Chapter 1

REVIEW OF LITERATURE

The current chapter focuses on three sections. The first section reviews literature in the areas of alcohol use disorders, the terminology, the historical background, the magnitude of the disease, the kinds of drinking behaviours, clinical understanding of alcohol use disorders (alcoholism\(^1\)), and the stages of addiction and the health consequences of alcohol abuse. The second section reviews the literature in the field of Emotional Intelligence (EI), models and current understanding of EI and examines EI in the Indian context. The third section funnels into and merges the two areas and examines the Adult Child of Alcoholic (ACOA) and the effects of alcoholism on the Emotional Intelligence.

Introduction

Box 1: A Case Study

He was born on 6 February 1911 and expired on 5 June 2004. His father was an alcoholic, a binge drinker. As a child he was always afraid of the times when his father would take his first drink. He was also afraid of Christmas as this meant that maybe father would start drinking again and then getting him to stop drinking would be a problem. He experienced economic insecurity and had to move homes many times as his father was unable to keep a job for long.

His relationship with his father was peculiar and he was much closer to his mother, a teetotaller and he remained close lifelong, counting her as his influence and his major supporter. He describes her as the backbone of the family, who did everything to keep the family unruffled. She would even stitch all the clothes the children wore as they could not afford to buy their own clothes. The family never owned their own home. His father’s drinking took a toll on the family. His most powerful childhood memory includes finding his father drunk and unconscious outside his house. Later he shared that he wanted to pretend that it did not happen. He was also exposed to parental fights as a child. As a consequence of this home situation he did not interact much and his

\(^1\) DSMV (2013) classifies those who are problem drinkers under alcohol use disorders; in this study alcoholism is used to mean those individuals who have had problem drinking. The two terms are similar in their meaning but the term alcoholism was used after much deliberation as it is easier for lay persons to understand and read and therefore clinical term of alcohol use disorders is not used. Since the term may connote different meanings to different groups of individuals, the term is part of the philosophical ontology that knowledge needs to demystified to reach individuals who will be benefit the most and avoid creating clinical hegemonies.
brother described him as an “introvert” who spent long hours alone reading or then playing with his toy soldiers or with his bird egg collection.

As he grew older he came to associate much shame with being ill. Even when he had a cancerous growth removed from his intestines he underplayed his health as this for him was a sign of weakness, to the extent that he kept it a secret from everyone even his own family.

His career graph rose from acting to becoming a politician and eventually becoming the president. He was married twice to women who were also actresses and had children who described him as being distant father; they were not able to get through to him and reported marked absence of closeness.

(Case study synthesized from journal article in Political Psychology, Vol 29, by Gilbert 2008)

The “he” referred to in the case study is (was) Ronald Reagan, 40th president of USA and an Adult Child of an Alcoholic. (ACOA)

Ronald Reagan, Stalin, Kelly Osborne, Charlize Theron, Drew Barrymore, Halle Berry, Demi Moore, Charlie Sheen, Farhan Akhtar, Kareena Kapoor and Twinkle Khanna

All the above personalities share a common factor.

They all had parents who had alcohol related problems. In fact Theron’s mothers had murdered her father when he was in an alcoholic rage in order to protect herself and Theron. Drew Barrymore is one of the youngest celebrities to have been admitted for substance abuse treatment at age 13 years. Lindsay Lohan is well known for her drunken behaviour and her various socially publicised arrests. Reagan describes his childhood as dreading Christmas as it could mean that his father may “fall of the wagon” due to his alcoholism and it would be a beginning of a long drawn weekend of bingeing and fights. (Gilbert, 2008)

All these individuals have grown up witnessing alcohol consumed by their father, mother or both and yet rose to have substantially rich careers or then become alcoholics or addict themselves. These are the Adult Children of Alcoholics (Rubin 2001, Ackerman 1989, Black 1982, Woititz, 1981) who on the surface seem to be the ordinary next door kind of children

2 “Falling off the wagon” was a term used to refer to a person who had started drinking after a long period of abstinence
but whose lives have been affected and sometimes the scars are so deep that they are not visible to the naked eye.

ACOAs are adults who are ensnared in the fears and insecurities of being children. They become adults without undergoing the developmental stages necessary for adulthood. (Ruben 2001)

**Statement of the Problem / Focus of Study**

The role that a parent plays in the child’s life as the first agency of socialization is unarguable. It is from the parent that the child learns the first lessons of life and living and they are his/her role models. This teaching learning experience is affected if the parent faces some challenges like being mentally ill or being on Alcohol or Drugs (AOD). Then the children will have incomplete learning. These ‘children in difficult situations’ (Shah and Vasi, 2002) are placed in the care of adults who are not in a position to provide support and guidance in fulfilling their basic emotional needs thus affecting their emotional health and their security. Black describes this behavior as parental immaturity. (1981)

The next section traces the understanding of alcoholism or alcohol use disorders.

The term alcoholism, abuse, substance misuse, abuse, alcohol dependent, chemical dependent are the many terms used to describe the drinking and drug taking behaviors. In the context of this study to avoid the clinical nomenclatures of the term, after much deliberation, the term “alcoholism” has been used. The term is not to discount or underplay the effects of substance abuse, but by using a lay term the need to demystify the term itself and also to provide a simpler picture to lay readers. The thesis is written with the understanding that all knowledge must be understood and accessed by the individuals who need to learn about it, in this case those families who are affected by the drinking should be able to comprehend the terms and hence the term alcoholic and alcoholism and adult children of alcoholics. Further since this term was given by a recovering alcoholic and not a clinician it adds weightage to its use (Richard Peabody 1930s). The clinical label of alcohol or chemical dependent is not preferred in this context.
Review of the Literature

The literature available on alcoholism is humungous. Some of the studies which have been undertaken in this area range from disease concept of alcoholism (NIAAA 2007, Jellinek, 1960), to magnitude of alcoholism (NFHS, 2009, National Survey, 2004), information and treatment of addictions (Kinney and Leaton, 1987; Milhorn1994; Miller, 1995 Labatt., Farrar J.E., and Serratella D.A.1992); to impact of alcoholism on the family (Mayer, Black, and McDonnell Nd); to children’s outcomes due to alcoholism (Robins Lee, West P, Ratcliff,K.S. and Herjanic B.M.1978) to impact of alcoholism on children of alcoholics (Ackerman 1989; Gondolf and Ackerman 1993; Black C, 1981; Weghscheider-Cruse 1981,Woititz 1981). The first area under examination is the history of alcohol drinking and the etymology of alcohol itself.

Background

The word Alcohol is etymologically derived from the Arabic word “al kuhl”. (Kinney and Leaton, 1987). It means something which is distilled and was used to refer to compounds obtained by distillation. One of the earliest alcoholic on record was on Cambyses, King of Persia 6th century B.C. Beer was first made in the year 3000 in Egypt.(Carson, Butcher and Coleman 1988)

The earliest Arabs used to distil alcohol and it was brought to Europe by Arabs. Alcohol came to be then consumed amongst all classes in Europe and it was considered manly to drink. The word “drunk” comes from Greek word to misbehave at the wine. (Kinney and Leaton, 1987).

Milhorn (1994) reports that alcohol drinking was not considered a problem till much later during the temperance movement which struggled to promote abstinence in 1789. Thus began the first movement that recognised that alcohol drinking was a problem.

The identification of alcohol as causing problems was absent, until medical practitioners began to record and write about it. Given below in the table is the brief history of how views towards alcohol underwent a change and it came to be viewed as a public health problem.
Table 1.1: Chronology of Recognition of Alcohol as a Serious Problem.

<table>
<thead>
<tr>
<th>Brief Chronology</th>
<th>Important events of Alcohol being considered as a serious problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>1804</td>
<td>Scientific Essay “An Essay, Medical, Philosophical, and Chemical on Drunkenness and its Effects on the Body” on Alcoholism by Dr Trotter. Scientific essay by Dr Benjamin Rush, “An Inquiry into the Effects of Ardent Spirits on the Human Body and Mind, with an Account of the Means of Preventing and the Remedies of Curing them.” Dr Trotter proposed that it was a disease and it should be considered as such.</td>
</tr>
<tr>
<td>1840</td>
<td>Washington Temperance society Six friends founded this society based on the principle of one “drunkard” help another to overcome “drunkenness”, membership of 1000000 formed common drunkards.</td>
</tr>
<tr>
<td>1841-1874</td>
<td>Dr Samuel Woodward and Dr. Eli Todd did not see “inebriates” as criminal and began to treat them differently. Slowly the attitude began to change from being treated as criminals to being sent to hospital for treatment and about 11 non-profit hospitals were set up.</td>
</tr>
<tr>
<td>1876</td>
<td>Journal of Inebriety was started. Discontinued due to lack of funding.</td>
</tr>
<tr>
<td>NA</td>
<td>Home for the Fallen, Boston Based on premise of one drunkard helping another.</td>
</tr>
<tr>
<td>1895</td>
<td>Anti-Saloon League Most popular temperance movement.</td>
</tr>
<tr>
<td>1904</td>
<td>Medical temperance Society which later came to be known as the American Medical Association for the study of Inebriety and Narcotics.</td>
</tr>
<tr>
<td>1919</td>
<td>18th Amendment act was passed making it illegal to manufacture or sell alcoholic beverages.</td>
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<tr>
<td>1930s</td>
<td>Yale laboratory Applied Psychology and Alcoholic Anonymous began. Re-focus on alcohol as a disease</td>
</tr>
<tr>
<td>1930s</td>
<td>Richard Peabody, a recovered Bostonian alcoholic started. Replaced the term “drunk” and “drunkenness” with “alcoholic”</td>
</tr>
<tr>
<td>Year</td>
<td>Event</td>
</tr>
<tr>
<td>-------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>1934</td>
<td>Alcoholic Anonymous</td>
</tr>
<tr>
<td>1930</td>
<td>Yale Yandell Henderson, Howard Haggard, Leon Greenberg and later EM Jellinek founded the Quarterly Journal of Studies on Alcohol. (known as Journal of Studies on Alcohol since 1975)</td>
</tr>
<tr>
<td>1930s</td>
<td>Yale centre of Alcohol Studies was established and The Classified Abstract was Archive of Alcohol literature was set up. The Yale Plan Clinic started to diagnose and treat.</td>
</tr>
<tr>
<td>1944</td>
<td>National Council for Alcoholism started by Jellinek and Marty Mann, a recovered alcoholic was started.</td>
</tr>
<tr>
<td>1960</td>
<td>Viewed in America as a public health problem.</td>
</tr>
<tr>
<td>1970</td>
<td>Legislation creating the bill The Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, Rehabilitation Act of 1970 also known as the Hughes Act.</td>
</tr>
</tbody>
</table>
1971 National Institute of Alcohol Abuse and Alcoholism was established as a result of this legislation. Sponsors research, treatment and public education and treatment.

1971 onwards It leads to the alcohol counsellor coming into existence. Treatment Centres established and advocacy for alcohol treatment and against drunken driving, marketing and advertising of alcohol beverages gained momentum.


From the above history one can infer that the seriousness of the problems created by alcohol began to dawn and this affected the views on alcohol. It was considered an illness in 1951 by WHO and five years later in 1956 the American Medical Association called it a disease. (Milhorn, 1994, AA literature) It took almost a decade for it accepted by the American Psychiatric Association as a disease in 1965.

**Disease of Alcoholism**

It has been defined by the American Psychiatric Association (1977) as

“**Alcoholism is an illness characterised by significant impairment that is directly associated with persistent and excessive use of alcohol, impairment may involve physiological, psychological or social dysfunction**”.

The definition does not include the emotional component which also plays a significant role in developing the dependency. Though in treatment of alcoholism one major component involves teaching and recognising emotional triggers.

**Classification of Alcohol as a Drug**

Drugs are psychoactive in nature, that is they affect the mental functioning. Some of these can be legally purchased like alcohol; while some are prescribed for medical purposes like barbiturates and some are illegal like heroin. (Carson, Butcher and Coleman 1988). Although, alcohol is recognised as a depressant and is placed alongside other chemical
substances, the role of emotions in developing this dependency is ignored. Some of the other drugs of use are as depicted in the table below.

Table 1.2: Classification of the different Drugs of Abuse

Some of the different kinds of alcohol commonly consumed are given in the table below.

(Table on Kinds of Alcohol Available (Compiled from Kinney and Leaton 1987, Milhorn 1994, Gururaj et al 2006 and Market survey of Alcohol available in Mumbai by researcher.)
Clinically, regardless of the kind of alcohol consumed, certain parameters of substance abuse are clearly defined. Much of the credit for the pioneering work in establishing alcoholism as a disease goes to E.M. Jellinek (1960) who studied the lives of over 2000 alcoholics and wrote the pivotal book, “The Disease Concept of Alcoholism”. He concluded that alcoholism like other diseases had definite symptoms, progress and outcomes. He enumerated detailed parameters on different kinds of alcoholics, premises on who could and could not be called an alcoholic. The next section provides the typology that Jellinek (1960) proposed.

**Jellinek’s Classification of Types of Alcoholics**

Jellinek (1960) based on his work with over 2000 AA members formulated that not everyone who drinks can be categorised as alcoholic. He proposed that people were different and could be classified as different types of alcoholic drinkers.
**Alpha Alcoholism**

This is psychological dependence on the alcohol; there is neither loss of control nor an inability to refrain. Alcohol is used for all problems and there may be problems in the family or workplace like decreased productivity. This species cannot be regarded as having an illness.

**Beta Alcoholism**

This type present itself when the physical problems from this stage ensue but there is no physical or psychological dependence. This maybe prevalent in a social group and result in nutritional deficiency. It may harm family and work and also affect the life span of the individual.

**Gamma Alcoholism**

He explained that it was marked by increase in tolerance, adaption to alcohol, withdrawal and craving. Thus there is a movement from psychological dependence to physical dependences. The stages of alcoholism are evident in this type and this is often the most harmful type of drinker. He proposed that Alpha and Beta drinkers could become gamma drinkers. Jellinek (1960) observes that this is the type which was found in AA programs, in America, Canada and the Anglo Saxon countries. Though he also shares that he found about 13% of his sample which was consisting of AA members who never lost control and these could be alpha drinkers whereas beta drinkers were more likely to be found in hospitals.

**Delta Alcoholism**

Here there is no loss of control though there is psychological and physical dependence. Though he can control his drinking he cannot abstain even for a day without experiencing withdrawals. This type of drinkers is found in France other countries where large wine consumption is prevalent and who he called the “inveterate” drinkers. These individuals may not come for AA as there is no psychological distress due to alcohol like in gamma.
**Epsilon Alcoholism**

This was significantly different and he called it the periodic alcoholism. These drinkers indulged in binge drinking. Unfortunately he did not study this typology adequately though today this category of drinker is found in the urban society.

He describes other types which he says cannot be categorised as disease but exist nevertheless. These other types are called the “explosive drinkers” which result in premature deaths; weekend drinkers who drink and cause problems by rowdiness, work absenteeism and dent to family budgets; “fiesta” drinkers who drink occasionally but cause accidents. This raises the eternal confusion that is present in the field of alcohol and drug abuse, who is then a problem drinker or an alcoholic.

**Who is a Problem Drinker?**

Jellinek (1960) put forth that the gamma type of drinkers are problem drinkers and will require help. Currently an individual is defined as substance dependent if he or she exhibits three or more of the following symptoms over a year according to the Diagnostic and Statistical Manual IV R (1995). The first symptom is increasing tolerance either by drinking more of alcohol or inability to feel the same effects with same amounts. The second symptom is experiencing withdrawals, which may involve symptoms caused by the substance itself or then taken to feel relief and avoid withdrawal. The other symptoms are that the quantity of substance increases over a period of time; efforts are made to control the substance use; a wish to reduce the intake; spending time to obtain the substance; forgoing important activities for the sake for the substance like giving up work or social or other obligations; continued use at the cost of the problems that it may bring about like psychological or physical.

The International Classification of Disease 10(1992) categorises substance abuse into two components of harmful use and dependence. Harmful use exists if there is harm physically or psychologically to the user due to the substance. Dependence is diagnosed if any of the three symptoms are experienced in the past year. The symptoms are; a strong desire to take the substance; difficulty in controlling the use of the substance; a physiological withdrawal;
increasing tolerance; neglect of other activities; persisting to use in spite of the knowledge of the harmful effects.

**Features of the Disease**

On closer inspection one can discern that the parameters of both the ICD and DSM overlap significantly and the following features of the disease emerge which are stated below. The first feature is it is a primary disease that is it needs to be treated by itself and not as a symptom of some other disease. The second feature is that is a progressive and terminal disease which means that it increases with the passage of time and if untreated can result in death. The third feature is that is treatable disease and one can arrest the condition. The fourth feature is that it is a disease which relapses meaning that the person can go back to the substance abuse at any time. Thus abstinence is recommended. (UNDCP, 2002)

**Stages of Alcohol Abuse**

The stages of substance abuse provide further clarification as the symptoms of substance abuse may appear over a period of time.

Jellinek (1960) proposed the stages of alcoholism after studying over 2000 AA members. He arrived at the four stages, the pre alcoholic phase; here there is external motivation to continue drinking and can extend for several months to two years. This phase is followed by the prodromal stage where the first warning signs of the illness set in. The person attempts to look normal and drinking maybe heavy but furtive. This may result in “palimpsest” or black outs. This stage can last from anywhere between 6 months to 5 years. The third stage is the crucial stage and this is the period where the alcoholic is propelled into the disease. He loses control over his drinking, his life and attempts at quitting and morning drinking initiates. The chronic phase is when the drinking is daily and loss of job or relationships is common. He may not be able to hold the alcohol any longer and stupor is common.

Interestingly this criterion is still used to describe the stages of alcoholism presently also. The stages of substance dependence are use, abuse and addiction. (UNDCP, 2002)
The use stage begins with experimentation usually with friends and the substance may be taken socially and the after effects are not felt much. The frequency maybe at social gatherings, the duration is short and the intensity of the effects is mild. At this stage individuals may try alcohol or nicotine and therefore these are known as “gateway drugs”.

The abuse stage is marked by drinking with friends or one may drink alone. The individual spends money on buying the substance. The individual may use it to cope with feelings such as depression, sadness or pain or guilt. He /she may drink several times per week or during the day also. Alcohol use may result in “black outs”. The individual has no memories of what happened during this black out and may forget events connected to the period when s/he was drinking. This can be interpreted by others as lying. The individual may try to relieve negative feeling by intoxication and thus cope with stress. The effects of substance abuse may result in guilt, fear or shame and result in mood swings, lying, changes in personality, conflict with family and an obsessive compulsive need for the substance is triggered.

The addiction stage is marked with daily use and continuous use of substance. The individual will continue to use in spite of problems s/he faces like deteriorating health problems, impaired family life, and loss of employment. The use is out of control and the individual wants to escape reality.

Recent Types of Alcoholics

A more recent understanding of the magnitude of the problem in America and the types of substance abuse is the study by National Institute of Alcoholism and Alcohol Abuse. (NIAAA, 2007) which also uses the stages of addiction to identify the types of alcohol drinkers found in America.

They are the Young Adult type (31.5%): These individuals are relatively well educated, and they don’t have family alcoholism and may not seek help for drinking behaviours.

The second type is the Young Antisocial subtype (21%): These are individuals who start drinking early, in their twenties. Most of them have family history of alcoholism and may
have psychiatric diagnoses such as antisocial personality disorder. 75% of this group also reported smoking cigarettes.

The third type is **Functional types of alcoholics** (19.5%): These are individuals who have a job and family. About 1/3 of these had a multigenerational family history of alcoholism. They also may have had some depressive illness and about 50% were smokers.

The fourth subtype is the **intermediate familial** type. About 19% of alcoholic in US come under this category. They were middle aged and 50% of these had multigenerational history. One in five had drug problems and 25% of these had taken treatment. Half had clinical depressions and 20% were having bipolar disorder.

The fifth are the **chronic severe subtype** constituted only 9%. They also had an early onset of alcohol use, and 80% came from families that had alcoholism. They had highest rates of psychiatric disorders, including depression, bipolar, antisocial disorder and high rates of smoking. They were the largest group of treatment seekers.

If one analyses the subtypes on risk factors for becoming alcoholics, one can observe that having a family history raises the risk for drinking problems significantly. In India at present we do not have study of this kind and it is difficult to predict if these subtypes can be found here too.

The background of the literature available highlights the paucity of research and the low priority to a population that is “high risk” (Miller, 1995; Shah and Vasi, 2002.) The next section focuses on the risk experienced by the drinkers.

**Effects of Alcohol Drinking**

Alcohol is a depressant and the action of the drug on the brain is that it depresses the pituitary gland affecting different areas. Depending on the amount taken, a person could feel mildly relaxed to even die due to overdose of alcohol. Thus the burden of the disease is not only physical, mental but also, financial as well as in multiple other areas. Presented below are some of the physical effects that may arise due to alcohol drinking. (Compiled from writings

Table 1.4: Physical Effects of Alcohol Drinking.

<table>
<thead>
<tr>
<th>AREAS</th>
<th>DISABILITY /EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurological</td>
<td>Wernicke syndrome, Korsokoffs syndrome, alcohol dementia, hepatic encephalopathy</td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Fatty liver, alcoholic hepatitis, Cirrhosis, Esophagitis, gastritis, gastric ulcers, vitamin deficiency, malnutrition, inflammation of pancreas leading to diabetes, malnutrition or diarrhoea.</td>
</tr>
<tr>
<td>Cardiovascular</td>
<td>Hypertension, cardiomyopathy, cardiac arrhythmias</td>
</tr>
<tr>
<td>Musculoskeletal</td>
<td>Swollen or weak muscles especially in the legs, gout</td>
</tr>
<tr>
<td>Immunological</td>
<td>Anaemia, Leukopnia (a depressed white blood cell count which leads to infections, coagulation (poor blood clotting) leading to severe bleeding.</td>
</tr>
<tr>
<td>Dermatological</td>
<td>Reddened face and nose, Roseacea, scaly skin or seborrhoea (like dandruff), purple areas of skin due to bleeding into the skin.</td>
</tr>
<tr>
<td>Nutritional</td>
<td>Nerve and heart problems due to thiamine deficiency, vitamin B and C deficiencies.</td>
</tr>
<tr>
<td>Cancer</td>
<td>Mouth and oesophageal, pancreas, colon rectum, stomach, prostrate and thyroid gland.</td>
</tr>
</tbody>
</table>

Some of the costs due to alcoholism are referred to as hidden, they are work, spouse and children. Presented below is the effect on these areas.

Table 1.5: Other Areas Affected due to Alcohol Drinking.

<table>
<thead>
<tr>
<th>AREAS</th>
<th>EFFECTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work</td>
<td>Absenteeism, workplace accidents, poor work performance, problematic relationships, loss of job, unemployment.</td>
</tr>
<tr>
<td>Spouse</td>
<td>Feelings of shame and guilt, withdrawn, depression, suicidal ideation or attempts, neglect of self, bruises which may be due to domestic violence, lifestyle not keeping with income.</td>
</tr>
<tr>
<td>Children</td>
<td>Poor academic performance not consistent with IQ, lack of concentration, hyperactivity, rebellion, aggression</td>
</tr>
<tr>
<td>Financial</td>
<td>Unable to meet regular demands of the family, inability to provide basic requirements.</td>
</tr>
</tbody>
</table>
The question at this point is if there are such severe repercussions caused due to drinking why do individuals continue to drink. There are several reasons proposed, given below are some of the reasons that have been put forth.

**Genetic**

People drink because they have a family member who has had drinking problems. This is being increasingly accepted as there may be a genetic component and studies (NIAAA, 2007, Milhorn 1994, Hecht 1973) seem to conclude that it may run in families, even when children are adopted the likelihood of becoming alcoholic is not reduced (Babor 2008). Children of alcoholics are seven times more likely than the normal population to drink. (Miller, Milhorn 1994). Babor T.F. (2008) maintains that there is a seven fold risk in first degree relatives of alcohol dependent. There is a 50-60% chances of alcohol transmission from parent to child. Research reveals that the gene for alcoholism is more complex and consists of myriad of genes and not one gene like in cystic fibrosis or other diseases. NIAAA (2008) also reports that there is a variation of breakdown of liver enzymes according to the race and alcoholism is not common among the Asians due to the way it is broken down leading to flushing, nausea and rapid heartbeats due to which they as a race drink less.

NIAAA (2008) puts forth that addiction has a basis in the brain and therefore it involves memory, motivation and emotional state. This is explained in the section on neurology.

**Personality**

The second reason why people drink is due to personality type, earlier known as addictive personality but research has not found conclusive evidence for this and it is no longer accepted. Though there is impact on personality when one is drinking no clear personality type emerges.

**Social**

The third reason that people may drink is due to social factors such as peer pressure or easy availability and accessibility of the substance. (UNODC 2008, UNDCP 2002) This increases the chances of experimentation.
**Disease**
The last is the disease model: People drink because they have a disease. Thus it has a clear symptoms and outcomes. It is often compared to diabetes. (UNDCP, 2002). E.M. Jellinek (1960)propounded that labelling alcohol as a disease meant that a sick person needed sympathy and not scorn. This is the model used for treatment and recovery worldwide amongst professionals in the field of substance abuse. This is the model used in the present study also . Though there are criticism against the model such as it abdicates an alcoholic from any responsibility and overlooks harm s/he does by masking it under the garb of the diseases.

The reasons why people drink can also be understood from the various perspectives of other eminent personalities and are elucidated below.

**Perspectives on Alcoholism**

Psychoanalytical perspective puts forth that the when an individual is facing anxiety s/he deals with it by going back to those behaviours when one felt most secure. Thus smoking, drinking, excessive talking, overeating are all manifestations of the fixation at the oral psychosexual stage. A chronic alcoholic is a victim of oral regression. He or she uses alcohol as a means to fight his unfinished battle with image of the pre-oedipal mother.(Bergler 1952)

Behaviour therapists opine that drinking is a learnt behaviour and is due to faulty role modelling.

Transactional analysis views alcoholism as a five handed game played by individuals in order to avoid intimacy. Transactional analysis calls the alcoholic as a life game. (Berne 1964)

Denzin’s theory (cited in Maines,1989) on the alcoholic proposes that one of the reasons to drink alcohol is growing up in an alcoholic family, experiencing feelings of emptiness and losing a closed loved one among other predisposing factors. He calls the alcoholic self- “the divided self” as it has fractions and is made up of the mood swings, contrasts and fictions. The alcoholism is an expression of the relationship to the world. The alcoholic drinks because there is a void which could be due to early death of members, sexual abuse, growing up in an alcoholic family. This is the theory of emotionality. The alcoholism is based on a theory of
emotionality, and recovery means getting to the root of the emotionally divided self. (Denzin cited in Hecht, M 1973).

Resentments as well self-pride are present in an alcoholic. Denzin says that alcoholics live in imaginary worlds and they run away not only from others but also from themselves thus living very solitary lives. Earlier emotional relationship needs to be shattered and new ways need to be learnt in order to truly recover and support group programs facilitate this growth. A significant factor one derives from the above section is that both the cause and the effects of substance abuse is the inability to handle emotions and thus the individual starts drinking or continues to drink. One could infer that emotions and alcoholism are deeply connected. Emotional health is one core area that is affected and the study addresses the same.

Vaillant’s study(1983) followed 660 men over 40 years of their life from adolescence to middle age for 1940 to 1980. Premorbid variables were analysed by Valliant’s study and he found that parental alcoholism was connected to childhood weakness. He used the childhood environment strength scale and the childhood environment weakness scale. From this he categorised homes as having warm childhoods, bleak childhoods or multi problem childhoods. He said that no matter what the subjective opinions of the men were about their childhood, they determined later mental health outcomes. Some of those who had bleak childhoods actually had poorer mortality and had early premature death due to suicide or violence. One of the finding was that the child’s later development outcomes were affected by “nothing going right than by several things going wrong”. He gave importance to emotional problems in childhood and this was included in the questions that the men answered.

Babor (2008) proposed two typologies of alcoholics. They are

1. “Type “A” alcoholics had later onset of alcohol problems, few childhood psychological problems, a less severe drinking history, and a more benign course of the disorder.
2. “Type B” alcoholics had an early onset of alcohol related problems, childhood behaviour problems, parental alcoholism, co-occurring psychopathology and a more problematic drinking history, severe alcohol dependence and a worse prognosis.

**Neurology Perspectives**

Neurology focuses on the effects of alcohol in the brain and several neuropsychological models have been put forth. They are the right hemisphere hypothesis, the premature aging hypothesis, mild generalized dysfunction hypothesis and frontal lobe hypothesis. The frontal lobe hypothesis has the most support. (Lezak, Howieson, Bigler and Tranel D., 2012).

From the literature above one can safely surmise that alcoholism is a complex amalgamation of biological, social, psychological, and neurological problem. No one cause or effect can be identified as a single most important factor which attributes to alcoholism. Though one cannot fail to deny that there is a tangible cost of this public health phenomenon as is presented below.

**Global**

Alcohol consumption has been identified as a risk factor due to the distress it causes communities in social and economic. WHO (2011) estimates alcohol as being responsible for 60 types of disorders. Alcohol consumption is the third global risk factor after childhood underweight and unsafe sex. Morbidity of alcohol use disorders is 3.47% for males and 0.42% for females. (WHO, 2011)

The 2008 report of United Nations office on Drugs and Crime (UNODC) reveals that at least one in 20 people try drugs in the world. The worldwide figures of the number of people who die due to alcohol related deaths are about 2.5 million.(WHO2011). The number of problem users is about 1/10 of the drug using population. The global burden of disease due to mental health and substance abuse disorders is about 7.4% worldwide which is greater than HIV/AIDS, and tuberculosis (5.3%), diabetes 2%, or transport injuries which is 3.3%. (Baxter, Ferrari, Erskine, Charlson, Degenhardt, and Whiteford, 2014) Overall alcohol contributes to 4% of disability adjusted life years.
The burden due to alcohol, opioid and cocaine dependence is more due to increasing prevalence of the disease than due to other reasons. (Baxter et al 2014)

Alcohol is the leading cause of for burden of disease and injury. It increases the risk of both intentional and unintentional injury. (WHO, 2011) The lack of adequate data on social costs particularly to others suggests it may be higher than anticipated. (Casswell 2008) Thus this is a gap in literature of who is affected and to what extent needs to be documented

The social and economic impact of alcohol is influenced by the culture of the country. Thus it depends on both the quantative variables and qualitative variables of each country (Easton 2008). Using the framework of WHO for estimating the cost of substance abuse, Easton (2008) found that the harm to others maybe in the following ways. The first is children born when one was under the influence of alcohol. The others are foetal alcohol syndrome and foetal alcohol effects which are a major source of mental and behavioural disorders some of which persist lifetime. The third is pain suffering, abuse and violence injury and death experienced by those close to the drinker. The fourth is pain, suffering and violence and death for the motor vehicle accidents experienced by the larger public. The economic cost of alcoholism is complex as it is connected to the poverty. WHO (2011) reported that lower socioeconomic status resulted in greater costs of the alcohol disease burden. This grim picture leads one to conclude that burden of the disease is severe.

There may be however certain individual factors which increase the likelihood of becoming alcoholic. Given below are some of the risk factors which affect the prognosis of the disease.

**Risk Factors in Alcoholism**

Lezak, Howieson, Bigler and Tranel D. (2012) have noted the following as risk factors that affect the individual due to the alcoholism.

**Age:** The age at which the alcohol drinking initiated was found to be important factor which predicted cognitive decline .The younger the age and longer the period of drinking the more the impact on the brain.

Race, some races are at reduced risk for alcoholism like the African-Americans who a carry the gene for rapid metabolism which leads to less pleasure from drinking and are found at a
reduced risk for alcoholism. In the past, France had the highest rates for alcoholism (Carson, Butcher and Coleman 1988) Though recent statistics by WHO (2011) rank Moldavia at number one.

Sex differences are also important as women tend to metabolize alcohol differently as compared to men and are likely to be addicted to alcohol or drugs quicker than men. Women’s hormonal cycles too seem to be affected by alcoholism.

Family history of alcoholism is a strong risk and as Lezak et al (2012) described it may be the most potent risk of all. This is supported by other research in the field too. (Babor et al 2008, NIAAA 2007, UNDCP 2002,)

Cognitive aging in alcoholism is similar for many alcoholics and affects the executive functions, e.g. mental flexibility and problem solving skills as well as the social emotional functions.

Here again if we observe from the data family history of alcoholism is a serious risk.

Though currently some global changes in alcohol consumption patterns have also been observed by the WHO (2003).

1. There is an advent of wine and beer drinking.
2. Women show an increase in drinking.
3. There is early experimentation and decreasing age of initiation.
4. A shift is noted from the urban to rural areas and transitional towns.
5. WHO reports that there is more “binge drinking”.
6. There is also a greater acceptance of drinking as an accepted social norm.
7. Alcohol use is combined with high-risk sexual behaviour.

Source: WHO, 2003

**Extent of the Alcohol Problem in India**

With a total population of 1, 240, 000, 000, (National Family Health Survey -3) India like other countries in South East Asia, has been witnessing changes in its macro as well micro domains of living and lifestyle. There is change in the youth today, their ways of thinking, their life style and their emotional, physical and psychological developments. The changes
are brought about by changes in media exposure, globalisation and a gradual shift in the world shrinking due to internet exposure.

All these changes affect the health behaviours of people too. Since people are exposed to newer cultures, newer ways of living and being are emerging. Gururaj et al (2006) add that these changes have resulted in changing health of Indian communities. Non-communicable disease result in morbidity, disability and poor quality of life which are affected by certain risk factors which precipitate, trigger or increase the outcomes. Some of the risk factor which occurs due to changes in behaviour and lifestyle are alcohol use disorders, tobacco use, sedentary lifestyles, and high risk sexual behaviours.

**Expenditure on Alcohol**

The government’s total expenditure on health care is at 3.9% (Global Health Observatory 2012). It is estimated that the government spends about 244 billion to manage the costs because of alcohol use which is more than what it is earning which is about 216 billion. These figures show that India loses more money than it is earning from alcohol (Gururaj et al 2006)

The percentage of family income spent on alcohol is 32 % in urban areas and about 24 % in rural areas. (Benegal V 2004 , NIMHANS) with a gross national income at 3910(in dollars).The amount of money that is spent on alcohol could have well been used for satisfying family needs or other needs like education.

**Alcohol Production and Consumption**

There is an awareness that alcohol has costs both human (abuse of women and children, crime) and economic (work absenteeism). If we examine the adult (15+) per capita consumption during 2003- 2005 in litres of pure alcohol in India it is 0.6 but the unrecorded consumption is 2 which actually mean it is 2.6 litres of alcohol being consumed.

According to The Alcohol Atlas, India is generally regarded as a traditional ‘dry’ or ‘abstaining’ culture (Bennet et al, 1993 cited in Alcohol Atlas of India 2005). Even then it
has one of the largest alcohol beverage industries in the world, the United Breweries Group, which is also the third largest spirits producer in the world after Diageo and Pernod Ricard.

India is the dominant producer of alcohol in the South-East Asia region (65%) and contributes to about 7% of the total alcohol beverage imports into the region. More than two thirds of the total beverage alcohol consumption within the region is in India.

There has been a steady increase in the production of alcohol in the country, with the production doubling from 887.2 million litres in 1992-93 to 1,654 million litres in 1999-2000 and was expected to almost treble to 2300 million litres (estimated) by 2006-07. (The Planning Commission of India, 2003)

WHO (2011) ranks India at 3 on 5 based on average drinking patterns. According to these criteria 1 is the least harmful and 5 being most harmful. This implies that Indians are average consumers; falling on the middle range it implies that the risk is moderate.

In spite of the so called average consumption there is evidence to show that patterns of consumption are changing and India is keeping up with these trends. A study by National Institute of Mental Health And Neurosciences referred to as The Bangalore Study (Gururaj, Girish and Benegal, NIMHANS 2006) estimated that 33% of men and 2% of women regularly consume alcohol. A majority of those who drank were from low levels of education and employment was married and had income levels which were less than 6000 per month. 40 % of these people did binge drinking and about 25% were pathological drinking.

The study also comments that the use of alcohol was not only increasing but also had a varying pattern of use in the lower and middle income sections. The study observes that hidden violence like emotional abuse, sexual abuse towards children and siblings was higher among alcoholics than non-alcoholics. It further asserts that the basic level of insecurity in the family had adverse effects. (Gururaj et al, 2006)
In a country where there are 62.45 million alcoholics (National Survey, 2004), assuming if even only 40% (between 11%-49% in the survey reported being married) are married and have at least one child, the number of children whose lives are affected by alcoholism is large. Yet we have no substantial study in this area in the Indian context.

About 43.9% persons have had alcohol from the data available from treatment centres. This number is lower in the general population, about 21.4 %. The mean age at which one experiments or uses alcohol is about 21 years with it being reported even lower from treatment centres, as early introduction as 15 years (about 9%). Thus, beginning early an individual may use alcohol as a **gateway drug** to experiment with more hard drugs like heroin or brown sugar. (National Survey, 2004) This means that people who are likely to face alcoholism have in all likelihood started very young.

In India about 40-44% persons seek treatment for alcoholism, nearly half of these are from Maharashtra (19%). It is therefore not surprising that the highest number of treatment centres are also in Maharashtra, about 53 centres (National Survey, 2004).

This data forces one to acknowledge the magnitude of a problem which is slowly burgeoning. Though, India as a country ranks low in consumption of alcohol, (2.6 litres of alcohol consumption per person) compared with other countries worldwide, the disturbing trend is that consumption has increased by about 106% in two decades here whereas other countries have witnessed a decline in consumption. (National Survey, 2004, Gururaj et al 2006)

This is further supported by statistics that highlight the incidence of family structures affecting drinking. Nuclear families witness higher drinking (44.3%), unlike joint families where drinking is less than half (18%). This could be attributed to the differences in the kind of social sanctions available in the two types of families, with the latter exercising more control and urbanization could be another factor. (National Survey, 2004)

Moreover, the number of people with a positive family history of abuse is 20-44%. That means that a family that witnesses drinking in one member is likely to face it in another member again. (National Survey, 2004)
Further funnelling down to Mumbai city, one observes the following figures for those who drink in slum versus no slum areas are as follows:

<table>
<thead>
<tr>
<th></th>
<th>WOMEN</th>
<th></th>
<th>MEN</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>% who smoke Cigarettes or bides</td>
<td>% who use any kind of tobacco</td>
<td>% who drink Alcohol</td>
<td>% who smoke Cigarettes or bidis</td>
<td>% who use any kind of tobacco</td>
<td>% who drink Alcohol</td>
</tr>
<tr>
<td>Mumbai</td>
<td>0.1</td>
<td>6.6</td>
<td>0.6</td>
<td>22.1</td>
<td>41.3</td>
<td>33.1</td>
</tr>
<tr>
<td>Census Slum</td>
<td>0.1</td>
<td>8.9</td>
<td>0.5</td>
<td>24.2</td>
<td>45.9</td>
<td>36.2</td>
</tr>
<tr>
<td>Census non slum</td>
<td>0.0</td>
<td>3.7</td>
<td>0.8</td>
<td>19.8</td>
<td>34.6</td>
<td>28.7</td>
</tr>
<tr>
<td>Poorest quartile</td>
<td>00</td>
<td>10.7</td>
<td>0.0</td>
<td>28.2</td>
<td>62.2</td>
<td>37.8</td>
</tr>
</tbody>
</table>

(Source NFHS3 2009)

From the above table, one cannot ignore the fact that the consumption of alcohol is highest (37.8%) in the poorer sections of the society. It is the cycle of being poor, having less resources and using more escapist forms of coping like alcohol which perpetuates more problems instead of alleviating them. The statistics above are reported and actual drinking maybe more but goes unreported. Gender wise non-slum (0.8%) women are drinking more than slum women (0.5%) and slum(36.2%) men report more drinking than non-slum men(28.7%). These figures collate with WHO findings that there is an increase in women who report drinking.

Mumbai figures for alcohol consumption in youth are about are about 19.7 overall. About 25.2 in slum areas and 14.6 in non-slum consume alcohol. (NFHS-3).

One can assess from the above that published Indian studies are not in the area of impact on adult children. One of the large scale and relevant set of studies published by the United Nation on Drugs And Crime (National Survey, 2004) in the Indian context has focused thematic studies on women in addiction, addiction in prisons, burden on women due to substance abuse, but has no mention of this burden on children-young or adult, impact on
them and street children in addiction. This is the gap in the literature as identified by the researcher.

Thus the question raised at this point is how the child is affected emotionally as s/he is probably the most vulnerable and most weak member in the family circle and is exposed to this parent and his divided self (Maines 1989). The next section attempts to comprehend emotional intelligence and the effects of alcoholism on the emotional intelligence.

**Emotional Intelligence**

**Antecedents**

In order to understand the effects we first need to answer the question what is emotional intelligence. (EI) and what is emotion?

**Emotions**

Emotions are defined in terms of four components, interpretation of the emotion or appraisal of some stimulus event, object or thought, in terms of well-being. Second is a subjective feeling such as fear or happiness. Third is experience of physiological responses, change in heart rate and fourth are observable behaviours such as smiling or crying. (Plotnik 1999)

There is no doubt that emotions are experienced but theorist disagree about the order in which they occur and thus there are various theories proposed like the James Lange Theory, Facial feedback theory, Schacter –Singer theory cognitive appraisal theory and Affective Primacy theory.

**Theories of Emotions**

Researchers like Plotnik, Morgan and King (1994), have elucidated some of the following theories.

The James-Lange theory asserts that the brain interprets physiological changes and responds to each emotion with different physiological patterns.
The criticism against this theory is that there need not be a separate pattern for each emotion and emotions can have same underlying patterns. The second criticism is that the people whose spinal cords are severed are also able to experience emotions and thirdly some emotions are more complex and their appraisal is more complex and may involve cognitive influences on the emotions.

The facial feedback theory, originally proposed by Charles Darwin estimates that sensations or movements of your facial muscles and skin are interpreted by your brain as different emotions.

This theory does indeed contribute to the mood or feelings and can intensify the emotional feelings one is experiencing. The criticism against this theory is that one does not need facial feedback to experience emotions as observed in the case of the patient who have paralysis.

The Schacter-Singer theory propounds that one’s interpretation of the situation influences the emotions. This was a classic study which introduces the cognitive element into the experience of emotions. Though one of the criticisms against this theory is that one could experience the emotions without first experiencing cognitive appraisal. The other is that one could experience physiological cues but they could be influenced by the internal thoughts, and appraisals.

The current cognitive theory states that the interpretation of the situation results in the emotions one would feel. The affective primacy theory on the other hand maintains that sometimes one feels the emotion even before one has time to interpret the situation. (Plotnik, Morgan and King (1994)

**Brain Areas Involved in Emotions**

The brain areas involved in prefrontal, hypothalamus, thalamus and cingulate, of these certain areas are activated in certain emotions like for happiness it was the media temporal and sadness it was the cerebellum. The amygdala is an important area for emotion. Amygdala is important in processing emotional stimuli from all major sensory modalities like the auditory, somatosensory, olfactory and gustatory and vision. This small organ is important
for processing emotions especially fear. The amygdala provides an “emotional tag” to memory traces. (Lezak ,Howieson ,Bigler and Tranel D.,2012)

**Basic Emotions**

The experience of certain emotions is universal like happiness, fear, anger, contempt, surprise, disgust and sadness. (Ekman 1992)

**Functions of Emotions**

Emotions serve different functions from being social cues to others; being necessary for adaptation and survival; helping arousal and motivation. Thus one can understand that emotions are important in one’s life but then why are some people adapting better than others. These individuals are believed to be more emotionally intelligent. The section below trails the roots of EI and reviews pertinent literature.

**Emotional Intelligence**

The roots of research on emotional intelligence can be traced to unanswered questions on why some people with high intelligence quotient were not as successful and others with average intelligence quotient (IQ) were quite successful. Research across the globe (Ziedner, Mathews and Roberts 2012, and Baron 2006, Goleman, 1995, Salovey and Mayer 1990) was propounding that IQ was not a predictor of success but other intelligences like social and emotional were more important.

Mayer, Robert and Barsade (2008) pointed out that EI emerged as a “hot intelligence” in the 1990’s as researchers began to explore more about the different kinds of intelligence.

The history and origin of the word EI itself is attributed to different researchers.

**History and Origin**

Reuven Bar-on attributes the first use of emotional intelligence to Charles Darwin in 1872 in his work on the importance of emotional expression for survival and adaptation. He is influenced by Darwin’s work. (Baron 2008) He argues that this intelligence was mentioned by Thorndike in 1920s as social intelligence or the ability to get along with people. He
comments that even Wechsler acknowledged that affect may play a role in development of intelligences, and that these “non intellective” or non-cognitive or conative factors are important and one needs to study these. Howard Gardner in his book “The Shattered Mind” used the terms intrapersonal and interpersonal as types of intelligences (1975) later referred to as EI.

The term EI has an incidental origin and was used in the 1960s by Van Ghent as a literary criticism and the first time it was used in a doctoral thesis title by Payne in 1986(both cited in Mayer, Salovey and Caruso, 2004). Keith Beasley (1987, Mensa Magazine) used EQ for the first time (Bar-on 2008). Bar-on has now shifted from calling EQ as EI to ESI (Emotional Social Intelligence) Reuven Baron does credit Salovey and Mayer to have written the first systematic understanding of EI in 1990. Goldman’s landmark book on Emotional Intelligence brought the construct of EI to the forefront of the world. (1995). Presented below are some of the ways in which EI has been defined.

**Definition of Emotional Intelligence**

Goleman (1995) defines EI as having five core concepts. The first is self-awareness or knowing oneself, it is about knowing how one feels and to be able to perceive it. Thus Socrates ‘Know yourself’. This ability has been described as a, metacognitive and Metamood ability. The second is the area of managing emotions. According to Goleman (1995) people who know how to look after themselves emotionally will be better adjusted and can bounce back after a failure. The third area is motivating self, and exercising emotional control these individuals are able to delay gratification for future gains. The fourth area put forth is recognizing emotions in others or the skill of empathy. As this is in connection to other people one can view it as an extension of awareness in self. The fifth area that Goleman claims is important in defining EI is handling relationships.

Baron defines EI now as Emotional Social intelligence as a “cross section of interrelated emotional and social competencies, skills and facilitators that determine how effectively we understand and express ourselves, understand others and relate with them and cope with daily demands”. (2008)
Darwin Nelson and Gary Low (2007) defined EI as a confluence of skills and abilities to accurately know yourself, feel valuable and behave responsibly as a person of worth and dignity, establish and maintain a variety of effective, strong and healthy relationship get along and work well with others and deal effectively with the demands and pressures of daily life and work.

The study uses the simple definition put forth by Mayer and Salovey (2000).

*Emotional intelligence as having the key components of perceiving emotion, using, understanding and regulating/ managing emotions. (Mayer and Salovey 2000)*

Since 1995 emotional intelligence has led to a great number of emotional intelligence models. This has resulted in much misrepresentation and misunderstanding of the concept (Ziedner et al 2012, Salovey and Mayer 2009, Snyder and Shane 2007). Salovey and Mayer (2004) theorize that emotions were important in adaptation and in guiding behaviour their model along with other models have been discussed in the following section. When accessing review of literature there are different models to study EI the most recent is trait and ability models.

**Models in EI**

Mayer, Robert and Barsade (2006) proposed that EI can be theoretically understood from three approaches. These being the specific ability model, integrative ability model and mixed model approach. Mayer et al (2008) reported that the area has been studied in different ways leading to confusion. They then examine it in the context of a nomological framework.

The specific ability model proposes that EI as basic to some specific ability like accurate emotional perceptions. Some models here try to use EI and understand emotions to facilitate thought, still others look at emotional appraisal, labelling and understanding, and still others believe emotional self-management as an important area.

The integrative model approach is like that proposed by Izaard’s. (Mayer, Robert and Barsade, 2008) The key premise here is the joining of many abilities to get an overall EI.
Izaard prefers to call it emotional knowledge as opposed to EI. Here the capacity for both learning new and unfamiliar things (showing aptitude) as well as recalling old familiar things (knowledge acquired) is both woven into this model.

The third approach is mixed models which target mixed qualities like non cognitive abilities and certain traits from personality. These lack primary focus on EI and also include personality variables like flexibility, assertiveness and need for achievement. Baron’s EQi (1997) and Schutte et al (1998) and Goleman’s (1995) framework have been developed on the lines of mixed model.

Salovey Mayer and Caruso (2004) proposed a four branch model of EI which is considered to be a pure model of EI whereas the later one by Goleman is considered to be a mixed model as it includes other abilities besides emotional. One could also position Darwin and Nelson understands of EI as categorised under the mixed model. They call the model, Transformative EI and their scale has been used in the study. The most acceptable according to Mayer, Roberts and Barsade are the first two models. They feel that the third, mixed model was not as acceptable, as it relies on factors other than EI and has not been scientifically proven. (Mayer, Robert and Barsade, 2008).

The field is still so new and growing in terms of understanding that it may be too early to conclude that only one approach is better than others or is the correct or appropriate one.

**Criticism of EI**

When one analyses the construct of emotional intelligence it appears to be in a nascent stage. Critically analysing EI one observes that similar concepts, personality traits and other psychological aspects have been clubbed together under the umbrella of EI. The combination and permutation differ depending on the ontology of the researcher and the epistemological underpinning selected. It raises questions on measurement of EI and whether knowledge constructed around this is too diverse yet falls under the bracket of EI. This is an area demanding further research on the variables included by different researchers to form the large conceptual whole called EI.
Similar concerns have been raised by Mathews, Zeidner and Roberts (2012) as a construct there are certain factors that have not been taken into account. They put forth the following points which are presented to achieve some clarity on EI and provide critical review of the filed as it is in current period.

1. There is a no clear understanding of what constitutes EI.
2. There is a lack of a single standard measurement of EI. Researchers find that the tests of EI overlap significantly with other measures such as personality. Convergent validity is low for EI tests. There are questionnaire methods and there are ability measures.
3. The theoretical base is absent. Much of the work in exploring the EI is by way of list and questionnaire instead of actual testing of cognitive and neurological processes.
4. Criterion validity is poor as the tests measures overlap with other personality constructs like emotional stability is like low neuroticism.
5. The cultural differences in EI which are not currently accounted for as this may change from culture to culture and thus EI maybe conceptually different. Here the challenge is whether construct validity is affected.

Like the above criticism on EI, a healthy debate is emerging on ways to study EI and its application. Since EI as a field is new and within the research community itself there is revision in different areas like Mayer and Salovey’s definitions of EI the term “managing “in 2000 was replaced by “regulating” in 2012), refining and at times redefining the construct (like the shift in Baron EQ to ESI) as also in typology of models(from three to two models in 2012, pure and mixed by Zeidner and others 2012)to it may be a while before there is a consensus on the construct of EI. One cannot neglect though that the domino effect of research in this area has resulted in an awareness of the emotional world and its repercussions on the individual. Thus in the context of this study the effects on EI because of the alcoholism in the father are examined in the third section of the literature review.
Effects on Emotional Intelligence

The effect of alcoholism is so widespread that this disease is often referred to as a “family disease”. Secrecy is important and is encouraged in this one disease. It should not be a surprise then that children in such families would be affected by this secrecy. Alcoholism is a two way process, the family is as affected and as ill as the alcoholic is. (Jackson J, 1958). The mental health risk of being a child of an alcoholic (COA) has far-reaching effects, well into adulthood. COAs are seven times more likely to become alcoholics themselves (Miller N, 1995) From the unwritten rules that weigh down the family to the don’t talk, don’t trust and don’t feel, and don’t think syndrome, (TTRK Foundation,1989; Kinney and Leaton,1987 ) living in a dysfunctional family affects coping especially the ability to handle ones emotions. (Robinson B and Rhoden J, 1998) and therefore affects EI.

Individuals who are high in emotional intelligence will show better ability to manage emotional information. Among other traits these individuals are higher in the above four areas mentioned by Goleman (1995), they are less likely to indulge in self-destructive behaviours like substance abuse, are higher in social and verbal intelligence have an openness and agreeableness in their personality (Mayer and Salovey2004). There is a negative relationship between EI and deviant behaviour like substance abuse. Those with substance abuse are likely to have a lower emotional intelligence. Salovey and Mayer (2004) found that individuals who are high in EI are less likely to indulge in behaviours that may be self-defeating like, smoking, drinking, drug taking or violence.

Findings in other areas of pathological gambling and EI also have found that individuals with higher EI have lower likelihood of problem gambling (Kaur et al 2006) A person with low EI found it difficult to identify emotions and use emotions to facilitate decision making. Further these individuals also had poorer understanding of emotions. The findings from their study propose that low EI can be predictive of a range of behavioural problems associated with impulse control.

Could this mean the parenting process by such individual will result in children who we can say would be inadequately honed in the above areas due to deficiencies in the parenting process of transferring these skills? A study by Steinhausen et al (2006) assessed the risk
factors of emotional and behavioural development of children born to mothers who were drug dependent. The findings of the study reveal that having a network of close relationships had a buffering effect on emotional and behavioural problems. Further mother’s mental health problems, educational status also influenced the outcome.

Another study by Petratis et al (cited in Ray et al 2004) found that emotional stability and self-efficacy were important deterrents influencing drug taking behaviour in adolescents.

Daniel Goleman in his book on Emotional Intelligence (1995) stated that family life is the first school of emotional learning. This schooling happens not only in what parents say and do but also in the models of the ways they handle their emotions. This schooling can be treated as intergenerational lessons on metacognition about emotion. Diamond and Aspinwall (2003) found that parents had ways of transmitting their emotionality to the children. Parents were also forced to become aware of their own temperamental emotionality and to make efforts to alter their behaviour and emotional expressions to enhance socialization of their children.

Goleman (1995) says, “Some parents are gifted emotional teachers and some others are atrocious. The children at greatest risk seem to be those whose parents are grossly inept – immature, abusing drugs, depressed or chronically angry, or simply aimless and living chaotic lives. (Goleman, 1995).” If we assess these parameters with respect to the AOD dependent then these traits of immaturity, depression, aimlessness, moodiness and chaos are all evident in the life of such individuals. (Hecht M, 1973) Further Mayer, Caruso and Salovey (2004) found that a higher emotional intelligence was correlated to higher parental warmth and attachment style. The theory of self-actualizing individuals argues that individuals are affected by their childhood experiences and one could be emotionally crippled if certain needs are not met. (Maslow cited Hoffman, 1999)

This is also reasserted by Taylor and Bagby (2000) that the failure in caregiving affects the neural and cognitive systems which are involved in emotional processing. Thus individuals who may have poor caregivers are at a disadvantage and alexithymia may be one of the consequences. A concept which is similar and overlaps with the EI concept is Alexithymia or low EI as EI researchers put it. Mayer and Salovey (2004) situate it at the lowest branch of
EI. It is proposed that individual with low EI may have alexithymia. Bar-On puts forward that alexithymia is on one end of the pathological continuum and psychological mindedness on the other end at eupsyhic. (2006)

Alexithymia

This section was reviewed following the findings that were obtained in the study which seemed to indicate further clarity and understanding of self-awareness and insight needed to be addressed.

Sifnoes (1973) coined the term Alexithymia from the Greek word which means “lack of emotion”. Many therapists (Horney, 1952, Kelman 1952 cited in Taylor and Bagby 2000) found that certain patients did not do well in insight oriented therapies and attributed this to a deficit in emotional areas like lack of self-awareness, poverty of inner experiences, interest in dreams was minimum, concrete thinking and externalized behaviours. These individuals were likely to develop psychosomatic symptoms like binge eating, alcohol abuse and other compulsive behaviours. Taylor and Bagby (2000) report that other researchers also reported similar characteristics in different condition like anorexia nervosa, drug addiction and a few link alexithymia to substance abuse, eating disorders, post-traumatic stress disorder and somatization.

Alexithymia basically is a personality construct comprising of the following features. Individuals have difficulty in identifying feelings and distinguishing between feelings and bodily sensations of emotional arousal. Secondly they may have difficulty in describing feelings to other people. Thirdly they may have constricted imaginal processes like lack of fantasy and fourthly a stimulus bound externally oriented cognitive style of coping or one could say a low emotional expressiveness.

These individuals have a fear of intimacy and have a restricted capacity to share personal information which maybe significant for them. Thus they have a difficulty establishing relationships and sustaining relationships. (Parker 2007)

The next section explores the management of the emotional intelligence which is affected in some ways by this chronic stress that they grow up with.
Management of Emotional Intelligence

Growing up: Early Life Experiences

Research has revealed that children of alcoholics do adapt to the immense stress they face and usually develop different roles to cope with the world around them. (Sharon Weghscheider-Cruse, 1981, Black, 1981; Ackerman1986).

They take on different roles often determined by circumstances around the child for e.g., usually the first-born becomes the hero, responsible and mature but has done so at the cost of a lost childhood.

This high risk group is said to be found among helping professions, like pastoral services, religious roles .Caring for others is what they had done all their life and knew best (Mc Elwee 1990).Some may be detrimental like that of a child who adopts the role of a scapegoat where he too takes to substance abuse.

Black (1981) puts forth that healthy families are consistent and allow individuals to express themselves freely. There is support offered and understanding provided. In contrast in a home where there is alcoholism there is inconsistency , freedom of emotional expression is absent and members struggle to maintain the family .Alliances which are constructive in healthy homes are also absent as it is usually one parent and child or children against another . Rules in the family such as no hitting are heard, but there are also unspoken rules like “you will not tell anyone how you got the bruise.”

In a family systems approach the roles in a family are governed by structure and a function. In the alcoholic family the alcoholic is at the centre of the system which itself is dysfunctional as this has to be flexible and depends on who needs what support and when. Satir’s analogy is that the family is like mobile, when one part move the other parts adjust themselves. Thus every person plays a certain part in the family. Melee (1990) argues that this is what makes children in same family so different.

Some of the rules in an alcoholic family are (Weghscheider-Cruse, 1981)

1. The dependents use of alcohol is the most important thing in the family’s life
2. Alcohol or Drugs is not the cause of the problem. Someone else caused it, s/he is not responsible

3. The status quo must be maintained at all costs

4. Everyone in the family must be an enabler

5. No may discuss what is going on in the family

6. No one may say what s/he is feeling

Roles as such are healthy and flexible in normal homes but in ACOA homes they become rigid and fixed. The child from regular home learns and changes roles as he grows, the ACOA may sometimes be locked in to the same role as it had brought stability to his life.

Black (1981) further argues that ACOAs are generally not the ones who are problem children or who become runaways or perform poorly in school. They appear typical and normal and rarely or never speak about the alcoholism in the family.

School counsellor or juvenile justice systems do not see these children as they do not draw attention to themselves.

Black has put forth 4 major roles taken by ACOAs. This may change within the family but are dysfunctional and as researchers (Ruben 2001, McElwee 1990, Ackerman 1989, Black 1981) emphasize “there is no healthy way to adapt to an unhealthy situation like alcoholism”.

1. The responsible one or the hero
2. The adjuster
3. The placator
4. The acting out child

**The Responsible One:**

The responsible one is who takes charge and helps to run the house if dad is drinking and mum is busy with him. The responsible one takes the role voluntary or at times it is expected as he or she is generally the oldest child. S/he is are very organised, become adept at
planning, manipulating the other siblings, and normally get elected as class leaders, captains of teams as he develops leadership skills and is able to accomplish goals.

They learn to rely on themselves and learn that the best way to provide security is to get it done themselves as they learnt that adults cannot be relied on when help is needed.

**The Adjuster**

This ACOA has learnt that to survive the chaos of the alcoholic home s/he must go along or simply adjust to what is happening around. The adjuster deals with the situations as it happens. The adjuster feels that anyways he can’t do anything to change the situation. These children are also seen as selfish and most detached by professionals. This is the child who is not at home, who spends most of his time with his friends and is unaware of the conflicts that are happening in the house. Adjusting children simply follow what is told to them which make life easier for everyone around them. These children are in denial or appear more selfish acting without thinking or feeling is typical of the adjuster.

**The Placator**

This is the ACOA who is called upon to fix others, their pain, and their sadness, lessens the tension and help in diminishing the fear. This child helps to make the life of others easier. These children are perceived as nice and they spend a lot of time pleasing other and making others feel better. He appears like a warm, caring and sensitive child. They are well liked in both school and at home.

**The Acting-out Child**

If all the above three act in ways that do not attract attention the acting out child draws attention to himself by doing things which are negative and display delinquent behaviour. The family focuses on this child rather than focus on the real problem that is the father’s alcoholism. They learn unacceptable behaviours from the parents who are role models.

Weghscheider –Cruse (1981) puts forth the roles as Hero, Mascot, Scapegoat and the Lost Child. The hero role overlaps with the responsible one. The scapegoat role overlaps with the Acting out child. Given below are some of the role descriptions.
The Family Hero

This role is usually adapted by the first born. These children need to show the world how wonderful the family they belong to is to produce a child such as him/her. They do become fearful and feel very lonely and have few close friends. They may however have admirers. They also learn to disregard their own needs.

The role affects them in that they become workaholics, they tend to burn out or have heart attacks as they take on more work than they can handle. They find it difficult to relax and may use alcohol or drugs to vent their feelings.

The Scapegoat

This child acts out the family pain. The scapegoat usually feels abandoned, hurt or lonely. The family anger is dumped on the scapegoat. They usually end up taking alcohol or drugs or getting into antisocial activities. This helps the family to take away the focus from the real problem, the alcoholism in the father and focus on something else.

The Lost Child

This child is not very important and may go unnoticed in the family. This child is confused, indecisive, and fearful, feels unimportant and is afraid to rock the boat. They have difficulty developing intimacy and close relationships. These are children who demonstrate the maximum characteristics of being ACOAs.

The Mascot

This child is usually very cute and diverting the family from the tension of the alcoholic father. Mascot are not involved in the family and usually do not know what is really happening as they are often mislead or truth is not told to them. The rest of the family protects them from knowing the secret.

These similar role taking behaviours have been discussed by others researchers too. Ackerman (1989) has from his own study proposed different types of ACOAs with a gender differences. Some of these roles are achiever, the triangulator; the other directed one, the passive one, conflict avoider, the hyper mature, detacher and invulnerable one.
In the current study one uses the terms the hero, the lost child, the scapegoat, the mascot. The placator role is close to what is a hero’s role as he takes care of others and fixes them. The mascot and the adjuster are two other terms which will be used as they were unique in the role characteristics attributed to them.

The table below delineates the three key researchers who have proposed the different roles that are adapted by ACOAs.

Table 1.7: Roles Observed in ACOAs.

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>• the family hero</td>
<td>• the responsible one</td>
<td>• the achiever</td>
</tr>
<tr>
<td>• the scapegoat</td>
<td>• the acting out child</td>
<td>• the triangulator</td>
</tr>
<tr>
<td>• the mascot</td>
<td>• the adjuster</td>
<td>• the other directed one</td>
</tr>
<tr>
<td>• the lost child</td>
<td>• the placator</td>
<td>• the passive one</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• hypermature</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• detacher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• conflict avoider</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• invulnerable one</td>
</tr>
</tbody>
</table>

According to Black (1981), who has done pioneering research with children of alcoholics, these children had fewer physical, social, emotional and mental resources to rely on. Physically the child may have low energy due to lack of sleep, socially they may hesitate to bring other children home, and emotionally there is fear, pain, and embarrassment. These children as adults might bury their feelings and thus achieve a semblance of control over their lives.

The popularity of the self-help group around the world for adult children of alcoholics indicates that a large number of children feel that they are having a difficulty in trust,
relinquishing control, identifying and expressing emotions and changing rigid behaviours. (L’Abate and others 1992) This seems to suggest that these roles though adjusting and allowing coping nevertheless may not work well into adulthood.

The hero is an overachiever and may have difficulties in being able to say no. It is hypothesized by Weghscheider that the hero grows up to become a workaholic, has a high need for control and is inevitably the responsible one. Contrast this with the problem child who is described as growing up to be irresponsible, likely to become an alcohol or drug addict. The hero’s role emerges from a low self-esteem whereas the problem child is from a feeling of rejection.

Researchers (Ackerman 1989, Black 1981, Weghscheider-Cruse 1981,) suggest that as a child, these roles helped the individual to cope but as an adult, the same roles may prove detrimental in establishing meaningful relationships.

Maslow argued that normal personality is affected by childhood experiences like early deprivation of basic needs and could lead to emotional crippling in adult life. (Hoffman, 1999)

Abate and others (1992) have proposed that growing up in a home with substance abuse can result in deprivation at mental, social, emotional and physical level. They propose that children may be emotionally neglected and parents may also be less available emotionally. Some children may develop an emotional numbness. Families might not be able to express intimacy or anger in appropriate ways. Communication patterns are often very inconsistent and mixed messages are normal. These families are also likely to experience a higher incidence of parental quarrelling, violence and divorce or separation. These findings are also substantiated by Hecht M (1973).

According to Goleman (1998), the amygdala in the brain encodes the emotions that an experience evoked. This information may be stored and used when required. These experiences known as emotional memories explain the way we react or act. Therefore, if one has been exposed to abuse at home, it is likely that this is encoded and coping response
could be emotional numbing. Emotional numbing over a period will result in poor emotional awareness, as there is no touch with one’s feeling.

The brain stores all the experiences as data which may be then retrieved on demand. A review study by Diamond and Aspinwall (2003) have also emphasized the importance of early environment for development of emotion regulation. They reviewed studies which implicated that a blunted HPA activity was found in maltreated human children in response to the chronic stress experienced by them. This protected the brain from damage due to heightened exposure to glucocorticoids.

Gardner (2011) proposed that family environment and caregivers do play a role in socialisation of emotional skills through both modelling and explicit instructions. They believe that children who are reared in homes where there is parental conflicts, low bonding and anger is expressed aggressively may have difficulties’ in learning emotional regulation. Further they assert that abusive homes will be detrimental to the development of perception, understanding and regulation of EI.

Sometimes the maltreatment and chronic stress may evince itself as even when parents are physically present with the children, they are emotionally unavailable to them (Dayton 1997). Dayton shares her own experience of being a child of an alcoholic. Her way of managing her emotions was to withdraw in a shell.

Dayton put forth that people cope with events that are overwhelming by developing defences like splitting (things are viewed as either black or white), dissociation (remaining physically present but psychologically absent), numbing (shut down our emotional response) and idealization. These defences are developed as children but are carried through into the adult life and are reflected in later relationships.

It could be that there are other factors which are responsible for mediating the experience of alcoholism. One crucial factor can be gender of the ACOAS. Research findings have concluded a genetic link in the father son transmission of alcoholism and the likelihood of adult daughters marrying alcoholics themselves known as assortative mating (Olmsted, Crowell and Waters, 2003; Miller N 1995; L’Abate 1992)
Gender and EI

A study on Adult daughters of alcoholics by Ackerman (1989) revealed that the experience of alcoholism had different meanings depending on some of the following factors. The age of the daughter seemed to affect the perception of alcoholism in the family. A younger child could not perceive alcoholism as similarly as older children who could understand deeper ramifications of alcoholism.

A second factor affecting alcoholism was the sex of the alcoholic parent. The women ACOAs are affected differently depending on who has the alcoholism, the father or mother or if both were alcoholics. Having an alcoholic father meant different problems vis a vis an alcoholic mother. The daughters of alcoholic’s fathers were more likely to face problems in relationships, role confusion, intimacy, sense of self, sexual abuse and perfectionism. The adult daughters of alcoholics having an alcoholic mother faced problems in role modelling, relationship, parenting skills, identity, and trust. Adult daughters of alcoholics who had both parents as alcoholic faced problem in relationships both with parents and significant others, concern over parenting, concern over alcohol or drug use both of self and of partners and a concern over how to get the parents sober. Since this was also observed from researchers own field experiences that ACOAs both men and women were affected differently depending on the sex of the alcoholic parent, it was decided to study only fathers alcoholism and impact on the ACOA.

A third factor that seemed to affect the experience was parenting style and behaviour. This was connected with the duty of fulfilling the parental role vis-à-vis alcoholic role. The two roles are played out differently. The last factor was the daughter’s perceptions on the alcoholism in the family. He further reported that the due to the parental alcoholism the daughters faced problems in intimate relations and parenting as they had no role modelling or faulty role modelling.

He has further refuted the dysfunctionality hypothesis and believes that inspite of all this ACOA is capable of taking charge of his/her life.
The adjoining tables provide an overview of some of the studies undertaken in alcohol drinking and the effects on children. Studies were reviewed using the following template to arrive at understanding of the impact of alcoholism.

### Table 1.8: Literature Review

<table>
<thead>
<tr>
<th>Date</th>
<th>1983</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>The Natural History of Alcoholism</td>
</tr>
<tr>
<td>Authors</td>
<td>Vaillant G.E</td>
</tr>
<tr>
<td>Objective/ Focus of Study</td>
<td>Understanding alcoholism over the lifespan and not focus on the individual after alcoholism develops.</td>
</tr>
<tr>
<td>Method</td>
<td>Quantative Longitudinal study -- 1940-1980</td>
</tr>
<tr>
<td>Sampling</td>
<td>Selected from Harvard School at age 18. Clinical sample from detoxification centres.</td>
</tr>
<tr>
<td>Sample Detail</td>
<td>660 men 204 from upper middle class, 456 from Boston school, 100 men and women followed for 8 years after they were admitted for alcohol detoxification.</td>
</tr>
</tbody>
</table>
| Research Question | 1. Is alcoholism a disease?  
2. Does alcoholism get progressively worse?  
3. Are alcoholics before they begin to abuse alcohol different from non-alcoholics?  
4. Is abstinence a necessary goal of treatment or can it be counterproductive?  
5. Is returning to safe social drinking possible for some alcoholics?  
6. Does treatment alter the natural history of alcoholism?  
7. How helpful is AA in the treatment of alcoholism? |
| Key Concepts | Alcoholism is a disease, premorbid factors in alcoholism. natural history of alcoholism. |
| Findings | 1. Reconfirmed that alcoholism is a disease.  
2. It is progressive for some of those who stated drinking but for a few of those who were drinking Vaillant said that they may continue drinking without progressing. He found that many of these men died prematurely (6) or became abstinent.  
3. He found three areas where alcoholics were different from non-alcoholics One was they were more likely to come for ethnic groups that tolerate drinking but do not teach children or adolescent how to drink safely. Second they were more likely to have parents or grandparent from English speaking countries than Mediterranean ones. He also found genetic links of developing alcoholism, increased likelihood of developing alcohol abuse as much as also becoming abstinent due to the Environmental reasons.  
4. Lastly future alcoholics do not appear any different from non-alcoholics Alcoholics came from homes where there was alcoholism in the parent Three variables that predicted positive mental health were boyhood competence, warmth of childhood, freedom from childhood emotional problems. Three variables that lead to poor mental health were family history of alcoholism, ethnicity, and adolescent behaviour problems.  
5. Abstinence is important goal and it was likely that person can attain recovery without abstinence. |
6. He felt it was possible to drink in a controlled manner.

7. He found treatment is possible if the following factors happened: the alcoholic found “substitute dependency”; medication like anta abuse; social support; or something that motivated him or her like religion.

8. AA was as helpful as other forms of treatment.

<table>
<thead>
<tr>
<th>Date</th>
<th>1978 from Book Currents in Alcoholism Psychiatric, Psychological, Social &amp; Epidemiological Studies ed. Selxas Franck</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Fathers Alcoholism &amp; Children Outcome</td>
</tr>
<tr>
<td>Authors</td>
<td>Robins Leen, West P, Ratclif.K.S, Herfanic B.M.</td>
</tr>
<tr>
<td>Objective/Focus of Study</td>
<td>Father's alcoholism, children’s school achievement, delinquency in child</td>
</tr>
<tr>
<td>Method</td>
<td>Quantitative Data collection Records of police, hospitals, Military services, credit bureau, school records, social agencies (last 6 years) Secondary Data analysis comparative analysis</td>
</tr>
<tr>
<td>Sampling</td>
<td>Tech-systematic interview schedule-(drinking History and Psychiatric sample sample)</td>
</tr>
<tr>
<td>Sample Detail</td>
<td>223 Black men aged 31-36 years</td>
</tr>
<tr>
<td>Research Question</td>
<td>1) What are the degree to which school achievements &amp; delinquency were rejected by fathers alcoholism</td>
</tr>
<tr>
<td></td>
<td>2) How much of these could be related to alcoholism itself</td>
</tr>
<tr>
<td>Definition of Key Concepts</td>
<td>Early fatherhood is significantly associated with alcoholism</td>
</tr>
<tr>
<td>Findings</td>
<td>1) Father's Alcoholism, Rate of Alcoholism -- 41%, 38% if they had no kids, 46% --- if kids not significant difference</td>
</tr>
<tr>
<td></td>
<td>2) Children Outcomes--61%, child repeated at least 1 semester, 17% had been truant or expelled, 36% drop out before graduation, 24% had police records before age 17</td>
</tr>
<tr>
<td></td>
<td>3) Association of (1) + (2), 24% seriously truant, 44% school dropouts, 28% delinquency</td>
</tr>
<tr>
<td></td>
<td>4) Statistical significance, between alcoholism &amp; truancy &amp; drop out</td>
</tr>
<tr>
<td></td>
<td>5) Comparison of different family settings in which African child are reared</td>
</tr>
<tr>
<td>Limitations and Gaps</td>
<td>Felt the criteria for selection of alcohol was inadequately defined. Anyone could be defined as an Alcoholic in this study.</td>
</tr>
<tr>
<td>---------------------</td>
<td>--------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Theory              | Question is genetic theory based on other factors 
…. Parental alcoholism 
…. Family Structure 
…. Pre alcoholic behaviour pattern are passed on from one generation to second generation i.e. providing an external conducive to develop these problem |

<table>
<thead>
<tr>
<th>Date</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title</td>
<td>Child care in families – Alcohol Addicted Parents</td>
</tr>
<tr>
<td>Authors</td>
<td>Maya. J., Black. R., Mac Donald. J.</td>
</tr>
</tbody>
</table>
| Objective/Focus of Study | 1) Investigate & compare the child care & frequency & types of child abuse neglect association 
2) Examine the report between stages in the cycle of D&A adequacy of child care & presence or absence of Child Abuse & Neglect 
3) Determine the extent with which social & situational factors associated with Child Abuse & Neglect are present in family history of Alcoholism or drug use. Different patterns of care |
| Method   | Quantitative Tools 
1) MMPI 
2) Survey on bringing up children 
3) Schedule of recent experiences |
| Sampling | Purposive (patients in patient Rx) |
| Sample Detail | Only those who were for a under the (a)ge of 18 - for at least a period of 6 months 
(b) 6 months baby then at least for 2 months 
Sample size: 45 -30 & 15 
Sample characters 
African descent : 12 
Marital Status: 27 married, 11 separated, 4 widowed, 2 single 
Religion: 25 Catholic, 15 Protest, 5 Others 
Employed: 33 Unemployed, 12 Employed |
| Definition of Key Concepts | Child Abuse 
Less of Control 
Child rearing 
Neglect |

**Findings**

Child Abuse is successfully avoided by Family history of alcoholism and drug use. Fathers learn to withdraw from parenting & discipline. It is more likely to manifest in physical neglect of the child. Mothers less able to withdraw caring and find it difficult to avoid abuse. More likely to lose control. Therefore females more likely to abuse due to situational factors.

**Limitations and Gaps**

1) Have not highlighted the different patterns of care When drinking fathers more likely use objects for beating
Date | 1964
---|---
Title | Causes of Delinquency
Authors | Travis Hirschi
Objective/ Focus of Study | delinquent acts of youth
Method | Classic survey …
  STEPS:
  1) Identifies contradictory theories
  2) Set out res design to test the theories
  3) Present relevant data
  4) Analyses data
  5) Support's one of the theories
  Tool: Questionnaire
Sampling | From a larger project
  Richmond Youth Project Sex was a constant (from process of elimination)
Sample Detail | Public junior & high Schools
Research Question | What are the causes of delinquency
Definition of Key Concepts | Delinquent act
Findings | High Attachment to parents low chance of delinquency.
  Control theory accepted. High attachment to School low delinquency non delinquent boys had to attach to non-delinquent peers & vice versa
  Little support for strain theory
Theory | 1) Strain Theory (why do people not obey laws)
  2) Control Theory (why do people obey laws)
  3) Cultural Deviance (people have their own standards of behaviours & operate accordingly to it. (phenomenological approach)

This American view on how it is managed is found to be different in understanding EI compared to the Indian view as some of the effects seen as traumatic are not as traumatising in the Indian context due to differences in parenting, socialization patterns and meanings attached to EI.
Indian View of EI

In the Indian context emotions are *rasas* and there are nine accepted *rasas* unlike the west where 8 are accepted as the basic emotions. The *bhav* here means an existence as well as mental state. It is through the union of the *bhav* that rasa is manifested. The bhakti movement speaks of the *bhav* being ecstasy, channelling of emotions and surrender and a connection with the divine. They are as follows – shringer (the mood of Eros), vira (knightly mood), karuna (mood of pathos), raudra (anger), bhayanka (the mood of terror), bibhasta (mood of revulsion) hasya (mood of jocularity) and adbhuta (mood of wonder) and shanta (mood of total freedom). (Sibia and Misra 2011)

In the Indian context EI is not a homogeneous concept but a concept which is shaped by the interaction with individuals. The Indian view is rooted in philosophy, traditions and religion. The family and society play a role in the shaping of emotions.

In the Indian view the self as viewed as an interdependent concept and the shared locus of control, helping others, deference to elders are a part of the EI component the self is viewed as “unchanging centre of awareness” (Sibia and Misra 2011).

The way to discover oneself is through the use of yoga way of life and mediation. In the Indian concept the emphasis is on the collective rather than individualistic way of being. The self is also discovered through the interaction with the guru, getting guidance from elders, reading books and going for discourses. (Dalai and Misra 2011)

Emotional learning is viewed as the on-going process and the concept of yoga, karma(deeds) dharma(duty), jitendriya (person who is able to manage his emotions and regulate them) are present. Sibia and Misra (2011) put forth that although these concepts have not been measured empirically they appear in the folklore, stories and songs and other popular literature. These are what one can say are the unique ways that one behaves in the Indian culture. Therefore a test of EI needs to be able to get to the essence of how Indians perceive, use, understand and manage emotions.
In the Indian context social competence is preceded by emotional. If one is able to be emotionally competent then one can adapt to the social context. Emotional responses are learnt from the culture one lives in and thus social meaning is important (Sibia and Misra 2011)

In the Indian culture there is an emphasis on collective actions and certain emotions such as sympathy, shame and respect are common emotions and expression of negative feelings is not encouraged. The Indian view is that in which the emotional experience itself is viewed in relations to the conditions and the coping one does. Fernandez, Berrocal, and Salovey (2005) had done a study if culture affects EI and subjective well-being and they concluded that there is an effect of culture. They compared individualistic cultures with collectivistic cultures. Subjective well-being is higher in individualistic cultures than collectivistic cultures as the former pay more attention to the emotional world of the individual compared to the latter. But they point out that even suicide and divorce is higher. Collective cultures focus on social cohesion and solidarity and this may affect subjective well-being.

In the Indian tradition, the Bhagvad Gita says that the attachment leads to problems and there is importance given to emotion regulation. The automatic feelings are controlled or overridden by reason. Parental role in the Indian context of providing role modelling, guidance and explanations are used as ways to impart values. Teaching control over anger with strategies such as chanting god’s name or a shlokas, verses and counting numbers backwards is encouraged by parents. (Sharma 2011). From the above one can infer that EI is construct that has been taught in the Indian context much before it has been written about in Europe or America.

**Family in India**

If one compares the role of the family and gender in India it is distinctly different from the west. The family in India has “**psychological jointness**”. Maintenance of close ties is still there and family advice can be taken in both important matters as well as mundane matters. This is the reason that parenting and socialization is complex compared to other countries like Europe and America. (Chandra 2011)
In India the concept of **multiple care giving** exist and mother may be busy with work and the elders or older sibling may look after the child thus becoming a collective responsibility of all. The level of parental involvement is high and it is a traditional style of parenting where responsiveness and closeness is high. (Chandra 2011)

This cultural ethos is resting on interdependence is and this is encouraged through the parenting process and socialization process. Harmony is emphasized and collective before self is taught. (Sibia and Misra 2011)

In India there is no concept of children sleeping in separate beds like in the west. Privacy in general is not a common norm and sharing is not restricted to space but also thoughts, feelings. Neerja (2011) argues that this allows the child to develop empathy and family is supportive in terms of giving advice.

In fact the grandparents are more involved, the father is marginalised and the role is that he is disciplinarian and provider and nurturance and affection is not expected. The father is traditionally an authority, he commands obedience and deference. (Raina 1989, Kakar 1978)

Sibling’s relationships become close as sometimes older siblings take over caring for younger siblings. This is called as “parentification” in Europe or American countries and is viewed as pathological but in India it is part of the responsibilities that older children grow up with. In the socialization patterns also there are gender differences. With girls across classes a tendency to encourage interdependence and be sacrificing is encouraged. This preparation is for the role of the good wife. Even women with career aspirations put family first. Girls are taught not to argue and answer back as they must go to another house. Girls are expected to be sacrificing though this may be changing in the urban context.

The regulation of emotions is already a part of the Indian system which in the other countries is the now gaining attention. There is a need to adapt a culturally appropriate model of EI.
Thus on review of literature though one fails to find literature which understands the effects of alcoholism on the EI of adult children of alcoholics. This is the gap in the literature that is addressed by the present research study.

**Conclusion**

Thus if we assess the Indian view of mental health and illness in this context is focused on treatment with holism rather than fragmentation. Even an indigenous system like Ayurveda is concerned with holism and propounds that medicine should always be of the whole person (rashi purusha) an individual falls ill because **emotional, psychological and spiritual self** fails to handle the stress that one is facing thus weakening the physical self. The body thus reflects the deeper struggles the human being undergoes. The importance to the emotions is distinct from the biomedical model of the American or European world where it is only recently being addressed. If we derive deeper understanding then EI construct is an inherent construct of Ayurveda and has always come under the ambit of cure and healing. This means that Indian systems due to the holistic nature of treatment seek to heal all the aspects of the individual, emotional and spiritual being as important as physical and mental.

Does this mean that the ACOAs experiences will be different in India compared to other countries this line of enquiry is explored in the study? These questions are raised and the methodology trailed to study them is elaborated in the next chapter.