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Adolescent Children of Alcoholics: Vulnerable or Resilient?

MaryLou Mylant, RN, CS, PhD, Bette Ide, RN, PhD, Elizabeth Cuevas, RN, MSN, and
Maurita Meehan, RN, MSN

BACKGROUND: *Children of alcoholics (COAs) have been described as both vulnerable and resilient. Although identified as at-risk for mental and physical health problems, chemical dependency, and child abuse and neglect, many go on to lead successful lives.*

OBJECTIVE: *The relationship between COA status and various adolescent risk behaviors, such as drug and alcohol abuse and sexual precocity, was assessed by addressing the following research question: Could parental alcoholism be a risk factor for teens engaging in problem behaviors?*

STUDY DESIGN: *A secondary analysis of a Wyoming high-risk youth data set was conducted (N = 1632). Werner's (1992) core resiliency factors provided the conceptual frame for the study.*

RESULTS: *Adolescent COAs scored significantly ($p < .000$) lower on all psychosocial factors of family/personal strengths and school bonding and significantly higher on all factors of at-risk temperament, feelings, thoughts, and behaviors than non-COAs.*

CONCLUSIONS: *Adolescent COAs are at risk for depression, suicide, eating disorders, chemical dependency, and teen pregnancy. It has been proposed that mental health professionals teach core resiliency factors to promote healthy behaviors for this vulnerable population. (J Am Psychiatr Nurses Assoc [2002]. 8, 57-64.)*

Adolescents are taking more risks with their health, their lives, and their future than ever before" (Danish, 1997, p. 291). Violent deaths account for 77% of all deaths for persons 15 to 24 years of age; unintentional injuries accounting for 42% and suicide for 13% of this number (National Center for Health Statistics, 1993). DiClemente, Hansen, and Ponton (1996) believe that the current trend of youth starting to use alcohol, tobacco, and other drugs

at earlier ages is an indication that adolescent risk behavior may worsen in the near future.

Although current knowledge about risk factors does not provide an exact formula for prevention, it does reveal potential targets for preventive intervention (Hawkins, Catalano, & Miller, 1992). Jessor (1991) believed the aim of research regarding adolescent risk behavior should be on the psychosocial antecedents and determinants, that is, "What are the risk factors for the risk factors?" (p. 600).

One of the single best risk factors or predictors that a child may "become chemically dependent is having family members who are chemically dependent or who have manifested a vulnerability to chemical dependency" (Kumpfer, 1990, p. 310). Children of addicted parents are the highest risk group of children to become alcohol and drug abusers because of both genetic and family environment factors (Kumpfer, 1999).

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Children of addicted parents are the highest risk group of children to become alcohol and drug abusers because of both genetic and family environment factors.

Children of alcoholics (COAs) have been found to be more vulnerable to mental health disorders and general

and specific health problems (Woodside, Coughy, & Cohen, 1993). A comparative study of children hospitalized for psychiatric disorders identified that more than 50% were children of addicted parents (Rivinus, Levoy, Matzko, & Seifer, 1992). COAs have also been identified with more than one and a half times the rate of injuries and poisonings and were 65% more likely to become physically ill than children whose parents were not alcoholic (Woodside et al., 1993).

BACKGROUND

Researchers have shown that although every child of an alcoholic seems to be touched by his or her experience in some negative way, not all experience the same degree of mental, emotional, and physical problems (Werner, 1992; Werner & Smith, 1977, 1982). In fact, many go on to lead successful lives.

Werner and Johnson (2000) pointed out that many COA studies have involved participants from clinical populations. To address this, Werner and Smith (1977, 1982, 1992) conducted a longitudinal study of children from various dysfunctional families in a community context. There were impoverished families, families of divorce, and children exposed to prenatal stress and parental mental health disorders, one of which was parental alcoholism. The COA subsample was monitored from birth through early and middle childhood and to late adolescence and young adulthood. They found that about one third of the high-risk children grew into competent adults who worked well, loved well, played well, and expected well.

Five protective factors of these seemingly invulnerable children were identified. These factors included having temperament characteristics that elicited positive responses from others, having an efficient use of abilities, being parented in a way that fostered competence and self-esteem, having supportive adults who fostered trust and acted as gatekeepers, and having an opening of opportunities at major life transitions. The temperament of these high-risk individuals also allowed them to reinforce and reward their own competencies. It was competence and the self-esteem and self-efficacy of these persons versus parental competence and support that directly influenced their adult adaptation (Werner, 1992).

Thus, this study addressed the following research question: Could parental alcoholism be a risk factor for those adolescents engaging in problem behaviors? The relationship between an adolescent's self-reported COA status and various adolescent risk behaviors, such as drug and alcohol abuse and sexual precocity, was assessed.

METHODS

Design

This research is a secondary analysis of a Wyoming high-risk youth study, which was conducted under the

auspices of the State of Wyoming and the University of Wyoming graduate nursing program. At the time, the state of Wyoming ranked second in the nation in teenage pregnancies. The state's Teenage Pregnancy Task Force combined efforts with the state's Youth 2000 campaign to address not only adolescent pregnancy but also other high-risk behaviors. Six counties that had higher rates of teen pregnancy and violent deaths to children and adolescents than the rest of the state were targeted to be surveyed.

At the time, the state of Wyoming ranked second in the nation in teenage pregnancies.

Measurement

The Wyoming Youth 2000 Survey was used (Barker, 1988), which consisted of 135 items. The survey includes demographics and items addressing psychosocial and family situations, high-risk attitudes, and behaviors, with responses as either a closed-ended (no/yes) or Likert-like format (i.e., *strongly disagree* [1] to *strongly agree* [4]). Twenty-eight items and three scales, the Cohesion and Adaptability subscales of the Family Adaptability and Cohesion Scale III (FACES) (Olson, 1986) and Rosenberg Self-Esteem Scale, (Rosenberg & Rosenberg, 1978) measured the teens' psychosocial and family situation. A high numeric score indicates high cohesion, adaptability, on self-esteem.

The FACES III, developed by Olson (1986), is a 20-item self report scale measuring two major dimensions of the family system, adaptability, and cohesion. A Likert-type scale is used, with 1 to 5 responses ranging from *almost never* (1) to *almost always* (5), respectively. Family adaptability is defined as the amount of change rather than ability to change, and family cohesion is the emotional bonding that family members have toward one another (Olson, 1993, 1994). The 10-item Rosenberg Global Self-Esteem Scale (Rosenberg & Rosenberg, 1978) is also scored on a Likert-like format from *strongly agree* to *strongly disagree*. A high score indicates high self-esteem.

With permission of the state's Department of Health and Medical Services, two additional questions that assessed COA status and sexual abuse were added by the primary author to the original high-risk survey. For purposes of this secondary analysis, COAs were delineated by one item, "Have you ever considered either of your parents as having an alcohol or drug abuse problem?" and answered "yes" or "no." This question has been found to be highly reliable and valid as an identifier of COAs (DiCicco, Davis, & Orenstein, 1984). The teens were also asked whether they had "ever been sexually abused by someone," and answered "yes" or "no."

Demographics included gender, ethnicity, grade point average, and education of youth and parents. Other items measured participation in activities, attitudes toward school, perceived help with problems, perceptions of parents' levels of anger and stress, feelings of negative emotionality (i.e., depression, hopelessness, and suicidal ideation), having been sexually abused, and importance of religion. High-risk attitudes and behaviors were measured by 50 items; the areas covered were substance abuse, disordered eating, driving, physical acting out, and sexual behaviors.

Procedures

Passive consent for both parents and adolescents was approved by the University of Wyoming Institutional Review Board. To protect the anonymity of the adolescent respondents, computerized answer sheets were used for the data collection. Cuevas (1991) and Meehan (1992) distributed the revised survey in classrooms in an urban, high-risk county and a rural, low-risk county, respectively. The urban county had a teenage pregnancy rate (66 births per 1000 females) that was higher than the state and national rates (Imfeld cited by Cuevas, 1991). The rural low-risk county, however, was ranked 13th out of 23 state counties in terms of incidence of adolescent high-risk behaviors. For the purposes of this secondary analysis, the surveys from both counties were combined ($N = 1632$).

ANALYSIS

Factor analysis was initially used to help simplify this large data set of 135 variables describing various family situations, including demographics, and high-risk behaviors, attitudes, and negative feelings. It was assumed that factor analysis might help identify any underlying, not-directly-observable constructs related to adolescent high-risk behavior and feelings.

The items that asked about the psychosocial situation of each student were selected from those items that asked about any high-risk behaviors, attitudes, or feelings. The underlying structure of each portion of the survey was then assessed using principal axis factor analysis. A .40 criterion was used to select important loadings. A rotated factor matrix was then used to interpret the main conceptual dimensions of the psychosocial and high-risk items. Additionally, multiple analysis of variance (MANOVA) and analysis of variance (ANOVA) were computed to examine the effect of COA status on each of the psychosocial and high-risk factors.

FINDINGS

Sample

The urban high-risk sample consisted of seventh through twelfth graders who had been randomly se-

lected. This sample of students ($n = 1016$) represented 16.5% of the population of the county. Seventy-eight percent of the participants were White, 11% Hispanic, 3% American Indian, 3.5% African American, and 4.5% identified their cultural descent as "other."

The rural low-risk participants were teens from public, private, and residential schools in the county. A 100% sampling was done of students attending the small private and residential schools in this county and a 10% random sampling was taken from three large public schools in the county, grades 7 to 12. Of the total rural low-risk participants ($n = 616$), 90% were White, 3.2% Hispanic, 2.8% African American, 6% American Indian, and 3.4% identified as "other."

The rural low-risk participants were teens from public, private, and residential schools in the county.

Twenty-two percent ($n = 352$) of the combined sample identified themselves as a child of an alcoholic. This is consistent with current estimates of children of parental period alcoholics, which is calculated to be 22% (Eigen & Rowden, 2000). Rodney and Mupier (1997), in a recent study among 595 African American boys age 13 to 17 years, identified that 23% of the participating teens were COAs. The National Association of Children of Alcoholics (NACOA, n.d.) estimates that there are 11 million COAs under 18 years of age.

Psychosocial

Two 4-factor models were sufficient to help explain the adolescents' psychosocial situations and high-risk behaviors, attitudes, and feelings measured in this study. Four psychosocial factors explained a total of 27.5% of the variance in the items describing the teens' family situations and demographics. The first psychosocial factor, with a standardized item alpha of .896, explained 10% of this portion of the variance and included many of the items from the Cohesion subscale of the FACES III (Olson, 1986). The items that loaded heaviest (.409 to .765) on this factor described family members who felt close to one another and spent time together; used each member of the family, which included the children, for support and problem-solving; and displayed positive feelings toward each other and their friends. These items described a family to whom a teen may turn for help with a serious problem or worry, such as teenage pregnancy, AIDS, stress, depression, anger, violence, drugs and alcohol, or an eating disorder.

The second psychosocial factor, with a standardized item alpha of .869, explained another 8.3% of the variance and included all of the items of the Rosenberg

Self-Esteem Scale (Rosenberg & Rosenberg, 1978). These items assessed the teens' feelings of pride, respect, attitude, worth, and satisfaction with self. The factor loading for each of the items of the 10-item scale ranged from .559 to .765.

The third factor with a standardized item alpha of .673 involved only six items and explained 5.5% of the variance among the psychosocial items. Each of the six items had a factor loading between .415 and .514. These items described education and school bonding and included grade point average, a self-evaluation of reading and writing skills, participation in school activities, whether the teen liked school and thought education was important, and the amount of school they expected to finish.

The last and fourth factor explained another 3.7% of the variance among the psychosocial items and included only four items of the Adaptability subscale of the FACES III (Olson, 1986). The standardized item alpha for this factor was .640. The factor loading for each of the items ranged from .513 to .541. The items included children making decisions and having a part in discipline of the family, and whether family members were able to change their way in handling tasks.

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High-risk Behaviors, Attitudes, and Feelings

Four factors explained a total of 29% of the variance among items describing high-risk behaviors, attitudes, and feelings. The first factor, with a standardized item alpha of .839, explained 10% of the high-risk variance. This factor included items describing characteristics of negative temperament or negative activity, sociability, and excitability. Items that described negative activity and sociability included taking physical risks, having trouble with using seat belts, trying to injure someone, and becoming involved in fights. An item that described negative excitability asked whether risky things made them feel excited. Other items, which loaded heavily (.425 to .646) on this first high-risk factor, included questions assessing high-risk thought processes. For example, these questions asked about expectations for getting in trouble with the police or at school and getting hurt. Follow-up questions then asked whether getting in trouble with the police, getting hurt, or getting pregnant would prevent the teens' negative actions.

The second high-risk factor included nine items that asked about "negative self-directed feelings, thoughts, and behaviors." High-risk factor two had a standard-

Table 1. Means and Standard Deviations for Psychosocial Factors by COA Status

Factor	M	SD	n
Family cohesion			
COAs	39.930	11.882	345
Non-COAs	46.000	10.816	1191
Self-esteem			
COAs	28.362	6.024	345
Non-COAs	29.764	5.985	1191
Education and school bonding			
COAs	20.377	4.167	345
Non-COAs	21.623	3.717	1191
Family adaptability			
COAs	9.348	3.376	345
Non-COAs	9.946	3.371	1191

Note. COA = Children of alcoholics.

ized item alpha of .811 and explained 9% of the variance among the high-risk items. Negative thoughts, feelings, and behaviors, which included depression, hopelessness, running away, and suicide, loaded heaviest on this factor, with factor loadings ranging from .633 to .720. The remaining five items had factor loadings ranging from .425 to .577 and included questions about disordered eating behaviors and thoughts and feelings of stress and anger.

The third high-risk factor included four items about "alcohol and drug use" and two items that asked about riding with a drunk driver and their friends' alcohol use. This factor had a standardized item alpha of .84 and explained 7% of the variance among the high-risk items. The factor loadings for these items ranged from .423 to .687.

The fourth high-risk factor included only two items about "sexual behavior." These two items asked whether the teen had ever had sex and whether he or she is currently having sex. The factor loading for each item was from .568 to .628. The standardized item alpha for this factor was .80. Sexual behavior explained 3% of the variance among the high-risk items.

COA Effect

A one-way MANOVA was calculated examining the effect of COA status on each of the psychosocial factors. A significant effect was found (Pillai's Trace = .059, $F(4,1531) = 23.983$, $p < .000$). Follow-up univariate ANOVAs indicated that family cohesion ($F(1,1534) = 80.504$, $p < .000$), self-esteem ($F(1,1534) = 14.630$, $p < .000$), education and school bonding ($F(1,1534) = 28.434$, $p < .000$), and family adaptability ($F(1,1534) = 8.426$, $p < .004$) were significantly lower among those teens who self-identified as a COA. Table 1 presents the group means for family cohesion, self-

Table 2. Means and Standard Deviations for High-Risk Factors by COA Status

Factor	M	SD	n
Negative temperament			
COAs	28.662	8.842	352
Non-COAs	25.062	8.370	1218
Negative self directed feelings & behaviors			
COAs	21.443	7.020	352
Non-COAs	17.369	5.810	1218
Drug & alcohol use			
COAs	13.398	5.248	352
Non-COAs	10.791	4.425	1218
Sexual behavior			
COAs	4.781	2.854	352
Non-COAs	3.635	2.498	1218

Note. COA = Children of alcoholics.

esteem, education and school bonding, and family adaptability by COA status.

A one-way MANOVA was also calculated examining the effect of COA status on each of the high-risk factors. A significant effect was found (Pillai's Trace = .092, $F(4,1565) = 39.613$, $p < .000$). Follow-up univariate ANOVAs indicated that negative temperament ($F(1,1568) = 49.253$, $p < .000$), negative self-directed feelings and behaviors ($F[1,1568] = 121.758$, $p < .000$), drug and alcohol use ($F[1,1568] = 86.887$, $p < .000$), and sexual behavior ($F[1,1568] = 53.867$, $p < .000$) were significantly higher among those teens who self-identified as a COA. Table 2 presents the group means for negative temperament, negative self-directed feelings and behaviors, drug and alcohol use, and sexual behavior by COA status.

Independent t tests comparing the mean scores for negative temperament (activity and excitability) and specific negative self-directed feelings, thoughts, and behaviors found significant differences between the mean scores of the teens who self-identified as COAs and non-COAs. The COAs were significantly more likely than non-COAs to identify with feeling excited when doing risky things ($t(1569) = 3.958$, $p < .000$), taking physical risks ($t(550) = 5.067$, $p < .000$), and feeling depressed and hopeless ($t(1573) = 8.572$, $p < .000$). Participating COAs were also significantly more likely to have had thoughts of suicide ($t(487) = 7.254$, $p < .000$) and suicide attempts in the last year ($t(463) = 5.040$, $p < .000$) than non-COAs. Table 3 presents the group means for negative temperament, feeling depressed and hopeless, thoughts of suicide, and suicide attempts by COA status.

DISCUSSION

The self-identified COAs participating in this study were more at-risk than the teens that did not identify

Table 3. Means and Standard Deviations for Negative Self-Directed Feelings, Thoughts, and Behaviors by COA Status

Feeling, Thought, Behavior	M	SD	n
Depression and hopelessness			
COAs	3.03	1.22	351
Non-COAs	2.42	1.16	1224
Often takes physical risks			
COAs	2.62	1.25	351
Non-COAs	2.24	1.20	1223
Feels excited doing risky things			
COAs	3.14	1.21	350
Non-COAs	2.86	1.18	1221
Thought of suicide last year			
COAs	2.30	1.48	352
Non-COAs	1.67	1.19	1226
Tried suicide last year			
COAs	1.52	1.52	352
Non-COAs	1.22	1.22	1222

Note. COA = Children of alcoholics.

their parents as having a drug or alcohol problem. Those teens that identified their parents as having a drug or alcohol problem scored significantly lower on all the psychosocial factors of family and personal strengths or resiliency and school bonding and significantly higher on all factors of at-risk temperament, feelings, thoughts, and behaviors than non-COAs. This significant number of high-risk thoughts, feelings, and behaviors may reflect a COA's vulnerability towards violence and accidents, depression, suicide, eating disorders, chemical dependency, and teen pregnancy.

Those teens that identified their parents as having a drug or alcohol problem scored significantly lower on all the psychosocial factors of family and personal strengths

Research to date does not show COAs as a group having significant personality disorders; however, previous studies do validate the findings described above. Werner (1986) identified that temperament (activity, excitability, and sociability) differed significantly between offspring of alcoholics who later developed serious coping problems in their teens and those who did not (Werner, 1986). In fact, the personality trait most associated with being a child of an alcoholic is impulsivity or disinhibition, which includes sensation seeking, aggressiveness, and impulsivity (Sher, 1997). Sher and Trull (1994) believe that these same traits are most often associated with the development of alcoholism and may be an important factor in the intergenerational transmission of alcoholism.

The level of depression, hopelessness, and feelings of stress and anger may also explain the high level of at-risk behaviors among the COAs in the present study. In 1986, Fosten-English identified that two out of three children who commit suicide are COAs. A strong relationship between suicidal ideation and behavior, cigarette, alcohol, and substance abuse, as well as aggression among teens has been identified (Garrison, McKeown, Valois, & Vincent, 1993). Depression is a common suicidal antecedent that may lead to smoking and substance abuse as a form of self-medication (Hemenway, Solnick, & Colditz, 1993).

Gravitz and Bowden (1984) stated that COAs who make no connection between their suffering and their parents' alcoholism are most vulnerable in becoming alcoholic themselves or marrying an alcoholic. Perhaps the participants in this study who identified themselves as COAs were unable to detach themselves from their parents' problems.

A sense of autonomy as a protective factor was first identified by Anthony (1974) in his work with children exposed to psychotic stresses. Children described as "invulnerable" were able to view their parents' illness and "distance themselves from too close an involvement with it" (Anthony, 1983, p.70). The term "adaptive distancing" was coined, along with the belief that children's ability to separate themselves from their parents' problems is crucial in preventing the wide admixture of psychopathology that one encounters in the offspring of these parents.

Rubin (1996) more recently described a similar phenomenon of "marginality" as the psychological bedrock on which survivors have been able to transcend even the most difficult past. Marginality taught survivors to comfort themselves rather than look to others who would not be there to give it. In every case of transcendence, Rubin (1996) described children who lived at the periphery of their family life; a sense of marginality made it possible to distance themselves very early in their lives, enabling them to disidentify with their family and grasp alternatives that passed them by.

Werner and Johnson (2000) stated that most of the resilient COAs in their study enjoyed school. Those who showed the greatest resilience put whatever abilities they had to good use, whether they were gifted or not. The COAs in this study, however, were significantly less likely to be involved in education and their school than the teens who did not perceive their parents as having a drug or alcohol problem. Johnston, O'Malley, and Bachman (1986) did identify that students who are less bonded and have a low commitment to school are more likely to use alcohol and drugs. The vulnerability of the COAs in this study may be further heightened by the absence of strong problem-solving skills. In a previous study, Mylant (1990)

identified that confrontive or active problem-oriented methods of coping did not develop among young adult COAs until late young adulthood and only after therapeutic intervention. Substance abuse, feelings of running away, attempting suicide, and fasting or vomiting to lose weight, which were significantly more common among the COAs versus non-COAs participating in this study, reflect more passive versus active problem-oriented solutions.

Those who showed the greatest resilience put whatever abilities they had to good use, whether they were gifted or not.

The seeming lack of core resiliency factors along with the number of high-risk behaviors among the COAs in this study certainly puts these teens in an "at-risk" category. Many COAs, however, never receive any intervention; they are usually only identified when their parent enters alcoholism treatment and most alcoholics never receive treatment (Emshoff & Anyan, 1991). Therefore identification of these children requires active screening using either the Children of Alcoholics Screening Test (CAST) (Jones, 1983; Sheridan, 1995) or adapting the CAGE (Ewing, 1984) questionnaire by asking the following questions (Price & Emshoff, 1997, p.242):

- Do you think your mom/dad needs to **cut down** on their alcohol use?
- Does your mom/dad get **annoyed** at comments from other people about their drinking?
- Does your mom/dad ever feel **guilty** about their drinking?
- Does your mom/dad ever take a drink early in the morning as an **eye-opener**?

According to Anthony (1983), if survival strategies (or core resiliency factors) can be naturally acquired by at-risk children then it may be possible to teach them to less resilient offspring. Bogdaniak and Piercy (1987) described the "sine qua non" of group therapy for adolescent COAs as substance abuse education. Most children lack basic information about alcohol and drugs and the disease concept of alcoholism or chemical dependency. For example, COAs often identify with only the positive effects of alcohol use, (Mann, Chassin, & Sher, 1987), thereby increasing their risk for excessive drinking (Price & Emshoff, 1997). Drug and alcohol information should include discussion of familial and genetic theories and the high risk for a child of an alcoholic to develop a substance abuse problem. Children of alcoholics who are aware of their risk status drink significantly less than COAs who are unaware of their risk status (Kumpfer, 1989).

Coping skills and problem-solving should be another

area of focus when working with COAs. Most programs teach specific emotion-focused and problem-focused coping skills (Nastasi & DeZolt, 1994), which are not mutually exclusive. Children who are able to use both methods of coping are better equipped to manage their lives (Price & Emshoff, 1997).

Adolescents who succeed in coping with emotionally disturbed parents are also able to clearly distinguish between themselves and their parents' illness. These teens conclude that they did not cause their parents' illness (Beardslee & Podorefsky, 1988). It is important for children from chemically dependent homes to also know that they did not cause their parents' chemical dependence. They can not control it, but they can learn to cope with it (Moe & Ways, 1991). One method of coping, which seems crucial for this population, is *adaptive distancing*, healthy detachment from their parents' chemical dependency problem. Detaching yet remaining aware and concerned can become the most important form of self-care for these children.

Adolescents who succeed in coping with emotionally disturbed parents tend to be doers and problem solvers (Beardslee & Podorefsky, 1988). Both children and teens need practical information on how to reach out and identify safe and supportive adults, to know it is okay to ask for help, and that there are people and places to help them (Moe & Ways, 1991). They need support and facts on how to access resources such as Alateen, school nurses, and counselors. School nurses are often the first to identify a child of an alcoholic because of the increased tendency towards physical complaints. The Children of Alcoholics Foundation has developed a workbook for nurses to help these children express their feelings and develop self-esteem (Woodside, 1997).

School nurses are often the first to identify a child of an alcoholic because of the increased tendency towards physical complaints.

After school programs also need to continue to be developed and made available, since so often this population is dealing with absent or poor means of transportation. Children are at schools for long periods of time and in large numbers, making school-based groups the most logical form of intervention effort (Price & Emshoff, 1997).

SUMMARY

This study identified a strong relationship between many high-risk behaviors and whether a teen felt that either or both of his or her parents had an alcohol or

drug abuse problem. It has been proposed that the majority of these teens may also lack core resiliency factors. By identifying these core resiliency factors and teaching them as survival strategies by use of experiential methods, it may be possible to buffer this vulnerable population from many mental, physical, and emotional problems in adolescence and adulthood. Resources, such as Alateen and Alakid, and prevention and intervention programs (Moe & Ways, 1991) have been developed around these core resiliency factors. The responsibility of nurses and mental health providers is to facilitate the use of these programs and provide ongoing support for their maintenance.

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