiences of adult children (See Section 2.4 and Section 2.5) such research is limited due to the difficulties in identifying and accessing these populations. There is thus a need to expand

this research to further explore the lived childhood experiences or social realities of adult children and, in doing so, better understand the interplay between structural, social and cultural and individual factors.

The aim of this research was to explore how adult children understand their own childhood experiences. Due to this categorisation, and previous research and arguments surrounding a Glaswegian context, the research questions are as follows:

RQ1: How do adult children perceive parental alcohol use to have shaped their childhood experiences?

RQ2: What factors enable adult children to cope with having grown up with parental alcohol use?

RQ3: How do these factors map onto the socioecological model?

RQ4: What are the policy implications of the research findings?

4.3 Ontology and Epistemology

This section outlines the ontological and epistemological factors that have shaped this research. Given the focus on participants' narratives and the importance of representing their lived experiences, the study adopts a data-driven approach. It is widely argued that researchers' professional and personal experiences and viewpoints influence research design, data collection, and analysis, and that these are closely linked to the ontological positions adopted (Bryman, 2016; Kang et al., 2017). This section therefore discusses how both personal and professional considerations have influenced the approach taken and the formulation of the research questions. In this study, an interpretivist and social constructivist position was taken, findings were analysed inductively, with a theoretical framework, the socioecological model, applied after data analysis. Interpretivism and social constructionism are used to understand how individuals construct their social realities. While interpretivism emphasises the influence of cultural context, social constructionism focuses on shared language and social interactions (Bryman, 2016; Kang et al., 2017). Taking an interpretive stance can lead to unexpected findings, but it also requires researchers to remain critically aware of their own positionality within the research process (Bryman, 2016). Inductive

research is data-driven, whereas deductive research is theory-driven (Braun and Clarke, 2021). The lived experiences of participants are therefore understood as being shaped by their social realities and interpretations of events.

Professionally, I am a researcher working within the discipline of social policy. With my background in biological and medical anthropology, I have an interest in the intersections between society and health and an interest in how culture shapes behaviours. Williams (2003) argued that there needs to be a consideration of both agency and structure to understand lived experiences. Based on this, he argues for:

a more historically-informed analysis of the relationships between social structure and health, using the knowledgeable narratives of people in places as a window onto those relationships. (Williams, 2003:131).

This research will focus on the narratives of ‘people in places’ as well as social and ecological factors (Williams, 2003). Consequently, I approached this research from the position of interpretivism and social constructionism, where knowledge is a product of human interpretation shaped by historical contexts (Kang et al., 2017). Researchers seek to understand how individuals within a social group perceive and make sense of their world (Bryman, 2016; Grant and Osanloo, 2014). Social constructivism is an epistemological position which argues against there being a collective social reality and that social viewpoints and meanings are continually created by individuals (Bryman, 2016). Social reality is unique to everyone, meaning that knowledge is subjective, however individuals are inevitably social products due to being influenced by the world. This research contributes to understanding the experiences of individuals who grew up with parents who used alcohol in Glasgow.

4.4 Study Sample

Participants were selected based upon specific eligibility criteria, established through the literature review and research questions. The justification for these and how they relate to the literature review and research questions will be discussed below. I decided to set only 3 criteria to determine participant eligibility. These were: self-identifying as an adult child, from Glasgow, and born between 1956 and 1988. The justification for these participant inclusion criteria is summarised below.

Firstly, and most importantly, participants had to have grown up with a parent or guardian who had 'problem alcohol use.' This meant that anyone who subjectively believed their parent or guardian had a problem with alcohol could participate. Individuals' parents did not have to be diagnosed with alcoholism but have some form of 'alcohol problem' as determined by their children to participate. This decision was taken to avoid using medicalised terminology and potentially stigmatising language as well as recognising that problematic drinking can have a negative influence on a child's life without the diagnosis of alcoholism (Foster et al., 2017). The language used in this thesis has subsequently changed since recruitment to be even more inclusive; however participants were recruited on the basis of 'parental problem alcohol use.' Moreover, this approach allows participation to be more open, whereby the researcher is then not imposing bias on selection of participants if participants self-identify.

Secondly, the individual must have lived in Glasgow as a child. As discussed above, there are historical problems in Glasgow surrounding substance use (National Records of Scotland, 2021) and deprivation that make Glasgow a useful context for this study. In research, there is confusion over which areas account for 'Glasgow city': this could either be the Glasgow city council area or the 'Glasgow city region' which includes all local authorities from Glasgow, East Dunbartonshire, West Dunbartonshire, North Lanarkshire, South Lanarkshire, East Renfrewshire, Renfrewshire and Inverclyde (Shipton and Whyte, 2011). There is also Greater Glasgow which consists of all localities which are physically attached to the city of Glasgow (Shipton and Whyte, 2011). That is not to say what is considered 'Glasgow' by Glaswegians in Glaswegian culture. Therefore, to avoid too much confusion anyone who lived in the G postcode was eligible for participating. As shown below, participants lived in a range of areas as children, those shown outwith the Glasgow area lived in multiple postcodes during childhood and are represented multiple times on the map below. Choosing Glasgow because of its social history, for instance, does imply that contextual knowledge has influenced the research design, meaning the approach is primarily inductive but not purely so. This is common in social research, where researchers often select sites that are information-rich or theoretically relevant to the phenomenon under investigation. In most realistic inductive approaches, such as those used in interpretivist or social constructionist research, contextual and theoretical considerations, like Glasgow's history of deprivation, are acknowledged as

informing the research site selection, even if the analysis itself remains inductive (Bryman, 2016). The following maps show the spread of participants collected from their postcode, where they lived as children and as adults. Some participants moved properties so did not stay in the same area and so are plotted multiple times on the map. As seen below there is a spread of participants from various localities of Glasgow.

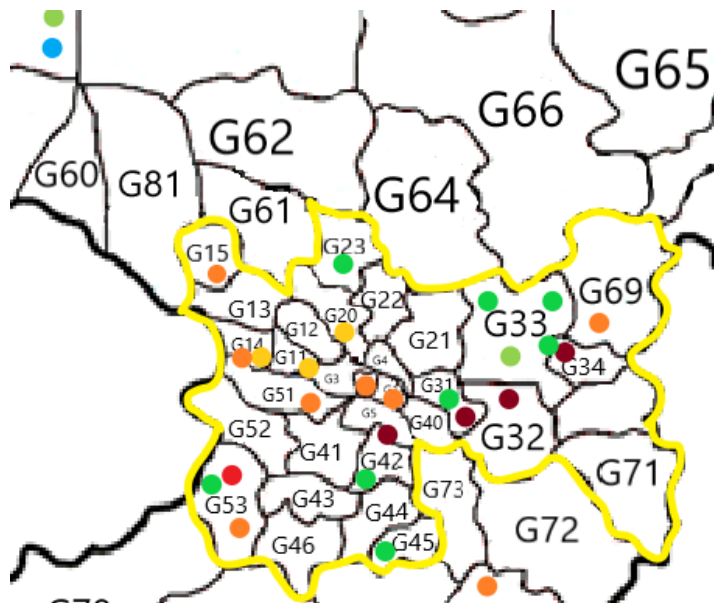


Figure 1 Map of participants locations as children some participants are marked multiple times if moved, colour of dots unimportant]

As adults, participants were more concentrated in the North and West end of Glasgow, as shown below, potentially highlighting some form of upward mobility in relation to housing.

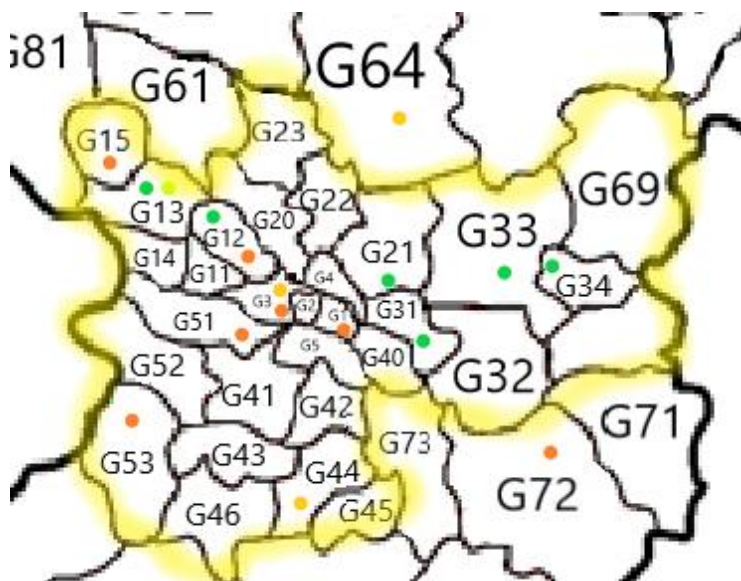


Figure 2 Map of participants location as adults [colour of dots unimportant]

Lastly, it was important that the individuals were born during the 1966 to 1988 and, therefore, aged between 31 to 54 years old during data collection (except for one participant born 1956). Excess mortality due to alcohol related illnesses in Glasgow has been prevalent since the 1950s but increased significantly in the 1980s, therefore if an individual was born at this time they may have been raised by parents who were part of this cohort (McCartney et al., 2011; Walsh et al., 2017). If individuals are born between 1966-1988 then they were aged zero to 25 during the relevant period of change and would have unique childhood experiences due to the changes in this time period. The age range was kept deliberately large; this is because the term 'child' refers to an age range that is itself ambiguous. The *Children and Young People (Scotland) Act 2014* defines 'child' as up to the age of 18, except where a child is in the care system therefore they are a 'child' up to the age of 25, whereas the 'National Guidance for Child Protection in Scotland 2021' defines an individual as a child up to the age of 16 (Scottish Government, 2022a). Biologically adolescent brain maturation can be considered to occur between the ages of 10-25 years (Arain et al., 2013). Every individual may not necessarily have experienced childhood in the same way and in order to not limit recruitment a singular age cannot be used.

4.5 Recruitment

Recruiting participants with potentially traumatic lived experiences, such as having parents who use alcohol, is challenging due to a variety of factors including accessing populations and gaining trust from individuals (Parker et al., 2019). As such, I adopted a sensitive and multi-pronged approach to facilitate engagement with the research and support recruitment. Passive recruitment involves distributing recruitment materials aimed at getting participants to contact the research team whereas active recruitment is when researchers are present and interact with individuals, actively getting them to take part in the study (Gelinas et al., 2017): I employed both for the purpose of this study. As will be discussed below, I initially employed active recruitment through being physically present, with permission, at sites such as local community centres, libraries and places where al-anon meetings took place. Additionally, leaflets were distributed. I then undertook passive recruitment through posters (see Appendix 9) at universities, conferences and community centres and emails to multiple recovery and charitable organisations in Glasgow, including but not limited to Al-anon, Alliance, Glasgow Association for Mental Health, Scottish families affected by alcohol and

drugs, Glasgow council on alcohol, and Clydebank community centres. After this I then enacted snowball sampling by attending recovery centres.

As discussed above, passive recruitment methods included posters and emails. Posters were created to promote the study (Appendix 9), which were presented at several academic and substance use related conferences. The language used in these posters considered the non-stigmatising language mentioned in Chapter 1, this was also phrased to include participants broader than those who identify as adult children in Al-anon, including 'have experience of living with a parent who had an alcohol problem', despite the language used in the thesis changing (see Section 1.2 and 1.3). In an attempt to reach the relevant demographic and be inclusive, this language was also included in the participant information sheet. These conferences were attended by third sector agencies with an interest in drug research as well as academics and policy workers. E-mails were also sent to third-sector organisations, unnamed to maintain anonymity and protect participants. I also recruited individuals online, I shared posters on my own personal social media accounts, Facebook and Twitter and asked colleagues and friends to 'share.'

Although the conference attendance and email correspondence were largely positive encounters and I did receive vital feedback and offers to help with recruitment, many organisations also expressed apprehension about my research group due to their potentially vulnerable status and were understandably protective about their service members. This appears to be common when conducting research with groups deemed vulnerable, as Walker and Read (2011) found when researching hospice patients (Walker and Read, 2011). I addressed this by reassuring staff members of my research and the anonymity of participation. An e-mail was also sent around members of a research network on alcohol use research I am involved in based upon this email I was able to recruit one male participant, and I received immense help from one organisation who introduced me to other organisations who could help with recruitment.

Ellard-Gray, Jeffrey, Choubak, and Crann (2015) found that posters were successful when used to recruit participants across a number of sociological studies, especially when care was taken over the language used and avoidance of stigmatising language (Ellard-Gray et al., 2015). Due to this previous success, I also placed my posters in various locations throughout

Glasgow. This included community centres, libraries, health centres, universities and other communal facilities. Staff at these locations were helpful and receptive and displayed my posters. On the poster I included an email address and work mobile number due to the difficulty for some individuals in accessing internet facilities or not having an email address. Six participants were recruited via this method; however, these were exclusively female professionals.

Gelinas and colleagues (2017) argue that it is important to establish a physical presence at sites when recruiting vulnerable participants in order to establish trust and familiarity. As such, active recruitment methods involved attending, with permission, al-anon 'open' meetings across Glasgow where I distributed hard copies of the information sheet prior to the meetings taking place and some members also agreed to introduce my research during the actual meetings. Al-anon meetings were chosen in addition to the recovery centres because they are specifically for individuals who are family members of individuals with alcohol use and have many individuals whose parents drank alcohol also. Unfortunately, this method of sampling did not directly lead to any participants. One female participant, who was alerted to the research via this method, overheard me defending my use of 'adult children' with a friend at lunch at the University of Strathclyde one day and approached me asking to participate in my research. This relates to previous research as leaflets have been found to not significantly increase recruitment (Brierley et al., 2012).

I also contacted over 30 organisations throughout Glasgow by email to ask for their assistance in recruitment. These included but were not limited to Al-anon, Alliance, Glasgow Association for Mental Health, Scottish families affected by alcohol and drugs, Glasgow council on alcohol, and Clydebank community centres. However, these services were either dubious about exposing their service users to my research or they did not have any individuals who met the criteria. Due to this, snowball sampling was also used to recruit participants. The use of snowball sampling provides a means of accessing 'hard to reach' groups (Atkinson and Flint, 2001). It is an informal method which is most frequently used to conduct qualitative research, primarily through interviews, and involves participants informing individuals they know about the research project (Atkinson and Flint, 2001). I fell back on the 'gatekeepers' I had met in person and individuals I had previously recruited, as well as contacts at the University of

Strathclyde, and received many more responses from these individuals contacting the relevant organisations on my behalf. Through this method I was introduced to individuals who were in recovery as a potential group for recruitment. It is known that those who grow up with problem drinkers as guardians have an increased susceptibility for the same behaviours themselves (Yap et al., 2017). Two participants were recruited as they were key contacts at recovery centres, and the subsequent 10 participants were recruited through snowball sampling, although not all were from the same site. All except one of these individuals were male. Male substance use was much higher than female substance use (Cotto et al., 2010). One female participant and nine male participants were in recovery programmes, with a further two male participants having progressed through recovery programmes. As another study was going on at the same time recruiting similar participants but offering financial incentives this made it difficult to recruit further participants as some felt that it was unfair that one study offered financial incentives, and another did not. As I was unable to offer monetary incentives, this prevented further recruitment from recovery centres.

4.6 Participants' Descriptive Characteristics

At this stage of study, I had recruited 20 individuals to participate in the study, 11 of whom identified as male and 9 as female (see Appendix 10). In discussion with my supervisors and through engagement with data it was agreed that I had obtained the number of interviews needed for the data to answer the research questions, with a mixture of male and female participants from across Glasgow. In line with Braun and Clarke's (2021c) critique of data saturation, the focus was placed on generating rich, meaningful analysis rather than achieving saturation, ensuring the dataset was sufficient to address the research questions in depth. Therefore, the sample size of 20 was adequate to assess key themes from the demographic, adult children in Glasgow. Pseudonyms were used for all participants. Participants, at the time of recruitment, ranged in age from 31 to 56 years old, with one participant who was 63 years old, referred to as Brian in this thesis. The sole older participant was a vital gatekeeper who ran a recovery centre, who helped extensively with recruitment and was keen to participate. I double checked that he knew the inclusion criteria at the beginning of the interview. However, he disclosed his age at the end of the interview, and the fact that he had neurological issues due to his previous substance use, at which stage it felt unethical not to include him in the study. The narrative he provided is used throughout this thesis as he

provided vital insight into not only his own journey, but an overview of the participants in his recovery centre, closely reflecting the inclusion criteria and research aims in other ways than determined by his age.

The descriptive characteristics of the study group were inferred from the narrative interviews and not questions which were asked directly, except for first half of their postcode to ensure they grew up in Glasgow. Participants in this study grew up in various areas throughout Glasgow, with only one individual identifying as being middle class and living in Swinton, an area in the Northeast of Glasgow but of a higher socioeconomic status. Six individuals grew up in G33 or G34, with Easterhouse, Carntyne and Cranhill being mentioned by name. Many participants had fathers who worked and mothers who were 'housewives' or worked in lower paid jobs for 'pin money'. In almost all the household's fathers had better paying jobs than mothers. Only three participants had both parents unemployed - Basil, Joe, Byron; six participants had their mothers unemployed. Siblings were mentioned by all individuals whether they had them or the lack of. Only five individuals were only children, the rest had one or more siblings, with the most siblings one individual had being nine – this was Matt. Most individuals had some level of formal education, although Lucas, Patrick, Joe and Hazel did not have any formal qualifications. Some individuals stayed in the same area as where they grew up as children. Those who moved house as adults were usually individuals who moved to higher SIMD areas and purchased property there, eight participants owned their own property, whereas the others rented or were in council accommodation.

As shown by the range of descriptive characteristics, the evidence has both strengths and limitations. The study was based on a relatively small sample of 20 participants, which inevitably constrains its representativeness. Within this group, there was some diversity in terms of gender and individual backgrounds. There were a large number of participants in contact with recovery services for their own substance use. The sample may be somewhat biased towards individuals who have achieved more stable or positive outcomes, particularly as many participants were engaged with recovery services. However, this offers valuable insight into processes of coping and resilience, highlighting how individuals navigate and overcome adversity. As such, the findings foreground not only harm, but also the capacity for adaptation over time. There was missing information regarding social class as this was not

explicitly recorded. Considering ethnicity, only two participants were self-identified as Indian, while the remainder were white. Only 2.25% of Glasgow's population identified as Indian in the 2022 census, in a sample size of 20 this would be only 0.45 of a person (Scottish Government, 2022b). There was also high level of educational achievement in participants, with 11 having higher degrees. In Glasgow, around 37.3% of adults (16+) have a qualification equivalent to a degree or professional qualification (Glasgow City Council, 2025). The equivalent number of a sample size of 20 would be 7.46 people. As such this is not a representative sample of individuals in Glasgow, as there is limited data on adult children it is hard to know if this is a representative group of adult children either. Despite these limitations, the use of in-depth interviews generated rich and valuable data, as participants spoke openly and in detail about their childhood experiences. While a more systematic spread of participants could have enhanced the breadth of the evidence, this thesis did not pursue selective sampling in order to avoid artificially shaping the study. Overall, the data proved to be robust, due to quality the narrative interviews, and provided sufficient depth and breadth to effectively address the research questions.

4.7 Research methods

Previously, it was argued that there needs to be more qualitative research on adult children (Chapter 2). Qualitative research with adult children can take many forms, a variety of approaches were considered for this study: structured or semi structured interviews, questionnaires or focus groups. These methods were all considered as they are good for targeted research asking direct questions (Frith and Gleeson, 2006). Due to the sensitive nature of the research, focus groups were ruled out as they may limit conversation due to individuals not feeling comfortable talking about personal issues (Nathan et al., 2019). Structured interviews were also not considered as they may be too prescriptive, not allowing participants to fully reflect on and explore their experiences and potentially bias responses (Frith and Gleeson, 2006). The need to avoid prescriptive questioning or inadvertently biasing participants is especially important when researching sensitive topics and regarding my research aims (Frith and Gleeson, 2006). Therefore, narrative interviews were selected to allow for more freedom of participants to express their experiences.

Narrative interviewing is a method of qualitative data collection in which a story is created through an interview (Allen, 2017). In this method of interviewing there is commonly less structure compared to other qualitative interview formats such as semi-structured or structured, this gives the opportunity for the participant to direct the interview (Allen, 2017). The aim of this research was to determine how adult children constructed the impact of their parent's drinking on their own childhood experiences. The 'narrative', which can be obtained as part of a narrative interview, can be regarded as a 'life story' where events participants think are important are shared (Czarniawska, 2004). It can be spoken or written (Czarniawska, 2004). It is argued that these 'stories' are useful and easily elicited as:

Telling stories is far from unusual in everyday conversation and it is apparently no more unusual for interviewees to respond to questions with narratives if they are given some room to speak. (Mishler, 1991:69).

Interviews can be considered a collaborative task, where both individuals are involved in the construction of the narrative (Järvinen and Mik-Meyer, 2020). Interviewing in this way allows the use of a collection of narratives to make sense of lived experiences (Allen, 2017). This style of interviewing was undertaken, to relate to the research questions and obtain the participants understanding of their own childhoods and not bias their responses by asking direct questions about specific childhood experiences (Czarniawska, 2004). It also allowed for participants to describe their own experiences and give them a platform they may not have previously had to share their stories. Therefore, narratives were obtained from participants in the form of narrative interviews, asking a single question; 'what was your life like growing up in Glasgow?'. Focusing interviews on this question was intentional to situate participants' experiences within a specific sociocultural context. Adult children's lives are shaped by more than parental alcohol use, and alcohol is often embedded within broader family and community practices. Asking about life in Glasgow allows participants to reflect on their experiences holistically, capturing the interplay of individual, familial, community and societal factors. This approach aligns with the socioecological model, enabling a structured exploration of multiple layers of influence on childhood and adulthood.

Some narrative interviewees require more structure to ensure that each topic is covered in the interview (Bourgeault et al., 2010). In this study, I developed an interview guide (Appendix

11), which, as discussed above, involved initially asking participants an initial question: 'What was your life like growing up in Glasgow?'. The interview guide then provided prompts for subsequent questions, either to elaborate on certain topics or to keep on topic of the influences in their childhood in Glasgow, which may have affected their experiences. Järvinen (2000) wrote about there being a risk in asking someone to construct a narrative based on their life history, particularly if they have experienced trauma, due to the forcing of a one-dimensional retelling of chaotic life circumstances (Järvinen, 2000). However, due to the epistemological position of this study, this inevitably was the data which emerged. In order to not retraumatise individuals, participants controlled the narrative and could share as much or little they wished, as well as being allowed to stop and withdraw data. Face-to-face interviews with each participant were conducted to build rapport and better understand the individual's inflections and emotional cues during conversation (Järvinen, 2000). This can address concerns about narrative interviewing with this population, as the participants body language can be viewed, alongside what they say, to assess how the person is doing, and interviews can be stopped whenever they wish.

In addition, it was hoped another interview could be organised if more, non-narrative information was needed. This was not possible or needed for all participants, and attempts were hindered due to the impact of COVID-19. These impacts will be discussed further in the conclusion chapter. However, additional interviews occurred for two of the participants. This was in the form of a semi-structured interview tailored to each individual. This interview primarily focused on demographic questions that were not covered by the initial interview, such as the age of the individual during the time period and which members of their family they lived with. This information was helpful in determining differing types of influences on their lives. Additional follow up questions were sent via e-mail to participants who could not be contacted in person.

Recruitment began in August 2019, however these had to be suspended for 6 months when I obtained a full-time research assistant position. Interviews were resumed in February 2020. Unfortunately, this gave me little time to conduct all data collection before the COVID-19 outbreak. However, during February 2020 and March 2020, 20 interviews were undertaken. These interviews were conducted in university premises or in rooms at recovery centres

which had been risk assessed and were supplied by gatekeepers at these services. Approximately half the interviews were undertaken in recovery centres as many participants there identified as having grown up with parents who used alcohol. The recovery centres visited offered services such as 12 Step Mutual Aid meetings, massage, acupuncture, arts and crafts group, Citizens Advice, IT classes with college tutors and yoga classes. They also offered free tea, coffee, soup, and sandwiches. They were friendly and open meetings in community centres. One service, where most recruitment was conducted for this group, accepted anyone regardless of whether they had a substance use issue and it was a real community resource, allowing those who wanted to socialise and help the community to come together. The gatekeepers at these places allowed me to integrate myself with relative ease, and food provided a medium over which many people were happy to talk. This did mean that in some cases interviews were undertaken in loud or noisy areas, as per gatekeepers' requests, slightly separate from individuals at the recovery centre to maintain their privacy but also my safety.

All interviews were recorded using an Olympus WS-853 recorder which offered settings for interview recording. This was beneficial as in some settings, particularly one recovery centre, there was quite a lot of background noise. Interviews were on average 45 minutes long but ranged from 7 minutes to approximately 3 hours (see Appendix 12). Although one interview was short, most were longer providing in-depth data. The shorter interviews were with individuals in recovery centres, they were limited on time and although happy to have a discussion wanted to participate in the recovery centre activities. There was also a difference in these timings in the different recovery centres, the one centre in which there was a more community atmosphere was louder, and food being provided at the time of interviews therefore a few of the interviews were shorter. I transcribed all the interviews, to allow for a thorough immersion into the data (Czarniawska, 2004). This also allowed for initial reflections to be added from notes made during interviews and so I could recall the interview and pick out any obscured words. Transcription was undertaken using a foot pedal to pause the playback and Olympus software to listen to the recordings. AKG headphones were also beneficial for picking up voices which were quiet and/or obscured due to background noise. Transcribed interviews were typed in Microsoft Word and saved to the University of Strathclyde's secure H drive, then subsequently saved in a password protected file on my personal computer. Direct quotes were used throughout this thesis, '...' showed a small gap

between quotes, whereas starting a quote on a separate line signified a large gap between quotes.

4.8 Data Analysis

Researchers agree that it is important to be clear about what you are doing, why you are doing it and have a clear description and justification for analysis methods (Braun and Clarke, 2006). This section outlines the data analysis method that was chosen, thematic analysis, in light of the research aims and questions and the group under study. There are many methods which can be employed when analysing data from narrative interviews, usually these are narrative analysis, grounded theory analysis, framework analysis or thematic analysis (Braun and Clarke, 2006; Järvinen and Mik-Meyer, 2020; Rhodes and Coomber, 2010; Silverman, 2019). The methods listed are also common analysis methods in addiction research (Rhodes and Coomber, 2010). Narrative analysis allows for an analysis of the individuals' narrative or story. It can involve an analysis of a particular story, a small group of stories or a larger collection (Allen, 2017). Interpretation of the narratives involves looking at elements within the stories and noticing patterns and themes and comparing how they fit together (Allen, 2017). Whilst looking at elements within stories was considered, it was deemed not suitable for this study as patterns across groups would also need to be considered (Connell et al., 2010). As such, an approach that would allow for multiple levels of influences on childhood experiences would be beneficial, as well as allowing for the voices of adult children to come through. This is why thematic analysis was chosen for this thesis.

Framework analysis requires a framework or predetermined coding framework which provides a systematic analysis of the content of interviews (Goldsmith, 2021). There is an organised structure of inductively and deductively derived themes used to conduct a cross-sectional analysis to identify, describe, and interpret key patterns (Goldsmith, 2021). Framework analysis is not used for this study as the knowledge gathered from the interviews is that based on individual experience and not that which comes from theoretical deduction as seen in framework analysis.

Grounded theory analysis allows for researchers to collect and analyse data simultaneously (Holstein and Gubrium, 2003). This type of analysis often occurs when the most significant social processes are not known and can be derived throughout the interviews (Holstein and

Gubrium, 2003). Grounded theory analysis was not used in this study as there is already a theory established, the socioecological model, and a known area of research on childhood experiences and outcomes.

Thematic analysis was selected instead of other methods such as framework analysis or narrative analysis due to the nature of the research topic and use of narrative interviews for data collection. Although it is argued that most thematic analysis in addictions research is probably akin to 'framework analysis' due to a pre-existing framework (Ritchie and Spencer, 1994), thematic analysis was selected for this research due to the fact that categories of themes do not need to be set up in advance, therefore allowing for any unknown factors to be assessed (Braun and Clarke, 2023, 2021a). This was important because themes which might not be known initially by the researcher could be found through analysis.

As discussed previously, this piece of research is qualitative in nature. Generally qualitative research is considered inductive due to the linking of specific observations about individuals to broader generalisations (Thomas, 2006). In this research an inductive coding approach was conducted to identify key themes. Inductive research is open-ended and exploratory, beginning with particular observations and proceeding to broader generalisations and theories based on patterns that emerge (Haque, 2022; Thomas, 2006). An inductive piece of research begins with 'specific observations' and moves to 'detecting themes and patterns in the data' (Thomas, 2006, n.p). This is the approach taken in this study, therefore through the data I am determining the themes, which can then be explored within the existing research and theoretical frameworks. Although, according to Bryman (2016), an inductive approach is potentially not as strong as some other methods, as it is hard to make accurate predictions, it provides a straightforward approach for deriving findings from interview questions (Bryman, 2016). The purpose of using an inductive approach is to condense data, to establish links with research objectives and develop a framework of understanding for the data (Bryman, 2016). Inductive research can be applied to the context of adult children and allow for their perspectives to be shown. As will be discussed in the next chapter (Chapter 6), the socioecological model was applied after the development of themes in the discussion of this thesis to then visualise the multiple levels of experiences of adult children.

The first step in data analysis was reflexive thematic analysis of the narrative interviews (Braun and Clarke, 2016), searching for important themes. Themes were assessed utilising Braun and Clarke's (2016) description of reflexive thematic method of analysis. In order to accomplish this level of analysis Braun and Clarke's 6 step process is followed. This is the most prevalent way of undertaking thematic analysis. However, Braun and Clarke (2023) emphasise how following their procedure does not necessarily guarantee 'good thematic analysis' but that these are tools for a process which can offer a flexible analysis of data (Braun and Clarke, 2023; Braun et al., 2023). Braun and Clarke's 6 step process of analysis was followed:

1. familiarise yourself with the data.
2. Generate initial codes
3. Search for themes
4. Review the themes
5. Define and name themes
6. Produce the report

Step 1 Familiarise yourself with data

Braun and Clarke (2016) believe it to be vital that the researcher immerses themselves in the data so that they are familiar with the depth and breadth of content. This usually entails 'repeated reading' of the data and reading in an 'active way' in which meanings and patterns are being thought of. The process of transcribing your own data can help with this familiarity (Riessman, 1993). As the only researcher on this piece of work, I interviewed, transcribed, read, re-read, analysed and re-analysed the data, as such I have an intimate knowledge of the data collected. My supervisors also supported this process.

Descriptive characteristics were recorded throughout transcribing, which was undertaken using NVIVO, to better understand the spread of participants and attempt to understand the data further. The descriptive characteristics were found throughout the interview and noted when mentioned to understand the spread of participants. A table was created which included: age, gender, postcode as a child, type of housing, rental status, current postcode, family composition as a child, family composition now, current occupation, who was the parental problem alcohol user (PPAU) and problem substance user (PSU) status. This was to

better understand the context behind each participant. Once the descriptive characteristics had been recorded for all individuals the interview data was thematically analysed.

Step 2 Generate Initial codes

Initial codes are important features of the data determined through a knowledge of the literature (Braun and Clarke, 2006), they are coded in a systematic fashion across the entire data set, collating data relevant to each code (Braun and Clarke, 2006). Codes are features of the data that appear interesting to the analyst and refer to:

the most basic segment, or element, of the raw data or information that can be assessed in a meaningful way regarding the phenomenon (Boyatzis, 1998:63).

Data throughout the whole data set is organised into groupings of similar content which can then be sorted based upon repeated patterns (themes). Codes were established throughout and reviewed to maintain relevance to the research questions. The generation of initial codes was systematic and across the entire dataset. Each interview transcript was analysed, and codes identified throughout, codes which were repeated and relevant to all data were used to create themes. Codes were changed and refined based upon interview data (see Appendix 16). These included 124 codes such as: bullying, comics, 'follow the steps', counselling, 'didn't matter what he drank', parental suicide, 'better job', 'study to help others', gang leader, 'looked after siblings', damp, poor health, well-fed.

Step 3 Search for themes

The codes established during step 2 are collated into potential themes, and all data relevant to each potential theme is gathered together, as suggested by Braun and Clarke's (2016) reflexive thematic analysis method. As such, I sorted and organised the list of differing codes developed in the previous into headings on differing themes. This re-focuses analysis at the broader level of themes rather than codes (Braun and Clarke, 2006). A theme "captures something important about the data in relation to the research question" and, as such, are concepts which summaries the core points or common or recurring patterns around these concepts (Braun and Clarke, 2006:82). This led to an extensive list which was sorted into groupings.

Themes in this thesis arose due to the highlighted importance to the individual and across individuals (see Appendix 13 for code and theme development) as well as patterns within the data. Initially, this was a long list including themes: good vs bad childhood, employment, housing, siblings, violence, education, work, children/family, suicide, masculinity, type of drinking, gender constructs, recovery, religion, escapism, community, peers.

Step 5 Define and name themes

Themes may change over the course of analysis. Step 5 requires “ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme” (Braun and Clarke, 2006:82). The themes are further defined and refined. These may not be explicitly stated but inferred at a deeper level in the data. For example, Braun and Wilkinson (2003) analyse women’s conversations about the vagina and found two overarching themes: as a liability and as an asset (Braun and Wilkinson, 2003). It was at this point in the data analysis process that these were clarified and defined. Themes were refined by merging overlapping codes, discarding less central material, and focusing on interpretive meaning. This allowed the descriptive codes to be distilled into coherent, analytically meaningful themes that captured the essence of participants’ experiences. This left the final themes Normalising dysfunction: Patterns of Harm and Gendered Roles, Disappearing: Loss and the Erosion of Childhood and Surviving: Coping and Active Agency, with sub-themes including gendered expectations, normalisation of family dysfunction, community violence, cultural acceptance of alcohol, historical gender roles, bereavement, loss of childhood, early caregiving, environmental and economic instability, turning points (substance use, self-harm, suicide), education and active agency, supportive relationships, community support systems, recovery pathways, and structural influences shaped by policy and history.

Step 6 Produce the Report

Finally, themes found in the study are written up in a “concise, coherent, logical, non-repetitive and interesting account of the story the data tells within and across themes” (Braun and Clarke, 2021a:8). The themes must be supported by the data and have examples which highlight the point being demonstrated. Braun and Clarke (2006) advise against using frequency for evaluating results as quantity does not ensure value, therefore frequency of

themes will not be mentioned but will be referred to in generalisations such as ‘most’, ‘many’, ‘a few’. Firth and Gleeson (2004) show this well by having a mixture of narrative and illustrative data extracts to explain how men’s feelings about their bodies influence their clothing practices (Gleeson and Frith, 2006). They sometimes broaden their analysis from a descriptive to interpretative level and relate their claims to existing literature. They acknowledge how they are both cultural members and cultural commentators. Examining the link between narrative interviews through a descriptive to interpretative level is what this analysis and the following and discussion chapters will aim to do. Direct quotations have been utilised to convey important themes in the participants own words and those which were most articulately described were included. This means that some phrases are written in Scots as that is how they were spoken, where required clarification is included in the supporting text in the Findings chapters. The ‘story’ the data tells will be highlighted and will be shown throughout each category and patterns identified, if there are any, in addition to differences. Participant quotations I chose for these narrative sections represent the themes, for example, repeated sentiments expressed by participants in the most comprehensive way noted throughout the interviews. After defining the final themes, they were mapped onto the socioecological to situate participants’ experiences within a multi-level theoretical framework. Each theme was linked to socioecological model levels, individual, familial, community, societal, and policy/historical, based on how participants’ narratives reflected influences at these layers. Sub-themes were used to capture specific aspects of experience within each level, such as gendered expectations and active agency at the individual level, loss of childhood and supportive adults at the familial level, community violence and support at the community level, cultural norms and educational opportunities at the societal level, and historical policy influences at the policy/historical level. This approach highlights the interactions between personal experiences and broader sociocultural, economic, and historical factors. Linking themes and sub-themes to the socioecological model an understanding of how these experiences were shaped by interconnected layers of influence (see table 2 below).

Table 2: Themes from this thesis within socioecological levels

Theme	Individual	Familial/ Relationship	Community	Societal	Policy/ Historical
Normalising Dysfunction: Patterns of Harm and Gendered Roles	Gendered Expectations: The view that men should be 'hard men' and women 'housewives'	That's Just What Families Are Like: Normalising violence, neglect, emotional suppression	Community Violence: Community behaviour reinforces home experiences and drinking	Everybody Drinks: Cultural acceptance of alcohol, especially among men	Historical Gendered Expectations and Labour Policies: Reinforced through historical norms and policies
Disappearing: Loss and the Erosion of Childhood	Bereavement: Suicide of parents, deaths of friends	Loss of Childhood: Early caregiving, bullying, shame, lack of friendships	Environmental and Economic Instability: Low-income communities, poor housing	Environmental and Economic Instability: Widespread deprivation in Glasgow	Environmental and Economic Instability: Linked to poor historical policies
Surviving: Coping and Active Agency	Turning Points: Substance Use, Suicide, Self Harm Education and Active Agency: Seeking support	One Supportive Adult: Mentorship and positive relationships	Community Support: Youth centres, safe spaces, community therapy Education and Active Agency: Recovery centres	Education: Societal acceptance of educational importance and programmes	Education: Policy to enable them to seek support and attend recovery centres

4.9 Ethical Considerations

This project dealt with sensitive issues and as such conducting trauma informed and sensitive research was a key concern, considered throughout each stage of the research process. From the initial ethics application, it was clear that this topic would need to be undertaken with a clear knowledge of how to approach these participants. Ethical approval was granted by the University of Strathclyde on 03/07/2019 by the University Ethics Committee – UEC19/44. Many studies have found that research on sensitive topics could expose participants to potential distress (Allmark et al., 2009; Decker et al., 2011; Jorm et al., 2007; Rosenthal, 2016). Therefore, it was vitally important to limit the amount of stress experienced by participants.

It was made clear exactly what was required from the individuals who undertook the study in the participant information sheet (Appendix 14). Informed consent was of great importance; participants were given time to read the consent form (Appendix 15) and information sheet and determine whether they wished to participate before an interview time was set. My contact details and those of the ethical department were provided if any party required clarification about the study. The inclusion and exclusion criteria were discussed by the researcher with the participants before the interview. Confidentiality was also important as sensitive or vulnerable topics were being discussed (Allmark et al., 2009; Decker et al., 2011). Participants, and any family members they mention are written in this thesis under a pseudonym which was created during transcription to maintain confidentiality. A name generator was used to produce pseudonym to maintain anonymity, however, it was made clear that the study was looking at areas throughout Glasgow and direct quotations would be used. It was also made clear that the interview transcripts would not be passed on and only in the event of them being a danger to themselves or others would confidentiality be broken. This relates to the importance of continuous informed consent, as discussed by Allmark and colleagues (2009). Amongst continually checking in with the participant and following up to ensure their consent, Allmark and colleagues (2009) found that informed consent could be problematic due to privacy as interviews sometimes include unexpected areas. If continuous informed consent is undertaken participants can then choose at the time of the interview how much information they wish to disclose or omit. This also relates to potential distress from the information brought up in the interview. Research on sensitive topics could expose participants to re-traumatisation and raises questions about whether participants experience distress or fully understand their level of anticipated stress (Decker et al., 2011; Walker et al., 1997).

There is the risk of potential psychological harm to the interviewees or interviewer. The psychological risks were considered to be low to the participants and the researcher in this study due to the selected methods chosen to minimise risk and safety of locations chosen. There have also been studies which have found that remembering the past was more likely to be helpful rather than stressful for participants (Allmark et al., 2009; Decker et al., 2011; Jorm et al., 2007; Rosenthal, 2016). A review of 46 studies that examined distress after participation in psychiatric research on sensitive topics found that only a small number of

participants in community and clinical samples reported distress immediately after participation, and positive reactions were more common than were negative ones (Jorm et al., 2007). In fact, as discussed previously, Rosenthal (2003) believes that a biographical narrative interview can be considered therapeutic. He spoke with individuals who have been through traumatic experiences such as World War I veterans and survivors of the Shoah and received positive feedback from participants about this process (Rosenthal, 2016). However, it was important for this study that, if psychological distress was displayed, appropriate measures were taken to mitigate this, including pausing the interview, obtaining a hot beverage and comforting the participant, and asking if they wished to continue. Draucker and colleagues, 2009 list five strategies to mitigate risk when talking about sensitive topics: “(a) employing interviewers who are trained to handle psychological distress, (b) consistent monitoring of participants' emotional reactions, (c) providing frequent breaks during stressful data collection procedures, (d) debriefing, and (e) providing information on available psychological or social services” (Draucker et al., 2009; Griffin et al., 2003). All of these methods were employed when interviewing individuals for this study. There was constant monitoring of participants' emotional reactions and if these were too extreme breaks were taken, for example when one participant was crying during the interview, I obtained her a drink and physically comforted her.

After the interview the participants were asked if they were well, and a follow up email was sent to remind them that they could withdraw their information if they wished and ensure participants were comfortable after the interview. Some interviews were difficult, and care was taken that I did not offer advice as I am not a trained therapist or counsellor, although I have had some training dealing with psychological distress from my work with the NHS, for example how to approach individuals with mental health issues or in acute inpatient wards. Therefore, I felt well prepared for this type of research. Participants were signposted to relevant services and comforted where appropriate. Interviewees were encouraged to contact the researcher via email if they had any concerns. However, only one participant emailed, and this was concerning future drug and alcohol related events he believed I would be interested in as part of a wider Glasgow substance abuse network.

It was difficult to maintain an emotional distance from participants as some of the topics discussed were extremely sensitive, for example when participants became upset or discussed abuse. Although this study had obtained University Ethics approval, not simply college level, due to the type of topics expected to be discussed with potentially vulnerable participants, this was unexpected. I did not think participants would reveal, in such in-depth ways, sensitive and intimate topics, such as sexual abuse. In the literature on researching vulnerable groups, it is often implied that building trust and rapport is difficult and requires extensive time with participants (Decker et al., 2011). However, at times it was necessary to show empathy and comfort the individual. It was also important that I was reflexively aware of my position and power relations during the interview (Elwood and Martin, 2000). I am a white, able-bodied, British woman. I grew up in a working-class household which became lower middle-class during my teenage years. I lived with both parents and had access to free healthcare and primary and secondary education throughout my life. I attended a grammar school and university, both of which hugely influenced my career outcomes, comparative to my family members. These factors have shaped my world view - thus it is important to acknowledge the position of privilege I approach this research from.

There is the view that academics have power in the interviews due to choosing the participants and the location, as well as the topic, although power can fluctuate and interviewers often feel indebted to interviewees (Elwood and Martin, 2000; Limerick et al., 1996). Research reflexivity is required as there is often a normalisation of 'middle class values' when interviewing which can 'create potential obstacles to establishing rapport' (Mao and Feldman, 2019). It is important to undertake interviews in a safe, comfortable place for all and to give participants the choice of where to be interviewed if possible (Elwood and Martin, 2000). This reduces the researcher-based power inequalities. However, personal experiences relating to my topic of study, have influenced my decision to research this area, this often made hearing the traumatic experiences and analysis of some narratives challenging. 'Debriefing' with family members, whilst maintaining confidentiality, was required to maintain my own mental health. In this sense, I have exercised my 'sociological imagination' (Mills, 2000). Mills (2000) attempts to reconcile the individual and society through sociological imagination, how a personal perspective on life involves developing a consideration of how it is influenced by historical experiences and the larger social context. From this Mills (2000

[1967]) viewed the role of a social researcher as transforming 'private troubles' into 'public issues' and relating these to larger patterns of inequality and imbalances of power.

This piece of work has incorporated ethical considerations of power and inequality throughout as well as including 'private' and 'public' understandings of the issues surrounding parental alcohol use and in relation to my role as a researcher, allowing for the voices of adult children to be at the forefront of the research and avoiding unethical recruitment of confidentiality practices.

4.10 Conclusion

This chapter has discussed the motivation behind the research aim and questions before moving on to justify my research design regarding recruitment, utilising narrative interviews and thematic analysis for this study. The aims of the study are identified as exploring how adult children understand the impact of their parent's drinking on their own childhood experiences. This research is undertaken from a constructionist, interpretivist, and inductive perspective to align with the need for participants to construct their own narratives. Recruitment involved many methods and had to be carefully considered. Narrative interviews were argued to be the best data collection technique for understanding individuals' interpretations of the world (Fehér, 2011). This allowed participants to narrate their own stories and be in control of the topics raised. The method of analysis, thematic analysis, allows for the theory and relevant literature to be woven through in the analysis and aligns with my epistemological approach. I argued that thematic analysis can be utilised to answer the specific research questions, following Braun and Clarke's (2006) steps for analysing data to support the generation of key without taking away from the importance of the individual narratives. This method of analysis supported the development of key themes which will be discussed in the subsequent Findings chapters. To provide a theoretical lens, these themes were mapped onto the socioecological model, allowing the analysis to capture how participants' experiences are shaped by interacting influences at individual, familial, community, societal, and policy/historical levels. Finally, I outlined the ethical considerations pertinent to this study. The people in this study can be deemed vulnerable due to their previous experiences and potential negative outcomes so care must be taken to ensure both them and the interviewer are safe. Additionally, talking about childhood experiences could

raise sensitive issues, which did occur for most participants, so the research had to be handled sensitively, with ethical research practice a key priority throughout.

Chapter 5: Understanding the Experiences of Adult Children

5.1 Introduction

To better understand the full range of adult children's experiences in Glasgow, it is useful to apply a theoretical framework to help organise them. In Chapter 4, I showed how I had derived three main themes from my reading of the raw data, but I still felt that it was necessary to develop an overall model to organise the discussion of those themes. The current chapter therefore describes the different models I considered and my reasons for resolving on the socioecological model. Theories can help in understanding the complex ways in which early experiences influence the lives of adult children. While discussions around adult children have traditionally focused on negative impacts, there are a range of experiences of these individuals which are not necessarily negative. These experiences can be organised into emotional, psychological, and physical arenas, as well as social and relational. Understanding the interplay of risk and protective factors across the lifespan is crucial for developing effective interventions that promote resilience and mitigate harm (Bränström et al., 2008; Felitti et al., 1998). By situating the context of adult children's lived experiences within relevant theoretical frameworks, this chapter highlights the theoretical frameworks' contributions and limitations. This theory chapter underscores the importance of protective factors and looking at multiple levels of experiences for adult children to better understand their lives.

This chapter critically examines a range of theoretical frameworks to explore the experiences of adult children of parents who drink. These frameworks were selected to reflect the multiple levels at which such experiences are shaped, from biological and psychological mechanisms to broader social and structural influences. Biological perspectives (section 5.2), such as foetal alcohol spectrum disorders (section 5.2.1) and intergenerational transmission (section 5.2.2), highlight potential developmental and hereditary pathways, but often do not account for the relational and contextual realities of adult children's lives. Psychological theories (section 5.3), including attachment theory (section 5.3.1) and locus of control (section 5.3.2), provide valuable insights into emotional regulation, coping, and the long-term effects of early caregiving environments, yet they tend to individualise experience and risk overlooking the wider social conditions that impact family alcohol use. Broader frameworks such as the social determinants of health (section 5.3.3) and adverse childhood experiences (ACEs) (section

5.3.4) begin to bridge this gap by connecting individual experience to structural inequality, but they still privilege deficit-based understandings of harm. As such, I argue that the socioecological framework (Section 5.4) provides an opportunity to address this gap by offering insights into the complex interplay of social and structural factors including individual, relational, and environmental factors that shape the lives of adult children (Dyar et al., 2022; Kilanowski, 2017). This model provides a different perspective to biopsychological models, which are too deterministic and fail to allow for divergency and also recognises the scope for individual variation and for the development of resilience. While the application of the socioecological model to adult children (Section 5.4) remains underexplored, it provides a valuable lens through which to examine how early adversities and protective factors interact to influence adult children's understandings of their childhoods.

5.2 Biological Mechanisms

While adult children's experiences are often examined through psychological frameworks, biological mechanisms also play a role. Prenatal alcohol exposure can disrupt neurodevelopment, contributing to cognitive, emotional, and behavioural difficulties, as observed in Foetal Alcohol Spectrum Disorders (FASD) (Mattson et al., 2019; O'Leary et al., 2010; Guerri et al., 2009). Emerging research highlights epigenetic effects, where both maternal and paternal alcohol use can alter gene expression related to stress reactivity, reward pathways, and alcohol metabolism, potentially increasing vulnerability to alcohol use and associated behaviours across generations (Lussier et al., 2017). These biological mechanisms may interact with postnatal environmental stressors, such as inconsistent caregiving or household instability, creating complex biopsychosocial pathways that influence adult wellbeing (Werner and Johnson, 2004). While biologically informative, these mechanisms alone cannot fully capture the lived experiences of adult children, which are shaped by the interplay of biological, psychological, and social factors.

5.2.1 Foetal Alcohol Spectrum Disorders

In cases where maternal alcohol consumption occurs during pregnancy, prenatal alcohol exposure can cause long-term neurodevelopmental changes consistent with Foetal Alcohol Spectrum Disorders (FASD). Molecules cross the placental barrier, exposing the foetus to similar blood alcohol concentrations as the mother but without the metabolic capacity to

break down ethanol efficiently, leading to prolonged exposure to alcohol and its toxicity (Mattson et al., 2019; O’Leary et al., 2010). This can impair neuronal development, particularly in brain regions associated with impulse control and emotional regulation (Guerra et al., 2009). Physical consequences may include growth restriction, organ damage, and characteristic facial features while cognitive impacts include learning difficulties and memory loss (Mattson et al., 2019). Recent research also highlights an epigenetic dimension, where prenatal exposure to stress can influence gene expression, reward pathways, and alcohol metabolism, with some changes potentially persisting into adulthood or even being transmitted intergenerationally (Lussier et al., 2017). While Foetal Alcohol Spectrum Disorders offer one biological mechanism for understanding the long-term effects of parental alcohol use, this theory has clear limitations when applied more broadly to the experiences of adult children. Many of my participants were not exposed to alcohol in utero, and their challenges are better explained through postnatal factors such as inconsistent caregiving, chronic stress, and attachment disruption (Werner and Johnson, 2004). Overemphasising FASD risks pathologising individuals without such histories and obscuring the complex social and relational contexts that shape their development. Moreover, traits often attributed to FASD, such as impulsivity or emotional dysregulation, could also arise from genetic predisposition or environmental adversity. Applying FASD too broadly risks oversimplifying what is a multifaceted interplay of biological, psychological, and social influences in the lives of adult children.

5.2.2 Intergenerational Transmission

Biological mechanisms may contribute to the intergenerational transmission of alcohol use, independent of postnatal environment. Evidence from both human and non-human studies suggests that parental alcohol consumption can produce changes in gene expression that influence offspring susceptibility to alcohol use and related behaviours. For example, paternal alcohol exposure has been linked to epigenetic modifications in sperm which can affect stress reactivity and alcohol metabolism in offspring (Lussier et al., 2017). Similarly, maternal alcohol use during pregnancy can induce epigenetic changes and neurodevelopmental alterations in the foetus, potentially increasing the risk of substance use later in life (Lussier et al., 2017). While these findings highlight a potential biological pathway for intergenerational risk, most evidence remains preliminary, often derived from animal models, and does not fully account

for the complex psychosocial and environmental factors that also shape alcohol-related behaviours in adult children.

5.3 Psychological Mechanisms

Most theoretical models looking at adult children focus on the health-related outcomes achieved through a psychological perspective. These focus on psychological and behavioural outcomes of adult children and how their unique experiences may have impacted them through either impacting their psychology such as attachment theory (Kelley et al., 2005) or mechanisms of internal locus of control (Rotter, 1966) or health outcomes (Arcaya et al., 2015; Aytur et al., 2022). These mechanisms, which have long standing roots in psychological and health literature, can however be very narrow in scope and deterministic in practice. They do not allow for a multi-level system that considers individual, familial, community and societal influences nor the interwoven nature of each of these levels.

5.3.1 Attachment theory

Attachment theory, originally conceptualised by Bowlby (1969), suggests that early interactions with primary caregivers shape an individual's attachment orientation throughout life. When caregivers are responsive and reliable, children develop secure internal working models, fostering positive self-perceptions and healthy relational expectations (Ainsworth, 1989; Bowlby, 1969). Alternatively, inconsistent care can lead to insecure attachment patterns which can persist into adulthood. Applied to adult children, attachment theory provides insight into how growing up in an unpredictable environment may contribute to attachment insecurity, heightened need for control, and difficulties in forming satisfying relationships (Brennan et al., 1991; Kelley et al., 2005). Research suggests that adult children, due to their early experiences of neglect or inconsistency, may develop maladaptive attachment patterns, which can manifest in romantic relationships as avoidance, anxiety, or ambivalence (Hazan and Shaver, 1987; Lopez and Brennan, 2000). This theory allows for an exploration of how early family dynamics shape later emotional and relational functioning.

While attachment theory provides a compelling lens for examining adult children's challenges, it is important to recognise its limitations. Psychological measures, such as attachment assessments, capture only one facet of an individual's life and should not be viewed as deterministic (Beesley and Stoltenberg, 2002). Suggesting a direct causal link

between early attachment experiences and adult relationship patterns risks oversimplifying complex developmental processes and downplaying wider factors such as resilience, social support, and personal agency (Mehdi Abadi, 2023). Moreover, the biological determinism implied in some attachment research can be problematic, as it overlooks the influence of environmental changes, personal growth, and therapeutic interventions in shaping adult relational outcomes (Mehdi Abadi, 2023).

5.3.2 Locus of Control

Locus of control can be used as a theory to understand outcomes of individuals. Locus of control is a theory proposed by Rotter (1966) which can be used to explain the degree to which individuals believe they are responsible for their own actions (internal locus of control) or some external force has influenced their outcomes (external locus of control) (Rotter, 1966). People with a high internal locus of control believe they have control over their own actions and are more likely to take responsibility for those actions. Whereas a person with a high external locus of control may perceive their behaviours as the result of luck or fate and not take as much responsibility for their own actions (Rotter, 1966). Rotter (1966) suggests that those with a high internal locus of control are better at resisting peer pressure. Locus of control has often been used as a measure in personality psychology and been linked to attributional styles (Macsinga and Nemeti, 2012). This construct has been applied in many areas of psychology, be it health or educational, but is not often used outside this discipline (Rotter, 1996; Richards and Nelson, 2012; Haynes and Ayliffe, 1991).

Locus of control is a useful mechanism for understanding adult children because growing up in a household with excessive parental drinking often creates a chaotic, unpredictable environment (Rotter, 1996; Richards and Nelson, 2012; Haynes and Ayliffe, 1991). In such settings, children may repeatedly experience events as beyond their control, missed emotional support, inconsistent rules, or conflict, leading to a sense of powerlessness (Seeman et al., 1988). Over time, this can foster an external locus of control, where individuals perceive that outcomes in their lives are determined by luck, chance, or others rather than their own actions. Although conflicted some studies have argued that adult children overall have a high external locus of control, especially those who are engaged in problematic substance use (Richards and Nelson, 2012; Haynes and Ayliffe, 1991). Similarly, individuals

growing up in lower socioeconomic status families, with inconsistent parenting and violence have also been found to have a more external locus of control (Rotter, 1966).

Locus of control as a mechanism that is psychological in nature and, while valuable for understanding the internal processes of adult children, does not fully account for the broader socioecological experiences that shape their lives. Although this framework was initially considered for this thesis, it is outdated, having not been updated since 1966, and was primarily used, post-thematic analysis, historically to explain how growing up in an alcohol-affected household might impact later life. However, the focus of this study has shifted toward understanding how adult children's retrospective accounts illuminate their parents' alcohol consumption and its broader effects during childhood. The locus of control framework, therefore, was not particularly relevant to the research questions unless the interviews had explicitly focused on the extent of control adult children perceived they had while growing up. Furthermore, some critiques highlight that in-depth interview data are not well suited to this theoretical lens (Macsinga and Nemeti, 2012). For these reasons, the framework was replaced with the socioecological model, which better accommodates the complexity of the adult children's experiences in context.

5.3.3 Social Determinants of Health

Building on and visualising the socioecological model, a model used throughout health and behaviour research is the Dahlgren and Whitehead Rainbow Model, summarised in their 1991 WHO report (Dahlgren and Whitehead, 1991; Dyar et al., 2022). The Dahlgren and Whitehead model of the main determinants of population health is the most widely used model of its kind worldwide (Dahlgren and Whitehead, 2021; Finch et al., 2023). This model maps the relationship between the individual, their environment and health. At the centre of their model is the individual, with layers of influences on them such as individual lifestyle factors, community influences, living and working conditions, and more general social conditions (Dahlgren and Whitehead, 2021). These factors can all influence an individual's health at different levels. The model by Dyar and colleagues (2022) contains the core features of the Dahlgren and Whitehead's (1991) rainbow model organises determinants of health in a hierarchical structure. This updated version adds psychological factors and shows biological mechanisms, helping to explain how many different factors can affect population health. Dyar

and colleagues (2022) argue that the optimal version of this model would also allow for adjustments due to the impact of differing factors changing over time and the creation of context-specific adaptations of the model. However, contrary to this model in this thesis, 'health' is understood broadly, not merely as the absence of disease but encompassing psychological well-being, social functioning, and overall quality of life, aligning with the holistic perspective embedded in socioecological approaches.

Social determinants of health offer a framework for understanding the experiences of adult children in the UK, as they often face multiple disadvantages (Marmot and Wilkinson, 2005; Smith et al., 2017). These conditions can increase exposure to stress and reduce opportunities for healthy development, contributing to mental health challenges (Bellis et al., 2019). Furthermore, the broader social context plays a significant role in shaping health outcomes for adult children. Research indicates that alcohol consumption is linked to socioeconomic inequalities in life expectancy and risks of violence (Institute of Alcohol Studies, 2020a). The 'alcohol harm paradox' occurs in the most deprived socioeconomic groups where they have higher alcohol-related mortality rates but have similar or lower alcohol consumption (Institute of Alcohol Studies, 2020b). This paradox underscores the complex interplay between individual behaviours and broader social determinants in influencing health outcomes. In the case of this thesis, the focus is on adult children's experiences, not simply health outcomes, therefore this model is restrictive in its application of adult children's understandings of their experiences.

5.3.4 Adverse Childhood Experiences (ACEs)

The Adverse Childhood Experiences (ACEs) model (Section 2.4.1) can be regarded as a theoretical framework, though it is not fully developed as a standalone theory and is often used alongside other models, such as the socioecological model. The ACEs model emphasises the ways in which early life experiences, particularly stressful or traumatic events, are related to later health outcomes, both mental and physical, highlighting a biopsychosocial perspective on the links between experience and health (Aytur et al., 2022; Danielson & Saxena, 2019; Garmon, 2021; Meléndez Guevara et al., 2024; Srivastav et al., 2020). While it primarily focuses on health consequences, the model has been expanded to consider a broader range of experiences, including relational and social factors. The model typically

relies on adults' retrospective accounts of their childhoods, linking these experiences to multiple levels of influence, from individual and relational to community and societal factors. Research has applied the ACEs model to adult children, predominantly examining factors that may mitigate long-term negative health impacts associated with ACEs and substance use (Forster et al., 2017; Smith et al., 2017). However, its limited explanatory power regarding resilience and positive adaptation, and its primary focus on health outcomes rather than broader life experiences highlight why the ACEs model is useful but also why it is not sufficient as a standalone explanatory framework.

5.4 Socioecological Model

The socioecological model is a broad approach to thinking of health and behaviour, it has been applied more extensively to studies around alcohol use compared to the other theories but has yet to be applied to adult children's experiences. The socioecological model explains health and behaviour through the relationship between the individual, the community, and the physical, social, and political environment. The model was first introduced by Urie Bronfenbrenner in the 1970s and later formalised as a theory in the 1980s (Bronfenbrenner, 1977; Kilanowski, 2017). Bronfenbrenner conceptualised human development using nested circles, with the individual at the centre. Surrounding the individual are four interconnected systems: microsystem, mesosystem, exosystem, and macrosystem, together with the individual forming five levels of influence (Bronfenbrenner, 1977; Kilanowski, 2017). He later added the chronosystem to account for changes over time, highlighting how temporal and environmental factors shape development across the lifespan. The microsystem includes the individuals' interactions and relationships in their immediate surroundings. The mesosystem includes influences such as work, school and church. The exosystem includes things such as community contexts or social network and the macrosystem includes societal, religious and cultural influences. The chronosystem includes historical influences and policy (Kilanowski, 2017). Therefore, this model incorporates many potential factors which can influence an individual's life. As will be discussed below the model has been refined over time and dependent on the context it is used in.

There is a focus on health within the socioecological model, however the model can be applied to broader experiences. The formal introduction of the socioecological model in

public health contexts emerged in the 1980s and 1990s (McLeroy et al., 1988; Stokols, 1996). Researchers recognised the need to understand how different levels of influence affect health behaviours. This model became particularly influential in health promotion and disease prevention, offering a more holistic approach compared to more traditional models focused solely on individual behaviour change (Stokols, 1996). Over the years, the socioecological model has been refined and adapted to various public health challenges, such as tobacco use, physical activity, and obesity prevention (Stokols, 1996). It has been integrated into health interventions and policies, highlighting the importance of creating supportive environments that encourage healthier choices.

The following sections highlight how the socioecological model has been applied in fields adjacent to adult children including ACEs (5.4.1), trauma (5.4.2), protective factors, risk factors and resilience (5.4.3) and alcohol use (5.4.4), although these can all have the same criticisms of being largely health focused. When applying the model to experiences of adult children, there will not be a narrow ‘health’ focus. However, the socioecological model has been used in research broader than health. For instance the model has been applied in environmental studies, looking at the consequences of ecosystem change for human well-being (Tallis and Kareiva, 2006), in education looking at school-to-work transitions (Schoon and Lyons-Amos, 2017) and workplace studies on burnout (Habeger et al., 2022). In the workplace, it guides interventions aimed at improving employee well-being, job satisfaction, and productivity through supportive organisational policies and practices (Stokols, 1996). None of these studies takes into account adults perceptions of their childhood experiences, nor do these studies apply the model after analysis has occurred, from participants’ experiences; instead, they impose the model on the phenomena being studied. This leaves a gap in the application of the model (see section 5.5).

5.4.1 ACEs and the Socioecological Model

Childhood experiences shape development; it is well known that safe, stable relationships lead to healthy development, however some experiences can lead to poorer outcomes. These experiences are now frequently referred to as ACEs (see Section 2.4.1) which have been found to lead to lifelong changes in learning and behaviour. Although, not the focus of this study the socioecological model provides a framework for understanding Adverse Childhood

Experiences (ACEs) by examining individual behaviour and development through the lens of intersecting levels—individual, relationship, community, and societal (Bellis et al., 2018). This can be adapted to aid in creating a framework for how adult children understand their own experiences.

While the socioecological model offers a robust framework for understanding multi-level influences on childhood experiences, few studies have directly applied it to alcohol use, and most focus on health-related outcomes rather than the psychosocial experiences central to adult children of alcohol-affected households (Aytur et al., 2022; Danielson and Saxena, 2019; Meléndez Guevara et al., 2024; Srivastav et al., 2020). Danielson and Saxena (2019) exemplify this approach, examining structural determinants of ACEs such as economic disparities, institutional support systems, and community policies. Their mixed-methods design, combining surveys with qualitative interviews, illustrates how societal structures interact with family-level factors, such as parenting practices and local attitudes toward health, to shape adverse experiences. Similarly, Srivastav et al. (2020) extend this framework through the Empower Action Model, which translates socioecological theory into systemic interventions aimed at fostering resilience and well-being across the lifespan. By integrating population-level survey data with community-level qualitative insights, they capture both broad structural trends and local contextual variations, demonstrating the layered pathways through which childhood adversity can be mitigated or exacerbated. Meléndez Guevara et al. (2024) further build on this work by embedding resilience-building within child and family service systems and adopting a longitudinal approach, showing how protective factors and coping mechanisms develop and change over time. Together, these studies illustrate the value of socioecological frameworks for highlighting the interplay between individual, familial, community, and societal influences, and they provide a strong rationale for using the socioecological model to explore multi-level factors which influence childhood experiences. However, despite their strengths, these studies share important limitations. They primarily operationalise childhood adversity in terms of ACEs, linking exposure to measurable health outcomes such as mental health, substance use, and physical illness.

While ACEs integrate naturally with the socioecological model, providing clear indicators of individual, familial, and community-level risks, they also have notable constraints. ACEs tend

to emphasise harm and deficit, focusing on the occurrence of adverse events rather than the subjective meaning or relational dynamics of those experiences. This approach can overlook the nuanced psychosocial and emotional realities that shape adult children's lives, particularly in households with alcohol use. Aytur et al. (2022) similarly illustrate the importance of multi-level factors, showing that community norms, peer influences, and other modifiable risk and protective factors affect adolescent outcomes beyond ACEs, such as suicidal ideation. This underscores the broader point that while ACEs provide measurable entry points for socioecological analysis, they risk narrowing understanding to a health-centric perspective, and they may not fully capture the lived experience or resilience of adult children. Consequently, while the socioecological model offers a valuable lens for examining the interplay between individual, familial, community, societal, and policy-level influences, this thesis does not rely on ACEs as a primary framework.

In this thesis, the socioecological model is applied more broadly to map how adult children's experiences of parental alcohol use are shaped across multiple levels, integrating relational, social, and structural dimensions without privileging deficit-based measures of adversity. By moving beyond ACEs, this approach allows for a more nuanced and contextually sensitive exploration of adult children's experiences, capturing both risk and protective factors. Using the socioecological model independently allows for a broader, more flexible exploration of how parental alcohol use affects individual behaviours, family relationships, community input and societal norms, while situating these experiences within wider historical and policy contexts. By applying this model, it is possible to move beyond isolated personal experiences and instead capture the complex interplay of factors that shape childhoods for these adult children.

5.4.2 Trauma and the Socioecological Model

As discussed in the Chapter 2: Literature Review, trauma relates closely to ACEs, especially when applying the socioecological model in the literature. One study which integrates trauma specifically and in-depth is Kelley and Colleagues (2016) 'Dynamic Socioecological Framework of Traumatic Stress' study which provides a holistic view of traumatic stress across various systemic levels, integrating insights from seminal works such as Walsh (2016). Kelley and colleagues (2021) argue that traumatic stress can alter the foundational structures of systems,

affecting how they operate and respond to future challenges. This study highlights the critical role of understanding these interactions to grasp the full scope of traumatic stress, suggesting that interventions must address not just the individual but also the systemic factors contributing to the stress.

The framework proposed in Kelley and colleagues (2021) study incorporates the concept of the defence cascade as proposed by Kozłowska et al. (2015) to assess the severity of traumatic stress across these levels (Kozłowska et al., 2015). Kelley et al. (2021) emphasise the role of sociohistorical context in determining how systems cope with traumatic stress over time. This dimension of timing is crucial, as Kelley et al. (2021) argue that prolonged exposure to traumatic stress can alter a system's response patterns, making future traumatic experiences more detrimental. These factors influence systemic resilience and healing, suggesting that effective interventions should be attuned to the multi-faceted nature of traumatic stress and the varying needs of individuals and systems affected by it. This modelling of trauma highlights the adaptability of the socioecological model to be used in different contexts.

5.4.3 Protective Factors, Risk Factors and Resilience and the Socioecological Model

The socioecological model provides a framework for understanding how various protective factors, risk factors and resilience influence the lives of adult children. According to UNICEF (2024) report, the socioecological model can be integrated into the discussion of trauma and resilience by highlighting how resilience develops through interconnected layers of a child's environment. The socioecological model, as articulated by UNICEF (2024), outlines the layers of influence on a child's development and wellbeing. It highlights how children's resilience is shaped by factors at multiple levels, including the individual, family, community, and societal contexts (Appendix 16). At the individual level, a child's personal coping strategies and self-worth are crucial, while family relationships and parental support contribute significantly to emotional regulation and security (UNICEF, 2024). The community level encompasses social networks, cultural norms, and supportive community resources that foster a sense of belonging and help mitigate the impacts of adversity. Societal factors, such as public policies and cultural attitudes, shape the broader environment, providing the structural supports needed for resilience. This multi-level perspective underscores the interconnectedness of

various protective factors, reinforcing the importance of comprehensive, context-specific interventions to promote resilience and wellbeing in children and adolescents.

Further research has combined protective and risk factors with the socioecological model (Austin et al., 2020; Benzies and Mychasiuk, 2009; Lee and Stewart, 2013). Austin and colleagues (2020) use the socioecological model to provide a broad review of protective factors for child maltreatment, examining influences across individual, family, community, and societal levels. This application allows for a comprehensive understanding of how protective factors such as positive parenting, supportive peer relationships, and community resources interact across multiple levels, suggesting that systemic interventions are needed to address risks associated with child maltreatment (Austin et al., 2020). Similarly, Benzies and Mychasiuk (2009) apply the socioecological model within the family context, identifying protective factors that foster family resilience, such as effective communication, strong family support networks, and access to community resources. Lee and Stewart (2013), on the other hand, apply the model within a school-based setting, evaluating the impact of the Health-Promoting School (HPS) model on student resilience. The HPS model integrates family involvement, peer support, and community engagement, effectively showing how a socioecological approach within the school environment can promote resilience by strengthening protective factors across individual, family, and community levels (Lee and Stewart, 2013). Each study listed above highlights the versatility of the socioecological model in understanding and promoting resilience, demonstrating that protective factors operate at multiple levels, and interventions must be multi-faceted to be effective. Relying solely on risk, protective factors, and resilience narrows analysis to discrete, often static variables, overlooking the dynamic, relational, and systemic contexts that shape adult children's experiences. In contrast, a broader socioecological approach captures the complex, multi-level interactions between individual, familial, community, and societal influences, providing a more nuanced understanding of their lived experiences.

5.4.4 Alcohol Use and the Socioecological Model

In relation to adult children, there is little literature that applies the socioecological model to retrospective adult accounts of childhood experiences. However, the socioecological model has been widely utilised in alcohol use research to explore how individual, relational,

community, and societal factors intersect to influence drinking behaviours (Brenner et al., 2011; Gruenewald et al., 2014; Jacobs et al., 2020; Vantamay, 2009; Walsh et al., 2023), albeit within primarily quantitative studies which limited the understandings of 'why' the specific alcohol use behaviours occur. Additionally, these studies all focus, as much of alcohol related studies do, on the individual's drinking behaviours and not on the experiences and impact of parental drinking on an adult child. This relates to the previous literature cited throughout this thesis of the assumption that children with traumatic childhoods will continue behaviours such as problematic alcohol use into their adulthood, which is not always the case. Most studies also focus on the reasons why the children's parents consumed alcohol and not the role played by parental alcohol consumption in explaining the adult children's own childhood experiences.

Gruenewald et al. (2014) and Walsh et al. (2023) highlight community and environmental influences, on alcohol consumption such as alcohol outlet density and campus drinking cultures, respectively. While both studies look at community-level factors, Gruenewald et al. (2014) adopt a macro-level view of city-wide environmental determinants, whereas Walsh et al. (2023) focus on localised campus settings, capturing individual variation. Gruenewald et al. (2014) identify a strong link between outlet density and alcohol consumption across California cities, suggesting that increased availability of alcohol fosters greater consumption and related harms. This study's reliance on broad community-level data contrasts with Walsh et al. (2023) who consider individual patterns by categorising college drinking behaviours into groups based on socioecological contexts. Walsh et al. (2023) found that campus drinking environments, such as accessibility and peer norms, significantly influence individual behaviours. This difference in scale reveals the socioecological model's flexibility but also highlights methodological trade-offs: Gruenewald et al. (2014) findings may lack specificity, while Walsh et al. (2023) focus may be generalisable beyond the college context. Together, these studies underscore the importance of community-level factors in shaping alcohol use but suggest that tailored interventions should consider both broad policy measures and the specific socioecological dynamics of smaller, defined populations like students.

Brenner et al. (2011) and Jacobs et al. (2020) both explore interpersonal influences on youth alcohol use, focusing on the role of peer and family dynamics, but differ in their demographic

focuses. Brenner et al. (2011) investigate adolescent drinking through socioecological and social lenses, finding that peer relationships significantly predict drinking behaviours. Neighbourhood disadvantage showed only indirect effects on adolescent alcohol use, mediated by interpersonal influences. This suggests that addressing peer dynamics may be more effective than community-level interventions for adolescents in certain urban contexts. In contrast, Jacobs et al. (2020) examine gender-specific determinants of alcohol use among Hispanic adolescents, revealing a pattern where male individuals are more influenced by peers, while female individuals are more influenced by family. Compared to Brenner et al. (2011), Jacobs et al. (2020) offer a culturally specific focus on the importance of considering gender and ethnicity in intervention designs. Both studies highlight interpersonal factors as critical within the socioecological framework, yet limitations exist. Brenner et al. (2011) rely on self-reported data, which can introduce response bias, while Jacobs et al. (2020) findings may not generalise to non-Hispanic populations. Despite these differences, the studies reinforce the importance of peer and family dynamics, underscoring the need for targeted approaches that address specific interpersonal and cultural contexts within broader socioecological frameworks. This reinforces the rationale for using a socioecological framework in my thesis, as it allows the exploration of how multiple levels, family, peers, community, and society, interact to shape the lived experiences of adult children.

5.5 Applying the Socioecological Model

It has been shown above that the socioecological model has frequently been used as a framework for understanding how individual behaviours are shaped by interrelated personal, social, and environmental factors within health research. It has informed a wide range of public health interventions targeting issues such as smoking (Brown et al., 2018) and physical activity and nutrition (Fenta et al., 2023; Townsend and Foster, 2013). Although there has been an extensive health focus, the socioecological model can be applied much more broadly (see Figure 3). It offers a powerful framework for examining the complex and layered experiences of adult children growing up with parents who used alcohol, particularly by focusing on their retrospective accounts of childhood experiences and exploring the role played by parental alcohol consumption in shaping their lives.



Figure 3: Socioecological model of Adult Children's Experiences as children, adapted from Dyar et al. (2022).

As discussed in the previous chapter 4, the analysis of interview data in this study used an inductive approach, as described by Corbin and Strauss (1998), in which “the researcher begins with an area of study and allows the theory to emerge from the data” (Corbin and Strauss, 2008: 12). Inductive research is open-ended and exploratory, beginning with particular observations and proceeding to broader generalisations and theories based on patterns that emerge (Haque, 2022; Thomas, 2006). This approach involves observing trends in the data, forming hypotheses, and developing conclusions or theoretical understandings. The approach to the analysis of the interview data revealed themes which then informed the development of the study’s theoretical framework. In the context of this study, data were collected and thematically analysed first, and then different frameworks, including the socioecological model, were considered to make sense of the findings, rather than starting with a pre-existing model to guide data collection. The socioecological model was subsequently used to organise the narrative and illustrate influences across multiple levels. Applying the socioecological model after data collection made it become possible to structure the narrative in a way that captures the interplay between individual, familial, community, societal factors and political and historical factors, while remaining grounded in participants’ own experiences. In this way, the socioecological model functions not as a prescriptive framework but as a flexible tool to make sense of the themes that were already apparent in the data, incorporating a consideration of the time period.

This study extends the socioecological model’s application beyond health outcomes to explore how adult children’s lives are shaped by multiple, intersecting systems of influence.

The inductive approach used in analysing interview data (as outlined in Chapter 4) revealed themes that at a later stage aligned with a socioecological structure. Kilanowski (2017) offers an in-depth interpretation of Bronfenbrenner's socioecological model, applying it particularly within the field of health research. She portrays the individual as embedded within a series of interconnected environmental systems, each exerting an influence on personal development and behaviour. These systems, typically described as the individual, relational, community, societal, and policy or temporal domains, demonstrate how personal characteristics, such as self-concept and coping capacities, are shaped by wider social, cultural, and structural environments. Kilanowski (2017) underscores the fluid and reciprocal nature of these ecological levels, highlighting that influences function through continuous interaction rather than in isolation. Her articulation of the model provides a valuable framework for examining complex health and social issues by linking individual experiences to broader ecological contexts. Following ideas from Kilanowski (2017) and her view of layers of influence on the individual (see figure 3), this research uses the socioecological model to identify and understand influences at five interrelated levels (Kilanowski, 2017).

The socioecological model will be used to highlight the interrelation of themes in this study. This approach integrates the range of experiences discussed in Chapter 2: Literature Review, with a specific focus on adult children growing up in Glasgow. It offers a coherent way of understanding how multiple influences interact and manifest across different contexts. This is significant for the way theory is applied in studies on adult children, with less of a focus on risk and more of a focus on the differential impacts of childhood on how adult children view their circumstances. The factors which influenced adult children's lives were reorganised in this section for an understanding of how these themes fit into participant's lives at differing levels (as shown in table 1). However, it is important to emphasise that the themes placed within the socioecological levels were often messy and overlapping, reflecting the complex and non-linear nature of lived experience; adult children's experiences do not fall neatly into discrete categories. This approach illustrates the fluid and interconnected nature of childhood experiences, emphasising that individual views are inextricably linked to wider community and societal structures. Organising themes in this way highlights practical intervention points while also recognising the resilience, resourcefulness, and agency that adult children often demonstrated in navigating complex childhood environments.

By mapping the themes from the thematic analysis on to the sociological model we can begin to see the multiple levels of factors which influence adult children's lives as children (Dahlgren and Whitehead, 1991; Dahlgren and Whitehead, 2021; Dyar et al., 2022; Marmot and Wilkinson, 2005). The findings chapters are organised by key themes, with the sub-themes organised relating to the socioecological model. As thematic analysis was undertaken first, not all the sub-themes related perfectly to the levels. However, as previously discussed, this is the nature of an inductive analysis and studies on humans, themes will not fit exactly into discrete categories. For example, an individual's coping strategies may be shaped both by personal attributes, such as self-efficacy or education, and by broader cultural norms around gender or family roles. To manage this complexity, themes were primarily categorised according to the level at which they operate: individual, family, community, or societal, while explicitly acknowledging where influences intersect multiple levels. The individual level refers to personal characteristics such as coping styles, emotional regulation, education, and beliefs that influence behaviour and wellbeing. The familial/relationship level captures the immediate relational environment, including parenting practices, family communication and peers. The community level encompasses influences from schools, neighbourhoods, and local services that can reinforce or challenge family dynamics. The societal level reflects broader cultural and structural factors, such as gender expectations, stigma, and social attitudes toward alcohol, that shape both individual and family experiences. Finally, the policy/historical level recognises the role of policy and historical shifts in gender roles or employment structures. For instance, gender norms and cultural expectations operate simultaneously at societal and individual levels, influencing both personal behaviour and family dynamics. Mapping themes in this way provides a structured framework to explore multi-level influences on adult children's experiences growing up, enabling a nuanced discussion of how individual, relational, and structural factors interact, even when these categories are not entirely discrete. This approach ensures that the socioecological model informs the organisation of findings without constraining the analysis, allowing participants' lived experiences to remain central, enabling a way to see individuals in the context of their 'system' which previous research has not given such sharp focus to.

5.6 Conclusion

This thesis offers a nuanced understanding of adult children's experiences growing up with parental alcohol use in Glasgow. Various models were considered for structuring the findings. Many of the models reviewed in this chapter, biological mechanisms, psychological frameworks, and ACEs, were primarily developed to explain health outcomes or individual-level processes. For example, attachment theory and locus of control were designed to explore patterns of interpersonal relationships and perceived agency, often in relation to emotional or behavioural outcomes. ACEs frameworks were developed to identify childhood risk factors linked to later health and psychosocial difficulties. Similarly, biological mechanisms such as foetal alcohol spectrum disorders or intergenerational transmission aim to explain physiological or neurodevelopmental consequences of parental behaviour. These frameworks are useful in contexts where the research question focuses on individual pathology or risk factors for health outcomes, providing a structured way to quantify or categorise experiences. However, these approaches are less suitable when the aim is to understand the broader lived experiences of adult children of alcohol-affected households, particularly the complex interplay between family dynamics, social context, and psychosocial impacts. While they can explain some mechanisms of risk or vulnerability for the individual, they often overlook social, environmental, and systemic influences that shape childhood experiences. The socioecological model, by contrast, integrates these levels to provide a more holistic analysis. The socioecological model promised to be a powerful framework for making sense of the themes determined from adult children's experiences, as it enables a layered, contextualised understanding. Rather than viewing adversity or protection as fixed, the socioecological model illustrates how these are shaped across multiple, interacting levels: individual traits, family dynamics, community supports, societal attitudes, and historical-political forces (Kilanowski, 2017), making it particularly suited to exploring how adult children retrospectively interpret their childhoods. Integrating psychological and social insights within the socioecological model allows for an exploration of both risk and resilience across time, a dimension rarely captured in quantitative or health-only models (Dyar et al., 2022; Velleman and Templeton, 2016). This thesis shows that many of the experiences that adult children describe are commonly considered as ACE's, trauma, and structural disadvantage as well as differing coping and resilience.

Chapter 6: Normalising Dysfunction: Patterns of Harm and Gendered Roles

6.1 Introduction

Across the interviews, social and cultural norms were discussed as a way of understanding, normalising, and accepting parental drinking and the dysfunction associated with this. This related to both the acceptance of alcohol by viewing it as something everyone does, and the role of gender in prescribing drinking patterns and behaviours. Social and cultural norms also had an impact on how childhood was experienced and future functioning of adult children. For participants, these ideas often provided a way of justifying parental drinking, which in turn appeared to minimise and explain the impact of associated behaviours, such as violence in the family home, whilst also shaping how they both perceived and conducted themselves. As such, this theme is discussed under subthemes arranged across the five socioecological levels (see table 4).

Table 3: Themes on Normalising Dysfunction linked to Socioecological Level

SE Level	Sub-Themes
Individual (Section 6.2)	Gendered Expectations: How individuals internalise societal norms (e.g. men as ‘hard men’, women as ‘housewives’).
Familial/Relationship (Section 6.3)	That’s Just What Families Are Like: Normalising violence and neglect within the family as typical dynamics.
Community (Section 6.4)	Community Violence and Alcohol Use: Exposure to violence and drinking behaviours in local environments that mirror or reinforce home experiences.
Societal (Section 6.5)	Everybody Drinks: Cultural acceptance of alcohol use.
Policy/Historical (Section 6.6)	Historical Gendered Roles and Labour Policies: Past employment and welfare policies shaping traditional gender roles and class-based drinking cultures.

This table maps the key themes from Chapter 6 onto the socioecological model to illustrate the multi-level influences shaping the experiences of adult children living with parents who use alcohol. Each theme is positioned within the level at which it most prominently operates, while overlapping influences are acknowledged to reflect the interconnected nature of individual, familial, community, societal, and policy/historical factors. For example, gendered

expectations primarily sit at the individual identity but also the societal level demonstrating how broader cultural norms are reproduced through personal and relational dynamics. Similarly, normalisation of dysfunction within families reflects not only interpersonal patterns but also community and societal acceptance of alcohol use. This mapping underscores that while the socioecological levels provide analytical structure, in practice these domains are fluid and mutually reinforcing. This is because participants were recruited specifically on the basis of their experience with parental alcohol use, they were subsequently asked to respond to a broader, more general question, which has allowed for participants to discuss a wider range of issues beyond alcohol-related experiences (see Appendix 10) for more information on participants).

These themes reflect current literature. The relationship between parental alcohol use, childhood violence, and Adverse Childhood Experiences (ACEs) is both well-documented and deeply interwoven (Meléndez Guevara et al., 2024). Children of parents who use alcohol frequently experience multiple ACEs within a single household, increasing their risk of encountering complex trauma (Anda et al., 2002). Anda and colleagues (2002) research found that parental alcohol use was not only linked to exposure to violence but also heightened the risk of emotional neglect, physical and sexual abuse, household dysfunction, and mental health challenges. Similar findings have occurred in this thesis, with gendered expectations reinforcing violence at differing socioecological levels.

6.2 Gendered Expectations

This section focuses on the individual gendered expectations described by participants of their parents and themselves. These accounts show how gendered expectations shaped individual behaviours and are influenced by societal forces. It highlights how alcohol use affected individual relationships differently depending on who was drinking, and how caregiving and domestic work were distributed within the household. In doing so, this section demonstrates the tangible, everyday ways in which broader cultural and economic forces were lived and negotiated in individual life. Although these experiences are discussed here at the individual, they were inseparable from the wider societal forces described above, as the realities of everyday life were directly shaped by structural inequalities, economic change, and entrenched cultural norms.

This section focuses on how participants' personal experiences and behaviours were shaped by gendered expectations within the household. Male participants often internalised ideals of toughness and emotional restraint, epitomised by the 'Glasgow Hard Man' archetype, which emphasised 'aggressiveness', physical protection, and drinking as a coping strategy. Male children described pressure to suppress vulnerability, avoid showing fear, and act as protectors when parental alcohol use created conflict. Female participants, in contrast, experienced expectations related to caregiving and domestic responsibilities, reflecting the enduring ideology of intensive mothering (Hays, 1994; Valentine et al., 2019; Laycock and Ryan, 2024). These individual behaviours were deeply intertwined with societal dynamics, but they also demonstrate how broader gender norms become internalised, influencing coping strategies and emotional expression during childhood.

Research has increasingly challenged monolithic constructions of masculinity, suggesting that there are multiple masculinities shaped by social, economic, and cultural factors (Mullen et al., 2007). Men are more likely than women to report using alcohol for escapism (Capraro, 2000; Gough and Edwards, 1998). In this thesis, participants noted how alcohol was used as a coping strategy by parents of both genders, with men often expressing the pressures of masculinity through substance use. This is consistent with research showing that men who experience high stress related to gender norms are more likely to engage in negative health behaviours, including substance use as a way to avoid emotional discomfort, physical pain, or interpersonal conflict (Copenhaver et al., 2000). This thesis found alcohol use to reduce stress occurring amongst mothers also, research does also support this (Fleming et al., 2025; Reisdorfer et al., 2023). These findings reflect how individual-level behaviours are deeply influenced by gendered societal norms and how alcohol is unique in its presentation.

At the same time, the gender of the parent with alcohol use significantly influences the risk factors faced by their children. Adamson and Templeton (2012) found that children of alcohol-dependent mothers are more likely to experience poor emotional and developmental outcomes compared to those whose fathers are the primary drinkers (Adamson and Templeton, 2012). Supporting this, Corte and Becherer (2007) found distinct consequences of maternal versus paternal alcoholism on children (Corte and Becherer, 2007). Paternal alcoholism tends to predict later drinking behaviours and social anxiety, while maternal

alcoholism is more strongly associated with major depression, generalised anxiety, and obsessive-compulsive disorder, especially among daughters (Corte and Becherer, 2007). These outcomes reflect how individual mental health and behaviour are shaped by gendered family roles, which are, in turn, embedded in wider societal narratives about parenting.

Glasgow 'Hard Man'

The 'Glasgow Hard Man' was a term which participants used to describe the male figures in their lives. This was predominately their fathers but sometimes used to refer to themselves, partners or wider male figures in the community. This term originates from McArthur and Kinsley Long's 1950s novel 'No Mean City' to describe individuals who worked in heavy industries, undertook hard drinking and were involved in gang culture (Johnston and McIvor, 2004). Yet in this study 'Glasgow Hard man' was part of the participant's vocabulary to describe fathers, and sometimes their own, behaviour as angry and aggressive and related to alcohol use. The perception of 'hard man' was considered an individual internalised viewpoint but also a cultural problem by participants. Miriam summarised this when talking about her father:

And my perception of it is that kind of cultural thing. Cultural drinking thing has been a[n] influence on his [father's] relationship with alcohol because he does not see himself as an Asian man, he sees himself as a white Scottish man. And he would like to behave in such a way that nobody would question that...but to me a lot of it is, it's a cultural thing where he wants to be seen as one of the boys. He wants to be seen as a Glasgow hard man. I think he's not you know. But I think a lot of that came across to me, the aggression and the shoutiness and the, you know...

Miriam, 39⁸

Miriam's father moved to Glasgow from India when he was a child and, according to her, attempted to assimilate to Glaswegian culture, which involved being angry, loud, and drinking alcohol. This view of Glasgow men was echoed by many participants, whereby the 'Glasgow hard man' perception also had strong connotations of a lack of fatherly emotion and focus on

⁸ Age at the time of interview

maintaining an uncaring demeanour, despite his father's physical presence as a young child. Alfie described how his father was:

...never ever there for me. I never had a male role model to look up to. All my kinda like male role models were drinking in the pub, they were away gambling, they were away to football.

Alfie, 46

Alfie was 46 at the time interview data was collected, he was in recovery for his own substance use and was particularly reflective on his experiences as a child. He lived with both parents until he was a teenager and then he lived with his mother in Easterhouse, he had one younger brother, and his father was physically violent. He did not have much family in close proximity, although he did mention an uncle and aunt in reference to when he brought a knife to their house:

I didn't have that positive male role model. I remember being down at my uncle's, I must have been about sixteen, eighteen years old, and I was carrying a lock back knife at the time. And it fell out down at my uncles and then landed on the floor and him being like 'ahhh' and my auntie went that straight away '[uncle] talk to your nephew'. No' our nephew, 'cause my uncle being my ma's big brother all of a sudden and my uncle went 'what do you want me to say, we all know Alfie is running around like a toerag, nothing I say is gonna change any of that' and it's so true. I had to learn from my own mistakes how to find a better way of life.

Alfie, 46

The above quotation also highlights the high level of aggression, which was iterated throughout many of the participants' stories. Whilst the presence of violence across the interviews is captured as a separate theme, discussed below, here the participants associated violence with masculinity, as evidenced by Alfie, Brian, Malcolm and Basil. Summarised below by Alfie, is the perception that boys were supposed to be 'wee men':

*He's [brother] like that: 'you just battered my da'. I'm going down and I'm shaking, I'm all nervous...that's where my dad's behaviour took me to. Was it right for me to do that? Nah. Two wrongs don't make a right and I realised that the day...that's just the way it was growing up here. Boys are supposed to be wee men. Boys arenae supposed to cry. It's not supposed to happen *sniffles* 'I'll do my best to stop greetin'', 'stop greetin' now', fear. Out and out fear. Not being allowed to clearly express myself. I did, I started lashing out. I started lashing out a lot of people that just didnae deserve it.*

Alfie, 46

This 'hard man' persona was thus an expression of emotion and, in many of the participants' stories, covering their fathers or their own trauma. Many participants described traumatic upbringings, yet predominantly the men felt like they couldn't cry and, as Alfie describes above, had to keep their emotions bottled up. From a young age, male participants described how they felt like they should not want comfort, and it took a long time for them to realise it was not a weakness to want that. For example, Brian describes how when he was 11 years old, he:

...got put onto a one-to-three-year child protection order for my own safety and I ran away [from the residential home] because of the abuse that was going on in there, physical, mental and sexual. Stuff that I could never tell anybody about, another human being, I carried that all my life. 'cause that would be seen as being weak, vulnerable and bullied and picked on. Questioned my own sexuality, was I excited because certain things happened outwith my control. So, I spent my whole life proving that it didnae work [in changing his sexuality, as he was abused by male adults].

Brian, 63

Brian mentions above the abuse he experienced at home and the sexual abuse he suffered in care. Brian lived in Summerston, with his father and stepmother after his mother passed away, he then lived in care and then with his aunts. He had an older brother and sister whom he blamed for not protecting him from this abuse for a very long time, until he re-examined his experiences and realised that they were children at the time too. Brian was part of a gang

engaging in criminal activities for much of his childhood, from age 12, and throughout his adult life until he 'hit rock bottom' and became an addiction worker. As Brian stated above, there was a fear of being seen by others as 'weak' or 'vulnerable'. Some participants extended this fear to their own children. For example, Malcolm mentions how he's worried his son is going to be a 'pussy' and not strong enough for the world:

The only thing is yeah man I think about Liam [son] and the age he's at [11]. Especially as he's not long over the age where I lost my mum and that but in general, I just think of yeah, he's kind of fucking a good bit better set up then I did with that. But I kinda wonder you know, 'fuck is he going to be too much of a pussy?' Things have been too easy for him do you know? Aye well I don't know maybe not, but I mean sometimes you do need to get an awareness of fucking, what the world could be like and get used to dealing with it to some extent maybe.

Malcolm, 39

Malcolm is a single father to a 11-year-old boy. He grew up with his father, mother and younger sister until his mother passed away and then remarried. His mother had a physical disability; she subsequently died by suicide in conjunction with Malcolm's grandfather. Malcolm mentioned how his father used a lot of psychological violence but there was only one instance of physical violence towards his sister. This demonstrates how Malcolm's experience of the world at his son's age was 'hard' and that there is a need to experience 'hard' things to "deal [...] with it" and develop resilience.

Conversely, Basil mentions how his experience of the world, means he does not want this view of men affecting his daughter. Basil is married with a daughter. He grew up with his mother and one full and three half siblings and various of his mothers' partners. His mother, as stated by Basil, was verbally abusive, and her partners were physically abusive. During his childhood Basil temporarily moved in with his grandmother, but this did not last long:

...it was about learning how to not repeat the same mistakes that your father made and sort of. I remember we'd been up to my mums [house] with my daughter on my knee and she'd said 'goodnight dad love you' and she [mum] was sort of of saying 'look at

that ye wee sook'. Do you know what a wee sook means? A wee sook in Scotland means look at you, she's too affectionate, she's showing emotion, she's sooking in with you thinking right... [I said] 'she's not a sook, she's just showing emotions and that's what we're gonna dae, we're gonna talk about that stuff. And if you don't like it then don't make her feel bad about it, ok?' and ma maw got it because she knew that I wasn't going to let her just continue putting that exact same shit onto her.

Basil, 53

Whilst this contradiction between Malcolm and Basil in wishes for their children could be due to their children's different genders these quotations show how, during the participants' childhoods, avoiding emotions was considered normal at home.

Male participants, as 'wee boys' also felt the need to protect their family from the often, male parental drinking. For example, Alfie talks about trying to protect his mother at a young age:

I can remember once when my da, my da was battering my maw actually. I ran in with a brush and I put it round my da's heid. I was about seven years old, and it caught his attention on it, and I refused to cry for him, and I started laughing and he said, 'what are you laughing at?'. And I was like I'm not always going to be this size. And that proved to be the case because I told you about the time, I was sixteen. That's not the only time I've set about my da. It's not the only time I've done it, am I proud of it? No. Did I feel justified in the end? Aye I did. In the end I did because I felt let down.

Alfie, 46

Likewise, Basil, was raised with a mother who drank and recalled how she began dating boyfriends who were abusive to her and him:

And I remember like getting flung about the room because at that age you can't, you get told in Glesga that you're the man of the house because you're the oldest boy right. Because my brother, my wee brother's ten. And I remember trying to attack this guy [mum's boyfriend] because he was hitting my maw and I remember getting flung across

the room but thinking you were just a wean. But I used to think 'how could you not protect?', because you're a wean.

Basil, 53

Overall, men were expected, or had placed the expectation on themselves, to be protectors and this frequently involved violence, especially when alcohol was involved. Participants who had been violent or a 'hard man' and been through recovery services realised that they did not have to continue that behaviour in later adulthood.

'Housewife'

Female participants in this study expressed the expectations that mothers often had to take on extra housework and childcare due to the other parent drinking in the home. This highlighted the traditional division of domestic labour which participant's mothers had internalised. There was also the view that if a mother drank that that was much worse than a father drinking due to the caregiving responsibilities of the mother. The internalised 'expectations of motherhood' were stated by many participants and the vital role mothers played in the raising of their children, as shown by Tasha below:

And so, I think a lot of that is to do with the gender expectations of motherhood and the fact that you know, when a woman drink's there's more expectations put on her 'cause she doesn't do the certain things. You know, you know things like the washing not getting done in the house, like the laundry not getting done. You know that was down to my mum. My dad's drinking you know. Yeah. I had but. If my mum was drinking actually things like, that's where the noticeable impacts would happen.

Tasha, 34

Tasha was an only child, with both parents drinking. She became her mother's caregiver as a teenager before she passed away, as her parents separated when she was older. Her mother was the one who undertook a caregiving role and her father did not do housework prior to her mother's passing. The amount of work mothers undertook in the house was also

mentioned by Rowena, listing the domestic labour that her mother did, and the lack of parenting duties undertaken by her father:

We were in this environment, my brother was extremely creative, we were well looked after, and my dad just did his own thing really. He was like a single guy and the mum's held it together and they were resilient, and they were strong.

And the women stayed in the house, and they made dinner and set the table, got the kids to school and made sure that they were washed and got their homework done. So, I was really lucky that it was my father that was an alcoholic and not my mother. I had a friend who, it was their mother, and I thought that that was much more devastating for her than it was for me because my mum was everything, she did everything.

So, although there was the violence there was another side where, the women, particularly the women, were more involved with the upbringing and the upkeep of the house.

Rowena, 53

Rowena is a middle child with 3 siblings. She grew up with her married parents, and her father drank. Her father was physically violent towards her mother but not the children. She remembers many mothers on her estate working together to raise the children.

From these perspectives, the impact of a mother's alcohol use was more noticeable than that of a father due to the labour division in the house and the expectations placed on mothers in relation to providing both nurture and structure. Therefore, whilst parental alcohol use might result in fathers being violent or absent, that a mother might not be able to take care of the home was viewed as far worse. At the individual level of the socioecological model, this highlights how participants' personal beliefs, attitudes, and internalised gender norms shaped their understanding of parental roles. Individuals perceived mothers as primarily responsible for caregiving and stability, so when maternal alcohol use disrupted these expectations, it was interpreted as more harmful and personally destabilising. The roles of most female participants and mothers in this thesis were as 'mothers' and 'caregivers'—positions they often maintained in an effort to mitigate potential violence and preserve normality in the

home. Even when mothers were the parental figure drinking, they were still associated with the same caregiving expectations; when these were unmet, participants who had mothers or both parents who drank appeared to feel this impact more deeply. This demonstrates how individual-level factors such as personal experiences, beliefs, and gendered expectations shaped participants' interpretations of family dynamics. Conversely, the role of males was constructed around strength and physical protection, linking to the cultural ideal of the 'Glasgow Hard Man'. At the individual level, this persona shaped how men understood and enacted their identities, as well as how participants perceived male behaviour in their families. Thus, both male and female participants reinforced gender norms through their personal beliefs and lived experiences, illustrating how internalised cultural ideals operate powerfully within the individual level of the socioecological model.

6.3 That's Just What Families are Like

Growing up in a family affected by alcohol use often shapes children in ways that persist into adulthood. Many adult children describe their early home life, as 'that's just what families were like,' reflecting normalised patterns of chaos and inconsistency. Understanding these experiences through the familial level of the socioecological model helps highlight how family dynamics and relationships influence their experiences growing up. The familial level reflects the patterns and dynamics of the household that shaped a child's experiences. In families with alcohol use, abuse and neglect were discussed as a basis of their relationship with predominantly their fathers.

Most adult children in this thesis were exposed to various forms of violence from their parents, be it verbal, physical or emotional, as well as witnessing domestic violence against the non-drinking parent and siblings or themselves, this increased risk of violence is also reflected in the literature (Park and Schepp, 2015; Velleman et al., 2008; Velleman and Reuber, 2007; Velleman and Templeton, 2016). The levels of violence witnessed in the family, particularly long-term violence can have a long-term impact on children's future lives and are often difficult to overcome (Gąsior, 2014; Hall and Webster, 2007). Abuse of all kinds and observing violence, including suicide, in childhood is associated with higher levels of smoking, alcohol abuse, depression, and poorer health in adulthood (Dube et al., 2003).

Familial violence was commonplace amongst participants, with many commenting on how violence increased throughout their childhood, with various family members, including domestic violence and abuse. Thus, violence was discussed by participants as frequent and escalating. As Sophie summarises, violence and 'chaos' occurred frequently and with multiple family members:

*And I don't remember how much violence there was 'cause there was just violence continuously. He [mother's boyfriend] was a binge drinker so we kind of walked on eggshells. In between binges of drinking and then it would be somebody's fault, and he would go out and have a huge, big binge...so, yeah...my grandfather kind of locked me in, me and himself in the bathroom one night. I was going in for a bath so at kind of like fourteen, twelve, kind of trying to go in for a bath and your grandfather locks the room, puts his arm around me and went 'shhhhh'. I didn't I went 'wahhhhh'. So yeah, so the door kind of got brayed and my gran and my mum huffed me one way and my grandfather went another way, and we left within a couple of days *laughs*...*

Sophie, 49

Sophie had two younger brothers, her father was physically violent towards the children, as were her mothers subsequent partners after her father had left. For a very short period of time after her father left her family lived with her grandparents but after the above event they moved. Here violence is both physical and sexual, resulting in feelings of trepidation, fear and uncertainty. Similarly, Alfie and Polly reiterate the constant fear of violence and the 'shared terror' with her siblings:

My childhood memories arenae very pleasant, they're not pleasant at all. I can remember always living in constant fear of my da. Constant fear. Sometimes, sometimes he would be alright, but I think that's. When he was drunk. You know. Used to beat up my ma, used to beat up me. I used to grab my wee brother and I'd shield my wee brother and I would take the hit.

Alfie, 46

So, I suppose kind of sometimes it wasn't all bad...I mean it's how things appeared, but I mean they were horrific. I think my dad...dragged my mum up four sets of marble stairs on holiday. He was creating absolute havoc, trying to batter down the adjoining doors because we'd managed to lock him out and then the security guards got involved and my mum wouldn't leave. This was quite far on into the violence, my mum wouldn't leave the room for about, I think we were away for about two weeks, but she was threatening to throw herself off a balcony and then it was all very much constant.

Polly, 48

Polly was the oldest of 3 siblings. She grew up in a 'nice house' with her siblings and parents until her father lost all their money and left when Polly was an older teenager. Her father was physically violent towards all family members. The above quotation also highlights how violence was such a common feature of Polly's childhood that it resulted in a constant feeling of dread and worry. Likewise, Basil discussed:

My maw had moved in with that guy, we got whipped out during the night because she'd stabbed him [mother's partner] in the stomach with a screwdriver, but it was that sort of household do you know what I mean. Just some chaos.

Basil, 53

As a reminder, Basil's mum drank alcohol in excess, and all her partners did also. Despite Basil's mother not being violent towards her children, she was evidently violent towards her partners. From both Basil and Polly's accounts we can see there was an acceptance of violence as part of family life.

Bonnie also shared how commonplace violence was at home, yet as discussed in the section below, understood this as common across all families in her community. Bonnie had a younger sister and grew up with both parents. Her father drank and was violent towards objects but not the family. She grew up in Glasgow city centre:

So, he was quite an angry drunk so there was lots of, not physical violence towards me, my brother or my mother but violence in terms of putting your foot through a door or

throwing things and smashing a window and all that. Which sounds horrific now when I think about it. But there were other neighbours who were the same and it was just normal.

Bonnie, 49

In Bonnie's quotation we can see how, looking back at her childhood, she realises how 'horrific' this experience was but that the feeling was one of 'normality'. Many of the participants shared similar reflections, whereby, having grown and had children of their own, they now look back on their childhood and realise how their experience of family life was not the same as everyone else and that the levels of violence, often whilst parents were drinking, can be seen as traumatic. Some participants, such as Hazel, only had this awareness during the interviews discussing violence, she had not thought her father had ever hit her, but then discusses a situation in which he was violent towards her and realises the trauma of this:

He [father] held a knife up to one of my sisters' throats, he grabbed one of my sisters with the throat up against the wall. But he never hit me, but I remember once he slapped my mum on the face and I was on her knee. And when I [was] sitting on the floor and he slapped me in the back of the head and my mum put her hand down in front of my face so my face wouldnae hit off the floor and I was about three or four then...

Hazel, 31

This quote reflects the type of relationship Hazel had with her father. Hazel grew up living with both parents when she was very young. She then lived with her mother and stepfather. She has 2 older half brothers and 2 older half sisters. Her father was violent towards the family. Her parents were separated by the time she started secondary school. Escalation of domestic or intimate partner violence is well documented (Boxall and Lawler, 2021). This is similar to what Polly discusses in the previous quotation in relation to her mum being dragged up a marble staircase. Likewise, Sophie highlights a specific incident of escalating violence, where her mother's boyfriend attempted to murder them with a knife:

*You know like we got chased down the street with knives at one point. He was going to kill us; we had to run down and into another neighbour's house *laughs*. Like they were*

in, and we managed to get in their house, and we phoned the police. And like he had the biggest knife in the kitchen. He was gonna come and kill us all. We're not talking like. It wasn't like little violence. You know it wasn't stuff like you know, that's alright we can, you know. This man was intent on killing us at times. And she kept going back and taking us back and taking us back.

Sophie, 49

Sophie is referring to her mother's partner above, both Sophie's biological father and mothers' partner used alcohol. There was a point where escalating violence within the family threatened participant's lives. This meant that, as previously mentioned, that participants potentially lived with fear and uncertainty.

Some participants eventually became violent to the fathers or mothers' partners who had undertaken the previous domestic violence. Alfie and Malcolm describe such instances against their fathers:

If you're asking me what it's like, was I scared of my da, aye I was scared of my da. I remembered when I was sixteen years old though, I remember battering my da. A red mist just came on me, remembering my da. My wee brother had knocked over a plant pot in my da's house and watching from my da coming back from the van with sweets or cakes or something. He came back and my da just got in and he went mental, he's just like 'six month it took me to grow that, and it took you six seconds to destroy it.' And I was sitting in one seat; my brother was sitting in another and my da went for him and I just remember standing up and standing in between my dad and my brother and then the next thing I remember is walking down Lochdoch Road like what just happened there?

Alfie, 46

I don't really remember much violence. Violence wasn't an ongoing thing but maybe psychological violence, but yeah. But then that time so yeah, he [father] wasn't actually trying to hit her [sister], but he did effectively hit her. And it looked like to me [he] was, so like that classic, belter of a left hook it was. Broke his nose with one punch so that

was when I was seventeen, just after I'd finished school. So, then I got my bag and went see you later and that was me moved out the house since then so that kind of gives you all of the main things about life in relation to parents, guardians.

Malcolm, 39

Lucas had 3 siblings, one older brother, one older sister and a younger brother. He himself started using substances at a young age and both his parents also used substances. He describes an incident in which he stabbed his brother six times whilst under the influence of 'speed and paste', stating that this was not his normal type of violence, but also contrasting this to gang violence that was 'just a laugh':

Big problem with my younger brother. The night of my twenty-first he slept with my girlfriend. Just before, a couple of months before that she'd lost my baby...[I] started on not much you know a bit of speed and paste and things like that. Just in the short term and then I remember in the hoose one night me and my younger brother were in the living room and my brother he was addicted to, still is addicted to cannabis, and I've not smoked it for a long time...But we were in the house one day and had my ma. And I ended up stabbing him, six times in the back. I've never been violent in that way and all that. I've done the gang fighting and all that growing up and that was just a laugh, you know what I mean. That was nothing serious, but I got the fright of my life, so I did. He took his t shirt off his back covered in blood and that. I just ran. I was out the hoose, I was away for a couple weeks, stayed with my friend and all of that. I never got charged or anything because it couldn't be proved, just say we had a domestic sort of thing.

Lucas, 45

The above quotation shows that familial violence was commonplace, to the extent that Lucas is matter of fact when describing stabbing his brother six times.

Brian uses his own drinking and recovery as well as experience as a recovery worker to talk about how alcohol use has broader ranging impacts than just the individual and that it effects his family and relationships also. Alcohol helped him form relationships outside the family,

which had an adverse effect on his family. Once he had recovered it was a 'family recovery' also:

And what might be traumatic for me might not be for you. Parents divorcing that can be traumatic for somebody. Somebody just not fit the square peg in the round hole looking in fra the outside we're ostracising ourselves even more. They don't know how to fit into this circle. Take a wee drink and you can sing, and you can dance, and you can fight, and you can dae all this stuff you couldnae do without booze. But the progression of the disease is it's gradually stripping you of everything and that included morals and principles and hygiene and respect and the loneliness and the isolation.

...So, the family illness became the family recovery. You know what I mean, if I get well everybody gets well.

Brian, 63

At the familial level of the socioecological model, these findings highlight how family dynamics and relationships shape participants' childhood experiences. Participants' reflections that 'that's just what families were like' indicate a normalisation of violence and dysfunction within the family environment. This suggests that the boundaries of acceptable behaviour were learned and reinforced within the family unit itself, where alcohol use, aggression, and emotional neglect were perceived as ordinary aspects of family life. Such familial norms illustrate how patterns of behaviour were considered commonplace amongst participants.

6.4 Community Violence and Alcohol Use

Community violence was common and normalised in this thesis. It could arguably be due to the research context, high levels of violence were known to occur in Glasgow during the 80s and 90s particularly in more deprived areas and are associated with drinking behaviours (Walsh et al., 2021, 2017). For example, Malcolm, discussed in quite a dismissive manner, that violence was something that 'could have been traumatic' but not necessarily was, especially as there was some community solidarity in Easterhouse, one of the areas he lived in for his father's work as a gardener, nor was it something they had considered traumatic until now:

And then there was some violence in the community up at Easterhouse. I don't know whether it had much to do with alcohol, but it was to do with the general environment. You witnessed stuff you know which could have been quite traumatic and then.

...But yeah, I suppose in the built-up areas there was just a lot of poverty and people would be, there'd be a lot of conflict between people, a good bit of solidarity as well around some people. Yeah, they'd be a lot of like violence and people being, and there was a bit of danger and stuff just walking about.

Malcolm, 39

It was only when reflecting or moving away that Malcolm realised that this behaviour within communities was not 'normal'. McAra and McVie (2010) support this finding of high levels of youth violence in working class neighbourhoods in Scotland (McAra and McVie, 2016). This process of reflection was also expressed by Daniel, who grew up in the G53, Crookston, Darnley, Hurlet, Nitshill, Parkhouse, Pollok, Priesthill, and Southpark area, also mentions the solidarity found within the violent areas, and Bonnie who grew up in the G1, city centre area:

They already had the same [violence]. Everybody was shit poor you know. But nobody bothered because they were all in the same circumstances as everybody. And everybody lived, you lived near each other, you went to school together, you came back, you socialised together. So, you never kind of moved out.

Daniel, 53

...I thought if you thought about some of the things that our parents said and did to each other when we were growing up in the '70s it's just there's no comparison, it's bizarre. They were just up the next day, and it would be 'och you had a few too many the night before' and it'd just brush it off and you're like 'this is absolutely crazy' but y'know the majority of the men who were all working class men growing up in that area that was what they did, that was normal, that was how they treated the families that they lived in.

Bonnie, 49

When communities became aware of the violence in families, there was an attempt to help when asked, but 'nobody bothered' to do anything to attempt to put a stop to the violence or drinking as it had become 'normal'. Many participants mentioned how violence became so commonplace it was ignored, especially if it was frequent, as shown by Sophie's mother no longer being asked about her bruises. Sophie who lived in various locations G2, G74, G51 with her siblings and mother and mother's partner:

So, my mum split with her alcoholic boyfriend eventually, when she was, when I was eighteen. So, two things happened same day, he hit her in the street, and it was the first time he'd actually ever hit her in the street. He'd done stuff in the household, but he hit her in the street. And bruising from that. The people in work didn't ask about it for the first time ever. So, people had been asking about the bruises for like six/seven years and she always made-up stories. But they didn't ask, and I think that gave her a real fright that they didn't ask. That the violence had taken a new step, and nobody asked about it.

Sophie, 49

This level of community acceptance of violence was also highlighted by Justin, who grew up as an only child living with predominantly his mother in the G5 Gorbals and G42 Battlefield, Govanhill, Mount Florida, and Strathbungo area, although he is referring to the Gorbals here:

I remember, I must have been, well I was a toddler, I remember being at the pub and my mum and I coming home and my mum had told me to get up the stairs and he [dad] threw a glass at her in front of everyone and it smashed up her legs but I don't remember anyone reacting so that maybe says more about that community culture of alcohol as well.

Justin, 37

Participants perceived violence within their families as unchallenged by the wider community, noting that neighbours or community members did not intervene or comment when domestic violence occurred. From a socioecological perspective, this reflects a community-level dynamic, where social norms and collective attitudes within neighbourhoods contributed to

the tolerance and normalisation of violence and heavy drinking. In many of the participants' accounts, community members were aware of domestic violence or parental alcohol use but regarded such behaviours as commonplace or inevitable. This silence and lack of intervention suggest a broader community culture in which alcohol-related aggression and family conflict were normalised rather than condemned.

6.5 Everybody Drinks: The Acceptance of Alcohol Use

Participants frequently described being around parental alcohol use from a young age. This was seen at a societal level throughout participants in this thesis. Cultural normalisation of drinking in certain environments may promote alcohol use (Dimova et al., 2023). For example, out of 9,508 participants of a questionnaire about adverse childhood experiences, from adults who had completed an evaluation at a large HMO, household dysfunction was found to have a prevalence of 25.6%, however 23.5% of the sample was specifically exposure to living with someone who was a 'problem drinker' or 'alcoholic' (Felitti et al., 1998). Adult children in Järvinen's (2015:819) study tended to normalise their drinking by saying that they "drank like their friends or colleagues" or like everybody else did back then in the 1980s and 1990s (Järvinen, 2015). This was very common in this thesis with participants frequently mentioning that alcohol use was common or normal societally. As Miriam, who is a second-generation Indian who lived in G3/G11 during her childhood and Basil, who lived in various areas G45, G53, G42 describe:

So yeah, I mean, like I say a lot of it is reflective stuff because while I was growing up it just all seemed normal.

Miriam, 39

...I just sort of grew up in that environment, so you thought it was normal, sort of normal. Drinking and drugs from a very early age.

Basil, 53

Alcohol was also discussed as the typical way for people, particularly men, to socialise. As most social events revolved around alcohol it was also seen as a learned behaviour in Scottish culture to drink it, as encapsulated by a statement from a study on drinking: "I am sure there

was a lot of mimicking in that because my father drank, my uncle drank, everyone drank. Voluntary sector service user, Male, Glasgow” (Lancaster and Dudleston, 2002:39). Participants reflected on how men were frequently in pubs, and this was normal behaviour for the whole neighbourhood:

I mean all of the men in the street went to the pub after work or they played pool, or they played dominos, or they played darts, and they went to the pub, and it was a sociable thing.

Rowena, 53

The areas participants lived in were mostly council estates or tower blocks in ‘New Town’ areas. In Glasgow, ‘New Town’ usually refers to planned post-war housing areas built from the late 1940s through the 1970s to address overcrowding in inner-city tenements. Some were entirely new settlements outside the city, while others were large-scale redevelopments within Glasgow’s boundaries. Some studies found that city centres offer an atmosphere where drinking is more acceptable. For example, in a city teenagers’ drinking culture was easier to see than in towns in England (MacLean and Moore, 2014). These physical environments were described as shaping the behaviour of parents, as Justin reflects:

And if you look at any, I don’t know about now but back then any multistorey flats that were built, there was a shop, a park, and a pub at the bottom. And it was a huge park. So, there was always alcohol...And I think that the normal thing for me maybe influenced by that alcohol was seen as a thing that was just in your life as far as my parents but there was almost that expectation that you would ‘get mad wae it’, as they say in Glasgow. And then you know you would, so much of our social lives are built around pubs and clubs and stuff like that...

Justin, 37

Justin found this mentality particularly relevant during his childhood in the Gorbals, when his parents were living together. As seen by the above quotations, parental alcohol use was considered a cultural ‘norm’ in the areas that participants were raised in and seen as ‘seen as

a thing that was just in your life' without question. The everyday acceptance of alcohol helped participants to justify behaviours and also proscribe behaviours into adult life.

Participants mentioned that alcohol use was a cultural norm and societally being Scottish or Glaswegian meant that alcohol was part of the culture. Justin and Sophie describe how drinking to excess was considered 'normal', if 'dysfunctional'. Although Justin mentions 'alcohol as a family unit' he did clearly establish that his father definitely had a problem with alcohol, whereas his mother and himself may/may not have a problem, they are 'being Glaswegian':

Alcohol I think is a family unit, 'cause my mum did drink as well. Alcohol as a family unit was a norm, alcohol I would say as a society being Scottish, being Glaswegian, is a norm.

Justin, 37

...so like, the whole family network was just really very dysfunctional and friends that I've spoken to. So, one of my very dear friends, her mum was my mum's friend from school you know she's got a very similar background, you know, grew up in a very dysfunctional network so my mum's closest friend was married to an alcoholic, so you know it's almost like all the dysfunctional people kind of grouped together.

Sophie, 49

Polly mentions something similar, in that alcohol use can be seen as a societal problem due to multiple generations drinking, including her grandparents, parents and brother and it being the 'environment' they grew up in. However, she did have the support of her siblings throughout her childhood and currently does not drink and therefore has 'stopped the cycle':

I had a sister and a brother, so I suppose like the terror was shared. What we went through, we had each other...

...I would say it was a generational thing, so if we go back. Because I've just done a genogram...I've stopped it, so I've stopped the alcoholism and the violence, but it was my mum and dad and their mum and dad, so it's going back generations. So, I'd say, it's

what you're accepting and what you've been show you know within the environment you've grown up in.

We're both, me and my sister, my brother's still there, he's bought a house there now although he's constantly going to be losing it all the time. And he kinda deals in drugs as well to cope. But my sister's a nurse but she's, so I want a profession now, but it's taken a long time to work off the damage. Alcohol brings a lot of damage. A lot of damage, aye.

Polly, 48

Polly mentions a clear intergenerational transmission of alcohol use. Her father drank, as did her paternal grandparents and her brother. Polly also married a man who had problems with alcohol use but divorced him to provide a better life for her sons.

Participants frequently described being exposed to parental alcohol use from an early age, a pattern that appeared widespread across participants in this thesis. This reflects influences at the societal level of the socioecological model, where cultural attitudes and longstanding traditions surrounding alcohol shape collective behaviours. Participants in this thesis expressed that alcohol use was not only common but also culturally sanctioned within society. Thus, the societal level highlights how broader cultural beliefs, social expectations, and historical patterns around alcohol consumption create an environment in which drinking, and its impact on families, becomes normalised and perpetuated.

6.6 Historical Gendered Roles and Labour Policies

At the historical and policy level of the socioecological model, broader structural, legislative, and cultural shifts shaped the social conditions within which participants' family experiences and gender roles developed. Historical and policy contexts further reinforced gendered dynamics, particularly through economic and regulatory changes that influenced patterns of alcohol use and identity formation. The process of deindustrialisation from the 1970s onwards disrupted traditional forms of male employment, contributing to a reconfiguration of masculine identity and rising levels of alcohol-related harm (Bellamy, 2006; Leyland et al., 2007; Shipton et al., 2013). Cultural expectations of fatherhood and masculinity, alongside

the enduring ideology of intensive mothering, were rooted in structural inequalities and long-standing gender norms, reflecting how historical social arrangements shape individual and familial behaviour.

At the same time, legislative reform around alcohol access reflected and reinforced these wider societal changes. The *Licensing (Scotland) Act 1976* marked a turning point in national alcohol policy, modernising previous licensing laws and introducing more flexible opening hours for licensed premises, including Sunday trading for the first time in decades. This liberalisation represented a move away from the restrictive alcohol controls of the early twentieth century and signalled a broader cultural shift towards the normalisation of drinking as part of social and leisure life. Such policy-level changes, in combination with the socioeconomic transformations of the period, created an environment in which alcohol became more accessible and culturally embedded, influencing both community norms and household behaviours.

Economic restructuring also had profound implications for gender roles. The decline of traditional industries left many men without stable employment, contributing to feelings of purposelessness and an increase in alcohol-related morbidity and ‘deaths of despair’ among working-class men (Shipton et al., 2013; Leyland et al., 2007; Walsh et al., 2017). Simultaneously, the entry of more women into the workforce from the 1980s and 1990s altered gendered patterns of alcohol use. For some women, alcohol consumption became associated with relaxation and autonomy after managing the dual demands of paid and domestic labour (Emslie et al., 2015). Mothers in this study reflected similar experiences, with some working part time or full time yet still expected to prioritise caregiving. Gina, whose mother did have a full time job, highlights how prevalent this rhetoric was when she was a child:

And I remember a kind of relationship which I also see in my husband’s mum and dad, maybe of that era, the families born about the ‘30s growing up all that time, the women were very submissive, and you know just sort of roundabout with a platter all the time. And they seem to just accept all that was going on around them without too much criticism or questioning. Which I think now, when I think back, it’s a bit odd.

Gina was 50 at the time of the interview. She was an only child predominantly raised by her mother, her father was present, but she does not remember him being around much, describing him as a 'happy drunk'. There is a consideration of how gendered divisions of domestic labour were clear, despite the fact that both of Gina's parents were employed.

This historical and policy-level illustrates how participants' family lives and drinking cultures were embedded within, and shaped by, broader economic transitions, gender ideologies, and legislative frameworks.

6.7 Conclusion

In this chapter, the theme 'Normalising Dysfunction' was considered, including how participants spoke about how drinking was a 'social norm', and in their perception, everybody lived in that manner. Social norms were also reflected in gender constructs and how they can reinforce drinking behaviours with the most commonly considered roles being the 'Glasgow Hard Man' and 'Housewives'. The 'Glasgow Hard Man' is used to describe individuals who worked in heavy industries, undertook hard drinking, and were involved in gang culture (Johnston, 2008), participants in this study found the persona analogous to drinking, violence and aggression. Women in this study expressed the expectations that mothers and female daughters often had to take on extra housework and childcare. When mothers did drink, the household fell apart, but it was still more common for fathers to drink. There was also a high level of community violence and acceptance of this behaviour.

From a socioecological perspective, these patterns of behaviour and norms are embedded across multiple levels. At the individual level, gendered expectations shape personal identities and behaviours, with men expected to embody the 'hard man' persona while women take on 'housewife' roles, influencing how individuals engage with drinking and family responsibilities. At the familial or relationship level, violence, neglect, and emotional suppression are normalised within families as everyday dynamics, reinforcing dysfunctional behaviours and coping strategies. At the community level, widespread violence and behavioural norms perpetuate and mirror experiences from home, further embedding harmful drinking patterns and acceptance of aggression. At the societal level, there is a

cultural acceptance of alcohol consumption, accompanied by a pervasive belief that 'everybody drinks,' especially men, which reinforces drinking as normal and expected. Finally, at the policy and historical level, longstanding gendered expectations continue to uphold traditional roles of 'hard men' and 'housewives,' limiting opportunities for change and sustaining systemic inequalities that influence drinking and family dynamics. This socioecological model has allowed organisation of the themes to highlight how during participants' childhood dysfunction was normalised not only through individual or family factors but also through broader community, societal, and historical structures, making it a complex issue at multiple levels.

Chapter 7: Disappearing: Loss and the Erosion of Childhood

7.1 Introduction

The theme of disappearing childhood captures how early experiences of loss and deprivation shaped the lives of individuals growing up with parental alcohol use. The interviews revealed that childhood was often eroded by multiple overlapping pressures, including bereavement, early caregiving responsibilities, bullying, shame, and limited social connections. These experiences were embedded within broader environmental and economic instabilities, such as low-income neighbourhoods, poor-quality housing, and wider societal deprivation in Glasgow. Historical and policy contexts further reinforced these challenges, illustrating how structural conditions and historical inequalities intersected with familial and individual experiences to diminish the security, freedom, and innocence typically associated with childhood.

Table 4: Themes on Disappearing linked to Socioecological Level

Socioecological Level	Sub-Themes
Individual (Section 7.2)	Bereavement: Suicide of parents, deaths of friends.
Familial/Relationship (Section 7.3)	Loss of Childhood: Early caregiving, bullying, shame, lack of friendships.
Community (Section 7.4)	Environmental and Economic Instability: The communities individuals lived in were predominantly low income, with poor housing quality.
Societal (Section 7.4)	Environmental and Economic Instability: Glasgow at the time had high levels of deprivation.
Policy/Historical (Section 7.4)	Environmental and Economic Instability: Historical policy could be deemed a reason for high levels of deprivation.

Table 4 above illustrates the experiences of participants across multiple socioecological levels, from individual to policy/historical contexts. At the individual level, participants reported significant experiences of bereavement, including parental suicide and the deaths of close peers. Research shows that children with parents who drink are more likely to experience traumatic bereavement, especially when the deceased parent's substance use and mental

health issues culminate in suicide (Alonzo et al., 2014; Dube et al., 2001). At the relational or familial level, participants described a 'loss of childhood', a term encompassing early caregiving responsibilities (parentification), experiences of bullying, shame, and social isolation. These accounts align with studies that identify children of parents who drank as assuming adult-like roles prematurely, often in response to parental incapacity (Woititz, 1990). This premature responsibility is frequently accompanied by social difficulties, including exclusion and bullying, which exacerbate feelings of shame and isolation (Harter, 2000).

At the community, societal, and policy/historical levels, a dominant theme of environmental and economic instability emerged. Participants frequently lived in communities characterised by poor housing conditions, underinvestment, and high levels of poverty. This was particularly evident in Glasgow, a city undergoing sustained socioeconomic decline during the participants' formative years (Walsh et al., 2017). The structural challenges faced by these communities, rooted in historical policy failures such as inadequate urban regeneration and deindustrialisation, exacerbated the hardships experienced by families already vulnerable due to addiction, as well as addiction influencing hardship (Bauld, 2010; Katikireddi et al., 2017; Walsh et al., 2017). It is important to note that several themes overlap across socioecological levels, highlighting the interconnectedness of participants' experiences. For example, participants' lives were shaped by community-level factors, such as low-income neighbourhoods, limited resources, and poor housing quality, as well as societal-level conditions, including widespread deprivation and entrenched social inequalities. These conditions were further influenced by historical and policy contexts, such as economic decline, deindustrialisation, and insufficient social support systems.

7.2 Bereavement

Bereavement, whether of parents, siblings, or close friends, was a recurring experience for participants, often occurring within a wider network of adverse circumstances at an individual level. These deaths were not isolated events, nor were they solely the consequence of parental alcohol use. Rather, they were embedded in complex, reciprocal relationships where grief, trauma, poverty, and unstable environments interacted dynamically with substance use. This echoes findings from research that links bereavement and cumulative adversity to heightened psychological vulnerability in children and young people, especially when such

experiences occur in the context of familial addiction and deprivation (Anda et al., 2002; Dube et al., 2001). It is therefore not accurate to frame alcohol as the sole cause of these outcomes; instead, alcohol use both shaped and was shaped by the broader context of loss, instability, and social disadvantage (Kroll, 2004; Velleman and Templeton, 2016).

Parental suicide was mentioned by three participants, this is another example of the violence and trauma occurring within families, in two instances occurring by mothers due to the escalating violence from fathers' alcohol use. Parental suicide was highly impactful on participants lives and happened at a young age. Both Byron and Malcolm lost their parents at eleven and twelve. Byron was raised by his grandparents after his father's suicide, both his parent's used drugs and alcohol. Malcolm's father used alcohol, and his mother was disabled and had mental health issues; his father remarried after his mother's suicide:

And my mum was always a part of my life, my dad oan and aff. And then when I was twelve throughout the drink and drugs and depression my dad hung himself when I was twelve. So that was kind of hard you know what I mean. That was like the first year at academy school and that's when I started kind of getting into crime and violence and taking drugs.

Byron, 33

But my mum had mental health issues, I don't know so like I witnessed a couple of breakdowns when she was like hospitalised...And then her...her and my grandad committed suicide when I was eleven. So that's a big part of it...

Malcolm, 39

Other participants, such as Brian, who lived with his father, in care and with aunties, also mentioned losing parents at a young age. Brian's mother died and his father re-married, he went into the care system as a young child and was there for a number of years, then he was raised by his Aunties:

My mother died when I was 4, nearly 5. My dad remarried within 2 years and even before then I think, so there's not really anybody alive that can tell me about my childhood, everybody I know is dead really...

Brian, 63

Some participants also mentioned how their mother's mental health deteriorated as the domestic violence escalated, and mothers turned to drink, such as Polly's mother. Polly mentions her father's ongoing abuse affecting her mother hugely, causing her mother to attempt suicide multiple times and eventually her mother turned to alcohol. Eventually, in Polly's case, her mother had multiple suicide attempts:

I was doing really really well at school and then my mum had, I think it was her second suicide attempt. Because there wasn't as much intervention as they've got now. Like the ambulance men kind of spoke to [her], I think now the police can kind of take over...It was just the fear.

Polly, 48

This pattern of bereavement continued amongst other family members, Rowena had a younger brother, an older brother and an older sister. Her father is still alive, and she was surprised her father had not passed away from alcohol related complications. She lost all her siblings quite young, her sister from diabetes and both her brothers were from alcohol use.

...my youngest brother died, and I just thought 'this cannot be happening' but it has. It has unfortunately happened. But my sister it wasn't because of my dad or anything like that. It was diabetes related complications with her. But my older brother who also died in his 40s. My sister died in her 30s and my two brothers in their 40s [from alcohol use]...

Rowena, 53

As shown in this section, the bereavement of participants many forms; with family members passing away and parental suicide attempts or completion. Across these narratives,

bereavement shaped participants' emotional responses, coping mechanisms, and sense of identity, illustrating the individual-level consequences of early loss.

7.3 Loss of Childhood and Isolation

Participants mentioned a 'loss of childhood' through parentification and difficulties in making and sustaining friendships. Regarding the literature around adult children, there has been research on the identification of 'roles' and the gendered aspects of attachment (Eiden et al., 2010; Veronie and Fruehstorfer, 2001). Eiden and colleagues (2010) found an interaction between fathers' alcohol use and bullying of peers by boys but not girls. More recent research also focuses on female adult children taking on caregiving roles and undergoing 'parentification' which can influence health (Kelley et al., 2007). Male adult children were found to have increased criminal behaviours (Mutzell, 1994) and scored higher on the psychopathic deviate scale (Knowles and Schroeder, 1990). Men drink more heavily and are more likely to die from alcohol-related causes than women (Emslie et al., 2015). Some of these gendered behaviours were found in this thesis.

Parentification

Children raised in households with parental alcohol use may develop a heightened sense of responsibility, believing they are accountable for any negative events within the family (Morgan et al., 2012). Despite this perceived responsibility, the child has little to no actual ability to influence the parent's drinking behaviours or alter the overall family dynamics (Ruben, 2001). This lack of control affects their physical and mental health (Richards and Nelson, 2012). Patrick, a 50 year old unemployed participant who grew up with both parents drinking and 2 sisters and 2 step brothers, talks about having to be the one to break up his parents' fights:

But my Mam and Da were always drunk and fighting, she felt embarrassed and all that because everybody could hear 'em fighting, like the neighbours, wans outside and all that. But it did affect ye. It did affect you when you were younger, trying to break them up when they were fighting in the hoose.

Patrick, 50

Sophie, a single student who grew up with her mother and two brothers, clearly stated throughout her interview the difficulties in caring for her two younger brothers and how there was parentification of her childhood:

You all of a sudden you have to take on this very very grown-up role which kind of makes you very responsible and you're gonna go one of two ways; you're kind of going to go off the deep end and be completely irresponsible or you become really really responsible. And my route was to become really responsible which helped at that point but as an adult it made me, it was really hard for me to like, and even now to not feel responsible for other people.

*There was a night where we were in the house on my own and my youngest brother had fallen and grazed his knee and I remember looking at this knee that was dirty and saying I have to clean it and I didn't know what I could clean it with...I remember being in the bathroom *Sophie cries* and getting really upset and trying to, trying to help this little boy and he's going 'it's too sore, it's too sore' and me going 'but I've got to clean it', if I don't clean it and it gets an infection in it then that's my fault*

Sophie, 49

As clearly shown by Sophie, her role as an older child meant that she had to take care of the home and her siblings, which she then views to have impacted her into adulthood, whereby she now feels a responsibility to care for others. This experience aligns studies that have found that young carers are at increased risk of mental health issues, including anxiety and depression, due to the chronic stress associated with caregiving responsibilities (Fleitas Alfonzo et al., 2022; Lacey et al., 2023).

Friendships, Bullying and Shame

Most participants mentioned a lack of friendships during childhood due to the social isolation of having a parent who used alcohol. Where they did have friendships, they felt shame in disclosing their living circumstances, or were encouraged to use substances themselves. Overall, most participants found it hard to maintain strong positive friendships. Sophie summarises the difficulty in making friendships when you have a parent who drinks:

When you can't tell anybody what your weekend was like, it's really hard to make friends...

Sophie, 49

Many participants did not want to tell their school peers about their situation as they felt shame at living in those circumstances. This was different to those who socialised with children who lived in their community in similar circumstances with parents who drank. Thus, the alcohol became a barrier to forming and sustaining friendships as mentioned by Polly, the only participant who identified as middle class as a child.

There was more people I kind of bonded with some there [school] but again I wasn't really able to sustain friendships. I don't know that I had learnt.

Polly, 48

Tasha, an only child who lived with both parents who drank and Basil, who lived with one younger brother and three older half siblings, a mother who drank and her various partners, talk about not having friends come round to their house, and feeling far more comfortable going over other children's houses:

I knew that something wasn't, I wasn't the same, I didn't like having people come round to my house. I, if I was meeting friends I would kind of make excuses to go to their house rather than have them come to mine because I didn't want them to see my mum kind of about the place...So, a lot of the friends I had I couldn't confide things in so when things were difficult at home.

Tasha, 34

I maybe told one pal who I knew dad was on pa-maw⁹ and dad drinking and they hid it, problems with drinking plus he come up my house once so. I sort of let him in a wee bit because I felt as if he wouldnae be as judgemental. But I remember I used to jump out with other people, and I'd never invite them up to my house, but I remember going up

⁹ 'pa-maw' is where Basil started to say a 'pa' word and changed to 'maw' [Mum]

to their house and it be. I remember this boy's mum offering me sandwiches and I was that self-conscious at that age that I wouldnae eat the sandwiches because I was scared that I'd make a mess, even though I wanted them. And it's crazy going back and you're thinking how are you so trapped within those thoughts that you feel as if you're not worthy of eating a sandwich at that time 'cause it seems like a completely different boy...It's just shame, you were just ashamed of what was going on in the house.

Basil, 53

As Basil states, he felt self-conscious in other children's houses. Polly, the oldest sibling of three and only participant who identified as middle class as a child, mentions how she felt different at school and Daniel, who lived with both parents, two older brothers and one younger and Tasha, an only child, summarise this feeling that the other children 'weren't like you' because of growing up with different experiences:

Kind of friends did I? I had my sister. No, I didn't really. I was quite different at school. I didn't really fit in, I kind of stood up and stood out.

Polly, 48

Because with [brother] we would go to gigs at the Queen Margaret union at Glasgow uni and stuff so you would. I wouldn't say socialise with people, but we would still be distant from them, but you'd be in the same kind of circles. And meeting like [omitted name] my pen friends. I think it, and actually you thought these people were alien. They kinda, they weren't like you.

Daniel, 53

I had, so I was pretty badly bullied when I was at primary and then when I went to secondary again I kind of found my niche and I found people that I kind of gelled with a wee bit...But when I was at [secondary] school, I had kind of, I had friends but I had friends I couldn't really talk to. So, a lot of the friends I had I couldn't confide things in so when things were difficult at home, I couldn't really talk about that to them because it wasn't, it wasn't something that we would talk about. So yeah.

Participants also spoke of the bullying or victimisation they faced due to growing up in poor households with a parent or parents who used alcohol. They were bullied because they didn't have much and were seen as 'different'. This appears to contradict earlier findings suggesting that alcohol consumption was normalised. A more critical reading suggests that alcohol may only have been normalised in specific spaces, times, or social contexts, and that its perceived normality was intertwined with socioeconomic conditions. This indicates that normalisation of alcohol is not universal, but rather contingent upon intersecting factors such as economic disadvantage and broader community norms, highlighting the need to consider context when interpreting participants' experiences. Gina, an only child whose father was a 'happy drunk' and Lucas, who had three brothers and a sister and both parents were violent and drank, talk about being bullied. Gina believes herself to be akin to 'Hermione Granger' from a 'know it all' character from the fantasy novel, Harry Potter but differs from her in that Hermione does have friends.

I remember one time swimming and they were saying look at her armpits. I wasn't liked. Unlike Hermione Granger who seemed to have friends, I didn't have friends at that school at all. I was really badly bullied, and it was horrible.

Gina, 50

I enjoyed school but I didn't because I got bullied quite a lot. My family never had much.

Lucas, 45

Participants overall found making and maintaining friendships hard and some were bullied. Where they did find friends at school, they were not sure if they had similar backgrounds to them and felt shame over their homelife, showing some sense of awareness that not all behaviours at home were the 'norm' throughout Glasgow city, only in the areas in which they lived.

At the familial and relationship level of the socioecological model, these experiences highlight how family structures and interpersonal dynamics shaped participants' emotional and social

development. The early assumption of caregiving responsibilities reflects a breakdown of traditional parent–child boundaries, where children became emotional regulators or practical caretakers within the home. This ‘loss of childhood’ demonstrates how the family environment, rather than providing stability and nurture, often required some children to adapt to ongoing instability caused by parental alcohol use.

7.4 Environmental and Economic Instability

Community, society, and historical policy cannot be easily disentangled when examining the context of Glasgow in the 1960s, 1970s through to the 1990s regarding environmental and economic instability. Structural economic changes, the social and material conditions of neighbourhoods, and the legacies of policy decisions all interacted to shape everyday life. Participants’ accounts of growing up during this period reflect how disadvantage was not experienced in isolation but as part of a wider web of interconnected pressures.

Growing up in Glasgow during the 1980s and 1990s meant experiencing broader patterns of economic and environmental instability that shaped family life and community well-being. The city was undergoing rapid deindustrialisation, with the decline of shipbuilding, steel, and heavy engineering resulting in widespread job losses and the collapse of previously secure employment opportunities (Pacione, 1995). For many households, this meant the loss of stable incomes and the onset of long-term unemployment, which exacerbated existing vulnerabilities. In families where alcohol use was already present, the financial instability produced by economic decline often intensified hardship, as scarce resources were redirected towards alcohol consumption rather than household needs (Herman, 2015). Participants described growing up in homes where money was tight and the unpredictability of income created a constant sense of insecurity, limiting opportunities for stability or upward mobility.

Participants in this study mentioned the economic impacts of growing up with parents who used alcohol, as part of a broader, interaction of a web of disadvantage. Financial instability can exacerbate the effects of parental alcohol use (Herman, 2015). Low income may contribute to alcohol use, but alcohol consumption also impacts how household income is allocated and undermines long-term economic stability. For instance, Daniel, who grew up in a deprived areas of Pollok, with his father, an engineer, mother, a shop assistant and 3 brothers, recalled that his father, spent:

...all of his money on drink. So, we used to wonder why, why is there no money in the house.

Daniel, 53

This reflects how alcohol use can directly deplete household resources, contributing to material deprivation. Research shows that child maltreatment is strongly associated with poverty and social disadvantage, with parental substance use a key risk factor (Anda et al., 2002; Dube et al., 2003, 2001). These structural inequalities are not background conditions; they impact all aspects of adult children's lives. The environment shaped by poverty and addiction also fed into broader community, societal and historical experiences, as reflected in the literature (Velleman and Templeton, 2016). Malcolm, whose father was a janitor and mother, a housewife, reflected on living in Easterhouse with his parents and sister, described a dual experience:

The thing about Easterhouse was there was fucking brilliant because you were right on the edge of the city so you had like loads of fields, loads of nature to explore and as a young boy...But yeah I suppose in the built up areas there was just a lot of poverty and people would be, there'd be a lot of conflict between people, a good bit of solidarity as well around some people. Yeah, they'd be a lot of like violence and people being and there was a hit of danger and stuff just walking about.

Malcolm, 39

These accounts illustrate how impoverished environments shaped and were shaped by addiction, social disinvestment, and reduced safety. Malcolm's account conflicts with claims by scholars that more deprived areas lacked social cohesion (Macintyre et al., 2002) . While he notes poverty, conflict, and danger, he also describes solidarity and social connection among residents. This suggests that, even in structurally deprived areas, informal networks and neighbourhood ties could foster a sense of community, highlighting that social cohesion was partial and context-dependent rather than entirely absent. Peripheral housing estates, such as Pollok, Easterhouse, and Castlemilk were largely developed through post-war rehousing schemes enabled by the *New Towns Act 1946*, which aimed to relocate families

from inner-city tenements to planned housing areas. While intended to improve living conditions, many estates were constructed rapidly with limited infrastructure and amenities, contributing over time to social isolation, weak community networks, and a sense of neglect among residents (Kearns, 2001; Kearns et al., 2000, 2012). Even reforms under the *New Towns Act 1981*, which increased local authority oversight and streamlined land development, could not fully address the persistent economic and infrastructural challenges in these peripheral estates, leaving families to contend with constrained opportunities and limited support.

Gilvarry (2005) highlights that adult children of parents who undertake substance use are more likely to face housing instability later in life, suggesting these early environmental stressors have long-term effects (Gilvarry, 2005). This interconnection of income, housing and crime is shown by Brian, who grew up in Summerston, and joined a gang at around 11 years old, discussing his perception as an older individual:

But polis come in then, I'm fucked. I'm gonna lose my job. If I lose my job, I lose my house, if I lose my house I lose my home. If I lose all that I've got a heid that'll tell me that the systems fucking me again, go and jump out a counter and steal money.

Brian, 63

Poor housing conditions were a common feature. Alfie, who grew up in Easterhouse with his brother and mother in a tenement flat, and Rowena, who grew up in Pollok/Priesthill in a flat roof tenement with her parents, two brothers and sister, explain not just material conditions but embodied experiences of loss of environmental stability:

it was a tenement. Cold, damp. We're going back to like the 1980s here. We're going quite far back. Oh aye. Born in the '70s growing up in Easterhouse 70s, 80s, 90s, 2000s. it was, drink and drugs was always round about me.

Alfie, 46

We always tried to keep the house warm but you had mould growing up the walls and on the, where the windows were...And then the water would just come in. And then we were above what you would call the cellars so the boys' room was particularly cold. So,

they would have like mushrooms growing out of the floorboards. And it was just, just a...very very damp. I just remember it being very very damp.

Rowena, 53

Rowena also noted the effects of urban planning and displacement; families were “moved out in their droves” and “decanted and moved all over,” disrupting social ties and exacerbating instability. These structural forces cannot be separated from alcohol use, which both results from and contributes to such conditions. National data supports these accounts, with a clear social gradient in interpersonal violence, particularly among young men; those in the most deprived areas have 5.5 times higher odds of hospitalisation due to violence than those in the least deprived areas (Institute of Alcohol Studies, 2020). Yet, even within these environments, moments of security and resilience emerged. Bonnie remembered growing up in Townhead, attending the church hall and community centre independently:

Whereas when we stayed across the road in Townhead, there was the church hall, there was the community centre and you just went to things, you weren't taken anywhere by your parents, you just went and that was it.

Bonnie, 49

Her reflection captures a paradox, how a sense of stability in childhood can exist despite economic hardship, only to be re-evaluated in adulthood. Taken together, these community, societal, and historical factors demonstrate how participants' experiences of parental alcohol use were deeply embedded within wider structural and policy contexts. Economic decline, urban planning decisions, and entrenched social inequalities interacted to shape everyday life, constraining opportunities and reinforcing cycles of deprivation.

7.5 Conclusion

The narratives presented here reveal that the lives of children of parental alcohol use are broader than simply the direct impacts of drinking, there are various factors including bereavement, loss of childhood and economic and environmental instability which coloured their lives. At the individual level, participants described how they internalised the bereavements they faced. At the familial level, early caregiving responsibilities and social

isolation reflect well-established patterns of 'parentification' and stigma among children with parents who drank, with long-term implications for identity formation and mental health (Woititz, 1983). At the broader community, societal and historical levels, participants' descriptions of their environments mirror research linking deindustrialisation, poor housing, and fragmented urban planning to Glasgow's enduring health and social inequalities (Bauld et al., 2005; McKee, 2010; Richardson et al., 2015). Yet, even within these conditions of adversity, participants recalled moments of relative safety, belonging, and resilience, often mediated by community ties or retrospective reinterpretation in adulthood. This underscores the importance of examining how socioecological levels interact, not simply through the lens of deprivation, but also through resilience, memory, and meaning-making.

It is noticeable that three of the five sub-themes, community, societal, and policy/historical, reflect the overarching theme of environmental and economic instability. Rather than being a limitation, this highlights the complexity and interconnectedness of participants' experiences. The socioecological model therefore provides a structured way to visualise the entwinement of personal experiences with wider structural and cultural factors, even when a single theme spans multiple levels.

Chapter 8: Surviving: Coping and Active Agency

8.1 Introduction

While much of the literature on adult children focuses on adversity and dysfunction, growing evidence highlights the role of protective factors and active agency in shaping more hopeful developmental trajectories (Werner and Smith, 1992). Participants in this study identified key turning points that marked a shift away from risk and toward recovery, given that many were involved in recovery services themselves this provides an interesting insight into intergenerational alcohol use. Turning points included cessation of substance use, moments of self-recognition, or accessing mental health support. These experiences, reflect the trauma that some participants experienced but also the resilience they displayed in overcoming it.

Table 5: Themes on Surviving linked to Socioecological Level

Socioecological Level	Themes
Individual (sections 8.2 and 8.3)	Active Agency: Seeking out support and ways out of their circumstances such as education Turning Points: Substance Use, Suicide and Self Harm
Familial/Relationship (section 8.4)	One Supportive Adult: Mentorship, positive adult relationships
Community (section 8.5)	Community Support: Youth centres, safe spaces, community-based therapy, groups, recovery centres ¹⁰
Societal (section 8.6)	Education: Societal support for educational resources and training
Policy/Historical (section 8.6)	Education: Adequate support for at risk children's education

The socioecological model is structured around discrete categories, which may not fully reflect the realities of the world; although these categories help to make sense of complex phenomena, they can also blur or oversimplify that complexity and some of the levels shown in table 6 overlap or are linked to multiple socioecological levels. At the individual level, participants described critical decisions and interventions, whether through education,

¹⁰ Recovery centres in this thesis are community based and peer/voluntarily run. They are commissioned by Glasgow City Health and Social Care Partnership.

therapy, or recovery programs, that enabled them to reshape their futures. This reflects broader findings that access to education and a sense of personal agency are vital for resilience, particularly among youth exposed to parental substance use (Park and Schepp, 2015; Valentine et al., 2019; Velleman and Orford, 1999). Across relational contexts, one of the most consistent protective factors was the presence of a supportive adult. Whether through a teacher, mentor, or extended family member, these relationships often offered emotional validation and stability, echoing research that emphasises the lifelong impact of even a single consistent caregiver (Benzies and Mychasiuk, 2009; Velleman and Orford, 1999). At the community level, participants identified youth centres, peer support groups, and community-based therapies as instrumental in fostering safety and belonging. These findings are in line with studies showing that well-resourced community services can buffer the effects of early adversity and promote psychosocial recovery (Burke Harris, 2018; Meléndez Guevara et al., 2024; Park and Schepp, 2015). Educational initiatives within recovery centres also related to multiple levels of the socioecological model, facilitating formal learning and policy and restoring a sense of purpose and identity, particularly for those who had disengaged from traditional schooling.

8.2 Active Agency

While many participants described environments shaped by adversity, including poverty, substance use, and neglect, some demonstrated a strong sense of active agency—an ability to seek out change or positive coping strategies despite significant barriers. Active agency, as described by Wlodarczyk et al. (2017), refers to the proactive ways in which individuals take control of their lives and circumstances rather than responding passively to challenges. It involves deliberate efforts to identify, implement, and adjust coping strategies to manage stressors or difficult situations, such as seeking social support, engaging in problem-solving, setting personal goals, or learning new skills. Active agency emphasises personal initiative and intentionality, enabling individuals to shape their responses and environment to foster resilience. Research suggests that it functions as a protective factor, particularly for adult children of parents with alcohol dependence or other challenging family dynamics, with those demonstrating active agency better able to cope, maintain psychological wellbeing, and reduce the risk of negative outcomes (Velleman and Templeton, 2016). In this study, active

agency was often shaped by a conscious desire to avoid replicating the experiences of one's parents or to escape harmful environments.

Active Agency During Childhood

Justin, who studied at university and worked in teaching and education, reflected critically on the intergenerational and cultural limitations faced by people growing up in poverty, particularly regarding aspirations and access to opportunity:

This is really controversial but I do think with some poor people there is a poverty of aspiration...they don't have those cultural connections to for example if you want to be a doctor right well I'm going to make sure that you do those extras that you need on top of your five A's or if you want to you know go onto business oh well actually you can, I know someone that's in business why don't you go you know do a bit of stuff with them. So, I think that's still missing.

Justin, 37

Justin's comments highlight how a lack of social capital and role models can constrain aspirations, even when individual motivation exists. In this context, Justin refers 'poverty of aspiration' as the limited ambitions or goals some individuals develop due to a lack of social, cultural, and practical support. Justin's reflections challenge the view of active agency as primarily an individual factor by emphasising the role of social and cultural constraints in shaping aspirations. While active agency suggests that individuals can act autonomously to achieve goals, Justin highlights how a lack of social capital and role models can limit the ability of people from low-income backgrounds to pursue certain career paths. Consequently, Justin's argument supports the perspective that active agency is only partially determined by individual motivation, as structural inequalities and intergenerational disadvantages can significantly constrain the choices and actions available to individuals.

Other participants, such as Alfie, spoke of the personal transformation that came through recovery and self-awareness. Alfie, who is currently in recovery for his own drug use and

obtained his Highers but no further education, has framed his journey as a process of learning to take responsibility while also recognising the complex roots of his behaviour:

No, my upbringing, that wasnae my fault. Just life, just circumstances. My ma, like I said my ma done the best with what she had. My da, I recognise that like me he suffered from an illness called alcoholism...I stopped beating myself up when I make mistakes because that's what I used to do. I used to, bury they way down shh don't tell anybody about what I done. Now to the best of my ability I get honest about them because I find that see when I'm honest about it, it doesnae hold any power on me. I don't feel any guilt, shame or remorse when I'm keeping completely honest about it. See another thing that I've realised is when I'm being honest, I don't need to have a great memory. That's just how it is for me and that's basically what it was like for me when I was growing up.

Alfie, 46

For some, active agency manifested even in childhood through imaginative or intellectual strategies. Alfie, whose father was abusive towards him from a young age, also shared how comic books became a form of psychological escape from physical abuse, symbolising his yearning for healing and strength:

You know I suppose that was my coping mechan-I found escape in comics. I think about it, I found escape in comics. I used to fantasize about being Wolverine. I used to fantasize about being Wolverine because of the comics how much he could take, and he would always get up and do something and I was like I want to be like that guy, that's cool. Being able to heal from anything. I think that's what it was, just wanting to heal. But it wasnae happening for me, it wasnae happening for me.

Alfie, 46

However, for some education provided a safe space and coping mechanism. This could in part be as a way to escape the family home but also as an awareness of education being a way out of their situation. This was especially evident in the accounts of those who linked academic

achievement directly to their motivation to change their lives. Rowena, Justin and Gina all obtained degrees or higher educational achievements:

I learned very quickly that the only way out of that was to get educated.

Rowena, 53

You know the importance of education and skills and knowledge and being able to just lift yourself I suppose out of poverty or any experience that you're having you know an alcoholic father or things like that I don't think the importance should ever diminish.

Justin, 37

I wanted better for myself if you know what I mean. I sort of thought to myself "you can be better than that." I want to do something, and I guess, do you know what I did get actually, I won some prizes at school.

Gina, 50

Active Agency during Adulthood

For others, such as Brian, who obtained no qualifications and was a member of a gang as a child, but was more motivated to act as an adult, active agency only emerged in adulthood, specifically during moments of crisis. He described how the emotional pain and desperation became a turning point toward recovery:

The greatest gift I probably got at that time was the gift of desperation. I was wanting to die but I wasn't really want to be dead. I wanted these fucking rotten feelings to stop. This self-loathing, the shame, the loneliness, just sat crying for months and months and eventually I got the help I asked for.

Brian, 63

While not all participants described this kind of clarity, Brian's account exemplifies how personal agency can emerge through a process of emotional reckoning, even after prolonged suffering. In a separate reflection, Alfie described his ongoing efforts to give back to the

community where he caused harm as an adult, illustrating a deeply felt sense of accountability and service:

I just stay down the road in Balornock so I do but this is home for me. Easterhouse is home. The reason why I come here on a Sunday...90% of my carnage I caused in this home. I cannae, I cannae think of any better of saying sorry to my community then me being an active member getting involved here and potentially help somebody through this scheme, lost in the same dark places that I was in hopefully I can go 'been there, I was shown how to get out of the hole, I can show you how to get out of that hole, provided you're willing to not fuck up.

Alfie, 46

While active agency was not mentioned by all participants in childhood, many participants demonstrated it through emotional insight, educational pursuits, or community engagement. These actions represent self-directed responses at an individual level of the socioecological model, highlighting how individuals navigate challenges, make meaning of their experiences, and influence their own trajectories independently of external pressures.

8.3 Turning Points: Substance Use, Suicide and Self Harm

Parental alcohol use likely influenced participants' own relationships with alcohol, but it was not the sole determining factor. Rather, parental drinking often coincided with neglectful caregiving, which in turn appeared to hinder the development of social and emotional skills. The pathways to substance use, as well as experiences of self-harm and suicidality, were complex and multifaceted. Within the narratives of adult children, these issues emerged as deeply interconnected rather than discrete or sequential experiences. Not all participants went on to use substances, nor were all impacted by their own suicide attempts and self-harm, but these interconnected issues did arise as a complex theme throughout interviews. These do reflect individual level coping behaviours.

Specific experiences of adult children play a significant role in shaping their life trajectories (Braitman et al., 2009; Nation and Heflinger, 2006; Ross and Hill, 2001). Research indicates a spectrum of adverse consequences, including heightened risks for mental health disorders,

unemployment, and substance use (Balsa et al., 2009; Braitman et al., 2009; Forrester and Harwin, 2008; Nation and Heflinger, 2006; Ross and Hill, 2001). Moreover, the number of risk factors to which individuals are exposed has been found to be predictive of substance use (Dillon et al., 2007). A UK Home Office literature review further identified factors such as poor parental discipline, lack of family cohesion, peer drug use, and genetic predispositions as contributing to increased substance use (Fisher et al., 2007). Numerous studies have shown that adult children are significantly more likely to engage in substance use themselves (Braitman et al., 2009; Christoffersen and Soothill, 2003; Epstein et al., 2020; Gilvarry, 2005; Kerr et al., 2020; Landberg et al., 2018; Ross and Hill, 2001). Psychologically, substances are often used to cope with stress, trauma, or mental health conditions such as depression and anxiety, while traits like impulsivity and sensation-seeking further increase vulnerability (Hawkins et al., 1992, 1992).

Substance Use During Childhood and Adulthood

Substance use operates simultaneously at the individual and familial/relationship levels. At the individual level, it reflects personal choices, coping strategies, and emotional regulation, as participants make decisions about when, how, and why to consume alcohol or other substances. At the familial and relationship level, substance use is shaped by social influences, including peer behaviour and friendship networks. For example, participants often described adopting substance use to make friends.

There were many participants in contact with recovery services. Substance use was mentioned as being viewed by approximately half the participants as a 'solution' to their lives, as a method of acceptance and as a way of coping with their home life. However, even when participants did not believe they had an alcohol issue, they did still have experiences with binge drinking, like Polly and Tasha, or strict drinking rules for their children, like Gina. Justin summarises his unique relationship with alcohol:

Still not ever say that I was an alcoholic, I won't use that word. I'll say that I had an alcohol problem maybe or drank too much or didn't know when to switch off, skirt round it use all this language but not say I was an alcoholic. And maybe that's because I don't know, because I've not sort any official help.... So I thought I wanted to say that

to you that maybe I'm an alcoholic, maybe I'm not, but I don't drink because I had an alcohol issue.

Justin, 37

Brian, who was a high ranking gang member in his youth and younger years, in his 50s started a recovery centre and retrained to work there after having alcohol related health problems, summarises this:

*...But I just drank every day, because that was a solution. That made me fit in but the minute I didnae have a drink *ffff* I'm a wee boy screaming to get out. Looking for a Mammy, looking for a hug, looking for a cuddle. But there's thousands like me brought up in that generation, I know I'm not alone. And you'll hear thousands of stories, people say 'oh you're inspirational' but there's thousands of us out there. Thousands of others.*

When you're a bit of a legend in the heid, how do you tell somebody I need help? I didnae even know what the emotions were that I was feeling and then I found out it's all the shame and guilt and remorse. And most of it wasnae my shame. Most of it wasnae my shame man, you know what I mean.

Brian, 63

Participants who mentioned having friends in childhood or 'felt like they fitted in', in childhood and adulthood, were often in peer groups which used substances. This started around adolescence when participants would 'bunk off' school and hang around with their peers doing 'stuff like that; drink, drugs, fighting, committing crime'. Alfie mentions feeling like having a connection with other boys in the gang but not realising he was being 'manipulated' by being 'rested as a fire in', this means he was sent in as a 'fallguy' or as someone disposable:

Yeah. And I found that the crazier the stunts that I would do. I thought I was being accepted not realising I was getting rested as a fire in. I was being manipulated. 'Alfie is daft enough to go and do it for us.' I found solace in all of that, it was like a badge of honour. The big boys will accept me. I'm cool, I'm in with the bigger boys. They were

using me. And I didnae know it. Aye, I found solace in doing stuff like that drink, drugs, fighting, committing crime. Basically, just doing things that wee boys shouldnae be doing.

...so, I found solace in the bottom of a bottle. I had my first drink when I was eight years old. My first blackout when I was fourteen. That took me into gang fighting things and all that stuff and I was seeking approval, getting involved in all the gang fighting. Seeking approval, just doing things that I shouldnae have been doing. Not because, not because I didnae know the difference between right or wrong. I wanted to be accepted.

It was, drink and drugs was always round about me. Always around about me. I suppose. It ended up coming to me personally and I used all that stuff that I'd experienced as justification for my own behaviours. 'youse drink and youse drugs ruined my life' ...me personally I discovered booze at a very early age and I turned to it and I turned to drugs as well at a very early age, that was to help me escape.

Alfie, 46

For a lot of participants, their childhood friends whom they used substances with were either still addicted or they had died due to drug use. Many participants started using substances around puberty and considered it 'usual' and very few of their peers were in recovery, like many of the participants of this thesis were, as highlighted by Hazel, who describes using drugs and leaving school early and Joe who also used drugs with friends from an early age:

Just when I got to like fourteen/fifteen I was started smoking cannabis and taking drugs and experimenting with drink. So, I left school, high school when I was fifteen and I didnae want to do anything but drink at the weekend with my pals and sleep other days....Aye, but we just drank and took drugs together.

Hazel, 31

A lot of friends yeah, quite a lot of friends. Jumped about together and did the usual things – drinking weekends and that kind of stuff...A lot of them are passed away and

things like that, some are in jail, but I still see quite a few that are still about aye. Unfortunately, most of them are still caught up in addiction in some way.

Joe, 47

The participants who used drugs formed friendships with people who were also involved with drugs. Around half of the participants had gone on to use substances themselves. This suggests that substance use can be in some ways a positive form of coping (Votaw and Witkiewitz, 2021), defined as the strategies used to manage stress and emotions, due to the support from peer relationships. Participants understood that not every adolescent uses substances but that it was common for them and their peers living in the same area as them. Byron, who had been imprisoned for murder at 17 and attempted murder twice as an adult, states how by acting a class clown and befriending those using drugs, similar to Alfie, he progressed onto more serious crimes:

Aye I had a large group of friends where I was kinda a class clown, kinda. You know what I mean always in trouble, suspended. Everything but aye I had a lot of friends and then like my friends all went kinda one way, and some of them went another way, and then there was other ones that didnae grow up and just was involved in drugs and selling drugs and that's where I kind of got [involved]...I'm not used to being, living a normal life with normal people you know what I mean. I now know that I'm an addict as well, I've got an addictive personality and that started when I was a wean you know what I mean. I was obsessed with like football big heids and all that stuff back in the day...I would be tuned into things like that and then that progressed onto like. I started smoking hash an' I thought like you know everybody's doing this you know what I mean...I'm easily led, and this is the first time that I've kinda, that I've done with that last [murder] attempt right.

aye I was the one that used to get everybody their bits of hash and that. I would scoop a bit off the top for meself and put a bit less money on to make the next a bit for myself you know what I mean? I was kinda selling it before I knew that I was selling it you know what I mean? And then aye that hing that got me involved and things like that at a bigger level from a very young age.

Substance use in this study operated across multiple levels of the socioecological model. At the individual level, participants used substances as a coping mechanism. At the familial and relationship level, meant that participants had a friendship group which could provide support, as well as providing a way to avoid their home life and provide solace from it, these are protective factors (Velleman and Templeton, 2016), however, this then meant that some participants also had substance use problems which resulted in difficult experiences as teenagers and adults.

Self-harm and Suicide During Childhood and Adulthood

Participants also described the violence that they directed on themselves, which they often associated with the impact of their home life on their mental health and their attempts to cope. This primarily related to self-harm and suicide. Different people self-harmed or attempted suicide for different reasons. In the literature, the risk of suicide attempts and self-harm was significantly increased when individuals had experienced other ACEs (Fuller-Thomson et al., 2016; Ports et al., 2017).

The wider impacts of parental alcohol use which can impact mental health, relationships and feelings of self-worth did lead some individuals to suicide attempts or suicidal ideation themselves. This was mentioned by Tasha, who struggled caring for her parents when they were drunk and her mother passing away in her teen years from alcohol related issues, with Hazel, who associated her suicide attempt with bullying at school and Lucas, who attempted suicide after losing his job:

Oh yeah, yeah. I mean there's no way I would be here if it wasn't for him [boyfriend]. I would have killed myself. Without a doubt, I would have killed myself. If it wasn't for him. And I tell him that, I've told him that a few times. And he kind of shrugs it off and things but he was the one person who I could talk to about everything that was going on at home who didn't feel like judged me. And didn't think I was almost embellishing it. He saw it. He saw me having to pick my mum up off the floor. I mean there was times when he came in with me to the hospital or we'd help you know me pick my Mum

up off the floor, put my dad to bed or. You know, the amount of times that my partner has seen my dad naked is just like ridiculous. It's not what you would want a partner to do but he does it. So he definitely did, he helped me through a lot of things but he also, conversely has also been. I think because he knows my sore points, he knows, he's probably the one person who could probably hurt me the most. 'cause he knows he can say things that will hurt me.

Tasha, 34

So, after I got sacked, I went to court, tried to, while I was in Iceland [store]. I tried to take my own life because everything was so hard. Took tablets but I just woke up the next morning and went to my work. 'til I was going work, I didnae tell anybody until three weeks after you know. Then February 2015 I tried to take my own life again.

Lucas, 45

No. I didnae like school 'cause high school I got bullied a lot. So that kind of led to my drink and drug using as well and I tried to kill myself.

Hazel, 31

The above quotation from Hazel also illustrates how the teenage years can be a particularly vulnerable period, as adolescents are still developing emotionally and socially. Negative experiences such as bullying can exacerbate feelings of isolation or low self-esteem, increasing the likelihood of harmful coping strategies, including substance use and self-harm (Takizawa et al., 2014). However, suicide attempts were sometimes pivotal in participants changing their lives in some way, for Bonnie, who lived with her parents until this incident, her father had issues with alcohol, this attempt prompted her to move out of her parents' house:

I left home when I was twenty-three. Erm A took some pills. Erm, I don't think it was serious. Erm but I did make an attempt on my life.

Bonnie, 49

Suicide attempts in individuals who used drugs often pushed them into recovery. Alfie, Matt, Brian and Joe, all who were involved with recovery services, summarise this:

But I had ended up having one pint and I went what's known as 'gawn back out the door' so seven years I used to be in a relapse going back out the door. And I stayed away places like this for seven year and at the end of that seven year I tried to kill myself off a motorway bridge because it was. Like I said I know the difference between right and wrong, but I was constantly hurting people. And I didnae know. It's not the wee boy that I remembered being. You know I was, my best thinking at the time was, everybody else's pain and misery will end if I'm not there. But I know the day that if I'd have been successful in my suicide attempt, the only person whose pain and misery would've ended would have been mine.

Alfie, 46

I just had enough. Just sick and tired of being sick and tired. I just couldnae go on. Sick of waiting to dying, waiting. If I hadnae stopped [drugs], I would be dead by now you know what I mean?

Matt, 48

...so all I could do is sit in the house and being bored drinking and my drinking got worse and worse and worse and then eventually there came a point in my life, phoned the doctor because he was worried about me and the doctor appeared and whipped me into hospital straight away, if I hadn't went to hospital I wouldnae have made it though the night.

Joe, 47

Although a few participants mentioned mental health coping mechanisms, such as self-harm. Polly, who was the only participant who identified as middle class and who has two sons, talks about how she coped with her parent's drinking by self-harming:

So, friends so I did make them, there was a lot of self harming behaviour as I hit the teenage years...I did make best friends but I supposed I kind of turned to alcohol a little like binge overlay but never every day but I did use it as a form of escape I would say but then I met a boyfriend when I was, he was a good guy, when I was 17 and I think he probably, I think having my kids saved me I would say.

Also, obviously a wee bit of the self-harm is another coping mechanism. But I never ever, never ever drank everyday. I think my goodness. But my brother has, and he has so like my sister and I haven't but we all have mental health issues, all three of us.

Polly, 48

Participants suicide attempts or suicidal ideation as well as self-harm were described above. Many participants felt that their lives were filled with pain, misery and fear and that they just wanted it to end. At the individual level, these accounts highlight how self-harm and suicidal behaviour functioned as deeply personal responses to cumulative stress and adversity. Participants' experiences illustrate that the psychological impact of parental alcohol use was shaped not only by individual coping strategies and self-concept, but also by intersecting influences across familial, community, and societal levels

8.4 One Supportive Adult

At a familial/relationship level, strong external support networks, such as extended family, teachers, or peers, can serve as protective buffers, helping to mitigate the negative consequences of a chaotic home environment (Dooley and Fitzgerald, 2012; McEwen et al., 2015). However, children with parents who drank are often isolated due to secrecy, shame, or stigma, reducing their access to such support systems and increasing their risk of developing maladaptive coping mechanisms (Templeton et al., 2006). Research has shown that these individuals frequently develop insecure attachment styles, manifesting as either anxious or avoidant behaviours in their adult relationships (Beesley and Stoltenberg, 2002; Kroll and Taylor, 2000; Newcomb and Rickards, 1995). Living in a household with substance use can negatively impact the emotional support necessary for some children to develop secure attachments (Gilvarry, 2005; Windle and Searles, 1990). As a result, adult children may struggle with various attachment related issues in relationships (Shapiro et al., 1994). This risk

factor is moderated by having a protective factor of 'one supportive adult' (Dooley and Fitzgerald, 2012).

The one supportive adult could be any adult that children were influenced by: a teacher, uncle or family member. Many, but not all, participants' lives were their grannies. Their maternal grandmothers were the people who would take them in, give them money and provide a 'safe haven'; even though some participants did not get on well with their grandmothers, they still provided a safe space. Justin summarises the help his nan was able to provide, alongside his uncle who lived with his nan and 'the village'. He predominantly mentions his nan's support, but he did also have other supportive family members in his life:

I mean I think my nan was central and I think my mu-if you could talk to my mum, I think she would say that. And actually, my own feeling is, and you hear it a lot you know 'if it wasnae for the grannies'. I think my nana was able to kinda give my mum a bit of an anchor. Somewhere to go. You know. We never had to go to a crisis centre or anything like that.

And my uncle, my mum's brother, lived with my nana so that gave me a male influence. I also had an uncle who lives in Giffnock in the Southside he had left school and done well through employment. And he was living a middle-class life and that kind of stuff. So, that actually gave me something to aspire to. It gave me someone who. I spoke earlier about cultural capital that gave me the insight to oh there is more to life. Then maybe living in high flats or something like that.

...But I had aunti-my mum's got a sister and 2 brothers and actually we all kind of helped. You know it takes a village as they say.

Justin, 37

Basil's granny also provided a 'calming influence' away from his mother's and her partner's drinking. She also allowed Basil to live with her, with his mother and alone:

I went to school first, second, third year in Castlemilk which wasnae the nicest school but I suppose I did pretty well there because I was settled and by this point. I'd sort of

skipped to the sanctuary of my grannie's house because she's quite a nice calming influence, do you know what I mean?

My granny moved about. My mum used to stay with my granny for a wee time then she, my mum would move into Castlemilk. My granny stayed in Castlemilk as well and I went and stayed there so I could continue on in the same school. But at fifteen when ma granny died, then I moved in with ma mum and that was over in Pollok. My maw had been through a homeless thing, and she'd moved over to Pollok. And I moved over there, and I never went to school much. Maw used to encourage it – 'you don't need to go to school, go and do this or do that.' She used to actively encourage it.

Basil, 53

Daniel, Byron and Sophie also spent time living with their gran's. Daniel did not get on with his grandmother but still went there every Sunday and lived with her for a year. The supportive grandmother role could suggest a contrast to alcohol as a family disease, however some participants mentioned that their grandfathers did drink but were not living with the grandmother, deceased, or divorced. A study by Helle et al. (2024) found that maternal grandmothers' investment, through childcare, financial assistance, and emotional support, can significantly reduce emotional and behavioural problems in grandchildren who have experienced multiple adverse early life experiences. This support was shown to have lasting positive effects into adulthood, underscoring the importance of grandmaternal involvement in mitigating the impacts of early adversity (Helle et al., 2024). Furthermore, research utilising data from the Millennium Cohort Study highlighted that grandparental care, especially from maternal figures, is associated with improved socioemotional development in children exposed to adverse childhood experiences (ACEs) (Riem et al., 2025). At age 3, children receiving grandparental care exhibited more prosocial behaviour and fewer externalising problems compared to those with non-grandparental care (Riem et al., 2025). This protective effect emphasises the value of extended family support in fostering resilience among children facing familial challenges.

Many participants quite frequently visited their grandparents. However, some like Daniel, Byron and Sophie lived with their Grandparents either temporarily, like Sophie and Daniel and others for most of their childhood, like Byron. Byron's grandparents took him in when he was

young and raised him for most of his childhood. Whereas Sophie's grandmother helped out her mother and both her grandparents took her in until her grandfather attempted to assault her:

I used to visit my gran every Sunday, and I stayed with her, and she stayed in Glasgow...So, I ended up with my wee brother going to live with my gran. For must have been about a year.

Daniel, 53

I lived with my nan and my papa. I had a good life with them, holidays, barbecues, took fishing and all that, shopping and spoilt you know what I mean. We did have a good. I've got a lot [of good] memories with nan and my papa.

Byron, 33

So, yeah but we went and stayed with my gran.

Sophie, 49

Grandmothers also provided monetary support, or there was the potential of support if required. As highlighted by Bonnie:

I know my grandmother would probably have helped out my mum if she was short of money but certainly, we weren't wealthy...

Bonnie, 49

This is reiterating the economic instability of the previous theme as well as the support Grandmothers played. In Polly's circumstances it was her 'Papa' who was her one stable relationship as her gran, who lived with her papa, also had a problem with alcohol:

And my papa was like my one stable. I would say relationship...So, my papa loved us, and he wasn't actually my birth blood papa. You know. He was my step, my step-papa but not to me he was my papa...He used to take me to Duke Street to Conner's café for wafers and midget gems and poke hats and ice cream drinks. Actually, we were talking

about that, we went up to gran and papa's and we were spoiled and the irn bru and the unhealthy. Mum was all about the healthy food you know the, whereas when we went up to papa's I think that's when my association with binge eating came in for comfort because when I went there it felt safe and I always felt safe at my gran and papa's. But not within my home.

Polly, 48

One supportive adult, often a grandmother aided participants in coping with their childhoods and provided support for them, although these grandparent relationships were not always present, nor as supportive as participants wanted. At the familial/relationship level, having at least one supportive adult offered participants emotional stability and resilience, buffering the negative effects of parental alcohol use.

8.5 Community Support

There was a lot of reliance on community support for some individuals. Although there was a lot of violence in the community, community services and centres provided support for participants. Research has shown that such informal and non-stigmatising environments can play a critical protective role, particularly for vulnerable young people, by fostering social connection, offering routine, and providing emotional safety in an accessible and non-clinical context (Benzies and Mychasiuk, 2009; Haverfield and Theiss, 2016; Valentine et al., 2019; Velleman and Templeton, 2016). Community centres were resources which were more commonly used as somewhere to socialise in and not labelled as supportive, therefore not actively sought out for support. However, they did provide a safe space for some children to socialise in. As shown by Rowena, whose brother frequently played his music at the community centre:

As a kid we played outside. There was a church hall. We all went to the brownies and the guides. The boys went to the BB [boys brigade] growing up, Sunday school on a Sunday. There was a couple of other wee drama clubs and youth clubs and stuff. There was something on everyday either in the church hall or in the community centre and that's what we did, we just hung out and played

Participants found a community with their neighbours and mentioned how they lived in neighbourhoods where there was a reliance on and help from neighbours. The community support in Glasgow during the 80s has been mentioned in the literature. Robertson (1998) discusses the role of community-based housing associations in the city's urban renewal efforts, emphasising their contribution to improving living conditions and fostering community engagement (Robertson, 1998). Briefly linking community levels to policy levels, the Glasgow Eastern Area Renewal (GEAR) project, which operated from 1976 to 1987, aimed to revitalise deprived areas through community involvement and support services (Nairn, 1983; Wannop, 1990). Rowena, who lived in a flat roof tenement in Priesthill, summarises this well, describing neighbourhood support and the community services they could go to which provided respite from her dad.

But it was very much a neighbourhood where you did rely on your neighbours if you were short of food or money. You kind of all, kind of worked together. As a community. So that was, I suppose that was a positive side. There was a community spirit where we lived, and I think that we all kind of kept an eye on each other's children.

...So, there were free sort of community services you could tap into that we could go to as kids, but I don't know if there's so many community things on now. I suppose there would be if I looked for them. But when we were young it was more like you would just go along to the community centres, you could play games or you would, you would watch my brother practise, and the bands would practise. And they'd do what you would call gigs and you would go to the gigs, or they would do an outside gig, or they would go to the schools and do gigs. Outside the playground.

...But I mean that, I suppose at the end of the day we did all have chinks of happiness but when you went home at night it was just a nightmare if my dad had been drinking.

Velleman and Templeton (2016) highlight the importance of protective environments in buffering children from the negative impacts of parental substance use. They argue that

resilience does not solely arise from internal traits but is deeply shaped by the presence of external protective factors, one being access to community-based resources. Community clubs often provided exactly this: consistent adult supervision, positive peer engagement, and a space that facilitated feelings of belonging and competence (Aytur et al., 2022). Polly went to a ballet school and found great comfort in that:

But it wasn't all bad, so I had my dancing. Actually, I was at the Glasgow Ballet School but that therein lies the contradiction. So, there was all this trauma. But then we had the privilege of a good education. So, it's like they were giving us the tools to make a successful life but what are the tools without self-esteem, self-worth.

Polly, 48

Polly felt that her access to services, as the only participant who identified as middle class as a child, was a privilege as she recognised that education and hobbies helped her cope with her father's alcohol use, but these positive experiences did not negate the impact on her sense of self due to the drinking at home. Miriam, who grew up in a terraced house in G3/G11 the west end of Glasgow, mentions how for her community services, this was brownies, something she still continues to this day:

...but because we'd moved to that area, she was keen for me to try and do something to make friends locally. And so, she signed me up for brownies. And subsequently I have been a guide leader for fifteen years. So, she signed me up actually for guides because I was that age at the time. So, I must have been ten because that's the age you're supposed to start guides at. But because I was so shy and lacking in social skills, they decided to let me stay in brownies for a year before they made me move up.

Miriam, 39

Although differing community services helped in different areas and for some community centres were places of recovery for adults. As Matt, who grew up in the G3 area, summarised:

...I stayed there [Riddrie] could look out of my window at the jail, right across the road from me. A reminder to be a good boy. You could hear the prisoners shouting from one

to the other, it was quite funny. I told myself my neighbours are polis and all you know what I mean, majority of them. It was a good area. Apart from the kids going to school in the morning. People using the street for a short cut, cause there's a bus' top at the bottom of the street. It's dead. Occasional person and a dog.

Aye, biggest majority of people in my area ended up touched wae addiction and then we all met up when we got older in the rehabilitation place down the road, they closed it down. All these people changed to methadone, changed their lives around. Fifteen people with their families, friends, and that. The community benefitted from them people getting better. They shut the place down. Then they opened a place where you can go and have heroin. Unbelievable you know what I mean.

Matt, 48

Overall, participants believed community services to be of great value but have acknowledged that there are not as many services available currently. Participants reflected on the supportive role of the community and services provided but these were not enough to negate the impacts of home life, with no comprehensive support systems provided addressing all of the different difficulties they were facing.

8.6 Education

Adult children often face significant challenges in educational attainment. Research indicates that these individuals may struggle academically due to the emotional and psychological burdens stemming from their childhood experiences (Braitman et al., 2009; Velleman and Templeton, 2016; Gilvarry, 2005). These personal challenges are embedded within broader societal contexts, making it difficult to separate the influence of social conditions from historical and policy developments. At a societal level, the 1980s in Glasgow were marked by increasing social segregation in schools, driven by the concentration of poverty in specific areas and patterns of parental choice (Danson and Mooney, 1997; Pacione, 2004, 1986). By the early 1990s, differences in academic achievement between Glasgow schools were comparable to schools in Edinburgh (Bailey et al., 2002; Croxford and Paterson, 2006). In 1995, 41% of secondary school students in Glasgow were eligible for free school meals, compared with 16% across Scotland, and schools serving the most deprived populations

experienced stagnation in attainment throughout the 1980s (Paterson, 1997). These societal conditions intersected with the experiences of children, compounding barriers to educational success.

Policy interventions during this period, however, were designed to address some of these structural inequalities. The 1980s saw the introduction of competency-based vocational education and training (VET) reforms, aimed at equipping young people, particularly those from disadvantaged backgrounds, with practical skills to enhance employability (Mulder, 2019). School leaver training schemes provided targeted support against youth unemployment and gradually improved in quality and reach throughout the 1980s and 1990s (Paterson, 2022). The 1990s further expanded educational opportunities through the *Further and Higher Education Act 1992*, which removed distinctions between universities and colleges. This reform led to the creation of new universities, such as Glasgow Caledonian and University of Paisley¹¹, and sought to widen access to higher education for individuals from deprived communities, thereby promoting social mobility. Targeted initiatives were introduced to support students from disadvantaged backgrounds (Paterson, 2022). During the 1990s, programs such as university summer schools and the Greater Opportunity of Access and Learning within Schools (GOALS) Project provided children from low-participation areas with exposure to higher education and preparatory experiences to enhance their readiness for university (Paterson, 2022). Despite these reforms, participation in higher education remained uneven, reflecting the persistent influence of societal inequalities alongside policy measures.

For some participants, school was still a safe place. Sophie, who was studying for her master's at the time of interview, used school to escape from her home life because her experiences at school were still better than being at home:

So, school was like a place where I got bullied but still a place of safety. Teachers were there, I got some of my self-esteem some of my resilience from good grades, good

¹¹ Previously known as Paisley College of Technology. In 2007, the University of Paisley merged with Bell College of Hamilton, and the institution was renamed the University of the West of Scotland (UWS).

feedback, kind of counterbalanced all of the 'you are shit, you are rubbish, you are useless, it's your fault' that I got at home.

Sophie, 49

This need for a safe community space was reinforced by Justin, a teacher:

...you can change lives and I think looking back you know, as a teacher now I think back to those one or two teachers who do push you and tell you and say you should do this, why you not doing that and type of thing. But I think you really need that kind of wider network and parental partnership and community partnership which I think there is more now in Scotland...

Justin, 37

However, not all experiences of education were straightforward. Justin, who later went on to become a teacher, described how attending university felt mismatched with his identity and background, having grown up in the Gorbals:

Because university actually I don't think I got a lot from university, and I don't think. I actually don't think that someone like me so to speak like a wee boy from the Gorbals. I'm not actually sure if being thrown into university is the best thing for me so that's something that obviously as an educator and a parent now reflect on that...And I was contributing to the bills and paying stuff and giving her [mum] money. And that was almost like, that felt like the built in thing to do rather than go to university and study.

Justin, 37

Other participants spoke of leaving education early or entering the workforce at a young age due to circumstances or early addiction. The *Education (Scotland) Act 1945* raised the school leaving age to 15, with the change becoming effective on 1 April 1947 (Woodlin et al., 2013). The school leaving age as set by the *Raising of the School Leaving Age (Scotland) Regulations 1972* then changed again to 16 from 1972 until 1994 (Woodin et al., 2013). Although Scotland had the Winter leaving Act, where students could leave in June if turning 16 between March

and at the start of the Christmas holidays if turning 16 between October 1st and the end of February (UK Government, 2025). The winter leaving could explain some participants leaving school at 15, however it is likely that economic, social and cultural factors also influenced this decision. Lucas did not manage to achieve any qualifications, despite this he loved school, but his addiction prevented him from pursuing education:

I loved school you know what I mean. I left with a bit of hope, but I was already in addiction like at school though, nae drink and drugs but gambling...I left school when I was 15. And to be honest with you I left school on the Friday and I started work on the Monday.

Lucas, 45

Daniel, who was studying for his PhD at the time of interview, reflected on the lack of hope he experienced during his school years, despite having achieved good grades and having maintained a job which could support his family, having just had a newborn, as an adult:

I always thought at school, I'll never get a job, I'll never get, I'll never be married or anything. I was kinda really bleak...Just no hope...I don't think I'm successful. I never said that to you. I think [I've] successfully held down a job for 30 years or 30 odd years...But I don't think I'm particularly successful. I don't think I've done the things that I've really wanted to do.

Daniel, 53

For some, education became both a personal and practical tool for social mobility. Rowena, who achieved good grades and a PhD, further described how her commitment to education shaped her adult life and housing choices:

If anything the poverty and the deprivation and the alcohol has made me say no I need to get out of this and the only way you can out of this is I need to get educated because if you're not educated you can't get a job and you need to get a job because you don't want to be back in those kind of areas again. And I live in a, it's still a council area but it's particularly nice, it faces onto a park and it's lovely.

However, the value placed on education was also contextualised by generational and class perspectives. Rowena, who did manage to move away from the poverty of her childhood years, contrasted her own path with her daughter's, highlighting different relationships to work and aspiration:

A lot of young people, like my daughter, she went to private school and so she's never really understood what it is to struggle but she's a very rounded person so. She's not, she'll do a job, when she moves on in life, that she'll enjoy. It won't be about the money for her. Whereas for me, my generation it was about doing a job, even if you didn't particularly like it you did it because you needed money because you needed to get out the poverty trap that we were in. I think it's all linked so. You could have a really bad start in life but still do not too bad if you've got the intelligence enough to see that's a way we can get on.

Rowena, 53

Others described how formal education later became part of their recovery process. Matt, who did not achieve qualifications as a child, mentioned how teachers did not think he would be able to 'amount to anything', however he challenged the low expectations others had of him:

So, I have no education, I got off the street. I learnt a lot but since going into recovery I went for further education so. Things are quite well. I got better. Teachers didn't think I'd amount to nothing so proved them wrong.

Matt, 48

Supportive educational interventions also played a role in nurturing participants. Basil, who at the time of interview ran a recovery centre, described how a community programme saw potential in him that he hadn't seen in himself:

I joined the Princes Trust course when I was first clean and from there they'd seen something in me that I'd never really seen myself. They offered me a post.

Basil, 53

Education acted as a key coping mechanism for participants, providing opportunities for personal growth that helped participants move from areas of high deprivation. At the societal level, schools offered spaces for skill development. At the policy/historical level, targeted initiatives for at-risk children reinforced these benefits by providing additional educational resources and guidance, demonstrating how both societal support and historical policy interventions could promote adaptive coping for adult children.

8.7 Conclusion

This chapter extends existing research by illustrating how resilience among adult children is shaped across the layered dimensions of the socioecological model. While individual experiences were often marked by exposure to trauma, substance use, and mental health struggles, participants also described a range of protective factors that helped them navigate toward recovery and growth. Not all of these coping strategies are positive. These included personal turning points, such as the decision to stop using substances or seek therapy, which align with individual-level resilience processes like self-awareness and active agency (Werner & Smith, 2001). Maladaptive coping strategies such as substance use, were mentioned at a relational level. Drinking or smoking in group settings can facilitate social bonding and help individuals gain acceptance or make friends, particularly during adolescence and young adulthood (Hussong, 2003). At the relational level, the presence of one supportive adult, whether a teacher, mentor, or extended family member, emerged as a pivotal protective factor. The community level also played a vital role. Youth centres, peer support groups, recovery centres and programmes, and educational opportunities within these spaces helped participants feel safe, supported, and socially integrated. Recovery centres not only addressed substance use but also re-engaged participants with education and purpose, facilitating identity reconstruction after trauma. At a policy and societal level, education was seen as a pivotal factor many participants could feel supported by and as a means to better their circumstances. The socioecological model reminds us that resilience is not solely a personal trait but a relational and structural process.

Chapter 9: Policy Implications

9.1 Introduction

In Chapters Two and Three, I reviewed the literature on adult children's experiences as children, adults, and within the context of Scotland and Glasgow, establishing that adult children represent an under-researched group with unique childhood experiences. Several key patterns emerge: firstly, it provides insight into the negative aspects of parental drinking from the adult children's perspectives; secondly, it sheds light on potential causes of parental drinking; thirdly, it identifies protective or mitigating factors that can influence children's experiences; and fourthly, it points to the long-term support needs of adult children in adulthood. Despite these insights from the existing research, policy specifically dedicated to supporting children who grew up with parents who used alcohol remains limited once those children reach adulthood. While extensive alcohol policy exists at both global and national levels, and some policies on children and families make reference to alcohol, implementation is complex due to competing stakeholder interests, cultural factors, and the involvement of multiple health and social sectors (WHO, 2019; Jankhotkaew et al., 2022). Effective policy should therefore aim not only to reduce alcohol consumption and children's exposure to parental drinking, but also to enhance resilience in affected children and provide ongoing support to adult children, helping them navigate the long-term consequences of their childhood experiences. By considering these issues, policy can play a crucial role in addressing both immediate and enduring needs of children and adult children affected by parental alcohol use in light of SEM.

In this chapter, I first consider how alcohol policy is shaped by neoliberal ideology (section 9.2), providing a framework for understanding why certain approaches, such as emphasising individual responsibility, dominate policy decisions. I then examine alcohol policy globally and the implementation gap (section 9.3), highlighting common challenges in translating policy intentions into practice. This sets the stage for a focused discussion of alcohol policy in the UK, and specifically in Scotland (section 9.4), where this study is situated. Importantly, while adult children are rarely considered in policymaking, current alcohol policies nonetheless impact them. Given the lack of information on this demographic and the potential long-term outcomes of parental alcohol use, exploring how policy affects adult children is a critical and under-researched area (section 9.5).

9.2 Neoliberal Ideology

It is argued that neoliberalism, an ideological approach that emphasises the primacy of free markets, individual responsibility, and limited state intervention, contributes to one of the biggest barriers to creating a comprehensive policy approach to preventing non-communicable diseases, including those related to alcohol use (Lencucha and Thow, 2019). Multiple studies have highlighted that alcohol policy is becoming increasingly impacted by neoliberal ideology (Haydock, 2015, 2014; Nicholls and Teasdale, 2016). Neoliberal ideas have grown in increasing popularity in public policy over the past four decades (Lencucha and Thow, 2019).

Higher prices for alcohol, restrictions on marketing and reduced availability have been found to reduce alcohol consumption (Burton et al., 2017), but these types of policies are not generally implemented because of opposition by commercial stakeholders and neoliberal ideologies (Fergie et al., 2019; Lesch and McCambridge, 2022; McCambridge et al., 2014; O'Brien et al., 2023; Savell et al., 2016). Global policy continues to encourage the production of alcohol, as well as tobacco and unhealthy foods (Lencucha and Thow, 2019). This has significant impact on the attempts to intervene in the supply of unhealthy products (Lencucha and Thow, 2019) and has led to policy incoherence (Blouin, 2007). Much of the research on policy incoherence has focused on the influence of these industry interests on shaping public policy to their favour, however there is an argument that the neoliberal policy paradigm enables the ability of these interests to influence public policy (Lencucha and Thow, 2019). This all influences the “accessibility, affordability, and nature of the products in the consumer environment and the ways companies operate” (Lencucha and Thow, 2019:516). The government is then accustomed to certain relationships regarding alcohol services between the government, the market and society (Lencucha and Thow, 2019).

Individualism is another key component of neoliberalism, where individuals are seen as responsible for their own actions and the influence of structural forces is considered less (McGregor, 2001). The pervasiveness of neoliberalism contributes to the separation of a collective or population approach from an individual approach (Mackenzie et al., 2020). Through a neoliberal ideological understanding of alcohol use, there is a view that some personal failure has occurred, and it is regarded as a personal responsibility to limit drinking

(Nicholls and Teasdale, 2016; Room, 2011). When this is applied to policy, there is more focus on how to change individual behaviour and less on the structural and market forces which may influence it (Lencucha and Thow, 2019). Furthermore, it places a societal expectation of the behaviours of 'good' citizens and 'problematic' persons, with the former self-regulating and latter viewed as undeserving of support (Room, 2011). This can be seen in research on adult children, where stigma and blame experienced in childhood can affect their willingness reaching out for and receiving support both as children and adults (Haverfield and Theiss, 2014).

Public policy needs to be reorientated from private interests to health protection. This can be seen in the tobacco industry with the Guidelines for the Implementation of Article 5.3 of the Framework Convention on Tobacco Control which guides interactions between the government and tobacco industry (WHO, 2008). There have been some challenges in implementation of tobacco control, but in contrast there has been widespread education and transparency on the harmful impacts of tobacco industry practices.

9.3 Alcohol Policy Globally

A study by Jankhotkaew and colleagues (2020) reviewing literature on global policy found that the main barriers to implementing effective alcohol policy were: "resource constraint; legal loopholes; lack of evidence to support policy implementation, particularly local evidence; low priority of policy implementation among responsible agencies; and insufficient skills of implementers" (Jankhotkaew et al., 2020:1). Some scholars argue that policies which regulate and control alcohol should be a global priority (Jankhotkaew et al., 2022). Globally, the causes of differential health outcomes are recognised as being due to unequal distributions of wealth and power (Mackenzie et al., 2020). However, implementing effective policies is difficult due to the input from multiple stakeholders. This links to the 'top-down' approach taken by many governments in policy (Hupe and Hill, 2015). The 'top-down' approach means that those implementing policy are not often involved in creating it, leading to an implementation gap where agencies do not have the implementation of policy as a priority or the policy is not effective in practice. Drinking 'norms' may also impact the reluctance of agencies to implement policy (Buvik and Tutenges, 2018).

To implement effective alcohol policy it was found that facilitators were: “establishing monitoring systems and local evidence to support policy implementation and early engagement of implementing agencies and communities” (Jankhotkaew et al., 2022:n.p). The World Health Organization has similar statements on effective alcohol policy in their ‘*European framework for action on alcohol 2022–2025*’ (WHO, 2022). This report incorporates the latest evidence on alcohol attributable harm and the best evidence to reduce such harm (WHO, 2022). The *WHO Action Plan (2022–2030)* was created in May 2022 to reduce the harmful use of alcohol globally (WHO, 2022). They focus on slightly different areas than Jankhotkaew and colleagues (2022), including: gender sensitive strategies to reduce health inequalities; evidence-informed priorities without the interference from industry; protection of children; and leaving no-one behind (WHO, 2022). The interference from the alcohol industry is highlighted throughout all policy documents, such as the loose advertising regulations around alcohol use, may indirectly impact adult children of parents who drank.

9.4 Alcohol Policy UK and Scotland

Alcohol policy in the UK is overseen by different devolved administrations in Scotland, Wales, and Northern Ireland, while certain responsibilities remain under the purview of the UK Government. Researchers have argued that both the English and Scottish governments have fallen short in implementing effective harm reduction strategies, particularly regarding the pricing, availability, and marketing of alcohol (Smye et al., 2011; Wright, 2019). There has instead been a focus on public information and industry self-regulation (Baggott, 2010). The UK government’s most recent alcohol strategy was published in 2012, with no updated alcohol strategy yet. ‘*The Government’s Alcohol Strategy*’ was published during the Conservative-Liberal Democrat coalition and reflected the ideologies at the time (UK Government, 2012). The aim of this document was to ‘re-establish public order’ by framing the problem in a neoliberal stance as one of individual responsibility and the risk of drinking as a threat to security (UK Government, 2012:2). The strategy did not consider the wider implications of alcohol use such as the impacts on family and wellbeing and only has a minimal reference to the harm caused to children affected by parental alcohol use (UK Government, 2012:23-24). The previous arguments made Shenker (2008) on alcohol policy, also remain true in the context of this new Alcohol Strategy:

[policy has] been rather individualistic in its focus on the drinker and failed to make any recommendations for action in response to the needs of children and families affected by parental alcohol use (Shenker, 2008: 6).

Velleman and Templeton (2016) have argued that families and affected others, such as adult children, remain 'invisible' within policy. Policies with a specific focus on drugs and alcohol are likely to focus on the whole family as a singular unit (Velleman, 2010, p. 20). This could be due to the competing interests of stakeholders in constructing policy (Hawkins, 2002; Lencucha and Thow, 2019). Policy does not align with the literature on specific outcomes for adult children which suggests that certain aspects of adult children's lives might need influencing to support better outcomes. Prior to the Conservative-Liberal Democrat coalition (2010-2015), the New Labour government (1997-2010) also treated alcohol policy as an individual responsibility, with a pro-business economic policy supporting deregulation (Baggott, 2010; Room, 2011). Consequently, it was an explicit policy goal in this period to promote the night-time economy, such as bars and nightclubs and it is argued that this policy agenda has not completely been eradicated (Baggott, 2010). As such, alcohol use is being promoted to some extent which arguably conflicts with policy ideas about alcohol control which may have an impact on families.

Scotland has maintained a distinguishable ideological difference in comparison to the UK Government, taking more of a health approach rather than a criminal justice approach to substance use (Public Health Scotland, 2024; Wright, 2019). Scotland's devolved government has introduced tackling alcohol use as one of its national performance framework national indicators. The Scottish Government published '*Changing Scotland's relationship with alcohol: A Framework for Action*' in 2009. This framework has highlighted the need for action in reducing alcohol consumption, supporting families and communities, positive attitudes, positive choices and improved treatment and support (Scottish Government, 2009). The 2018 Framework '*Preventing Harm - next steps on changing our relationship with alcohol*' builds on this with a focus on protecting young people, tackling health inequalities, improving national systems and having a whole population approach (Scottish Government, 2018a). Scotland also has a policy focus on protecting children and 'getting it right for every child' (Scottish Government, 2023). However, none of these reports specifically mentions adult children,

although the *'Review of Drug Treatment and Rehabilitation Services'* by the UK government states that families play a key role in treatment (UK Government, 2022b), this has not been translated into concrete action points. A report by Short, Stevens and Crome (2005) looking into 546 studies on alcohol use in the UK found that none made a reference to families and children (Short et al., 2005). Thus, political, attention, and associated action, has focused primarily on the individuals who use alcohol or drugs themselves (Institute of Alcohol Studies, 2020). This approach overlooks the important role of family dynamics in both the development of alcohol-related problems and the support systems needed for recovery (Institute of Alcohol Studies, 2020). As a result, families often lack adequate resources and support, exposing children to the long-term effects of parental alcohol use that continue into adulthood (The Alcohol and Families Alliance, 2018). A whole-family approach, integrating family support into treatment and prevention strategies would better protect all members affected by alcohol-related harm (Alcohol and Families Alliance, 2018). Nonetheless, there is still no specific mention of adult children, despite research arguing that this is a population who experience negative outcomes due to their parents' drinking behaviours.

Scottish governmental studies argue that there is a need to change the attitude of the population and there needs to be more focus on children and families (Scottish Executive, 2002b). The Scottish Executive's *'Plan for Action on Alcohol Problems'* shows the need for changing culture (Scottish Executive, 2002b). Additionally, the country has implemented the *Licensing (Scotland) Act 2005* and *The Alcohol etc. (Scotland) Act 2010*, which make the sale of alcohol restricted to licensed premises and establish restrictions for its sale, for example restricted hours between 10am and 10pm and the *Criminal Law (Consolidation) (Scotland) Act 1995* which includes legislation restricting the consumption of alcohol at football games. Glasgow also has bylaws on the drinking of alcohol in public, under sections 201-203 of the *Local Government (Scotland) Act 1973* anyone consuming alcohol or in possession of an empty container has committed an offence. In May 2018 *The Alcohol (Minimum Price per Unit) (Scotland) Order 2018* was implemented which puts limits on the minimum price of alcohol. This was also introduced in Wales with the *Public Health (Minimum Price for Alcohol) (Wales) Act 2018* and in Northern Ireland a consultation on minimum unit pricing took place in 2022, although minimum unit pricing has still not been implemented. To-date no action with regards to minimum-unit pricing has taken place in England. The difference in UK and

devolved policy agendas highlights the slight difference between the neoliberal focus and overwhelming influence of the alcohol industry which could impact policy agendas and limit the focus on adult children. None of the four countries has an in-depth consideration of how this policy impacts adult children, in effect families are minimally present but adult children are completely hidden despite the problems associated with alcohol use being well known.

9.5 Alcohol, ACEs and Trauma Informed Policy Regarding Family Members Affected by Alcohol Use UK and Scotland

Despite the increasing focus on the needs of children with parents who drink in national policies aimed at preventing substance including alcohol use, political attention in the UK and Scotland has focused primarily on the individual using alcohol or drugs themselves, although the impact on family has been given more importance, politically in recent years (Templeton et al., 2006). A UK based report by Short, Stevens and Crome (2005) looking into 840 substance use studies of which 65% discussed alcohol (546) and 30% covered tobacco/nicotine, found that none made a reference to families and children (Short et al., 2005). Where the child or family is mentioned, these efforts have primarily concentrated on drug use, neglecting the specific effects of parental drinking and the experiences of children (Finch et al., 2023; Scottish Executive, 2002b; Scottish Government, 2018b; Short et al., 2005; UK Government, 2021). Adult children are rarely mentioned, and when they are it is as collective family members who can help support the individual who drinks and not as adults who may be in need of support, as suggested by this thesis findings.

Recent political reports on alcohol use have begun to emphasise the societal and familial impact on children, particularly through the 2012 Children's Commissioner's report based in England, *'Silent Voices'*, which featured excerpts from interviews with children to highlight their experiences living with parental alcohol use (Adamson and Templeton, 2012). While the report drew on findings from We All Matter (WAM) and The National Association for Children of alcoholics (NACOA) to complement existing statistical data, it revealed a significant research gap: there was limited direct inquiry into the experiences of children affected by parental alcohol use, a trend evident both nationally and internationally.

The most recent Scottish 'Good Practice Guidance for agencies and practitioners working with children, young people and families affected by alcohol or drug use' focuses on the impacts

as children and a whole family approach rather than the potential experiences of the adult (Scottish Government, 2013). Scottish policy argues that there is a need to help children affected by parental substance use; *'Getting our priorities right: good practice guidance'* was published by the government, for all frontline staff and organisations working with children and young people who live with parental alcohol or drug use (Scottish Government, 2013). The *Children (Scotland) Act 1995* can also apply to children of problem drinkers but does not explicitly mention them.

Scotland's more recent policy agenda focuses on children's voices and adverse childhood experiences (ACEs) (see the Government's Programme for Scotland 2019-2020; Scottish Government, 2019). However, these policy documents do not combine the information on these high ACE scoring children and the adults they become who may be addicts themselves. ACEs and the trauma-informed approach have also been given attention within UK policy (Emsley et al., 2022; Maynard et al., 2019; Walsh, 2020) in Wales (Public Health Wales, 2021) and in Scotland (Scottish Government, 2024b). The Scottish Government stated their intentions to become an ACE aware nation in their Programme for Government 2017/18. However, these reports have little direct research or testimony from adults who have experienced ACEs and descriptions of their experiences. In 2024, Scotland, a National Trauma Transformation Programme was created in order for the country to become the first ACE-aware nation, being funded almost £10 million since its inception (NHS Education for Scotland, 2023; Scottish Government, 2024b). This does not explicitly provide support for adult children as adults, although this is an ACE so there is some support included for children currently in these situations. The ACEs approach has been expanded upon in the recent push in Scotland for trauma-informed policy and practice.

In Scotland, the Scottish Government's 'Rights, Respect and Recovery' strategy highlights the importance of a rights-based and person-centred approach to reducing harm, including support for children living with parents who have problematic substance use (Scottish Government, 2018b). Local NHS services, such as Child and Adolescent Mental Health Services (CAMHS), provide mental health support to children and young people affected by parental alcohol use but no equivalent provisions exists for adults who were affected in childhood. However, CAMHS in Scotland face significant challenges related to demand and capacity. In

the quarter ending March 2025, 91.6% of children and young people started treatment within 18 weeks of referral, surpassing the Scottish Government's target of 90% (Public Health Scotland, 2025b). Despite this progress, 4,674 children and young people remained on the waiting list at the end of the quarter, indicating ongoing pressures on the system (Public Health Scotland, 2025). The availability of mental health services for adults, including those who were affected by parental alcohol use during childhood, remains limited (Public Health Scotland, 2025). While organisations like the National Association for Children of Alcoholics (NACOA) provide resources and support, the negative effects of childhood exposure to parental drinking are not limited to childhood, therefore there is a notable policy gap addressing the adult consequences of childhood exposure to parental drinking.

9.6 Conclusion

In this chapter I discuss how alcohol policy at both global and UK levels continues to be shaped by neoliberal ideology, globalisation, and the influence of powerful industry stakeholders (Lencucha and Thow, 2019; Room, 2011; Shenker, 2008). As a result, policy overwhelmingly prioritises changing individual behaviour rather than addressing the structural, commercial, and societal forces that shape alcohol use (Lencucha and Thow, 2019). This individualised framing reinforces expectations about the behaviours of 'good' citizens who self-regulate and 'problematic' individuals deemed undeserving of support (Room, 2011). Such assumptions obscure the broader social and relational contexts in which alcohol use occurs. Crucially, much alcohol policy, globally and within the UK, fails to consider the wider implications of alcohol use for families, particularly the long-term consequences experienced by adult children. These individuals remain almost entirely absent from policy discussions, despite evidence that parental drinking shapes both childhood experiences and adult outcomes (Jankhotkaew et al., 2022; Shenker, 2008; UK Government, 2012). Although Scotland has made progress in recognising some 'hidden' groups affected by substance use (Wright, 2019), adult children as adults remain largely invisible within policy frameworks. This invisibility limits the support available to them in adulthood and prevents policy from addressing the intergenerational and lifelong nature of alcohol-related harm.

Chapter 10: Conclusion

10.1 Introduction

The primary aim of this research was to examine the experiences of adult children, through their own perceptions of their childhood. This concluding chapter will assess the extent to which this aim was achieved, through the research questions, reflections on this thesis and summary of previous chapters. The overall aim of this research was to understand the experiences of adult children. The research questions identified, in the context of Glaswegians born 1966-1988 were:

RQ1: How do adult children perceive parental alcohol use to have shaped their childhood experiences?

RQ2: What factors enable adult children to cope with having grown up with parental alcohol use?

RQ3: How do these factors map onto the socioecological model?

RQ4: What are the policy implications of the research findings?

In this concluding chapter, I summarise the reflections and limitations, conceptual relevance and policy recommendations related to this study. In Section 10.2 I reflect on the empirical contributions. Section 10.3 includes theoretical contributions. Section 10.4 includes methodological contributions. Section 10.5 includes reflections and limitations and 10.6 includes recommendations for policy, practice and research. Lastly, I end with some final thoughts about this project in section 10.7.

10.2 Empirical Contributions: Situating the Findings in the Existing Literature

The empirical contributions that this study makes to what we know about adult children's experiences are found in the links and differences between the findings from this thesis and the literature. Whilst many of the findings align with existing literature, this study contributes to the field by providing a comprehensive, multi-level analysis of how individual, familial, community, societal, and historical/policy factors intersect to shape the lived experiences of adult children. It highlights the complex interplay between personal coping strategies, family

dynamics, and broader socioeconomic and policy contexts, demonstrating how experiences of bereavement, caregiving, and exposure to alcohol-related harm are embedded within structural and cultural frameworks. Furthermore, by focusing on Glasgow in the 1970s–1990s, the study offers insights into a historically and geographically specific population, shedding light on how deprivation, community conditions, and historical policy shaped family life and childhood experiences. Previous research found as children, adult children were more likely to describe their household in terms of shortage of money, arguments, violence, stress, worry, and shame, with experiences of parental mental illness, domestic violence, poverty and socioeconomic disadvantage, discrimination, housing, social exclusion, unemployment and mental health problems (Callingham, 2004; Velleman and Orford, 1999a; Velleman and Templeton, 2016).

Participants in this study spoke at length about violence, embarrassment over taking friends home, domestic violence, and mental health problems of both themselves and parents. However, many of the other key aspects of adult children’s lives from the literature were not considered as important by participants, specifically around in-depth discussions around housing or unemployment. These themes were mentioned, but not in as much detail (as seen in Section 7.4), with the understanding that most participants believed Glasgow to be a city of such high socioeconomic disadvantage and poverty when they were children that most individual’s experiences were similar. As such, due to the nature of narrative interviewing, although the experience of housing or unemployment may have impacted on their childhood experiences, they were not discussed in this study as an independent area importance, although they are mentioned in regard to communities within housing estates and economic issues within communities. Given the nature of narrative interviewing, participants are encouraged to share experiences in ways that hold personal meaning to them, rather than responding to predetermined themes. Consequently, the absence of explicit discussion about specific areas previously highlighted as important in the literature does not imply that these factors were unimportant, but rather that they were normalised and embedded within participants’ everyday experiences. In this sense, their omission reflects the strength of the narrative approach, which prioritises participants’ own framing of their lives, while also highlighting a limitation, that broader structural influences may remain implicit rather than directly articulated.

As will be further discussed in this chapter, the findings also advance current alcohol policy and practice by showing how something which may operate positively may mask problems in other areas, or something which may be perceived negatively may be viewed positively by a child because it protects them or their family from harms in other areas (Sawyer and Burton, 2012). For example, 'avoidance' was effective as a child with their parents but less effective as an adult in other relationships (Velleman and Orford, 1999), or children from high adversity backgrounds can do well and be high achievers academically (Forrester and Harwin, 2008). The findings further indicate the existence of multiple levels of impacts on adult children, throughout their lives. Hence, the factors cannot be considered in isolation. The majority of participants have degree-level or higher qualifications despite experiencing significant childhood adversity, including bullying, parental violence, and poverty. This juxtaposition highlights a complex relationship between early disadvantage and later educational attainment, suggesting resilience, delayed achievement, or the influence of adult learning and recovery programmes. Equally, the sample contains a high proportion of individuals with histories of substance use or mental health difficulties, which may have shaped both the content and tone of the narratives. Many also grew up in council or social housing and in households marked by unstable parental employment or violence, yet now occupy more stable housing situations, often with their own families. These characteristics suggest that participants' narratives are less about 'typical' childhoods and more about navigating adversity and transformation, meaning the findings may not generalise to all communities but provide rich, in-depth insights into the long-term impact of parental alcohol use on my participants. There is significant overlap across the findings for this thesis, in Chapters 6, 7 and 8. The key areas being perceptions or social constructions regarding gender-based behaviour and the levels of violence across the socioecological levels.

Studies have linked the 'hero' or caregiving role to daughters due to them nurturing younger siblings (Alford, 1994; Brisbane, 1989; Kelley et al., 2007), and the extension of this role to romantic relationships (Wells et al., 1999). Overall, women were believed by participants to be pivotal in raising children, and without them, there was difficulty in a household functioning at all. There is little research on the impacts on adult children who had mothers' who drink, however previous research has found that with maternal alcohol use daughters had higher internalising and depression scores than sons (Christensen and Bilenberg, 2000).

This study extends existing research by broadening understanding of the gendered roles adult children may be exposed to and reinforce. By situating participants' experiences within the context of their environments, this study demonstrates that caregiving roles can transcend traditional gender boundaries, offering new insight into how early adversity and maternal substance use influence adult children's behaviours, protecting their younger siblings and feeling responsible for them no matter the gender. Motherhood also allowed for a reformulation of a woman's sense of self (Emslie et al., 2015; Haynes, 2008). Killingsworth (2006) has argued that alcohol can be used to demonstrate agency when balancing the 'fractured' identities of 'mother' of young children and 'independent woman' (Killingsworth, 2006). This was not mentioned in this thesis, with female participants with children disclosing that they behaved differently around alcohol due to their upbringings and few reflecting on their mothers' drinking and identities outside of the role of 'housewife'. Women drinking in Emslie and colleagues (2015) and Brown and Gregg's (2012) studies drank to provide temporary relief from their identities and relationships. Participants in this thesis did mention that where mothers drank it did start in order to escape their relationship with fathers. This suggests that maternal drinking may function as a coping mechanism rather than simply a manifestation of dependency. Consistent with Emslie et al. (2015) and Brown and Gregg (2012), the findings indicate that women's alcohol use often emerges as a response to emotional strain, relational conflict, and constrained social roles. For participants in this study, mothers appeared to drink as a way of escaping difficult or oppressive relationships with fathers. This highlights the importance of understanding women's substance use within a relational level, where drinking is intertwined with societal gendered expectations.

Other studies have found male adult children to have increased criminal behaviours (Mutzell, 1994) and scored higher on the psychopathic deviate scale (Knowles and Schroeder, 1990) but even though the term has been used to describe individuals who worked in heavy industries, undertook hard drinking and were involved in gang culture (Johnston and McIvor, 2004), it has not previously been linked to adult children before. The benefit of making such a linkage between specific Glaswegian culture-based gender roles and adult children lies in the ability to broaden theoretical understanding and contextual interpretation of behaviour. Furthermore, it highlights potential continuities between working-class identity, trauma, and coping mechanisms. The context of men's drinking in midlife is associated with the

construction of masculinities (Emslie et al., 2013). In their study Emslie and colleagues (2013) found that men in the West of Scotland regarded drinking pints of beer in the pub together as an 'act of friendship' and this functioned as a way to communicate with and support each other, it also allowed for topics which were not normally discussed to be disclosed such as mental health and emotions. This is similar to how participants in this thesis discussed their parents, although they also spoke about alcohol allowing them to maintain traditional masculine roles.

Chapters 6, 7, and 8, each explore the persistence of violence, loss, and coping within the wider psychosocial and sociohistorical context. This echoes much of the literature on adult children surrounding violence, whereby adult children have been found to be exposed to various forms of violence (Anda et al., 2002; Leonard, 2002; Park and Schepp, 2018; Templeton et al., 2006; Velleman et al., 2008; Velleman and Reuber, 2007; Velleman and Templeton, 2016). While Chapter 6 'Normalising Dysfunction: Patterns of Harm and Gendered Roles' focuses on how gendered expectations and cultural norms perpetuate harmful behaviours within families and communities, Chapter 7 'Disappearing: Loss and the Erosion of Childhood' extends this discussion to the emotional consequences of bereavement and instability. Chapter 8 'Surviving: Coping and Active Agency' then considers how individuals attempt to manage or transcend these experiences through coping mechanisms, education, and community support. The findings in this thesis highlight the varying and often extreme violence that participants lived with across socioecological levels. The links between parental alcohol use and exposure to community violence have been established (Hanson et al., 2006; Zinzow et al., 2009) and the findings in this study support this idea that community violence was common and normalised. This finding is arguably context specific, given that high levels of violence were known to occur in Glasgow during the 80s and 90s (Walsh et al., 2017). Yet the findings support Zinzow and colleagues (2009) research that suggests that community violence can often lead to the acceptance of familial violence (Zinzow et al., 2009). In this study, familial violence, particularly domestic violence, was quite common amongst participants, and this appeared to be normalised due to the frequency with which participants heard or saw violence happening in the community.

Domestic violence has been found to escalate and occur predominantly from men towards women and be a common occurrence for adult children (G et al., 2011; Velleman et al., 2008). The findings demonstrated that escalating and gendered violence was feature of the participant's lives, with mothers of adult children often being the injured party, as well as the adult children themselves. The links in the literature between familial violence and adult children do not often go further than domestic abuse whereas the findings from participants in this thesis have shown violence at multiple levels within multiple familial relationships, such as Lucas stabbing his brother. Violence in the family is most strongly linked to the incidence of psychopathology or mental health problems in the adult child (Balsa et al., 2009; Gąsior, 2014; Gilvarry, 2005). This was not directly linked by participants in this study, however, there were many experiences of violence from male adult children towards family members, as well as both genders having self-directed violence, such as through suicide attempts and self-harm. The prevalence of self-directed violence has been found in the literature on adult children, although there are debates surrounding the gendered prevalence (Hanson et al., 2006; Richards and Nelson, 2012; Serec et al., 2012).

Alcohol is known in the literature to effect families and be a 'family disease' (Velleman and Orford, 1999), this has strongly been shown in this thesis with family acceptance and impact of parental drinking. The 'one supportive adult' (Section 8.3) literature to combat the 'family disease' has sometimes been debated, but has been considered to immensely improve the outcomes for adult children (Dooley and Fitzgerald, 2012; Kelley et al., 2010). These sources of support included reliable support from a female caregiver and elders and peers in their community who provided emotional support such as a favourite teacher (Templeton et al., 2006; Velleman and Templeton, 2016; Werner and Johnson, 2004). In this thesis, a primary supportive adult was a key aspect of their lives, someone who provided somewhere safe to stay and monetary as well as emotional support to participants. The support of a grandparent was immensely beneficial to some participants due to their difficulties in making friends.

Kelley and colleagues (2010) found more positive relationships to peers significantly reduced the association between being an adult child and depressive mood, however it was often difficult for participants in this thesis to make friends due to the 'shame' they felt at having a parent who drank (see Section 7.3). The experiences of shame have been documented in the

adult children literature (Rafferty and Hartley, 2006; Ruben, 2001). Ruben (2001) came up with a list of 'rules' for operating in a home with problem alcohol use. Two of these which were also mentioned by participants in this thesis are 'don't talk about family problems' and 'limit communications' (Ruben, 2001). 'Don't talk about family problems' refers to the belief that problems within the family are supposed to stay in the family, children are strongly pressured by the family to pretend to the larger community. Ruben (2001) found that 'limit communications' meant that the child may often limit communications with outsiders to maintain family secrets, so they do not accidentally reveal the troubles at home. In this thesis, these 'rules' were not explicitly stated but it was clear that participants found it difficult to communicate with other children who did not have parents who drank.

Chapter 8: Surviving: Coping and Active Agency includes the importance of relationships amongst other coping mechanisms or protective factors. Relationships have been shown to have a hugely positive outcome around coping with parental alcohol use (Dooley and Fitzgerald, 2012), although in this thesis participants mentioned how friendships may not always be beneficial as well as the acceptance of alcohol use in the community aiding in the participants attempts to befriend individuals and 'cope' by using substances. 'Coping' with parental alcohol use can occur in differing ways, coping mechanisms can be acts such as education or community support that need not always be positive but are simply ways in which individuals try and maintain their wellbeing in stressful situations. In this thesis, few participants had the active agency to seek positive coping mechanisms and many mentioned community services and networks and substance use as coping mechanisms.

Community factors have been found to positively influence adult children's lives in various studies (Hall and Webster, 2007; Jaffee et al., 2007; Velleman and Templeton, 2016). Multiple community services were found to be positive to participants in this study; from community centres to educational services, ballet, and football, all were helpful in participants physically being outside of the home as part of coping with their home life. Around half of participants started using substances at puberty as a method of coping. Hall and Webster (2007) note that social acceptance of drinking practice is a coping mechanism but also a risk factor in influencing drinking behaviour. Substance use has been found to be a common way in which adolescents seek to explore their identities (Orenstein and Lewis, 2023), and more common

in men than women (Mereish and Bradford, 2014; Sher et al., 1991). Participants in this study mention adolescence as a key period of creating coping mechanisms for living with a parent who uses alcohol, with far more male participants mentioning this. Adult children have been found to have an increased risk of substance use (Braitman et al., 2009; Epstein et al., 2020; Gilvarry, 2005; Sher et al., 1991), however contrary to these previous studies it was shown in this thesis that substance use provided, if only for a short time, support and friendships that they were not receiving from familial connections. This shows a potentially beneficial aspect to substance use, peer relationships, which has not been mentioned by previous scholars on adult children.

This study offers a distinctive, strengths-based contribution to the understanding of adult children who grew up around parental alcohol use. Unlike much of the existing literature, which has tended to adopt a predominantly psychological and risk-focused lens (Velleman and Templeton, 2016), this research highlights the resilience, adaptability, and resourcefulness demonstrated by adult children growing up in Glasgow. Despite there being a large objectively negative component to the themes established, there were positives interwoven in their narratives. While grounded in qualitative inquiry, the study explores the nuanced interplay between individual, familial, community, societal and historical/policy factors that shape these experiences. The primary focus is on adult children's recollections of growing up in Glasgow 1970s-1990s and they were recruited based on parental alcohol use, providing insight into their lived experiences of this specific group. By focusing on Glasgow as a key site, the research also recognises the value of situating these narratives within a specific social and cultural context, showing how local norms and community dynamics contribute both challenges and sources of strength. By shifting the lens away from alcohol itself and toward the lived experiences of those affected, this thesis contributes a more holistic understanding of adult children's lives.

10.3 Theoretical Contributions: Utilising the Socioecological Model

In this study I utilised a thematic analysis of narrative interviews then mapped the themes onto the socioecological model. This inductive approach allowed me to code for themes organically from participants' retrospective accounts, revealing how adult children faced a range of potentially negative but also positive experiences, such as 'Normalising Dysfunction:

Patterns of Harm and Gendered Roles’, ‘Disappearing: Loss and the Erosion of Childhood’, and ‘Surviving: Coping and Active Agency’. Mapping these themes onto the socioecological model shows that childhood experiences are messy and overlapping, reflecting that individual agency, relational dynamics, community structures, and societal norms are interconnected rather than discrete. This has policy implications which extend beyond just alcohol. For example, gendered expectations at the individual and familial levels intersect with community violence and culturally accepted drinking practices, illustrating how experiences are embedded across multiple socioecological layers.

Utilising the socioecological model as a tool to organise the themes contributes to theoretical knowledge by providing an understanding of how various levels of experiences of adult children’s lives were broader than parental alcohol use and across multiple levels. This study demonstrates how individual, familial, community, societal, and historical influences intersect and provides an account that is not just risk based but highlights the broader influences on adult children’s childhoods (Dahlgren and Whitehead, 1991, 2021; Dyar et al., 2022; Marmot and Wilkinson, 2005). This theoretical contribution is significant because it shifts the focus from the aforementioned risk-oriented perspective to one that incorporates the potential for resilience. Themes such as ‘Bereavement’, ‘Loss of Childhood and Isolation’, and ‘Environmental and Economic Instability’ illustrate how adversity and protective factors are intertwined, revealing previously underexplored pathways through which parental alcohol use shapes adult children’s experiences. A previously unexplored pathway highlighted in this thesis is the connection between adult children’s experiences and the Glasgow “Hardman” persona, operating simultaneously at the individual level (see Section 6.2) and the political/historical level (see Section 6.6) of the socioecological model. The socioecological model also provides a framework to understand how access to supportive adults, youth centres, and recovery services (community and policy levels) interacts with individual coping strategies and familial support to influence adult children’s lives. By integrating retrospective qualitative accounts with the socioecological model, this study extends the model beyond traditional health applications, offering a richer conceptualisation of childhood experiences.

10.4 Methodological Contributions: Richness of Qualitative Data

The methodological contributions to knowledge lie in the narrative approach to my interviews and to organise data collection around a broad question: ‘what was your life like growing up in Glasgow?’. By organising data collection around an open, contextually grounded question, the research invited participants to construct their own accounts of their childhood within the context of parental alcohol use in Glasgow. This narrative approach privileged participants’ voices, enabling them to situate their experiences within the social, cultural, and economic realities of Glasgow. While there is strong and recent existing research on parental alcohol use (Meulewaeter et al., 2022; Richards and Nelson, 2012), few studies have explored the perspectives of adult children qualitatively (Balsa et al., 2009) and even fewer in Glasgow. Much of the existing literature relies on quantitative data, which often overlooks the complexity, nuance, and emotional depth of lived experience (Velleman and Templeton, 2016). By contrast, the narrative method used here allowed participants to articulate both positive and negative dimensions of their childhoods. The in-depth, contextually rich interviews generated a level of qualitative detail rarely found in existing studies of adult children. The combination of narrative methodology and Glaswegian context therefore advances methodological practice in social policy research. It demonstrates how grounding qualitative inquiry in place and story can reveal the interconnected social, cultural, and emotional dimensions of living with parental alcohol use, insights that might otherwise remain invisible in more traditional, data-driven approaches.

10.5 Reflections and Limitations

Limitations are a part of any piece of social research. This section will include information on the key limitations of this study, some of which were addressed and accounted for in the research design. This includes changes regarding data collection and COVID-19 impacts.

10.5.1 Participant Cohort

Overall, there were 20 participants in this research, all were interviewed for this project and those interviews transcribed. Whilst I argued in Chapter 4 (section 4.6) that there was enough data obtained to identify themes, more information could be collected in certain areas. Due to the changeable nature of all of research, especially regarding my participant group of adult

children and their varied experiences, it was hard to establish if there was enough data collected. However, as narrative interviews were conducted, I found that the interviews provided a good depth of information which could be applicable to the changing remit of this piece of research. Participants were an almost equal mixture of female (n=9) and male (n=11). Male participants were predominantly found through recovery centres and identified as having a problematic relationship with drugs or alcohol. Female participants were predominantly identified through posters in universities and community centres. The majority of participants were white, with two exceptions - one participant identified as South Asian and another as Indian. This relates to the wider issue around recruitment. As explored in Chapter 4, the recruitment process for this study required many different recruitment methods and was inevitably impacted by the COVID-19 pandemic. This therefore provides information on the perspectives of adult children prior to COVID-19.

On reflection, it would have been useful to collect more extensive demographic information, particularly ethnicity, as there may be differences in perceived identity. The justification for not doing so was to maintain participant's anonymity and to make them feel more comfortable about the information they'd shared in the interview. However, social class can be difficult to measure and collecting full postcodes and not partial postcodes would allow the use of Scottish Index of Multiple Deprivation (SIMD) to 'map' socioeconomic difference (Carstairs and Morris, 1990). This would have allowed for more detailed understanding of how social class impacts experiences and identities in families based on the SIMD. Additionally, although participants were open about mental health issues, further information on specificity about these could have provided more insight into how this impacted their belief systems and which resources they had reached out to for support. Despite these highlighted limitations, this research achieved the overarching aim and addressed the research questions.

10.5.2 Method and Quality of Data

The method of recruitment for this dissertation was snowball sampling, there are a number of limitations of this method including when the 'snowball does not roll' and that establishing representativeness of samples is questionable (Parker et al., 2019). Although, this method

was established as the best for obtaining interviews with individuals on sensitive topics, Waters (2015) lists four limitations on a similar topic, when researching older adult drug users:

1. *When potential participants view the topic being researched as too personal, impacting on disclosure.*
2. *When potential participants perceive risks with participation, such as exposure of friends.*
3. *When characteristics such as age and nationality differ between the researcher and the potential participant.*
4. *When there are no social relations within the study population so no friends/colleagues to share the study with or 'snowball'.*

(Waters, 2015:368)

Many of these limitations were true for my snowball sampling method but these issues did not seem to impact recruitment due to the multiple active and passive ways I employed for recruitment. The predominant stopping force for recruitment was that of the COVID-19 pandemic.

There are also limitations to consider with the data collection method, narrative interviewing. Although, a good method for gathering retrospective stories of participants, there are challenges around the anonymity of reporting, ethical problems and bias (Aarikka-Stenroos, 2010). There are also uncontrollable expectations of the informants and often an unrealistic view of the procedures of narrative interviews (Jovchelovitch and Bauer, 2000). For this research the narratives were vital in obtaining more in-depth information about participant's childhoods and outcomes. A rich depth of narratives was obtained, despite limitations, with participants sharing extremely personal information about their lives. The retrospective nature of the interviews allow participants a time to reflect about their lives and view their childhoods through a different lens. However, there could have been slightly more structure to ensure the research questions were directly answered, as some interviews had more depth than others. Some interviews were quite brief, although this was in a more 'high risk' service in which participants did not have to be abstinent to attend, but despite this valuable information was obtained and this also informed other individuals about participating who

undertook longer interviews. This partial snowball method of recruitment could be biased, as only adult children with particular experiences and at a certain stage in their journey would be happy to speak with me, however (as seen in Appendix 10) there were a range of individuals at differing stages of recovery and life course. There is also valuable data to be obtained from individuals who may have more 'positive outcomes' in terms of education or recovery than others, highlighting a potential resilience within participants. Therefore, the sample of participants is a useful sample of this group providing insight into their unique childhoods and covering a range of experiences growing up in Glasgow with parents who drank.

10.5.3 Potential for Memory Bias

Retrospective accounts in research offer both challenges and advantages, particularly when examining how adult children interpret their childhood experiences. On the one hand, memory biases, selective recall, and the impact of trauma can affect the accuracy of such accounts, potentially leading to distortions or omissions in reporting past events (Henry, et al., 1994). On the other hand, the retrospective nature of interviews provides participants with the temporal distance necessary to reflect on their experiences, allowing for deeper insight into how early events have shaped their identities and current perspectives. This reflective capacity makes retrospective interviews particularly well-suited for exploring the meaning adult children attribute to their childhoods, as it captures not only what happened but how those events are interpreted over time.

10.5.4 COVID-19

The novel coronavirus pandemic impacted my work greatly. Not only did it affect my own mental and physical health, in addition to multiple family members it also affected more practical aspects of my research. Recruitment was impacted, my Research Assistant position occurred between August 2019 and January 2020, leaving only 3 months for recruitment before lockdown was initiated in March 2020. This led to a restricted recruitment time frame in which individuals were available in person. Due to the vulnerable nature of participants and difficulties in recruitment prior to COVID, these enhanced difficulties reaching populations. All recovery meetings and centres were closed or suspended for quite some time before online services became available. Recruitment was also problematic as I moved back home to look after family members. Attempts were made to further recruitment online but

after some promising emails, this did not occur, and it was concluded that data was comprehensive enough to answer research questions.

10.5.5 Glasgow as the location of the study

The research context of this study was Glasgow 1970s-1990s when participants were children growing up in the city, this has been discussed extensively in Chapter 3. The context of Glasgow has changed in recent years, although there is still an issue with parental alcohol use. The city's long-standing socioeconomic inequalities, rooted in deindustrialisation, urban policy changes, and social fragmentation, have had enduring effects on public health and family life. Excess mortality in Glasgow is still high, with premature deaths over 30% higher than in comparable cities, and alcohol and drugs accounting for nearly half of all excess deaths under 65 in data prior to 2010 (Walsh et al., 2010). These patterns continue, with alcohol-specific death rates in Glasgow substantially above the Scottish average in 2024, and mortality in the most deprived areas up to 4.5 times higher than in the least deprived communities (National Records of Scotland, 2025).

Alcohol and drug-related harm are intertwined with socioeconomic disadvantage. Studies highlight that high unemployment, particularly among working-age adults, and the clustering of alcohol outlets in deprived neighbourhoods, exacerbate inequalities (Ellaway et al., 2010; Richardson et al., 2015). As Sir Harry Burns noted, social and economic upheaval has left a 'void' in people's lives that is often filled with alcohol, drugs, and associated harms (Puttick, 2013). Glasgow has seen particularly high rates of alcohol-related mortality among working-age men, and drug-related deaths have more than doubled in the last five years (Whyte et al., 2021).

The COVID-19 pandemic further complicated this landscape. National data indicate increased alcohol consumption in the UK during lockdowns between April and July 2020 (Kilian et al., 2021). In Scotland, while overall alcohol sales and hospital admissions decreased, alcohol-related deaths rose, reflecting ongoing health inequalities (Richardson et al., 2022). COVID-19 exacerbated existing disparities, particularly in deprived areas such as Glasgow and Inverclyde, which already experience some of the highest rates of alcohol-related deaths in the UK (Whyte et al., 2021).

Post COVID-19 the alcohol landscape changed slightly, in 2024, alcohol-specific deaths in Scotland decreased by 7% to 1,185, the lowest number recorded since 2019 and 92 fewer than in 2023 (National Records of Scotland, 2025). Alcohol-specific mortality rate also declined, falling from 22.5 deaths per 100,000 people in 2023 to 20.9 per 100,000 (National Records of Scotland, 2025). Despite this improvement, new data from Public Health Scotland (2025) shows that Scots continue to drink at levels 50% above the recommended safe limits, with those in the most deprived communities bearing the greatest burden. On average, adults consume '21.6 units of alcohol per week', well above the guideline of '14 units for both men and women' (Public Health Scotland, 2025c:n.p). The statistics reveal significant inequalities, as the difference between the most and least deprived areas relates to a difference of six times the likelihood to be hospitalised or die from alcohol-related causes (Public Health Scotland, 2025c). These findings highlight the persistent alcohol-related challenges in Scotland and emphasise the need for further research into how childhood experiences may influence adult drinking patterns.

10. 6 Recommendations for Policy, Research and Practice

This section combines the current policy addressed in this chapter in Scotland, to the findings from the thesis to determine and explore how the lives and experiences of adult children might inform policy, practice and research. Therefore, recommendations are as follows:

1. Alcohol policy further prioritised by the political agenda.
2. Consideration of appropriate policy measures which have worked in reducing health inequalities in smoking applied to policy surrounding alcohol use.
3. Further research into Minimum Unit Pricing policy.
4. Additional, further research on the lived experience of adult children's perspective due to the necessity of listening to 'hidden voices'.
5. Further research into how we can help individuals develop healthier gender constructions and identities.
6. Incorporation of alcohol use into trauma informed training into practice.
7. Consideration of the preferred language for people with relationships to drugs and alcohol.

8. Integrated support services which have taken into consideration the important experiences of adult children and can target services towards educating families, frontline staff and policy makers.

These recommendations will be expanded upon below, with an inclusion of how the findings from this thesis relate to the arguments around changes and improvements in policy, practice and research for adult children in a Glaswegian and by extension Scottish context.

Policy

1. *Alcohol policy further prioritised by the political agenda.*

As discussed in Chapter 3, Scotland has had the lowest life expectancy in the UK since the 1970s and, in recent decades, has ranked among the lowest in Western Europe (Finch et al., 2023). Among men aged 15–44, ‘deaths of despair’ or suicide, alcohol, and drug-related deaths are the primary causes, contributing to two-thirds of the inequalities (Finch et al., 2023). Alcohol-specific mortality rates also remain higher in Scotland than elsewhere in the UK. In Scotland there were 21.5 deaths per 100,000 people in 2020, compared to 19.6 in Northern Ireland, 13.9 in Wales, and 13.0 in England (National Records of Scotland, 2020). Although rates have fallen over recent decades, those living in the most deprived quintile are still five times more likely to die from alcohol-related causes than individuals in the least deprived quintile (National Records of Scotland, 2020). This implies that current policy could be strengthened (Finch et al., 2023).

Understanding how various factors combine to influence people’s wellbeing, especially mental health, can direct policy attention to where it is needed most, including at various individual, family, community and societal levels. As shown by the participants in this study, there is a lack of support services for adult children, especially around the closing down of community services which provided valuable support (Section 8.5) and difficulties in maintaining positive relationships (Section 7.3 and 8.4). Without sources of support or funding into how alcohol parental alcohol use as well as recent changes in alcohol policy have impacted adult children then there is a large number of individuals who are missing support

tailored to their individual need both as a child and into the future. Therefore, this policy should also give more focus to both children and adult children impacted by alcohol.

2. Consideration of appropriate policy measures which have worked in reducing health inequalities in smoking applied to policy surrounding alcohol use.

Taking a public health approach to alcohol and adult children is required, as it allows for universal health measures to tackle inequalities in policy. This is already a focus for the Scottish Government, but has been implemented thoroughly with smoking campaigns (Drug Deaths Taskforce, 2022). Marmot and colleagues (2005) found that improvements in housing, education, and employment would target the underlying social conditions which foster high levels of smoking (Marmot et al., 2005). The same could be said for alcohol use. This approach has been seen in Planet Youth, where they attempt to bring together and empower communities through an evidence based substance use prevention model (Drug Deaths Taskforce, 2022). It enables communities to identify both risk and protective factors for substance use and to develop and implement targeted plans and interventions. While several areas in Scotland have begun adopting this model, Highland is currently the only region receiving funding through its Alcohol and Drug Partnership (ADP) to build capacity within schools. This type of collaborative, public health focused working, identifying impacts outside of individual health choices is required in alcohol use policy. In this thesis, participants noted that alcohol was accepted as a normal part of growing up in their circumstances and accepted as such due to their cultural norms (Chapter 6), despite alcohol use impacting the whole family (Section 6.5). Community services were of great support to adult children (Section 8.5) and having them involved in policy to identify community aspects of alcohol use would be beneficial to improve the lives of adult children.

Research

3. Further research into Minimum Unit Pricing policy.

The Alcohol (Minimum Pricing) (Scotland) Act 2012 implemented in Scotland in 2018 has currently been shown to be improving health by reducing alcohol related hospitalisations and deaths (Wyper et al., 2023; Clay et al., 2025). Minimum Unit Pricing (MUP) in Scotland is

associated with a significant reduction in deaths and hospitalisations wholly attributable to alcohol consumption in the four most socioeconomically deprived deciles in Scotland (Wyper et al., 2023). Three full years after implementation, the impact of MUP reduced sales of alcohol in Scotland by 1.1% which is in contrast to an increase of 2.4% in England and Wales (where MUP is only implemented in Wales and not England) (Giles et al., 2022). In Wales, MUP was connected to an overall drop in alcohol buying, particularly among people under 28 who halved their cider intake (Billan et al., 2025). This is predominantly due to off-sales and not on-sales. Nonetheless, why this reduction in both consumption and alcohol related consumption has occurred is not clear. According to the Public Health Scotland (2023:n.p) evaluation, there is “no consistent evidence of impact, positive or negative, on wider social harm however there is some evidence of negative consequences, particularly for those with alcohol dependence on low incomes”. Measures such as Minimum Unit Pricing (MUP), while designed to reduce overall consumption, can unintentionally intensify pressures within households where a parent is alcohol-dependent and financially vulnerable. For children growing up in these contexts, the strain of increased financial hardship may compound existing instability, insecurity, and neglect. In this thesis, participants did not mention MUP as impacting their current situations or those of their parents. There was little discussion, if any, around the cost of alcohol impacting their lives or changing their behaviours. Participants mentioned consuming alcohol as strongly linked to what was deemed normal practice in the participants’ communities, or to cope with difficult situations. This suggests that MUP, while potentially effective in reducing overall consumption, is unlikely to be sufficient as a stand-alone policy. Its impact must be understood as context dependent, shaped by wider multi-level issues including those found in this thesis household dynamics, structural inequalities, community drinking norms, and the availability of support services, as well as a consideration of how these link to health inequalities (Wilkinson and Pickett, 2010).

4. Further research on the lived experience of adult children’s perspective due to the necessity of listening to ‘hidden voices’.

There is a lack of up-to-date qualitative research on adult children’s experiences. Walsh and colleagues (2020) found that there could be more research undertaken to understand deprivation in Scotland as existing data and measurements are not adequate. This sentiment

is echoed by Walsh and colleague's (2017) previous work and that of Clare Bamba in her book *Health Divides* and one which is strongly emphasised throughout this piece of research (Walsh et al., 2017; Walsh et al., 2020; Bamba, 2016:214). The lack of representation of the 'true nature of deprivation' in Scotland can be resolved by research incorporating the direct views of those who grew up in these circumstances (Bamba, 2016). The multiple levels of experiences described by participants in this study highlight this. Adult children have 'lived experience' of the circumstances and therefore can identify problems for individuals who have experienced deprivation with first-hand knowledge. As shown by the key themes, there were themes or factors which have not been fully explored in the literature.

There is research which incorporates understandings of lived experiences of deprivation but few studies which specifically identify the unique experiences of adult children and their childhoods. This type of research can lead to implementation of policy which changes the emphasis from supplying services to empowering people to take responsibility for their own lives, and believe that they have control over this (Davis, 2016). One report which has incorporated 'hidden voices' of adult children is the Silent Voices project, a review of the direct input that children of parents who drank had in research and policy development (Adamson and Templeton, 2012). Silent Voices used information gathered from research studies and treatment programs to develop over 35 recommendations aimed at guiding policymakers on how best to support this population (Adamson and Templeton, 2012). The findings highlighted that children preferred support that was empathetic and trust-based, provided by caring individuals who could understand and take time to help them over a long term (Adamson and Templeton, 2012). Recommendations from the Silent Voices project include: non-time limited support, assessment of the prevalence of parental alcohol use, focusing on all children affected by parental drinking not just those 'at risk', consideration of not just parents but all children who may be at risk for a range of negative outcomes. Further research on the lived experiences could highlight which of these recommendations would work for adult children.

The risk of negative outcomes also relates to the risk of mental health issues. Children of parents who drink often require mental health support both during childhood and later in adulthood (Kelley et al., 2016). During childhood, timely intervention can help mitigate these

effects and support healthy development (Smith et al., 2017), while in adulthood, many individuals continue to experience difficulties with relationships, self-esteem, and coping strategies linked to earlier experiences (Woititz, 1983). Evidence suggests that without appropriate early and ongoing support, these challenges can persist across the lifespan, highlighting the importance of access to mental health support across different life stages (Kelley et al., 2016).

5. Further research into how we can help individuals develop healthier gender constructions and identities.

Further research is required to understand how individuals can develop healthier and more flexible gender constructions and identities, moving beyond rigid and culturally embedded roles. Emslie and Hunt's (2009) work on masculinities and health highlights the diversity of ways men "do" gender across the life course and how gender identities are shaped by social contexts such as class, work and family roles, rather than being fixed or universal categories. This aligns with broader UK research emphasising the need to view masculinities and femininities as socially constructed identities rather than static traits, with implications for health behaviours (Bottorff et al., 2011). In the Glasgow context, culturally specific personas such as the "Hardman" and "Housewife" reflect locally salient performances of masculinity and femininity that can both constrain and enable individual self-understandings; exploring how such identities are internalised, resisted or reshaped can inform interventions that promote more expansive and psychologically healthy gender identities.

Practice

6. Incorporation of alcohol use into trauma informed training into practice.

Incorporating alcohol use into trauma-informed training requires a structured approach that acknowledges the specific challenges faced by adult children of parents who drink. Training for practitioners across health, social care, and community services should include modules on recognising the long-term impacts of parental alcohol use (Scottish Government, 2024b). Case studies and lived-experience narratives can be integrated to help staff understand the subtle ways in which trauma manifests across the lifecourse. The training should emphasise

trauma-informed communication strategies, practical support pathways, and early identification of at-risk individuals, ensuring that adult children are offered interventions that promote resilience and wellbeing. Furthermore, it is important to highlight the intergenerational nature of alcohol-related harm, equipping practitioners to provide holistic, family-aware care that addresses both past experiences and ongoing challenges.

7. Consideration of the preferred language for people with relationships to drugs and alcohol.

During the drafting of this thesis, I have used different language to describe adult children and their parents drinking. It is difficult to maintain a person-centred approach when discussing other academic's research and government policy as different organisations use different terms which they believe to be less stigmatising (National Collaborative, 2023 (Appleseth et al., 2023; Kelly et al., 2016)). There was a variety of language which could be used to describe adult children, their parents and individuals who drank or used substances and all could be considered to have a lack of specificity or to be stigmatising. Where possible, I have used participant's preferred language. Although each participant may have differing preferred terms, it would be beneficial in academic and government policy and practice to adopt the same terminology throughout to aid in a sense of identity for adult children and a coherent set of policies, as well as decreasing the stigma around being an adult child.

8. Integrated support services which have taken into consideration the important experiences of adult children and can target services towards educating families, frontline staff and policy makers.

Policy in Scotland has acknowledged that multi-agency task forces are required to aid in alcohol related issues (Drug Deaths Taskforce, 2022). Alcohol and Drug Partnership (ADP) services attempt to do this but could do more in identifying specific resources for particular groups, such as adult children (Drug Deaths Taskforce, 2022). There is a need to have pathways tailored to these groups across the lifespan to ensure they can "access the support they need when they need it", as found in this thesis, participants did not have adequate support at multiple levels throughout their lives. Findings from this thesis highlight the importance of developing tailored pathways of support across the lifespan, as participants

sometimes only recognised the difficulties of their childhood once they were older or had left the family home, yet lacked adequate support at multiple stages of their lives. In December 2021, the Scottish government published a report on families affected by alcohol use which aims to develop a consistent high-quality holistic whole family approach in Scotland. There were many positive aspects to this framework which could be embedded in resources to support everyone impacted by a family member drinking (Drug Deaths Taskforce, 2022). As shown in this study, charitable organisations such as Recovery Community Café's are key to aiding adult children. Alcohol and Drug Partnership services can work with these organisations to better align key priorities and help a wider range of individuals. Copello, Velleman and Templeton (2005) review family interventions for adult children (Copello et al., 2005). They list 3 different methods: an intervention which puts forward a way for entry and engagement of individuals with substance use into the treatment system; working with the individual undertaking substance use and family members and responding to the needs of family members on their own. All these areas have been seen to need further work. However, with these interventions it means the primary focus is still on the substance use and not the impact on family members who often are neglected when help is required. In this study, adult child participants noted that there is no joined up support for them. This would align with the Rights, Respect and Recovery report in which Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths is summarised (Scottish Government, 2018b). This report highlights how "individuals, families and communities have the right to health and life free from the harms of alcohol and drugs, with fully supported communities to find their own type of recovery" (Scottish Government 2018b:n.p). This also involves efforts to integrate the work of the Scottish Government, Health Boards, Local Authorities, Police Scotland, the Scottish Prison Service, the Third Sector, and other key organisations, particularly through collaboration with local communities and recovery groups (Scottish Government, 2018b).

10.7 Concluding Statements

This thesis explored the childhood experiences of adult children in Glasgow. Throughout this thesis, I argue for a consideration of adult children, with a specific focus on multiple levels of experiences as structured by using the socioecological model, to understand the experiences in the participants lives. The findings suggest that adult children have a range of positive and

negative experiences growing up with parents who use alcohol, not all of which are considered by current literature, particularly given unique cultural viewpoints in Glasgow. This gap in knowledge has important implications for policy, practice and research. In this thesis, it was found that there is a lack of consideration on the gendered aspect of parental drinking, the cultural acceptance of drinking at both familial and community level, and the sometimes-positive function alcohol plays in adult children's lives in building relationships. Therefore, there needs to be adequate individual, familial and community sources of support.

This thesis has challenged me as a researcher and enabled me to embrace new skills and expand my knowledge of theory. Having been new to the Social Policy discipline, it has allowed me to gain an appreciation of how applied research may shape policy. The difference in social policy between England and Scotland and specific context of Glasgow gave me an appreciation of the city and of the similarities between the devolved nations but that there are also unique factors to consider. It was important to note that the experiences of the participants were varied and really highlighted how people can change their lives around and make a difference. In this study, the socioecological model provides an organisational tool for explaining the experiences of adult children's lives. This is significant for the way theory is applied in adult child studies, with less of a focus on risk and more of the broader impacts of childhood on how adult children view their circumstances. I argue there is a need for policy to focus on the context of the lives of adult children due to the long-lasting impact of parental problem alcohol use and changes throughout adulthood as well as childhood. This in turn can help determine which factors aided them in their lives when analysing the similarities and differences in narratives.

To reiterate Brian, in Section 6.3:

...So, the family illness became the family recovery. You know what I mean, if I get well everybody gets well.

Brian, 63

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Appendices

Appendix 1: Tony A's (1978) The Laundry List – 14 Traits of an Adult Child of an Alcoholic

1. We became isolated and afraid of people and authority figures.
2. We became approval seekers and lost our identity in the process.
3. We are frightened by angry people and any personal criticism.
4. We either become alcoholics, marry them or both, or find another compulsive personality such as a workaholic to fulfill our sick abandonment needs.
5. We live life from the viewpoint of victims and we are attracted by that weakness in our love and friendship relationships.
6. We have an overdeveloped sense of responsibility and it is easier for us to be concerned with others rather than ourselves; this enables us not to look too closely at our own faults, etc.
7. We get guilt feelings when we stand up for ourselves instead of giving in to others.
8. We became addicted to excitement.
9. We confuse love and pity and tend to "love" people we can "pity" and "rescue."
10. We have "stuffed" our feelings from our traumatic childhoods and have lost the ability to feel or express our feelings because it hurts so much (Denial).
11. We judge ourselves harshly and have a very low sense of self-esteem.
12. We are dependent personalities who are terrified of abandonment and will do anything to hold on to a relationship in order not to experience painful abandonment feelings, which we received from living with sick people who were never there emotionally for us.
13. Alcoholism is a family disease; and we became para-alcoholics and took on the characteristics of that disease even though we did not pick up the drink.
14. Para-alcoholics are reactors rather than actors.

Appendix 2: Woititz's (1989) The 13 Characteristics of A.C.O.A.

1. Adult children of alcoholics guess at what normal behavior is.
2. Adult children of alcoholics have difficulty following a project through from beginning to end.
3. Adult children of alcoholics lie when it would be just as easy to tell the truth.
4. Adult children of alcoholics judge themselves without mercy.
5. Adult children of alcoholics have difficulty having fun.
6. Adult children of alcoholics take themselves very seriously
7. Adult children of alcoholics have difficulty with intimate relationships.
8. Adult children of alcoholics overreact to changes over which they have no control.
9. Adult children of alcoholics constantly seek approval and affirmation.
10. Adult children of alcoholics usually feel that they are different from other people.
11. Adult children of alcoholics are super responsible or super irresponsible.
12. Adult children of alcoholics are extremely loyal, even in the face of evidence that the loyalty is undeserved.
13. Adult children of alcoholics are impulsive. They tend to lock themselves into a course of action without giving serious consideration to alternative behaviors or possible consequences. This impulsively leads to confusion, self-loathing and loss of control over their environment. In addition, they spend an excessive amount of energy cleaning up the mess.

Appendix 3: Jones (1981) Children of Alcoholics Screening Test (CAST)

Please check the answer below that best describes your feelings, behavior and experiences related to a parent's alcohol use. Take your time and be as accurate as possible.

- Have you ever thought that one of your parents had a drinking problem?
- Have you ever lost sleep because of a parent's drinking?
- Did you ever encourage one of your parents to quit drinking?
- Did you ever feel alone, scared, nervous, angry or frustrated because a parent was not able to stop drinking?
- Did you ever argue or fight with a parent when he or she was drinking?
- Did you ever threaten to run away from home because of a parent's drinking?
- Has a parent ever yelled at or hit you or other family members when drinking?
- Have you ever heard your parents fight when one of them was drunk?
- Did you ever protect another family member from a parent who was drinking?
- Did you ever feel like hiding or emptying a parent's bottle of liquor?
- Do many of your thoughts revolve around a problem drinking parent or difficulties that arise because of his or her drinking?
- Did you ever wish that a parent would stop drinking?
- Did you ever feel responsible for or guilty about a parent's drinking?
- Did you ever fear that your parents would get divorced due to alcohol use?
- Have you ever withdrawn from and avoided outside activities and friends because of embarrassment and shame over a parent's drinking problem?
- Did you ever feel caught in the middle of an argument or fight between a problem drinking parent and your other parent?
- Did you ever feel that you made a parent drink alcohol?
- Have you ever felt that a problem drinking parent did not really love you?
- Did you ever resent a parent's drinking?

- Have you ever worried about a parent's health because of his or her alcohol use?
- Have you ever been blamed for a parent's drinking?
- Did you ever think your father was an alcoholic?
- Did you ever wish your home could be more like the homes of your friends who did not have a parent with a drinking problem?
- Did a parent ever make promises to you that he or she did not keep because of drinking?
- Did you ever think your mother was an alcoholic?
- Did you ever wish that you could talk to someone who could understand and help the alcohol-related problems in your family?
- Did you ever fight with your brothers and sisters about a parent's drinking?
- Did you ever stay away from home to avoid the drinking parent or your other parent's reaction to the drinking?
- Have you ever felt sick, cried, or had a "knot" in your stomach after worrying about a parent's drinking?
- Did you ever take over any chores and duties at home that were usually done by a parent before he or she developed a drinking problem?

Appendix 4: Gondolf and Ackerman (1993) Adult children of alcoholics (ACOA) Index

Instructions: Please indicate how often you engage in the following behaviors or traits. Put the number that best applies to your situation in the space to the left of each statement: 1 = almost never, 2 = seldom, 3 = sometimes, 4 = frequently, 5 = almost always.

1. I guess at what is normal.
2. I have difficulty following projects through to the end.
3. I lie when it would be just as easy to tell the truth.
4. I judge myself without mercy.
5. I have difficulty with intimate relationships.
6. I manage my time poorly and do not set priorities in a way that works well for me.
7. I look for immediate as opposed to deferred gratification.
8. I see tension and crisis and then complain.
9. I have difficulty having fun.
10. I fear rejection and abandonment, yet I reject others
11. I take myself very seriously.
12. I overreact to changes over which I have no control.
13. I am either super responsible or irresponsible.
14. I think carefully about all my actions.
15. I constantly seek approval and affirmation.
16. I am extremely loyal even in the face of evidence that the loyalty is undeserved.
17. I fear failure, but down grade my successes.
18. I lock myself into a course of action without serious consideration to alternate choices or consequences.
19. I feel different from other people.
20. I avoid conflict or aggravate it, but rarely deal with it.
21. I fear judgement and criticism, yet I criticize others.

Dimensions: perceived isolation (1, 5, 19), self-condemnation (4, 9, 11), fear of failure (10, 17, 21), approval needs (3, 15, 16), control needs (12, 13, 14), rigidity (8, 18, 20), inconsistency (2, 6, 7).

Appendix 5: Hawkins and Hawkins (1995) Adult children of alcoholics Tool (ACAT)

1. I tend to not talk about the real problems in relationships with people I care about.^a
2. I try to take a lot of responsibility for people and things.^a
3. When there is a problem in my family we can talk about it. (reverse scored)
4. The idea of loss of control is intolerable to me.
5. It is hard to share problems with people I love.
6. It is easy to trust members of my family. (reverse scored)
7. It is difficult for me to set aside responsibilities for awhile and enjoy play.
8. When I have a problem with someone I care about I am reluctant to discuss it for fear of “rocking the boat.”
9. I find it easier to avoid situations where I have to take control in my family or personal relationships.
10. Consistency and predictability are usually the rule in my family.
11. I usually look out for others’ needs before my own.
12. People who know me might call me a compulsive giver.^a
13. There is very little predictability in my family.
14. I have always felt comfortable bringing my friends home to meet my family. (reverse scored)
15. Ever since I was young I have learned to be tough and not to cry.
16. If I can just ignore a problem it will not hurt so bad and I can handle it easier later.
17. There is something about me that seems to attract needy individuals or people with any kind of problem.^a
18. I want to trust others, but it is so much easier to just rely on myself.
19. I have trouble following a project from beginning to end.
20. I tend to overreact to changes over which I have no control.

21. It doesn't matter much to me whether others approve of my actions or not. (reverse scored)
22. When I start a new project I usually have no difficulty finishing it. (reverse scored)
23. Deep down I have usually felt that I am quite different from other people.^a
24. I have difficulty forming intimate relationships with others.
25. I have a strong need for others approval and affirmation of my actions.
26. It is hard for me to decide when to get close to people and when to back off from them.
27. Telling the truth about problems is encouraged in my family. (reverse scored)
28. Sometimes I find it hard to draw a line between my feelings and the feelings of people who are close to me.
29. I have a tough time being honest about my feelings toward others.
30. There are times when I think that anyone who could love me is stupid or worthless.
31. I tend to keep a cool head during a crisis, while others are getting upset.^a
32. My judgements of others are not nearly so harsh as my judgements of myself.^a

NOTE: The directions are: "The following questions refer to your family of origin, the family with which you spent the most time when you were growing up. Indicate how strongly you agree, or disagree, with each statement by choosing the appropriate letter. Fill in the blank preceding each statement with the letter A, B, C, D, or E, depending on your choice: A = Strongly agree; B = Somewhat Agree; C = Neutral; D = Somewhat Disagree; E = Strongly Disagree." Item scoring weights are as follows, corrected for reverse scored items: A= 3, B = 2, C = 1, D = 0, E = 0. ACAT total score = Sum of items 3, 4, 5, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 18, 19, 20, 21, 22, 24, 25, 26, 27, 28, 29, and 30. A. Indicates item deleted from 25-item scale.

Appendix 6: Felitti et al., (1998) ACEs Questionnaire

Prior to your 18th birthday.

1. Did a parent or other adult in the household...

- Often or very often swear at, insult or put you down?
- Often or very often act in a way that made you afraid that you might be physically hurt?

No ___ If Yes, enter 1 ___

2. Did a parent or other adult in the household...

- Often or very often push, grab, slap, or throw something at you?
- Often or very often ever hit you so hard that you had marks or were injured?

No ___ If Yes, enter 1 ___

3. Did an adult or person at least 5 years older than you ever...

- Touch or fondle you or have you touch their body in a sexual way?
- Attempt oral, anal, or vaginal intercourse with you?
- Actually have oral, anal, or vaginal intercourse with you?

No ___ If Yes, enter 1 ___

4. Did you live with...

- Anyone who was a problem drinker or alcoholic?
- Anyone who used street drugs?

No ___ If Yes, enter 1 ___

5. Was a household member...

- Depressed or mentally ill?
- Attempt suicide?

No ___ If Yes, enter 1 ___

6. Was your mother or stepmother:

- Sometimes, often or very often pushed, grabbed, slapped, or had something thrown at her?
- Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard?
- Ever repeatedly hit over at least a few minutes?
- Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?

No ___ If Yes, enter 1 ___

7. Did a household member go to prison?

No ___ If Yes, enter 1 ___

8. Did you often or very often feel that ...

- No one in your family loved you or thought you were important or special?
- Your family didn't look out for each other, feel close to each other, or support each other?

No ___ If Yes, enter 1 ___

9. Did you often or very often feel that ...

- You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
- Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?

No ___ If Yes, enter 1 ___

10. Were your parents ever separated or divorced?

No ___ If Yes, enter 1 ___

Now add up your "Yes" answers: _____ This is your ACE Score

Appendix 7: Velleman and Templeton (2016) Protective Factors Table

BOX 2 Protective factors and resilience in children affected by parental substance use, as revealed in the literature

<p>Individual factors</p> <ul style="list-style-type: none"> - Internal locus of control – a sense that they can make a difference to their circumstances and have the power to change their situation - ‘Active agency’ in adopting coping strategies, seeking support and choosing what to share about their circumstances and with whom^a - Personal qualities and social skills (e.g. expression of feelings, knowledge, life choices, self-reflection, easy individual temperament/disposition, emotional regulation, self-efficacy) - Having a hobby or a creative talent or engagement in outside activities or interests (e.g. sport, singing, dancing, writing, drama, painting) – anything that can provide an experience of success and/or approbation from others for the child’s efforts - Self-monitoring skills and self-control - Coping and problem-solving skills – ability to think about and make decisions about coping - Plans for the future/yearning for a better future - Intellectual capacity - A sense of humour - Sense of self-strength relative to substance-dependent parent. Resisting over-identification with, and maintaining psychological separation from, parental problem - Perceptions of ‘substance use’ behaviour. Good knowledge and understanding of the parental problem(s) - Not taking drugs or drinking - Achieving a balance between supporting the parent(s) and looking after themselves - Religion or faith in God <p>Family factors</p> <p><i>General</i></p> <ul style="list-style-type: none"> - Supporting and trusting relationship with a stable (non-substance misusing) adult (e.g. uncles, aunts, grandparents) - Close positive bond with at least one adult in a caring role (e.g. parents, older siblings, grandparents) 	<ul style="list-style-type: none"> - Adequate finances and employment opportunities/income; good physical home environment - Constructive coping styles and deliberate parental actions to minimise adversity for children - Knowledge of protective factors - Strong family norms and morality - Characteristics and positive care style of parents (a balance between ‘care’ (parental support, warmth, nurturance, attachment, acceptance, cohesion, and love) and ‘control’ (supervision, monitoring, clarity about family rules and boundaries, parental discipline, punishment)) - Parental modelling of the behaviours expected of or wished for from their children - Absence of domestic violence/abuse, family breakdown and associated losses <p><i>Specific to parental substance problems</i></p> <ul style="list-style-type: none"> - Parental problems are of mild intensity and shorter duration - One parent does not have problems - Parent is receiving treatment - Drug paraphernalia, activity and associates are kept away from children - Substance use occurs away from the home <p>Community/environmental factors</p> <ul style="list-style-type: none"> - Cultural connectedness, values and identity - Support from an adult/adult role model (e.g. teacher, neighbour) - Strong friendships and relationships with peers, including those who a young person can talk to about the problems at home - Living in a community where there is a sense of caring, mutual protection - Community engagement and supportive social networks; strong bonds with local community/community involvement - Positive school experiences and influences; opportunities through education and employment – out-of-school/community activities - Attendance at school, achievement, monitoring of progress and acknowledgement of success - Teachers’ expectations and discipline
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<ul style="list-style-type: none"> - Early and compensatory experiences and a good relationship with primary carer(s) in first years of life; low levels of separation from the primary carer in the first year of life - Demonstration of affection from members of extended family - Parental self-efficacy and good parental self-esteem - Family observing traditions and rituals (cultural, religious, familial) - Consistency and stability in everyday family life (e.g. social life, rituals, roles, routines); families spending time together - Parents having high expectations of the child, and clear and open communication of both expectations (about alcohol use/non-use and also generally) and potential disapproval if expectations are not met - Openness and good communication within the family, including open and appropriate discussion of family problems - Child having family responsibilities - Small family size, larger age gaps between siblings 	<ul style="list-style-type: none"> - Positive opportunities at times of life transition - Support from key community services such as healthcare <p><i>Evidence of resilience that these protective factors encourage</i></p> <ul style="list-style-type: none"> - Deliberate planning by the child that their adult life will be different - 'Active agency': see Individual factors - High self-esteem and confidence - Good self-efficacy - A sense of direction or mission - Skills (both verbal and cognitive) and values that lead to good use of personal abilities to achieve - A range of problem-solving skills - An ability to deal with change - Feeling that there are choices - Feeling in control of own life - Previous experience of success and achievement - Feeling safe and secure, loved and cared for - An ability to play <p>a. 'Active agency' is both a protective factor in itself and also evidence of resilience</p>
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Appendix 8: Adamson and Templeton (2012) Protective Factors and Resilience Table

Individual	Family	Community/Environment	Evidence of Resilience
<ul style="list-style-type: none"> - A sense that one's own efforts can make a difference; a belief in self-help - Personal or 'inherent' qualities (e.g. expression of feelings, knowledge, life choices, and emotional intelligence) - Temperament and intelligence - A child's own coping skills—ability to think about and make decisions about coping and an internal locus of control - A child's view of themselves - A sense of self-strength relative to the substance-dependent parent - Plans for the future/yearning for a better future - Early and compensatory experiences and a good relationship with the primary carer in the first years of life - Positive opportunities at times of life transition - Perceptions of 'substance abuse' behavior - Aversion to parents' dependence - Not taking drugs or drinking - Behaving well and balance between supporting the parent(s) and looking after themselves 	<ul style="list-style-type: none"> - Open acknowledgement of the alcohol (or drug problem) - Small family size, larger age gaps between siblings - A supporting and trusting relationship with another (non-substance-using) adult in the family or extended family (aunts/uncles, grandparents) - Parental self-esteem - Consistency with everyday family life, such as family size, rituals, and roles - Families spending time together - Adequate finances and employment opportunities - Constructive coping styles and deliberate parental actions to minimize adversity for children - Receiving treatment (parents) - Openness and good communication - A knowledge of 'protective' factors - Low levels of family conflict, absence of domestic violence/abuse and cohesive parental relationships - Parenting style—clarity about family rules that are appropriately and consistently enforced - A wish to protect siblings from substance dependence 	<ul style="list-style-type: none"> Cultural connectedness, values, and identity - Support from an adult, such as a teacher or neighbor - Strong friendships, including with those who a YP can talk to about their problems - Community engagement and supportive social networks - Positive school experiences with influences, opportunities through education, and employment 	<ul style="list-style-type: none"> - Deliberate planning by the child that their adult life will be different - High self-esteem and confidence - Good self-efficacy - Skills and values that lead to good use of personal ability - A good range of problem-solving skills and the ability to deal with change - Feeling that there are choices - Feeling in control over own life - Previous experiences of success and achievement
<p>(Bernays et al., 2011; Cleaver et al., 2011; Ronel and Levy-Cahana, 2011; Sawyer, 2009; Moe, Johnson and Wade, 2007; Velleman and Templeton, 2007 and 2006; Bancroft et al., 2004; Tunnard, 2002; Velleman and Orford, 1999; Alcohol Concern, 1997; Werner, 1986)</p>			



RESEARCH PARTICIPANTS NEEDED

**Adult children of problem
drinkers in
Glasgow 1980s-2000s**



**Would you be willing to discuss what your
life was like growing up in Glasgow in the
1980s-2000s?**

**CONTACT PENELOPE LAYCOCK:
EMAIL—PENELOPE.LAYCOCK@STRATH.AC.UK
TELE—07780784763**

**ARE YOU:
AGED 30-55
FROM GLASGOW
HAVE
EXPERIENCE OF
LIVING WITH A
PARENT WHO
HAD A PROBLEM
WITH ALCOHOL**

Version 1.2

Appendix 10: Descriptive Characteristics

Pseudonym	Gender	Age ¹²	PSU? ¹³	Childhood housing	Parental Occupation	PPAU ¹⁴	Siblings	Abuse	Peers	Education level	Employment Status	Current housing	Current Family	Mental Health
Bonnie	F	49	N	G1 Council House, bought (Tenement)	Father: Driver/Car Mechanic Mother: Housewife	Father	Younger Sister	Father violent to objects	still friends with a lot of girls went to school with	Degree or higher	Administrator	G12 Owned	Married, 3 children	Attempted suicide
Rowena	F	53	N	G53 Council Housing (Tenement, flat roof)	Father: brewery trade/engineer Mother: odd jobs for 'pin money'	Father	Younger Brother, Older Brother, older Sister	Father physical violence to Mother	bullied	Degree or higher	Administration Manager	G53 Owned	Single parent, 1 child	2 Brothers with mental health issues. Her and Sister do not have issues
Gina	F	50	N	G14 Owned (Tenement)	Father: Swimming Attendant	Father	Only child	Father "happy drunk"	Bullied but played in street	Degree or higher	Administration	G15 6 Owned	Married, 2 children	Not mentioned

¹² At the time of recruitment

¹³ PSU = Problem Substance Use

¹⁴ PPAU = Parent with Problem Alcohol Use

Pseudonym	Gender	Age ¹²	PSU? ¹³	Childhood housing	Parental Occupation	PPAU ¹⁴	Siblings	Abuse	Peers	Education level	Employment Status	Current housing	Current Family	Mental Health
					Mother: Nurse				with neighbours					
Malcolm	M	39	N	G31, G34, G32 Rented/link ed to Fathers job (House, Garden)	Father: Janitor Mother: Housewife	Father Mother Step-Mother	Younger Sister	Father psychological violence, one instance of physical violence	Lots of friends played football with	Degree or higher	Data analyst/Student	G3 Rent	Single, 1 child	Mother and grandad committed suicide. Sister with mental health issues
Polly	F	48	N	G69 Owned (Detached 4 bed House)	Father: Owned a business Mother: Housewife	Father Mother later on in life	3 years younger Sister, 6 years younger Brother	Father physically violent towards children and Mother	Not many friends	College	Student	G72 Council	Divorced, 2 sons	Self harm. Her and siblings have mental health issues. Her Mother attempted suicide multiple times

Pseudonym	Gender	Age ¹²	PSU? ¹³	Childhood housing	Parental Occupation	PPAU ¹⁴	Siblings	Abuse	Peers	Education level	Employment Status	Current housing	Current Family	Mental Health
Sophie	F	49	N	G2, G74, G51 (Nan Council (multistorey))	Mother: Cleaner Father: Caretaker	Father Step-Father	2 years younger Brother, 7 years younger Brother	Father physically violent towards children and Mother. Attempted sexual assault by grandparent	I didn't really make many friends in school	Degree or Higher	Student/Social worker	G1 Rent	Single, unable to have children	Mental health issues
Miriam (Indian)	F	39	N	G3/G11 Owned (Terraced House)	Father: 'odd jobs' e.g. Amusement Attendant Mother: Biomedical Scientist	Father	Only child	Father "Loud and aggressive but never hit me" emotional abuse and neglect	I did have friends occasionally	Degree or Higher	Researcher	G51 Owned	Unknown, Adoptive parent	Motivated to get out of bed for others
Joanna (S. Asian)	F	40	N	G20 Owned (House)	Father: Worked on Building sites Mother: Sewed Cagoules for a penny	Father	3 Older Siblings (11, 12 and 14 years older)	Not mentioned	Had friends in school, wasn't allowed them outside	Degree or higher	Researcher	G3 Owned	Single, no children	Not mentioned
Tasha	F	34	N	G14 Council	Father: Telephone engineer	Father Mother	Only child	Parents "never really	Had friends she wasn't	Degree or Higher	Researcher	G3 Rent	Living with partner,	Would have killed

Pseudonym	Gender	Age ¹²	PSU? ¹³	Childhood housing	Parental Occupation	PPAU ¹⁴	Siblings	Abuse	Peers	Education level	Employment Status	Current housing	Current Family	Mental Health
				(Flat, multi-storey)	then redundant Mother: Housewife			argued...supportive and happy."	very close to				no children	herself without partner
Daniel	M	53	N	G53 Council (House)	Mother: Shop attendant Father: Engineer	Father	Two older Brothers, one younger	Father "would just take me and just dump me in certain places where he went in"	had a small group of kinda weirdo friends	Degree or Higher	Mental Health Nurse	G44 Owned	Married, 1 child (just born)	Fear of death
Justin	M	37	N	G5, G42 Social housing (flat)	Father: Skilled Baker who lost job Mother: Factory line worker/made redundant	Father	Only child	Not mentioned	A few friends	Degree or higher	Teaching co-ordinator	G64 Owned	Married, 3 children	Not mentioned
Basil	M	53	Y	G45 (3 clean locations + 27 years Nan), G53, G42 Council (High rise flat)	Mother: Unemployed Mother's Partners: Unemployed	Mother , Mother's partner	1 younger brother , 3 Older half siblings	Mother verbally abusive, Mother's partners physically abusive	Had some friends, never invited them home	Degree or higher	Recovery worker	G31 Owned	Married, 1 child	Not mentioned

Pseudonym	Gender	Age ¹²	PSU? ¹³	Childhood housing	Parental Occupation	PPAU ¹⁴	Siblings	Abuse	Peers	Education level	Employment Status	Current housing	Current Family	Mental Health
Byron (In Kinship Care)	M	33	Y currently using	G82 Owned (House)	Both Parents unemployed Grandparents Retired	Mother Father	Only child	Not mentioned	Friends who got involved with drugs	Highers	Unemployed	G13 Supported Housing	Single, 3 children	Depression, anxiety, drug induced psychosis
Hazel	F	31	Y 9 months clean	G82 Unknown (House)	Mother: Cleaner 1 st Step Father: base in Helensburgh, 2 nd Step Father: Welder	Father Mother's partner	2 older half-brothers, 2 older half-sisters	Father violent towards other siblings and Mother	Bullied a lot	None	Unemployed	G13 Supported Housing	Single, 2 children (in care)	Attempted suicide
Brian (In Care)	M	63	Y 12 years clean	G23 Council	Father: Worked on shipyards Step Mother: Unemployed	Father Step-mother	3 years older Sister, 4 years older Brother	Father and Step-Mother physically and verbally abusive (at home) and sexual abuse (while in care)	bullied	College	Addiction Worker	G12 Rent	Divorced, 3 children	Wanted to die, neglected own health
Lucas	M	45	Y currently using	G33 Council (flat)	Father: Worked in Playschemes	Father Mother	Younger Brother, 2	Parents violent towards each other	got bullied quite a lot	None	Unemployed	G34 Council	Single, no children	Attempted suicide

Pseudonym	Gender	Age ¹²	PSU? ¹³	Childhood housing	Parental Occupation	PPAU ¹⁴	Siblings	Abuse	Peers	Education level	Employment Status	Current housing	Current Family	Mental Health
					Mother: Housewife		Older Brothers, Older Sister							
Matt	M	48	Y 7 years sober	G33 Council (flat?)	Father: Motor Mechanic Mother: Housewife	Father	4 Sisters, 1 Step Sister,3 Brothers, 1 Step Brother	Father violent towards children and Mother	No friends, ill for a lot of childhood	Further Education in Recovery	Student	G34 Council	Single, children	Would have killed himself without help
Patrick	M	50	Y currently using	G31, G33 Council (flat?)	Mother: Worked in Bars Father: showman then unemployed	Father Mother	2 Sisters, 2 Step Brothers	Parents violent towards each other	Friends who took drugs	None	Unemployed	G33 Council	Single, 2 children (estranged)	Not mentioned
Joe	M	47	Y 6 years sober	G34, G33 Council (flat?)	Both Parents Unemployed	Step- Father Mother	One half Brother , 2 Step- Brothers,	Not mentioned	Friends who drunk and took drugs	None	Volunteer	G34 Council	Single, no children	Neglecting own health

Pseudonym	Gender	Age ¹²	PSU? ¹³	Childhood housing	Parental Occupation	PPAU ¹⁴	Siblings	Abuse	Peers	Education level	Employment Status	Current housing	Current Family	Mental Health
							Younger Sister							
Alfie	M	46	Y 2 years clean	G34 Council (tenement flat)	Father: in Navy Mother: Housewife	Father	Younger Brother	Father physically violent towards children and Mother	No real friends, was in a gang and the 'fire in'	Highers	Labourer	G21 Unknown: rent or council	Single, 1 child (estranged)	Attempted suicide

Appendix 11: Interview Schedule

Introduction

- (Establish Rapport) [shake hands] My name is Penelope. I'm a postgraduate study at the University of Strathclyde, we met at _____/ you contacted me via _____.
- (Purpose) I would like to ask you some questions about your life during the 1980s-2000s. Specifically what it was like growing up in this time, what you felt helped you and how that's influenced where you are now.
- (Motivation) I hope to use this information to help determine what life was like for individuals during that time frame and what can help them.
- (Time Line) The interview should take about an hour or however long you feel comfortable talking to me. Are you available to respond to some questions at this time?
- (Consent form)

Opening Question:

- What was your life like growing up in Glasgow?

Additional questions (if not mentioned organically):

- What were your housing conditions like?
- Who did you live with?
- Did you move at all?
- What was the area like?
- What were your parents'/guardian's occupations?
- Did they get any qualifications for that?
- Did that have any influence on your career choices?
- What was your education like?

- Would you think of yourself as being poor?

Prompt:

- Can you expand on last topic mentioned?
- Do you remember anything else about this?
- What happened after that?

Closing

- (Maintain Rapport) I appreciate the time you took for this interview. Is there anything else you think would be helpful for me to know so that I can successfully introduce you to our class?
- (Action to be taken) I should have all the information I need. Would it be alright to arrange a follow-up interview I have any more questions?

Thanks again

Appendix 12: Length of time of Interviews

Participant name	Length of Interview
Bonnie	44:25
Rowena	46:21
Gina	42:11
Malcolm	36:13
Polly	31:47
Sophie	1:36:26
Miriam	42:51
Basil	25:06
Byron	12:08
Hazel	15:52
Joanna	17:34
Tasha	31:01
Daniel	39:31
Brian	2:52:07
Justin	24:15
Lucas	15:03
Matt	12:29
Patrick	08:46
Joe	14:00
Alfie	28:24

Appendix 13: Initial codes and themes

Initial codes organised

Theme	Codes
'good' vs 'bad' childhood	Well fed Clothes Holidays Money
Employment	Parents didn't work Poor health Good job
Housing	Damp/mould Area Gangs Fields Places to play Purchased house Tenements
	Worked hard to own flat Just purchased flat Wanted to move away from area Homeless Giving back to the area I damaged
Siblings	Lucky siblings have problems with mental health but I don't Looked after siblings Looked after cousins, kept me going

Violence	Stabbed brother Uncle found my gun In prison Drug running Gang leader Lots of violence/gangs Older brothers protected Neighbours heard Common Try to stop Run away Old enough to take Da out Wolverine Kept on going back to him 'happy' He didn't hit me but things
Education	Got to work to get where want to be person wanted to be Study to help others Kept off of school Didn't go to school Illness prevented studying
Work	Better job Better for children Wanted income Not where I want to be Had a plan Skip work to take drugs Knee damaged so stopped work
Children/family	Wanted better for children Tell my children dangers of drink

	<p>Grandparents as examples</p> <p>Want to quit drugs to get children back</p> <p>Having children changed</p> <p>Not even having children changed</p> <p>Partner saved me</p>
Suicide	<p>Couldn't go on</p> <p>Wouldn't be here without partner</p> <p>Needed to change</p> <p>Family members mental health</p> <p>Recovery</p> <p>Counselling</p> <p>Parental suicide</p>
Masculinity	<p>Wee sook</p> <p>Worried he'll be a p***y</p> <p>Crying out for mummy</p> <p>Trapped little boy</p> <p>Hard man</p>
Type of drinking	<p>Didn't matter what he drank</p> <p>Alcohol at dockyards</p> <p>Spirits worse</p> <p>Home drinking vs. pub drinking</p> <p>'happy' drunk</p> <p>'bad' drunk</p> <p>Day drinking</p> <p>After work</p> <p>Waiting outside pub</p>
Gender Constructs	<p>My brothers had problems with mental health</p> <p>Brothers had problems with drink</p> <p>Alcohol related brain damage</p> <p>Sisters/nieces try to stop me drinking</p>

	<p>Sorry for people whose Mothers drank</p> <p>Lucky Mum didn't drink</p> <p>Mum didn't drink until later</p>
Recovery	<p>Al-anon – didn't help</p> <p>Counselling</p> <p>AA</p> <p>Follow the steps</p> <p>Wanted to change</p> <p>Didn't want to change but want community</p> <p>Want children back</p>
Religion	<p>Higher power</p> <p>Community</p>
Escapism	<p>Dancing</p> <p>Comics</p> <p>Education</p> <p>School place to hide</p> <p>Alcohol</p>
Community	<p>All touched wae additction</p> <p>Community halls/clubs</p> <p>Everyone same – violence/drinking/income</p>
Peers	<p>Education</p> <p>Bullying</p> <p>'bunking off'</p> <p>Not liked</p> <p>Played football with friends</p>

Initial Themes

'good' vs 'bad' childhood

Housing

Employment

Parents

Siblings
Violence
Type of drinking
Community
Escapism
Peers
Education
Work
Children/family
Suicide
Masculinity
Gender Constructs
Recovery
Religion

Discarded themes

Type of drinking
Violence
Religion
'good' vs 'bad' childhood

Amended themes

Domestic violence was combined with violence
Community separated and expanded
Parents separated into problem drinker and employment
Masculinity was apparent throughout all other themes/cultural context, added to information on Gender constructs

Reviewed/defined themes

Gender Constructs
Violence
Peers

Support systems

Reanalysed/combined themes

Normalising dysfunction

Disappearing

Surviving

Appendix 14: Participant Information Sheet

Version 1.2
19 June 2019



Participant Information Sheet for Study on Adult Children of Problem Drinkers in Glasgow 1980s-2000s

Before you decide whether or not to take part, it is important for you to understand what this will involve. Please take time to read the following information carefully. Feel free to ask any questions about it. This investigation is being carried out by a doctoral student – Penelope Laycock, at the University of Strathclyde. Contact details can be found at the bottom of the sheet.

What is the purpose of this research?

This study is to understand people's experiences of growing up with parents who had problems with alcohol in the 1980s-2000s in Glasgow. It is hoped that researching this subject will help understand what the positive and negative experiences were. There is currently a lot of evidence on the health impacts of familial drinking but little on the lived experience. It would be helpful to determine whether there is a cultural issue with alcohol in Glasgow and what precisely this is.

Do you have to take part?

No. It is entirely up to you to decide whether or not to take part. You can withdraw from the study at any time, without giving a reason. You can also withdraw all or any part of the information you have shared any time up until the final report has been completed.

You can request a copy of the questions that will be asked or interview schedule at any time and do not need to have agreed to take part in the study to do so.

What will you do in the project?

If you are interested in taking part, you will have an interview with the researcher. This conversation can be as long as you like and will cover your life during the 1980s-2000s. The interview will take place in a location in which you feel comfortable – usually at either the organisation through which you were approached or a room at the University of Strathclyde. The interview is very broad and unstructured so you can reveal as much as you wish to about your life. The conversation will be recorded and transcribed but no information which can identify you will be included, and recordings will be deleted after transcription.

Further interviews may be requested to follow-up on certain information. These further interviews are entirely voluntary and will follow the same format as your initial interview.

Why have you been invited to take part?

You have been invited to take part as you have disclosed that you were a child of a parent who had problems with alcohol in the 1980s-2000s and lived in Glasgow.

What are the potential risks to you in taking part?

We believe that this study is safe and do not expect you to suffer any harm or injury because of taking part. Psychological distress may be possible. If you do become upset while taking part or experience any psychological distress, the researcher will stop the interview. If you wish to continue, time will be given for you to recover. If you wish to leave, you are free to do so and information on relevant services you may wish to contact will be given. These are found at the end of the participant information sheet. If imminent harm to yourself or others is revealed the interview will be terminated and relevant services will be contacted by either yourself or the interviewer.



Who will have access to the information?

All information that is given during this study will be kept confidential and safe by the study researcher. Every effort will be taken to anonymise information so people will not be able to identify you. Direct quotes from the interview will be likely to be published in the final report.

If you decide to take part in the study, you will be given an alias or participant ID which will be used instead of your name. All of the information from the study will be transcribed using a participant ID/alias and any other names revealed will also be changed. This means your name, or any other personal details will not be seen by others once the research is complete. Once you have completed participation in the study, your data will be archived and not passed on. Only if you reveal that you are an imminent serious danger to yourself or others will this confidentiality be broken.

What will the information be used for?

Information you reveal during the interview will be used for research purposes including; presentations, academic conferences, scientific publications, and the researchers PhD thesis. Direct quotes from the interview will be likely to be published in the final report. However, as previously mentioned every effort will be made to make sure you are not identifiable from this.

Where will the information be stored and how long will it be kept for?

Your contact details will be retained (with your permission) if you want to be updated about the study process. For this your contact details will be stored in a secure password protected file on the university network storage facility. Any physical files, including consent forms, will be stored in a lockable cupboard on University of Strathclyde premises which is only accessible to the researcher. The details will be kept until the study is published and then destroyed.

The recordings of the interviews will be deleted once the research project is completed. The transcribed recordings will be stored in a university network storage facility. You cannot be identified from this data. All data will be destroyed after 5 years using the Universities secure and confidential waste disposal service.

Please also read our [Privacy Notice for Research Participants](#)

What happens next?

If you are interested in taking part in the study, please contact the researcher who provided you with this information sheet. A convenient time and place to conduct the interview will then be agreed upon. You will then be asked to re-read the information sheet and sign a consent form. The interview will then proceed and be recorded. This interview can last as long as you wish to talk. You do not have to participate, and you can leave at any time without giving a reason.

Researcher contact details:

Name: Penelope Laycock
Address: 141 Saint James Road School of Social Work and Social Policy, Lord Hope Building, University of Strathclyde
Phone: 07379766796
E-mail: penelope.laycock@strath.ac.uk

Chief Investigator details:

Name: Professor Ian Greener
Address: 141 Saint James Road, School of Social Work and Social Policy, Lord Hope Building, University of Strathclyde
Phone number: 0141 444 8754
Email: ian.greener@strath.ac.uk

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This research was granted ethical approval by the University of Strathclyde Ethics Committee.

If you have any questions/concerns, during or after the research, or wish to contact an independent person to whom any questions may be directed or further information may be sought from, please contact:

Secretary to the University Ethics Committee
Research & Knowledge Exchange Services
University of Strathclyde
Graham Hills Building
50 George Street
Glasgow
G1 1QE
Telephone: 0141 548 3707
Email: ethics@strath.ac.uk

Information on support services if required:

Scottish families affected by alcohol or drugs:

SFAD provides support to family members and friends who have been affected by the substance use of a relative or loved one. They help raise awareness of issues affecting them as well as providing information, help and support through a wide variety of resources.

<https://www.sfad.org.uk/>

Telephone: 08080 101011

E-mail: helpline@sfad.org.uk

Al-anon family groups:

Al-Anon Family Groups provide support to anyone whose life is, or has been, affected by someone else's drinking, regardless of whether that person is still drinking or not. There are various meetings in the Glasgow area.

<https://www.al-anonuk.org.uk/>

Telephone: 0800 0086 811

Glasgow Council on Alcohol:

A voluntary organisation working with individuals families and communities to promote health and well-being. They offer maybe help and support services for both individuals wishing to abstain and family members.

<https://www.glasgowcouncilonalcohol.org/>

Address: 14 North Claremont Street, Glasgow, G3 7LE

Telephone: 0808 8029000

Appendix 15: Consent form

Version 1.2
19 June 2019



Consent Form for Study on Adult-Children of Problem Drinkers in Glasgow 1980s-2000s

Please read the statements below and sign if you consent to them:

- I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.
- I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long).
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences.
- I understand that I can request the withdrawal from the study of some personal information and that whenever possible researchers will comply with my request. This includes the following personal data:
 - audio recordings of interviews that identify me;
- I understand that anonymised data (i.e. data that do not identify me personally) cannot be withdrawn once they have been included in the study.
- I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
- I understand that confidentiality may be breached if it is revealed you are at risk of 'serious imminent harm' to yourself or others.
- I consent to being audio recorded as part of the project.
- I consent to my anonymised data being used for research purposes including: academic conferences, scientific journal publications and be used for researcher's PhD thesis
- I consent to being a participant in the project.

Optional Consent:

- Do you wish to have a summary of the findings once the study is completed: Yes/No
- Do you consent to having your details retained for a summary of the findings? Yes/No
- Do you consent to having your details retained for any potential follow-up study? Yes/No

(PRINT NAME)	
Signature of Participant:	Date:

Appendix 16: UNICEF (2024) Socioecological Model: Risk and Protective Factors Table

<i>Risk factor: Any attribute, characteristic or exposure that increases the risk of developing an adverse mental health outcome Protective factor: Any attribute, characteristic or exposure that that reduce risk factors, or independently act to increase positive outcomes</i>		
Level	Risk Factors	Protective Factors
Individual	Genetic or familial predisposition Gender, age Childhood neglect Discrimination due to minority status (e.g. gender identity/ sexual orientation, belonging to a minority group, etc.) Ethnicity Disability or chronic health condition Socioeconomic status Exposure to trauma (witnessing or experiencing), including involvement in armed groups. Post-conflict/ emergency/crisis/natural disasters/ displacement/ insecurity/ or other hardships (i.e. hunger, housing) including household-level. Experience of physical or sexual abuse	Self-esteem Coping styles Civic engagement Individual agency/ locus of control Religious beliefs and practices Access to livelihoods (including household level) Supportive and inclusive learning pathways (schools, training centers, etc.) Access to care and support services
Family and Peer	Loss of caregiver/family member A history of mental health conditions, including depression, suicide and self-harm within the family Alcohol and substance use within household Intimate partner violence (witnessing or experiencing)	Parental support and parental monitoring Secure attachment Positive family functioning Nurturing care including responsive caregiving Mother's education Quality of home environment Caregiver positive mental health

	<p>Household-level economic stress</p> <p>Caregiver poor mental health</p> <p>Caregiver trauma exposure</p> <p>Abuse and neglect within family</p> <p>Stigma and discrimination</p>	<p>Peer social support</p> <p>Participation and engagement</p>
School Level	<p>Destruction of schools/ lack of access to inclusive educational opportunities</p> <p>Violence experienced at school – by peers or teachers</p> <p>Lack of connectedness and a sense of belonging to schools – including through teasing, discrimination, stigma experienced at school.</p> <p>Lack of capacity of teachers</p> <p>Lack of accessible physical environment and education materials</p>	<p>School retention/ level of schooling achieved</p> <p>Teacher social support</p> <p>Counselling/peer to peer support</p> <p>Social cohesion programs</p> <p>Mental and physical health promotion in school settings and in educational plan/ curricula</p>
Community Level	<p>Disruption of social networks</p> <p>Changes in gender or religious dynamics</p> <p>Cultural norms/ concepts, i.e. hiding distress, etc.</p> <p>Community-level violence</p> <p>Stigma and discrimination /</p> <p>Prevailing perceptions of mental health/illness and acceptable coping strategies within communities</p>	<p>Cultural norms/ practices/ concepts, i.e. adherence to ideology and connection to land</p> <p>Community acceptance</p> <p>Trust</p> <p>Community cohesion</p>
Macro Level	<p>Housing/ settlement options – i.e. temporary vs. permanent</p> <p>Ongoing conflict</p> <p>Displacement status, i.e. refugees, IDPs</p> <p>Limited access to services in deprived communities and humanitarian contexts</p>	<p>Supportive policies and legal frameworks</p> <p>Trust in national system and government</p> <p>Children and adolescent specific mental health policies</p> <p>On the move support (migrants)</p>

	Modes of delivery of humanitarian aid	Disability inclusive services and assistance in all contexts
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