CHAPTER - II

2. LITERATURE REVIEW

A review of literature refers to activities involved in identifying and searching for information on a topic and developing and understanding the state of knowledge on the topic. An extensive review of literature relevant to the research was done to gain insight and collect maximum information for laying the foundation for the study.

The purpose of review of literature is to obtain comprehensive knowledge and in depth information about Children of alcohol dependent parents. This literature review will help in developing a broad conceptual context into the research problem. This chapter consists of three sections

2.1 SECTION 1: THEORETICAL LITERATURE RELATED TO ALCOHOLISM

Literature related to

2.1.1 PART I : Alcoholism

2.1.2 PATR II: Children of alcohol dependent parents

2.2 SECTION II: Empirical literature related to children of alcohol dependent parents

Studies and literature related to

2.2.1 PATR I: Health Effects of children of alcohol dependent parents

2.2.1.1: Physical Health of children of alcohol dependent parents

2.2.1.2: Psychological health of children of alcohol dependent parents
2.2.2 PART II: Coping strategies adopted among children of alcohol dependent parents

2.2.3 PATR III: Problems of children of alcohol dependent parents

2.2.3.1: Academic problems of children of alcohol dependent parents

2.2.3.2: Family problems of children of alcohol dependent parents

2.2.3.3: Social problems of children of alcohol dependent parents

2.3 SECTION III: Modified Conceptual Frame work based on Roy’s Adaptation model (1964)

2.1 SECTION I: THEORETICAL LITERATURE RELATED TO ALCOHOLISM

2.1.1 PART I: Literature related to Alcoholism

Definition

Alcohol dependence (also known as alcoholism or alcohol dependence syndrome) is defined as a cluster of behavioural, cognitive, and physiological phenomena that develop after repeated alcohol use and that typically include a strong desire to consume alcohol, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to alcohol use than to other activities and obligations, increased tolerance, and sometimes a physiological withdrawal state (WHO, 1992b) [109].

Incidence

The incidence of alcohol dependence is 2 per cent in India. While 20-40% of subjects aged above 15 years are current users of alcohol and nearly 10 per cent of them are regular or excessive users. Nearly 15-30% of patients are developing alcohol – related problems and seeking admission in psychiatric hospitals. [65].
Etiological factors: According to Ahuja [110] the etiological factors are

Biological Factors
i. Genetic vulnerability (e.g. in type II alcoholism)
ii. Co-morbid psychiatric disorder or personality disorder.
iii. Co-morbid medical disorders.
iv. Withdrawal effects and craving

1. Psychological Factors
i. Curiosity; need for novelty seeking
ii. General rebelliousness and social non-conformity
iii. Early Initiation of alcohol and tobacco.
iv. Low self-esteem
v. Concerns regarding personal autonomy
vi. Poor stress management skills
vii. Childhood trauma or loss
viii. Relief from fatigue and/or boredom
ix. Escape from reality
x. Psychological distress

2. Social Factors
i. Peer pressure (often more important than parent factors)
ii. Modelling (imitating behaviour of important others)
iii. Ease of availability of alcohol and drugs
iv. Strictness of drug law enforcement
v. Intra familial conflicts
vi. Religious reasons
vii. Poor social/familial support
viii. Rapid urbanization
Alcohol use disorders: Types:

According to Jellinek [111], there are five ‘species’ of alcohol dependence (‘alcoholism’) on the basis of severity

A. Alpha (α) Alcoholism:
   i) Excessive and inappropriate drinking to relieve physical and / or emotional pain.
   ii) No loss of control.
   iii) Ability to abstain present

B. Beta (β) Alcoholism:
   i. Excessive and inappropriate drinking.
   ii. Physical complications (e.g. cirrhosis, gastric and neuritis) due to cultural drinking patterns and poor nutrition.
   iii. No dependence.

C. Gamma (γ) Alcoholism:
   Also called as malignant alcoholism
   i. Progressive course.
   ii. Physical dependence with tolerance and withdrawal symptoms.
   iii. Psychological dependence, with inability to control drinking.

D. Delta (δ) Alcoholism:
   i. Inability to abstain
   ii. Tolerance
   iii. Withdrawal symptoms.
   iv. The amount of alcohol consumed can be controlled.
   v. Social disruption is minimal
E. **Epsilon (ε) Alcoholism:**

   i. Dipsomania (compulsive drinking)
   
   ii. Spree-drinking

**Medical complications**

A. **Gastro-Intestinal System**

   i. Fatty liver, cirrhosis of liver, hepatitis, liver cell carcinoma, liver failure.
   
   ii. Gastritis, reflux esophagitis, oesophageal varices, Matlory-Weiss syndrome, achlorhydria, peptic ulcer, carcinoma stomach and oesophagus
   
   iii. Malabsorption syndrome, protein-losing enteropathy
   
   iv. Pancreatitis: acute, chronic, & relapsing

B. **Central Nervous system**

   i. Peripheral neuropathy
   
   ii. Delirium tremens
   
   iii. Rum fits
   
   iv. Alcoholic hallucinations
   
   v. Alcoholic jealousy
   
   vi. Alcoholic dementia
   
   vii. Suicide
   
   viii. Cerebellar degeneration
   
   ix. Head injury and fractures

C. **Miscellaneous**

   i. Acne rosacea, palmar erythema, rhinophyma, spider nevi, parotid enlargement, ascitis.
ii. Foetal alcohol syndrome (cranio-facial anomalies, growth retardation, major organ system malformations)

iii. Alcoholic myopathy

iv. Anemia, thrombocytopenia, Vit. K. Factor deficiency, haemolytic anemia

v. Accidental hypothermia

vi. Risk for coronary artery disease

vii. Malnutrition, pellagra

viii. Decreased immune function and proneness to infections, like tuberculosis

ix. Sexual dysfunction

II. SOCIAL COMPLICATIONS

i. Accidents

ii. Marital disharmony

iii. Divorce

iv. Occupational problems, with loss of productive man hours

v. Increased incidence of drug dependence

vi. Criminality, occasionally

vii. Financial difficulties

Management:


a) Treatment of withdrawal:

In the absence of serious medical complications, the alcohol withdrawal syndrome is usually transient and self-limited, the patient recovers within several days regardless of treatment, Insomnia and irritability may persist for longer periods which require minor tranquilizers (diazepam etc).
b) **Treatment of alcoholism:**

The key objective of a treatment program is the recovery of the alcoholic, his physical rehabilitation, his control over the craving for liquor and his abstinence from drinking. The different measures used are:

- **Biological measures:**

  They are applied in a hospital setting. The various drugs are used to control acute withdrawal symptoms (nausea, omitting, tremors, convulsion etc.) and help alleviate the tension and anxiety e.g. Buspirone, Alprazolam, Chlormethiazole etc.

  The other group of drugs used in treatment is to produce aversion for alcoholism. They produce extremely uncomfortable effects when followed by alcohol. The commonly used drugs are disulfiram, Emetine, Apomorphine, Acomprosate (anti craving drug), Naltrexone etc.

- **Psychological measures:**

  The various psychosocial measures in the treatment of alcoholism more often involve group therapy, family therapy to remove family or marital conflicts). Individualized behaviour therapy (to modify the maladaptive behaviour especially during stressful situation, socio-therapy (to remove aversive or stressful life situations e.g. broken homes, delinquency, unemployment etc.) and to help the drinkers achieve more satisfactory adjustments in key areas of their lives such as marriage, work and social relations.

- **Alcoholic Anonymous:**

  (AA) This organization was started in 1935 by Dr Bob and Bill in Akron, Ohio. It operates primarily as a psychotherapeutic program in which both person to person and group relationships are emphasized. To ensure the anonymity of the alcoholic, only first names are used. AA accepts both teenagers and adults with drinking problems, has no dues or fees, does not participate in political causes and is not affiliated with any religious sect, although spiritual development is a key aspect of its treatment approach.
An affiliated movement, Al-Anon Family groups has been established for the relatives of alcoholics. In India, instead of Alcoholics Anonymous or other movements, primary treatment is hospital centred.

- **Treatment of complications**

  Like anxiety, depression (with antidepressant drugs), vitamin deficiency (by giving Thiamine in dose of 100 mg injection for 3 to 5 days), fits (by giving anticonvulsant drugs like diazepam, chlormethiazole etc.), dehydration (by giving electrolytes intravenously), cirrhosis (by giving glucose) etc.

**Outcome:**

The outcome is most likely to be favourable when the drinking problem is discovered early, there is no family history of alcoholism, sociopathic type of drinking, highly motivated individual, good family or peer support, the individual realizes that he needs help with his drinking and adequate treatment. The results are poor if there are antisocial traits, low self-esteem, depression, high neuroticism or cognitive impairment. Most relapses occur within 6 months of discharge from the hospital and they occur less and less frequently after that time period.

2.1.2 **PART II: Literature related to children of alcohol dependent parents**

**Definition**

Children of alcoholics (dependent parents) are defined as any child whose parent uses alcohol in such a way that it causes problems in the child’s life [65].

Adult children of alcohol to be any one who comes from a family either the family of origin or the family of adoption, where alcohol was primary and unwanted issue [113].

**Incidence**

As of 2001, the National Association for children of Alcoholics has reported 76 million Americans about 43% of the US adult Population, have been exposed to alcoholism in the family. Almost 1:5 adult Americans (18%) lived with an alcoholic
while growing up. There is an estimated 26.8 million children of alcoholics in the US. Preliminary research suggests that over 11 million of these children are under the age of 18 [65].

**Adopted Common roles**

Dr Black, [114] a COA herself and national advocate for children's rights, cites four common roles that recur in alcoholic households:

- **Responsible Child:** Some kids assume the role of the parent, by feeding and caring for younger brothers and sisters.

- **Adjuster Child:** Here, kids simply accept whatever behaviour a drinking parent dishes out. Many hide and become quiet and withdrawn.

- **Acting-Out Child:** Some children assume blame for their parent's drinking and deflect attention from family problems by creating problems of their own at home and school.

- **Placated Child:** These kids ignore their own unhappiness to comfort others. Some become family clowns and try to cover problems with jokes.

- **Consequences for Children:** According to Lisa Turney [115], Common problems of COAs can include:

  1. **Behavioural consequences**

     There is a higher prevalence of depression, anxiety, eating disorders and suicide attempts among Children of alcoholics than among their peers. In addition, Children of alcoholics are 3-4 times more likely than others to become addicted to alcohol or other drugs themselves.

  2. **Medical and psychiatric consequences**

     Studies of Children of alcoholics in childhood have documented increased rates of several physical illnesses generally believed to be stress-related, including enteritis, colitis, and asthma
- Eating disorders
- Anxiety and depressive disorders
- Pathological gambling
- Sociopathy

3. **Educational consequences:**

Children from alcohol dependent families are more likely to have learning disabilities; repeat more grades; attend more schools; and are more likely to be truant, delinquent and drop out of school because of pregnancy, expulsion or institutionalization.

4. **Emotional consequences**

Mistrust, shame, Guilt, Confusion, Ambivalence, Fear, Insecurity and confusion about sexuality. A number of behavioural signs can warn of a parental drinking problem, including:

- **Guilt.** The child suspects that he or she somehow caused the parent's drinking.

- **Anxiety.** Fear of arguments or violence can cause constant worry and emotional hyper vigilance.

- **Embarrassment.** The child is ashamed of the family "secret" and withdraws from friends or other family members.

- **Confusion.** A drinking parent's mood swings and unpredictability can cause uncertainty and inner turmoil in the child about what to do next.

- **Inability to Trust.** Repeated disappointments and broken promises by an alcoholic parent can make it hard for a child to trust and develop close bonds with others.

- **Anger.** The child usually resents the drinking parent and may transfer the anger to the non-drinking parent for lack of support and protection.
- **Depression.** Feelings of loneliness and helplessness are common -- and almost inevitable. parents

**Traits of Children of alcoholics**

**Janet Geringer** [116] widely acknowledged as the founder of the Adult Children of Alcoholics movement, lists 13 traits to look for.

These individuals have:

- Can only guess what normal behaviour is
- Have difficulty following a project from beginning to end
- Lie when it would be just as easy to tell the truth
- Judge themselves without mercy
- Have difficulty having fun
- Take themselves very seriously
- Have difficulty with intimate relationships
- Overreact to changes over which they have no control
- Constantly seek approval and affirmation
- Usually feel that they are different from other people
- Are either super responsible or super irresponsible—there's no middle ground
- Are extremely loyal, even in the face of evidence that the loyalty is undeserved
- Are impulsive. They tend to lock themselves into a course of action without giving serious consideration to alternative behaviours 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.
The Healing Process

Probably the most difficult step in the healing process is the first one -- for the child to openly identify the problem and begin to talk about his or her sadness and anger. Out of love or fear, most children try to keep family problems as secret.

Believing that they're the ones with the problem and may even be somehow to blame, children with drinking parents often hide behind a wall of denial and defensiveness.

Some recommend dietary changes (especially low-sugar diets), and such stress-reduction techniques as meditation, aerobics, and visualization or affirmation exercises.

Still, whatever form treatment takes, children of alcoholics need to develop a healthy sense of self-esteem -- free of guilt, fear, and blame -- to see themselves as okay even when those around them may not be. - Charles [117].

Approaches to Healing:

1. **Awakening** by us and the clinicians that there is more to recovery than simply “don’t drink” (or don’t try to control another’s use) and go to meetings.

2. **Discovery and Identification** of our real self (child within) and our spirituality.

3. **Validation** of our experiences of growing up in a dysfunctional family.

4. **Permission** to do healing work or recovery.

5. **Structure** for the specifics of what to do to accomplish the healing process.

6. **Recovery** from our confusion, suffering and lack of purpose meaning and fulfilment in life.
**Early Intervention:**

Prevention program should begin early with these high risk children. By four or five, many have adopted unhealthy coping patterns to deal with the stress of living with an addicted parent. The longer the child depends on these coping patterns the harder they will be to reverse. A commitment to prevention must focus directly upon these children, their parents and other significant adults in their lives. Otherwise the intergenerational cycle of addiction will continue unchecked.

**Goals: The four main goals are**

1. To teach children about addiction and its familial effects.
2. To help them understand and cope with their feelings.
3. To let children know that they are not alone, others shared their problems and there are places where they can find assistance.
4. To guide children towards healthier personal outlooks and coping skills.

**Level of intervention**

1. Education.
2. Expression and the validation of feelings
3. Skill development and reshaping behaviour

**Preventing strategies:**

1. **A focus on the value of work and responsibility** where children have chores, responsibilities and money is earned through neighbourhood jobs (e.g. Babysitting).

2. **Discipline, curfews, rules that set clear**, responsible limits and provide caring supervision, yet avoid harsh and frequent punishments.

3. **Extra-curricular activities** that encourage children to pursue their interests and strengths.
4. **Restricted TV viewing** because too much television viewing increases isolation in families and inhibits communication. Also television can serves as an escape and become a dependency, or addiction in itself and programs often model non-feeling, abusive behaviour (both verbal and physical violence).

5. **Developing good parenting characteristics** like being a good listener who communicates pride in his/her children. Consult children on family decision but don’t let their needs over rule yours; be firm for those issues that require that parent have the final say. Also being affectionate, warm parents who laugh, have family fun and sense of humour.

6. **In addition work toward consistency** with regular bed time, meals, parenting behaviour and clear consistent rules. Also work towards a flexible, caring approach that is not rigid and controlling and reduce isolation through the following measures:

   - Involvement in the community
   - Encouraging children to bring friend home and join after school activities.
   - Increasing interaction with each other (healthy expression of feelings and conflict resolution as well as family function)
   - *Don’t pressure kids to take sides during parental disputes and remember to comfort children when there are problems.

**Most Important:**

It is important to provide a healthy role model for the child. Get help for and take good care of yourself. Model healthy self-expression of parents own feelings and ideas and positive self-esteem. Children identify with and model their own behaviour upon those of the significant adults in their lives. Provide your child with focused attention: (a time even 10 minutes per day) when you attended to your child,
showing an interest in his feelings, experiences and thoughts, share a story or game together [118].

Disruption of the Bonding Process

Goldman, J., & Salus, M. K [119] describes the disruption of the bonding Process:

- Have a limited ability to feel remorse or empathy
- Demonstrate a lack of confidence or social skills
- Demonstrate impaired social cognition

Children often have misperceptions about their role in parents’ problems. One approach to helping children deal with issues associated with a parent’s AUD is to talk through lessons, such as the three Cs:

- You did not cause it (the parent’s AUD).
- You cannot control it.
- You cannot cure it (which addresses the issue of the child taking on the role of the parent in the parent-child relationship).

Similarly, caseworkers can discuss a number of other important issues with children whose parents have an AUD, including:

- Addiction is a disease
- The child is not the reason that the parent has an AUD.
- There are many children in situations like theirs.
- They can talk about the problem.
2.2 Empirical literature related to health effects of children of alcohol dependent parents

2.2.1 PART I Studies related to Health Effects of children of alcohol dependent parents

2.2.1.1 Studies related to Physical Health Effects of children of alcohol dependent parents

Tomasz et al [120] in their study assessed the impact of parents’ alcohol addiction on growth and prevalence of underweight and overweight in their children. 80 children of alcohol addicted parents (ChAAP) aged from 7 to 14 years were compared with reference group (RG) of 1000 children selected in terms of age and place of residence. Differences in z scores for height and Body Mass Index (BMI), prevalence of underweight and overweight were assessed. Families of ChAAP were characterized by: lower parents’ education, higher unemployment rate, a greater number of children than in RG. The differences between ChAAP and RG in z scores for height (z scores: −0.54 vs. 0.45, t = −7.01, p < 0.001) and BMI (z scores: −0.61 vs. 0.29, t = −6.28, p < 0.001) remained significant when impact of the parents’ employment (for height: F = 8.88, p = 0.003; for BMI: F = 21.90, p < 0.001) and the number of children (for height: F = 30.89, p < 0.001; for BMI: F = 21.89, p < 0.001) were controlled. Children raised in families with alcohol addicted parents were shorter and had lower BMI than children of the reference group. Underweight was more frequent in that group, and overweight and obesity were rare. The observed differences seem to result from other factors than bad living conditions, e.g.: chronic post-natal stress, or adverse events during foetal development.

Rao et al [121] in their study on nutritional neglect and physical abuse in children of alcohol dependent parents has been compared with children of non-alcohol dependent parents in a General Hospital. 72 children of alcohol dependent parents were pared with 81 normal controls. 86.1% in case group and 49.4% in control group had malnourishment of various grades. 45% of the children of alcohol dependent parents had physical injuries in contrast to 23.4% of children of non-alcohol dependent parents. Malnutrition coexisted in almost all injured children of
alcohol dependent parents. The investigators concluded that alcoholism in parents of malnourished and injured children was frequently ignored in routine clinical evaluation and suggested that if the risk children are identified early some of the morbidity can be avoided.

Karen G. [122] has done a systematic review of 39 articles on children of alcohol dependent parents and their inherent vulnerability. Parental drinking problem can directly effect on their children. For this reason, children of alcohol dependent parents (COAs) tend to show negative outcomes while they are growing up, such as depression, anxiety, suicidal ideation, substance abuse or interpersonal difficulties. However, there are several factors that effect on COAs that minimize or maximize the impact of adverse experiences related to their parental drinking problem, and it is important to understand those factors to prevent or minimize the negative outcomes in COAs. Thus, this study examined both risk and protective factors of COAs, which affect their adverse outcomes. This study identified risk, protective, and biological factors in COAs, and categorized into four levels: individual, parental, familial and social. Each level contains specific factors that positively or negatively affect the development in COAs. In addition, biological differences between COAs and non-COAs and between resilient COAs and vulnerable COAs were discussed. Findings from this study should be applied to COAs and adult COAs through evidence-based interventions in order to help them in terms of preventing or minimizing the negative outcomes they might experience in their lives.

Serec M et al [123] in their study examined potential differences between children of alcohol dependent parents (COAs) and controls aged between 12 and 18 years in their health-related lifestyle, mental and, physical health. 57 COAs (72% response rate) and 84 controls (88% response rate) completed a postal questionnaire about their health-related lifestyle, and mental and physical health. Bi-variate analysis showed that COAs families have higher unemployment rates and lower economic status (P = 0.000). COAs reported poorer school performance (P = 0.000), spending more time in sedentary and less time in physical activities, having poorer eating habits, a higher substance use and more mental health difficulties (emotional symptoms: P = 0.015, conduct problems: P = 0.012, suicidal tendencies: P = 0.007,
mental disorder: P = 0.040). Among COAs, girls reported more emotional and somatic symptoms compared to boys (P = 0.020 and P = 0.047, respectively). Multivariate analysis showed that after controlling for socioeconomic status, significant mental health and health-related lifestyle inequalities between COAs and controls persist. The finding suggests that COAs have a less healthy lifestyle and more mental health difficulties above and beyond the poorer economic environment they live in.

Cleveland G. B. et al [124] in their study examined the association between adolescent health, including physical complaints, mood, and social adjustment, and perceived severity of parental substance abuse. Baseline data from a study of school-based support groups for adolescents with substance-abusing family members (n = 121) were used to examine the relationship between the severity of substance abuse and adolescent health. Participants were divided into three groups on the basis of severity of parental substance abuse. The high-severity group had significantly more medical conditions, physical symptoms, and negative moods than those in the low-or moderate-severity groups (p <.02).

A recent systematic review by Girling et al [125] of international research studies on the impact of heavy parental alcohol use on children’s physical and psychological health in a range of areas including foetal alcohol syndrome and ingestion during pregnancy; eating disorders, specifically in female children; sexual behaviour of adolescence and earlier pregnancies; hospital admissions for mental disorders, injuries and poisoning; and children’s own misuse of substances might be helpful in informing future European work in this area. As apparent in the research evidence, parental alcohol problems can have an impact, together with many other problems, on children at all stages of development and in all aspects of their lives. Therefore, it has been concluded by the authors, to understand the complexities of children and adult’s lives require a range of academic disciplines to further investigate the impacts and consequences on children in the UK.

Overall aim of the study conducted by Babita et al [126] was to see parent-child relationship in children of alcoholic and non-alcoholic parents. The sample consisted of 30 alcoholic and 30 non-alcoholic parents and their children taken from
Kanke Block of Ranchi district. Socio-demographic data sheet and Parent Child Relationship Scale were administered to the children. In a child’s perception of father in various domains of parent-child relationship, significant difference at P < 0.01 was found in the domain of symbolic punishment, rejecting, objective punishment, demanding, in different, symbolic reward in loving and neglecting, and in child’s perception of the mother. Significant difference at P < 0.01 was found in the domain of symbolic punishment, rejecting, objective punishment, indifferent and in neglecting. The result showed that the children of alcoholic parents tended to have more symbolic punishment, rejecting, objective punishment, demanding, indifferent, symbolic reward loving and in neglecting than children of non-alcoholic parents.

**Stirling J et al [127]** have identified in their study that children who have suffered early abuse or neglect may later present with significant behaviour problems including emotional instability, depression, and a tendency to be aggressive or violent with others. Troublesome behaviours may persist long after the abusive or neglectful environment has changed or the child has been in foster care placement. Neurobiological research has shown that early abuse results in an altered physiological response to stressful stimuli, a response that deleteriously affects the child's subsequent socialization. Paediatricians can assist caregivers by helping them recognize the abused or neglected child's altered responses, formulate more effective coping strategies, and mobilize available community resources.

A study by the **Priory Clinic group in 2006[128]** found that children who grow up with alcoholic parents bear emotional, behavioural and mental scars and their early lives were characterised by chaos, trauma, confusion and shame and, quite often, sexual and physical abuse. Studies have also shown that a third of daughters of alcohol dependent parents experienced physical abuse and a fifth sexual abuse – up to four times higher than in non-alcoholic homes. The report said that children reacted in one of three ways: they became withdrawn, went into denial or used the experience to benefit themselves by becoming stronger. They also struggled to develop strong personal relationships. The report added: "Their feelings about themselves are the opposite of the serene image they present – they generally feel insecure, inadequate, dull, unsuccessful, vulnerable and anxious."
Walsh, MacMillan and Jamieson [129] examined the relationship between reported exposure to child abuse and a history of parental substance abuse (alcohol and drugs) in a community sample of 8,472 adults. The association of self-reported retrospective childhood physical and sexual abuse and parental histories of drug or alcohol abuse was examined. Results revealed that rates of physical and sexual abuse were significantly higher, with a more than twofold increased risk among those reporting parental substance abuse histories. The rates were not significantly different between type or severity of abuse. Successively increasing rates of abuse were found for those respondents who reported that their fathers, mothers or both parents had substance abuse problems; this risk was significantly elevated for both parents compared to father only with substance abuse problem. The study was concluded that parental substance abuse is associated with a more than twofold increase in the risk of exposure to both childhood physical and sexual abuse. While the mechanism for this association remains unclear, agencies involved in child protection or in treatment of parents with substance abuse problems.

Kroll and Taylor [130] summarise several qualitative studies in this area, observing that children often reported violence, rather than substance misuse, as the greatest problem they faced, with parental alcohol misuse in particular tending to cause aggressive behaviour. They conclude that, while the interaction between violence and alcohol misuse is not necessarily straightforward, there are indications that ‘violence is a significant variable in the degree to which other adult behaviours impact upon children – in other words, it may not be the drug or alcohol misuse per se that does the damage but the violence that accompanies it’.

Shanta and Dube [131] has done a detailed examination of the association between parental alcohol abuse (mother only, father only, or both parents) and multiple forms of childhood abuse, neglect, and other household dysfunction, known as adverse childhood experiences (ACEs) among 8629 adults to retrospectively assess the relationship of growing up with parental alcohol abuse to 10 ACEs and multiple ACEs (ACE score). Results concluded that compared to persons who grew up with no parental alcohol abuse, the adjusted odds ratio for each category of ACE was approximately 2 to 13 times higher if either the mother, father, or both parents
abused alcohol (p<0.05). For example, the likelihood of having a battered mother was increased 13-fold for men who grew up with both parents who abused alcohol (OR, 12.7; 95% CI: 8.4–19.1). For almost every ACE, those who grew up with both an alcohol-abusing mother and father had the highest likelihood of ACEs. The mean number of ACEs for persons with no parental alcohol abuse, father only, mother only, or both parents was 1.4, 2.6, 3.2, and 3.8, respectively (p .001). It was concluded that although the retrospective reporting of these experiences cannot establish a causal association with certainty, exposure to parental alcohol abuse is highly associated with experiencing adverse childhood experiences.

Chaffin, Kelleher and Hollenberg [132] conducted a prospective study to investigate risk factors for physical abuse and neglect in a community sample of 7,103 parents from the National Institute for Mental Health’s Epidemiologic Catchment Area survey who self-reported physical abuse or neglect of their children only at Wave II. In addition, several psychiatric disorders, including substance abuse disorders and depression were examined. Risk models were developed using hierarchical logistic regression. At the second point of data collection, 63 parents reported physical abuse having occurred while 84 reported neglect. Physical abuse and neglect were found to have distinct sets of risk factors, with minimal overlap between the groups. Substance abuse disorders were strongly associated with the onset of both abuse and neglect (relative risks = 2.90 and 3.24 respectively). Depression was found to be a strong risk factor for physical abuse (relative risk = 3.45). It was concluded that substance abuse disorders were the most common and powerful factor associated with physical abuse and neglect, increasing the risk of maltreatment three-fold when other factors in the analysis were controlled.

2.2.2.1 Studies related to psychological health of children of alcohol dependent parents

2.2.2.2 Studies related to Stress among children of Alcohol Dependent Parents.

Ohannessian C.M [133] in his study examined whether adolescent-parent communication moderates the relationships between parental problem drinking and adolescent psychological problems. Surveys were administered to a community
sample of 1,001 adolescents in the spring of 2007. Results indicate that parental problem drinking was associated with adolescent alcohol use, whereas maternal problem drinking was associated with adolescent depression. These results highlight the need to consider both the gender of the adolescent and the gender of the parent when examining the adolescent-parent relationship.

Ana et al [134] rigorously assessed the long term impacts of parental problem drinking on adult children’s mental and self-perceived overall health. The detailed information about personal and family characteristics, including alcohol and other substance use, for a cohort of individuals who were between the ages of 14 and 22 when first surveyed in 1979 were collected. The survey was re-administered each year through 1994 and on a biennial basis since then. The dataset provides information on parental drinking and identifies problematic drinking behaviours both among mothers and fathers. Beginning with the 1998 survey, an extensive health module was administered to respondents over 40 are of age to provide a baseline health profile of the respondents before retirement. It includes a set of measures that assess the mental, physical, and behavioural health of the respondents when they reached the age of 40. The results indicate that parental problem drinking is associated with significant mental health consequences for children that persist far into adulthood. Adult respondents with a problem drinking father were more likely to have been diagnosed with mental health problems relative to other respondents, while those with a problem-drinking mother had poorer self-perceived health and mental health (SF-12) scores. Respondents with a problem drinking mother were also more likely to have ever been diagnosed with a mental health problem. Outcomes were worse for daughters of problem drinkers than for sons.

Reddy et al [96] conducted a study with the aim to access the experiences of adolescents affected by parental alcohol abuse. The qualitative research method was followed and the semi structured interview technique was used to gather data from seven adolescent learners who were affected by this phenomenon. The participants were adolescents between 13 and 16 and who were from Grades 7 to 11. The literature study focussed on adolescence as a stage of vulnerability, and explored the impact of parental alcohol abuse on the family as well as on the self-development of
the adolescent. The empirical research confirmed the findings of the literature study that growing up in an environment of parental alcohol abuse does indeed have a negative effect on the adolescent’s total development. It was found that the adolescent’s relationships with the self as well as with others in their life-world were impacted upon, thus affecting the formation of a stable identity. Several recommendations are offered to assist the adolescent as well as his family members to manage their lifestyles constructively.

**Marshall et al [135]** examined stressful life events as mediators of the relationship between parent alcoholism and adolescent pathological alcohol involvement, and to examine whether or not this mediated pathway was stronger for adolescents with ADHD than for adolescents without ADHD. The participants of 142 adolescents with a childhood ADHD diagnosis (pro bands) and 100 demographically matched control adolescents without childhood ADHD and at least one of their parent were interviewed about drinking behaviour; pro bands and controls were interviewed about negative life events. Results showed that the relationships between parent alcoholism and 2 of the stress variables (“family” stress and “peer” stress) were significant for pro bands only, and that stress in the pro bands mediated the parent alcoholism effect on offspring alcohol involvement. These results provide preliminary support for the hypothesis that offspring characteristics might moderate the life stress pathway to alcoholism, and indicate that ADHD may serve to facilitate the transmission of pathological alcohol use from parent to child.

**Andrea et al [136]** in their study with an objective to examine differences between children of alcoholic (COAs) and non-alcoholic parents in their experience of negative life events across 3 longitudinal studies together spanning the first 3 decades of life. The authors posited that COAs would differ from their peers in the life domains in which they were vulnerable to stressors, in the recurrence of stressors, and in the severity of stressors. Scale- and item-level analyses of adjusted odds ratios based on stressors across 7 life domains showed that COAs consistently reported greater risk for stressors in the family domain. COAs were also more likely to experience stressors repetitively and to rate their stressors as more severe (in adulthood). Implications for prevention and intervention programs targeting this risk
group are discussed. In conclusion, the current study indicates that COAs were not only at greater risk for more negative life events than are their peers, but that they also differ from their peers in the types of stressors that they experience, in the severity of these stressors, and in the chronicity of stress exposure. These findings were strengthened by our use of three longitudinal studies that avoid biases inherent in treatment-based samples.

The objective of the study conducted by Irene et al [137] was to examine the relationship of parental alcohol or drug diagnosis to offspring personality in a population based sample of 17-year-old twins (568 girls and 479 boys) participating in the Minnesota Twin Family. Whether offspring personality characteristics 1) are specific to the type of substance use disorder in parents (alcohol versus drug) and 2) are found in high-risk offspring without substance use disorders as well as in offspring with substance use disorders was investigated. Personality was assessed with the Multidimensional Personality Questionnaire; substance use disorders were assessed in person through diagnostic interviews. Results identified both male and female offspring, parental history of alcohol dependence was associated with greater negative emotionality, aggression, stress reaction, and alienation but lower wellbeing parental history of drug disorder was associated with lower constraint, control, harm avoidance, and traditionalism but higher social potency. Excluding offspring with a substance use disorder had virtually no effect on the statistical significance of these findings.

Ohannessian et al [138] studied the relationship between parental alcohol dependence (with and without coexisting psychopathology) and adolescent psychopathology in a sample of 665 adolescents aged 13 to 17 and parents. Results showed adolescents who had parents diagnosed with alcohol dependence alone did not significantly differ from adolescents who had parents with no psychopathology in relation to substance use, conduct disorder or depression. In contrast, adolescents who had parents diagnosed with alcohol dependence and a psychiatric disorder had a significantly elevated risk of developing conduct disorder, depression and substance misuse problems. More over the subgroup of adolescents whose parents were
dependent on alcohol and drugs and had major depression consistently fared the worst, regardless of the psychiatric disorder assessed.

**Roosa [139]** conducted a study on children of alcoholics have been shown to be at risk for the development of mental health problems. However, there is little empirical research that would allow one to determine which of these children most at risk are. Hypothesizing that the amount of parental drinking-related stress a child experiences may be a factor that discriminates those children of alcohol dependent parents who are most at risk from others, the Children of Alcohol dependent parents Life-Events Schedule (COALES) was developed. Using samples of high-school students, the COALES was found to have satisfactory test-retest reliability, internal-consistency reliability and construct and concurrent validity. Children who self-identified as having an alcoholic parent reported higher levels of negative events and lower levels of positive events than did their peers from non-alcoholic homes. Scores on the positive- and negative-event subscales were significantly correlated with the children's scores on measures of anxiety and depression. Compounding the psychological impact of being raised by a parent who is suffering from alcohol abuse is the fact that most children of alcohol dependent parents have experienced some form of neglect or abuse. A child being raised by a parent or caregiver who is suffering from alcohol abuse may have a variety of conflicting emotions that need to be addressed in order to avoid future problems. They are in a difficult position because they cannot go to their own parents for support. Some of the feelings can include the following; Guilt, Anxiety, Embarrassment, Inability to have close relationships, Confusion, Anger, and Depression.

**2.2.2.3 Studies related to Self-esteem of Children Alcohol Dependent Parent.**

**Kanus E et al [140]** in their study to investigate the influence of parental alcohol abuse on the self-esteem of secondary school students in Kenya. The result of the study showed that students who reported parental alcohol abuse had significantly lower self-esteem than those who did it. Result indicated that there was a significant influence of parental alcoholism on student’s self-esteem (t (398)=33.3,p_<05). The study also indicated that there was a strong and negative correlation between the scores of students’ rating of direct effect of parent alcohol
abuse and scores of self-esteem (r=0.69, 0.05). Therefore it was concluded that parental alcohol abuse negatively influenced the self-esteem of students. The investigator gave recommendation that every school needs to assist its students to develop a high self-esteem. This can be done by setting up an effective guidance and counselling department which will make it possible to identify those students who need assistance and offer them the assistance they need. Moreover, parents and teachers' meetings should be made regular in the schools.

**John. D and Godwin PS [44]** have carried out a study in India with 200 college students of them 61 boys and 47 girls (54% of the students) affirmed the presence of an alcoholic person in their family. The investigators identified the prominent areas of concern in their family and personal life related to self-esteem. About 75% of the boys as well as the girls compared their home with those of their females and felt very low about themselves. Almost one out of every 2 of them felt that they were ashamed of their homes. The COAs had a propensity for guilt and blame and have the motive to use drugs.

**Moolakkatt C. J., and George S [141]** explored the characteristic influence of self-esteem and social relations of 50 adolescents between the age group of 14 to 18 years, having a parent with problem of alcohol dependence. When the self-esteem scale was analysed it was found that 72% of the respondents have higher self-esteem. Only 28% of the respondents reported to have lower self-esteem. Investigator has concluded out of his study that 70% of the children of alcohol dependent parents on whom the study was conducted opined to have better adjustment capacities in the home and school environment. This could be because of the other family members who also share the same environment of living with father alcoholic, understand the child better. It was found that 84% of the respondents have poor adjustments with the teachers in the school and 64% of the respondents also have poor adjustments capacity with the school. Investigator speaks of possible social work response to the situations of children with the problem of parental alcoholism that many families suffer because of the mal practice of drinking at home. It has to be tackled for the healthy development of the children of alcohol dependent parents.
A comparative study by Sylwyn & Vanitha et al [142] investigated the manifestation of self-esteem and adjustment in a group of fifty adolescent children of alcohol dependent parents (COAs) and a matched reference group of adolescent children of non-alcohol dependent parents (nCOAs). The Self-esteem Index and Adjustment Inventory were the instruments administered. An ex-post facto research design was used. The self-esteem scores showed a highly significant positive correlation with the overall adjustment score (r= 0.68, p<0.01) and also with all its component sub-dimensions namely, home adjustment (r= 0.65, p<0.01), education (r= 0.42, p<0.01) as well as emotional (r= 0.59, p< 0.001) and social adjustment (r= 0.52, p<0.01). The data revealed lower self-esteem and poor adjustment in all domains studied, in the adolescent COAs than the controls. These deficits can be attributed to the increased stress and vitiated alcohol complicated domestic environment of the COAs. This study indicates that the stressful and vitiated domestic environment prevalent in alcohol complicated familial relationships was responsible for the low self-esteem and deficient adjustment seen in adolescent children of alcohol dependent parents. The authors hence recommended for an imperative need for therapeutic intervention with this population.

Ranganathan S et al [143] in their study examined the role of perceptions of family environment and family communication as mediators of the effects of parental alcoholism on the self-esteem of adult children of alcohol dependent parents. Participants (N = 227) completed self-reports of parental alcoholism, family environment, family communication patterns (FCP), and self-esteem. Results indicated a negative relationship between the seriousness of both maternal and paternal alcoholism and self-esteem. Paternal and maternal alcoholism were related to the two dimensions of family environment, family stressors and parental disregard, although the effect for paternal alcoholism was larger. The relationship between maternal alcoholism and offspring self-esteem was partially mediated by parental disregard, whereas the relationship between paternal alcoholism and self-esteem was mediated by parental disregard and perceptions of a conversation-orientation Family communication pattern.
According to Sadock and Sadock [144] adolescence is a stage of life in which people from the ages of 12 to 19 work towards an integrated self-concept. This is a provisional stage of life in which peer relations develop, self-sufficiency in decision-making improves and intellectual searches and social belonging are required. They described that this stage is also regarded as a stage comprised of an increasing capacity for mastery over multifaceted encounters of academic, interactive, and emotional responsibilities while searching for new interests, capacities, and social identities.

Killeen, M. R. [145] focused on the processes by which alcoholic parents affect their children's self-esteem. The impact of families on children's self-concept and self-esteem is examined within the framework of a transactional model of self-concept development. Next, a model of self-esteem for children of alcohol dependent parents, including risk factors and protective factors for self-esteem, was proposed. It was suggested that alcoholic parents influence their children's self-concepts so that their children judge themselves on unique dimensions, and use atypical standards to interpret their behaviours. The result is that the children do not learn to realistically assess their strengths and abilities. Finally, the role of social support, within families and from other persons, was explored in relation to self-esteem.

Andreas J B and O’Farrell T J, [146] in their study found Psychosocial adjustment in children of alcohol dependent parents (N = 114) was examined in the year before and at three follow-ups in the 15 months after their alcoholic fathers entered alcoholism treatment, testing the hypothesis that children’s adjustment problems will vary over time as a function of their fathers’ heavy drinking patterns. Three unique patterns of heavy drinking in alcoholic fathers were identified through cluster analysis. The results demonstrated significant and meaningful associations between these drinking patterns in fathers and adjustment problems in children over time. Overall, children whose fathers remained mostly abstinent following their treatment showed lowest and decreasing adjustment problems, while children whose fathers continued and increased heavy drinking following their treatment showed greatest and increasing adjustment problems over time.
Hendel [147] A reported that often alcoholic parent spend less time at home or less time interacting with children. This affects boys a great deal as they need that connection to a male role model. Girls are generally more social and are able to get some of those emotional needs met through other people, but boys are discouraged from expressing emotion and do not seek out others in an appropriate manner to get these needs met. Boys try to get these needs met in other ways, like acting out and engaging in attention-seeking behaviours, thus appear to be the “bad child”.

Rangarajan [148] has done a study with the objectives to examine the effects of parental alcoholism on adult offspring’s self-esteem, to identify and test possible mediators and moderators of parental alcoholism effects on the self-esteem of adult offsprings and to examine the utility and relevance of attachment theory. There were 515 participants completed retrospective reports of parental alcoholism, family stressors, family communication patterns, parental attachment and a current measure of self-esteem. The results showed support for the detrimental effects of parental alcoholism on offsprings self-esteem and offered partial support for family stressors as a mediator of parental alcoholism effects on parental attachments and parental attachments as a mediator of parental alcoholism effects on offspring self-esteem, respectively. Finally, support was found for family communication patterns as a mediator of the effects of family stressors on attachment. The study findings offer preliminary support for the utility of attachment theory in explicating parental alcoholism effects on the self-esteem of adult offsprings. Findings from the present study make salient the need to consider factors beyond the identification of parental alcohol abuse when explicating individual differences in offspring self-esteem in adulthood.

The study by Elaine Rodneya & Robert M [149] sought to determine the relationship between parental alcoholism, feelings of self-esteem and depression among children of alcohol dependent parents (COAs) in a sample of 649 African-American adolescents twelve to nineteen years old. Three instruments were used in the study: The Children of Alcohol dependent parents Screening Test (CAST), The Hopkins Symptom Checklist (HSCL) Revised and The New York (Rosenberg) Self-esteem Scale. The results showed that about one out of four adolescents was a COA.
COAs scored lower on self-esteem than the nonCOAs and females in general scored lower on self-esteem than males. COAs were found to experience a higher level of depression than the nonCOAs and higher levels of depression were also found in females in general than in males. Depression was the strongest predictor of the status of being a COA. All these findings were statistically significant. The study has implications for counselling and prevention efforts among African-American adolescent COAs.

2.2.2 Part II: studies related to coping strategies adapted among children of alcohol dependent parents.

Kaur D [150] has done a literature search which revealed significant problems in coping among family members of alcohol dependent persons. It was found that there exists a huge burden on the immediate family members of the chronic alcoholic. Parentification and emotional caretaking were found in the children of chronic alcohol dependent parents. This can have a major impact on the psychological development of these children. Recent studies have shown that the offspring of alcohol dependent parents were at a high risk for Conduct Disorders, Attention Deficit Hyperactivity Disorder, Major Depressive Disorder, and Substance Dependence. Marital and Family therapy may have a role in therapeutic as well as preventive care approaches in alcoholism. It is clear that the alcoholic's family does show characteristics of dysfunctionality and poor adaptation. Thus, it is vital that special attention was paid to the needs of the family in the management of alcohol dependence and they suggested further systematic reviews were needed on this issue.

The study by Vincent T [151] was purposed at exploring the experiences that adolescents living with parents who abuse alcohol and the coping mechanisms that they employ to deal with such experiences. A descriptive method was adopted with six convenient samples to assess the experiences of adolescents living with parents who abuse alcohol in Appelsbosch were comprised of lack of proper parental supervision, lack of parent’s involvement in the adolescents’ school work, poverty, being sent out at night, witnessing parent’s conflicts, and assuming a role of a caregiver at an early age. These adolescents have got challenges which prevent them from doing well in their school work, they cope by belonging to certain soccer teams.
and also individual based coping mechanisms like positive self-talk. The home environment of the adolescents living with alcohol abusing parents was permeated by feelings of fear, unhappiness, confusion, constant lack of trust and poor home supervision. They sometimes compromise their socialization and funny activities as well as their love for reading material due to economic limitations deriving from parental alcohol abuse. These adolescents were positive about their future and they are keen to be successful.

Hyun et al [152] conducted the study to investigate factors related to mental health of offspring according to parents' drinking behaviour, adopting cross-sectional design with 547 university students. The scales used for this study were the Korean version of the Children of Alcohol dependent parents Screening Test, Symptom Checklist-90-Revision (SCL-90-R), Rosenberg’s Self-esteem Scale, and the Way of Coping Checklist. Participants were classified into three groups; nondrinking-parents group (53.5%), social drinking-parents group (21.8%), and problem drinking-parents group (24.7%). Participants whose parents were problem drinkers had significantly higher scores on all the subcategories of SCL-90-R compared to those of other groups. In the participants group whose parents were problem drinkers, mental health problem had a significant positive correlation to passive coping methods and a negative correlation to self-esteem. There was a significant negative relationship between self-esteem and positive coping methods. The results of this study indicate the mental health of university students may be negatively affected by parents’ drinking behaviours.

The specific objectives of the study conducted by Katherin et al [153] were to explore: young people’s lived experiences (daily life experiences) of family life over time; their relations within the family and extended family; their coping strategies and ways of managing family life; parents’ lived experiences of parenting in a context of substance misuse; and service providers’ perspectives on coping at the level of the individual and the family, and on service access and impact. The study is a Family Life Project which involved interviews with 50 young people aged 10-18 who, at the time of recruitment, all had experiences of parental substance misuse within the last year. A total of 130 in-depth interviews were carried out as part of the
Project. Key areas explored during the interviews included: family life; parenting; awareness of substance misuse; harms related to substance misuse; coping strategies; help seeking; and recovery between May 2008 and May 2010. All interviews were transcribed verbatim, thematically coded and analysed throughout the study with a particular focus on relational dynamics. Overall the study findings suggest that the absence of social interventions that tackle the social harms associated with parental substance use may limit the impact of current interventions as well as reinforce hidden personal harms.

**Orford et al [154]** outlines the stress-strain-coping-support (SSCS) model which assumes that having a close relative with a substance misuse problem constitutes a form of stressful life circumstances, often long-standing, which puts affected family members at risk of experiencing strain in the form of physical and/or psychological ill-health. Coping and social support were the two other central building blocks of the model. Affected family members were viewed as ordinary people faced with the task of coping with such stressful life circumstances. It was an assumption of the model that, difficult though the coping task is, family members need not be powerless in maintaining their own health and helping their relatives. Good quality social support, in the form of emotional support, good information, and material help, was an invaluable resource for affected family members, supporting their coping efforts and contributing positively to their health. It can be seen as a way of increasing the positive social support available from professional sources.

The literature reviewed by **Garcia C [155]** published between July 2008 and June 2009 with a total of 367 articles to examine the conceptualization and measurement of coping in adolescent research. A wide range of stress-related risks or conditions were examined, including psychological stressors; physical stressors; familial stressors; social stressors and difficulties in settings such as school, prison, or a homeless shelter; and societal stressors such as discrimination. Coping is a complex construct yet worthy of examination because it can be a critical point of intervention in the health trajectory of adolescents and young people. Research is needed to advance the conceptualization and measurement of adolescent coping such that interpretation of findings across studies is enhanced.
Hampel P, Petermann F [156] investigated age and gender effects on perceived interpersonal stress, coping with interpersonal stressors, and psychological adjustment among early and middle adolescents. Furthermore, the associations of perceived stress and coping with adjustment were examined. The sample included 286 Austrian adolescents aged 10 to 14 years who attended the fifth to seventh grade. Self-report data on perceived stress, coping, as well as emotional and behavioural problems, were assessed. The results showed fifth graders scored lower on maladaptive coping strategies and externalizing problems and reported more adaptive coping strategies than sixth and seventh graders. Compared with boys, girls evaluated a higher amount of perceived interpersonal stress and used more social support. Additionally, girls scored higher on maladaptive coping strategies and emotional distress and scored lower on distraction than boys. Problem-focused and emotion-focused coping were negatively related to emotional and behavioural problems, whereas perceived stress and maladaptive coping was positively associated with adjustment problems. These relations were stronger in female than in male adolescents. The study has concluded that evaluating multidimensional coping patterns is supported. Particularly, implementation of primary preventive programs during late childhood is suggested.

The study by Hussong A M and Chassin L, [157] in a longitudinal design examined the development of coping styles over adolescence, continuity in these coping styles from adolescence to adulthood, the impact of coping on adult stress and substance misuse, the ability of coping to buffer effects of stress on substance use, and differences in coping between at-risk youth (i.e., children of alcohol dependent parents [COAs] and their peers. A sample of 340 adolescents over 11 to 23 years were assessed using latent trajectory models. Greater levels of planning coping in early adolescence predicted greater active coping in young adulthood ($\beta = 0.36, z = 4.50, p < 0.001$). Moreover, greater levels of adolescent cognitive coping ($\beta = 0.26, z = 3.35, p < 0.001$) and lower levels of adolescent planning coping ($\beta = -0.27, z = -3.59, p < 0.001$) predicted greater young adult avoidant coping. The results revealed that coping of children of alcoholic parents had limited impact on the stress and substance use in adulthood.
Skinner, Edge, Altman, and Sherwood [158] conducted a study on 100 assessments of coping used with young people and adults. They found out 400 uniquely different manners of coping these people had. Considering some coping strategies like problem focused coping, it has been associated with higher levels of self-esteem and resiliency, whereas other coping mechanisms such as denial have only led to negative outcomes and feeling in general. Coping was an important aspect in understanding how the adolescent cope with the stressors and how to they adjust in order.

2.2.3 Part III studies related to problems of children of alcohol dependent parents.

2.2.3.1 Studies related to Academic Problems of children of alcohol dependent parents.

Vijay R. et al [95] in their research evaluated 32 children for psychopathology, neurodevelopment, cognitive functioning and family environment to compare the nature and extent of these problems in children of men with and without alcohol dependence. Children of alcohol-dependent fathers had higher scores on the neurodevelopment and lower scores on the performance. These children also made more errors on the Trail Making Test. The family environment of COAs was characterized by lack of independence for its members, greater perceived control and lack of adequate cultural and intellectual and they have difficulties with frontal lobe functions and neuro developmental tasks. There are also difficulties in the family, which are related to alcohol consumption by the father.

Raman V et al [160] in their study aimed to compare the nature and extent of behavioural and cognitive problems in children of men with and without alcohol dependence. 32 children (17 in study group and 15 controls) were evaluated for psychopathology, neurodevelopment, cognitive functioning and family environment. Tools used were Socio-demographic data sheet, Malin's Intelligence Scale for Indian Children (MISIC), Child Behaviour Checklist, Trail Making Test, Neurodevelopment Scale and the Family Environment Scale. The results showed children of men with alcohol dependence had higher externalizing than internalizing
scores. Children of alcohol-dependent fathers had higher scores on the neurodevelopment scale and lower scores on the performance scale of the MISIC than the children in control group. These children also made more errors on the Trail Making Test. The family environment of COAs was characterized by lack of independence for its members, greater perceived control and lack of adequate cultural and intellectual activities. The study concluded that children of men with alcohol dependence have difficulties with frontal lobe functions and neurodevelopmental tasks. There are also difficulties in the family, which are related to alcohol consumption by the father. This study endorses these findings in the Indian context.

Diaz R et al [94] in their study identified the possible risk factor and negative outcomes associated with parental alcoholism. Secondary aim was to determine the influence of the family density of alcoholism on children of alcohol dependent parents' (COAs) psychological functioning. A multisite epidemiological study was conducted in 8 Spanish cities, sample of 371 COAs (whose parents were in contact with alcohol treatment centres) and 147 controls (from schools in the same localities as COAs). Both groups were 6-17 years old and received a comprehensive evaluation of mental disorders (according to DSM-IV criteria); alcohol and other substance use (none, occasional, regular and risky consumption); school achievement (low, middle and high) and other academic performance indicators (WISC-R Information and Arithmetic subtests, school support activities and failed subjects and courses). Lastly, several cognitive functions were measured. Logistic regression methods were used to compare both groups and a linear regression model was used to determine the influence of the family density of alcoholism. Children of alcohol dependent parents were twice as likely as controls to present subclinical symptoms and four times more likely than controls to have a definite diagnosis of any mental disorders. COAs had worse results on all the cognitive tests used and their of low school achievements was nine times higher than that of controls. Family density of alcoholism was significantly related to several psychiatric disorders and to low academic and cognitive performance in these children.
Lisa Turney [115] clearly stated in her work with children of alcoholics that no statistic can measure the psychological pain that children of alcohol dependent parents grow up with and often carry into adulthood. A number of behavioural signs can warn of a parental drinking problem, including: School absences or truancy, Withdrawal from classmates and friends, Frequent illness or physical complaints, Drug or alcohol abuse, Overly aggressive play, Delinquent behaviour, Under-achievement in school and Emotional distance from peers.

Mcgrath [161] in his study tested whether adolescent children of alcohol dependent parents (COAs) showed poorer academic performance than did demographically matched controls, and whether such parent alcoholism effects varied as a function of heterogeneity within the COA sample. He also examined whether relations between parental alcohol dependence and academic performance could be accounted for by COAs' lower levels of task orientation, heightened levels of environmental stress, lowered levels of family organization and less parental involvement in their school activities. A sample of 221 adolescent COAs and 196 demographically matched controls (53% boys), and parents, were included.

Adolescents were selected from a larger 3-year longitudinal study in which participants were interviewed three times at annual intervals. Academic achievement data were collected from school records. Multiple regression analyses indicated that COAs received lower school grades than did their non-COA peers (mean = 2.19 +/- 1.08 vs 2.54 +/- 1.01, respectively). COAs with two alcoholic parents (mean = 1.80 +/- 1.17) and COAs with at least one parent diagnosed alcohol dependent (mean = 2.01 +/- 1.01) showed particularly low grades. Parental alcohol dependence was also associated with lower math achievement scores (mean = 48.52 +/- 24.68 vs 62.47 +/- 26.71). The study confirmed that COAs achieve relatively lower academic outcomes in comparison to non-COA peers, which may be partly due to impaired motivation and organization.
2.2.3.2: Studies related to Family Problems of children of Alcohol Dependent Parents

The study by Shin et al [162] examined associations between exposure to Child Maltreatment (CM) and trajectories of Heavy Episodic Drinking (HED) from adolescence to young adulthood for the US population. Four waves of data from the National Longitudinal Study of Adolescent Health were used. A total of 8,503 adolescents followed from adolescence (7th–12th grades) into young adulthood (ages 24–32) were assessed on CM and past-year HED frequency. Using growth curve modeling, trajectories of adolescent HED were examined, with subtype, frequency, and severity of CM as the primary independent variables. All of our analyses controlled for common risk factors for adolescent HED, including demographics, parental and peer alcohol use, parental education and employment, family income, parent-child relationship, and adolescent depression. The Results confirmed that after controlling for potential risk factors, neglect and physical abuse – both individually and in conjunction – were associated with faster increases in HED during adolescence and persistently elevated HED over much of adolescence and young adulthood. The frequency of neglect and physical abuse – individually and in conjunction – was also associated with the trajectory of HED, such that additional instances of these types of maltreatment were associated with faster increases in HED during adolescence and higher rates of peak use during young adulthood. It has been concluded that child neglect and physical abuse appear to have long-lasting adverse effects on HED beyond adolescence and throughout much of young adulthood

Deepa S T[163] in her study aimed to find out the Problems faced by the children of alcoholic fathers attending selected de addiction centres in Mangalore, India. An explorative survey approach was adopted for the study, with the sample of 60 children (10 to 14 years) of alcoholic fathers. The data collection tool included rating scale to assess the problems faced by the children of alcoholic fathers, Observation checklist to assess the physical health status of children and Baseline Performa. Among 60 samples 16.6% had severe, 61.7% moderate and 21.7% of them experienced mild degree of problems due to their father’s alcoholism. The chi-square
values between degree of problems faced by the children and selected variables like age, sex, birth order of children, income of family, duration of father’s alcoholism and treatment received for alcoholism were not significant at 0.05. The focus of health practitioners was directed towards primary prevention. The study concluded that nursing personnel, who comes in closer contact with the children of alcoholic fathers, can identify the problems of these children and help them to cope successfully with emotionally hazardous experience.

Two year empirical study conducted by Cleaver, H, et al. [164] using documentary analysis of ACPC procedures/policy documents; postal questionnaire to practitioners; analysis of identified social work case files (357 cases of which half parental substance misuse); qualitative case studies with seventeen families (parents and practitioners). Of the cases where there was an initial assessment (267), just over one third of parents had problems with alcohol. A quarter of children were affected by domestic violence and parental drug or alcohol misuse. Domestic abuse was more likely in families were there were problems with alcohol rather than drugs: 20.9% of cases parental alcohol misuse compared to 13.7% of families with parental drug misuse also reported domestic violence. Findings from the initial assessments showed 56.8% of children had unmet needs in family and social relationships, 43.5% of children had unmet needs in emotional and behavioural development, 34.9% children had unmet educational needs, 27.9% of children had difficulties in identity and social development, 23.9% of children had unmet health needs. A quarter of children were assessed as having no unmet needs. However, almost a third of cases has ‘severe development needs’. Significantly, 38.2% of children affected solely by parental alcohol misuse had severe development needs. (Compared to 334.5% exposed to domestic violence and 29.5% exposed to parental drug misuse).

Aravind T [165] in a study among 139 children of alcohol dependent parents and normal sample of 250 boys and 250 girls found that children of alcohol dependent parents were seen to have more problems, maladjustment and unstable root personality compared to other problem children and normal. Psychological interventions seem to produce beneficial changes in Children of Alcohol dependent parents and Problem Children. There is some indication that MGIT, specially
designed peer group social interaction technique filth awareness may produce better results than usual intervention techniques for children as a whole or for Children of Alcohol dependent parents particularly in the case of girls. A larger proportion of children of alcohol dependent parents in general had endorsed more family problems than problem children. Children of alcohol dependent parents showed in general more maladjustment tendencies and less stability (more inertia and Activation) compared to Problem children.

Johnson J L et al [166] in their study research, relationship between parental substance abuse and subsequent abuse and subsequent alcohol problems in their children has been documented extensively. The single most potent risk factor is their parent's substance-abusing behaviour. This single risk factor can place children of substance abusers at biologic, psychological, and environmental risk. These researches support the beliefs that COAs are at high risk for a variety of problems that may include behavioural, psychological, cognitive, or neuropsychological deficits. Given the studies reviewed in these articles, it is unclear whether we see true deficits or developments delay. Differences in outcome could be studied simultaneously to understand whether antecedents discovered for one are specific to it or general antecedents leading to a broad variety of outcomes.

2.2.3.3: Studies related to Social Problems of children of alcohol dependent parents.

Cross-sectional study conducted by Orford J., et al. [167] with the sample of 100 subjects (50) in each group, using family diagrams constructed during personal interviews to explore childhood family experiences. Values were assigned to bonds drawn on family diagrams during the interviews so data could be quantifiable. ‘Offspring’ diagrams indicated significantly less positive bonds between mother and father, between self and problem-drinking parent, and in the family as a whole. There were also significant differences, not predicted, with regard to bonds between siblings, which were less positive in the diagrams of “offspring”. Families of offspring of parents with drinking problems may be comparatively deficient in positive aspects of family cohesion, experiencing particular difficulties in the quality of parent-child relationships, family breakdown and domestic violence.
2.3 CONCEPTUAL FRAMEWORK

Sr. Callista Roy’s adaptation model [170] was identified as the most suitable theory and adopted for the study to assess the health effects and coping strategies among the children of alcohol dependent parents residing at Kirumambakkam Primary Health Centre, Puducherry.

According to Sr. Callista Roy, individuals are Bio-psycho-social beings with an open and adaptive system. Individual are open and constantly subjected to various external and internal stimuli the individual is in constant interaction with a changing environment. To cope with a changing world, person uses both innate and acquired mechanisms which are biological, psychological and social in origin. To respond positively to environmental changes, the person must adapt. The person’s adaptation is a function of the stimulus what he is exposed to. The person has 4 modes of adaptation: physiologic needs, self-concept, role function and inter-dependence.

When stimuli processed in the input are favourable, the adaptive levels at throughput is enhanced, this leads to an adaptive response with the environment by the individuals. This response blends well so as to bring an optimum health in the individual. The theorist also clarifies any input that is not favourable to the individual and that does not blend with the environment cause maladaptive response where in there is a constant friction between the stimuli and the environment. This makes the individual to deviate from the optimum health. Illness level depends on the intensity, content and quality of the stimuli. The more these inputs are, the higher and more chronic is the level of problems.

**Major concept of the theory includes:**

- Adaptation - goal of nursing,
- Person - adaptive system,
- Environment - stimuli,
- Health - outcome of adaptation and
- Nursing - promoting adaptation and health.

Major concept of the theory in the present study includes:
INPUT

In this study, as a part of the input the investigator identified the innate acquired stimuli like age, sex, education, religion, number of children in the family and type of the family which constantly interacts with the children of alcohol dependent parents and that can cause deviation in the biological aspect like Body Mass Index (BMI), Haemoglobin (Hb) and the overall physical health. The psychological aspects like stress and self-esteem are also influenced with their input. The external stimuli include demographic variables of parents and their clinical variables like duration of alcohol dependency, health effects of alcohol problems and de-addiction treatment. These strongly influenced the parent themselves who are even vulnerable to various Bio-psycho-social effects and letting their children also at risk of developing the same. The environment is having a constant interaction with the parent children and influenced their health outcomes. The child is weak, and vulnerable to all sort of unwanted health outcomes. The investigator assessed the health effects like physiological (BMI, Haemoglobin and clinical symptoms), psychological (stress and self-esteem), coping strategies adopted, and problems (Educational, Family and Social) experienced by the children.

THROUGH PUT

- Adaptation (goal of nursing) - Responding positively to environmental changes through desirable promotion in the physiological aspects, such as improvement in BMI, Haemoglobin, as well as psychological aspects including positive self-esteem and lower level of stress and perception of less problems in educational, family and social aspects. This could be achieved through enhancing coping adapted by the children of alcohol dependent parents by the nurse.

- Person (adaptive system) – the children of alcohol dependent parents.

- Environment (stimuli)—villages at Kirumambakkam Primary Health Centre area. It also included all other nurturing components in the living area of the children such as food, recreational activities, play, exercise, school
environment, and the influence of peer group.

- Health (outcome of adaptation) – Adaptive responses like productive coping adapted by the children to manage effects of parental alcoholism or Maladaptive responses like developing physical health problems, low self-esteem and perceiving high level of stress.

- Nursing (promoting adaptation and health) - the activities to promote adaptation of the children thus contributing to health, and quality of life, by providing them the necessary knowledge related to their parental alcohol dependence and the ways by which they can keep themselves safe and happy. These activities influence adaptive abilities of the children.

- The adaptive response in the study includes reduction in the physiological and psychological health effects through enhancing effective coping and positive self-esteem.

**OUTPUT:**

Output is the adaptive response of the children of alcohol dependent parents. When effective coping mechanisms (productive coping) are implemented by the child, an effective adaptive response is evidenced by less or absence of physiological and psychological effects, lower levels of stress and high self-esteem. If in case when the coping was ineffective (non-productive and other coping), the child develops physiological and psychological effects. They include altered BMI, Anaemia, Symptoms development, high level of stress and low self-esteem. Upon adaptive responses, investigator would reinforce means of effective coping mechanisms and provide basic information regarding ill effects of alcohol dependency as a holistic approach on the individual well-being, whereas upon mal adaptive responses reassessment of the stimuli related to the study will be done until achieving the adaptive response which is not a part of the study, represented in dotted lines.
CHAPTERIZATION

Chapter-2 dealt the section I and II which presented the overviews of literature that support the study, Section III presented the Conceptual framework.

Chapter-3: Is devoted to the methodology which includes aspects like Research approach, Research design, Variables in the study, Setting, Population, Sample, Sample size and its calculation, Sampling technique, Criteria for sample selection, Development and description of the tool and its scoring procedure, Pilot study, Validity of the tool, Reliability, Ethical consideration, Data collection procedure, Drop outs and its analysis and Plan for data analysis.