Chapter 2

METHODOLOGY

*For the meaning of life differs from man to man, from day to day and from hour to hour. What matters, therefore, is not the meaning of life in general but rather the specific meaning of a person’s life at a given moment.*

- Viktor Frankl

The following chapter addresses the methodological process and praxis undertaken by the researcher and enunciates the rationale, research questions, research design, key concepts, conceptual framework, the sampling frame, analysis and ethical principles. The chapter presents the challenges as well changes which were undertaken in the iterative process of research.

The methods selected to study a research question are determined by the research questions themselves. With this clear methodological stand by the researcher mixed methods or the third paradigm was the clear choice. Since the ontological base of the researcher is that no phenomenon can be understood from only one perspective, multiple perspectives add richness to the data, mixed methods were better suited in the context of this particular research. The emphasis was on the fact that the process should be scientific and should be relevant. Though the mixed methods approach emerged in the last 20 years this now seems to be the choice of behavioural and social scientists. (Teddlie and Tashkorrie, 2009). Mixed methods are defined in the research design as a use of quantitative and qualitative approaches in the type of questions, research methods and data collected, analysed and inferred. The philosophical route is through pragmatism and thus truth can be relative and not final. This means that what is adopted is suited to what is applicable and useful instead of being restricted to a particular approach.

There is little doubt that alcoholism cannot be studied using only one of the paradigms but in the context of this research using mixed methodology was part of the epistemological route that would provide a holistic picture. The same may not emerge using only one of the designs. Howe (1988) has argued that mixed methods are compatible and epistemologically possible.
But what prompted this enquiry and why did the researcher select the areas of alcoholism and emotional intelligence

**Rationale**

As a researcher, there was an interest in understanding the impact of alcoholism on Emotional Intelligence in Adult Children of Alcoholics (referred to as ACOA from now onwards) and how do these children cope so that the scars of alcoholism do not impair their well-being. If we assess the treatment centres, in Mumbai, which deal with alcoholics and their families they are few and not a single one has a separate program for the children. The rationale to undertake this study was to bring attention to the ACOAs. The researcher encountered many children in her therapeutic practice - who were, frightened, nervous, angry, nursing broken dreams, emotionally stunted and fighting their personal battles alone. Two children particularly stand out. A little boy who stood everyday along with his sister in the balcony of their house, scared and afraid to go in the room as his father would be drinking, they would wait for their mother to come home from work to feel safe enough to be in the same room as his father. He needed counselling support later in life as academic performance was affected. One other ACOA also stands out. He was a bright young adult and he asked relevant questions when the researcher was working as a family counsellor in a de-addiction centre. Later it emerged that his father’s alcoholism had prompted him to study medicine and he was studying to be a doctor. He was on an internship in a government hospital at that time. It provided the researcher a fresh picture and steered her to start a group of ACOAs in the centre so the two different types of children could meet and support each other to become more productive and learn from each other positively. How did one child get affected badly and another it seemed emerged unscathed?

The researchers pondered on how many of these children were affected and how did it affect their emotional intelligence? This self-reflexivity lead to the research question for the current study.

The research question for this study is:
What is the effect of alcoholism on the emotional intelligence of adult children of alcoholics?

The key objectives of the study are as follows:

**Objective 1:**
To explore the effects of Alcoholism on Adult Children Of Alcoholics

**Objective 2:**
To explore the effects on EI of Adult children of Alcoholics (ACOAs).

**Objective 3**
To explore the psychosocial factors that affect the Adult Children Of Alcoholics in Mumbai

**Key Concepts and Operational Definitions**

The two concepts that the study proposed to explore were emotional intelligence and adult children of alcoholics.

For the purpose of the study *alcoholism* was defined using the APA definition. APA defines alcoholism as a disease which affects an individual's physical, social, and psychological capability.

Ackerman and Gondolf’s (1991) definition of Adult Children of Alcoholic (ACOAs) was used for the purpose of the study. This was based on the answer received for the question: When you were growing up did you have a parent who drank too much? On the basis of the answers received the individual was classified as ACOAs or non ACOA. Those who responded in the affirmative were placed in the ACOA group, the others were placed in the non-ACOAs group.

Thus for the purpose of the present study the ACOAs was defined as any individual who reported that s/he has had a parent who drank too much. This was a self-reported definition.
For the purpose of this study emotional intelligence is defined as “the ability to perceive emotions, to understand, to be able to use emotions, and manage the emotions one experiences.” This has been adapted from the Salovey and Mayer ‘s definition of emotional intelligence. (2000)

The skill and the problem areas of EI in this study were defined from Darwin, Low and Nelsons (1999) ESAP and are as follows:

**Interpersonal Communication Under Stress**

*Assertion:* The ability to communicate one’s thoughts and feelings in an appropriate fashion.

**Personal Leadership**

*Comfort:* The ability to understand how to deal with people and how far one could go in personal interactions.

*Empathy:* The ability to accurately understand and correctly respond to the expressed feelings thoughts and behaviour.

*Decision Making:* The ability to plan, formulate, initiate, implement effective problem solving procedures.

*Leadership:* The ability to positively impact persuades and influences others and in general make a positive difference.

**Self-management**

*Drive Strength:* The ability to direct personal energy and motivation to achieve personal goals and career goals.

*Time Management:* The ability to organise tasks into personally productive time schedule and use time effectively for task completion.

*Commitment Ethic:* The ability to complete tasks, projects, assignments, and personal responsibilities in a dependable and successful manner even in difficult circumstances.

**Intrapersonal development**

*Self-esteem:* The ability, belief, and skill to view self as positive, competent and successful in achieving personal goals.
**Stress management:** The ability and skill to choose and exercise healthy self-control and self-management in response to stressful events.

**Potential Problems Areas**

**Aggression:** The degree to which an individual employs a personal communication style or pattern that violates dominates or discredits another’s person’s feelings or behaviours.

**Deferece:** The measure to which an individual employs an indirect, self-inhibiting, self-denying and ineffectual style for the accurate expression of thoughts feelings or behaviour.

**Change Orientation:** The satisfaction or dissatisfaction that an individual has with his current state of personal and emotional skills and an acute interest in making personal changes and or a strong conviction of the need to make personal changes.

All the above concepts are based on certain philosophical premises that are layered upon a conceptual framework that is harmonious with the overall background of the present study.

**Conceptual Framework**

The theoretical framework that the study was seeking to explore was the effect of father’s alcoholism on the emotional intelligence of the ACOAs, the interpretation of this experience and the meaning that the ACOA had attached. Thus the study explored the understanding of the parental alcoholism and its effect on emotional intelligence as mediated by the process of interpretation undertaken by the ACOAs.

The conceptual map was envisaged with variables that linked literature review and the objectives of the study. Thus the ability to perceive, use and understand and manage the EI was crucial in the ACOAs understanding of alcoholism and their interpretation of the experience. This construction of meaning by bracketing was projected to be a crucial area for negotiation of this experience of alcoholism in the family.
The conceptual framework was envisaged as a merging of positive psychology, humanistic framework and phenomenology’s symbolic construction. (Resnick, Warmoth and Serlin, 2001)

**Humanistic Psychology:**

Humanistic school of psychology emerged as a third force in psychology and attempted to study those areas that were clinically not given importance such as psychology like love, self-actualization, self, meaning, play, courage. (Severin, 1965). Some of the basic postulates of this approach are presented below.

Five Basic Postulates of Humanistic Psychology. (Bugenthal 1964)
1. Humanistic psychology attempts to understand that the human being is a more holistic being than consisting of small parts and did not view human beings from the lens of the reductionism that positivists school viewed.

2. A human being is located in a context and in a cosmic ecology.

3. A human being has awareness of self and of others in context to self.

4. Human beings have choices and along with that a responsibility

5. Human being can premeditate their goals, their future events and seek meaning, value and creativity.

Thus it means that in this context ACOAs are responsible and can create the life path they wish to undertake and can make better choices. Maslow ‘s humanistic approach guided the researcher as the observation was that though individuals face problems they also demonstrate a capacity to overcome them through the use of free will and choices they make, one of the postulates of humanistic approach. Maslow proposed that we do not understand human beings and need to study them more. (Maslow, 1957) Maslow felt that it was important to study good life experiences and not only study suffering and tragedy as he felt that healthy people had an ability to reintegrate negative experiences to good use. (Hoffman, 1999). He remarked that there was a preoccupation with negative aspects and a tendency that life was a process of avoiding pain and unhappiness. He felt that human beings had a tendency to grow stronger, wiser, and healthier. (Maslow, 1957). Also he commented that a human being was unique and so his path of growth was also unique and not comparable to another person’s path. His task was to be the best of himself. He further remarked that psychological illness was essentially a struggle to health. (Maslow, 1957) This was closely aligned with the researcher’s belief system.

He proposed that all individuals had a capacity and a potential to be the best, most he felt may have it knocked out due to experiences, so it is worth noting that it was not only alcoholism but various other factors which would affect an individual. This was reaffirmed by Brackett (2013) who proposed that one of the tasks in EI is managing information especially from people who maybe negative or critical.
Positive Psychology

The second area which is closely linked to humanistic approach is positive psychology. The definitions of positive psychology are varied but the original thinkers in the field Seligman and Csikzentmihalyi have provide the deinfitions that is encompassing. Seligman and Csikzentmihalyi (2000) define “positive psychology at the subjective level to be about valued subjective experiences: well being, contentment, and satisfaction (in the past); hope and optimism (for the future); and flow and happiness (in the present). At the individual level, it is about positive individual traits: the capacity for love and vocation, courage, interpersonal skill, aesthetic sensibility, perserverence, forgiveness,originality, future mindedness,spirituality, high talent and wisdom. At the group level it is about the civic virtues and the institutions that move individuals toward better citizenship, responsibility, nurturance,altruism, civility, moderation,tolerance, and work ethic.”

Thus positive psychology concerns itself with not only well being and a need for making life worth living but with a larger goal of living in the society.

Positive psychology is the scientific and applied approach to uncovering people’s strength and promotes their positive functioning. (Shane and Snyder, 2007). Positive psychology believes that strength along with weakness need to be explored. This is (Shane and Snyder, 2007) not a way to undermine human pain but to provide a balanced view on attribution in the area of meanings socially constructed and process of reality negotiation. This means that humans are not only objects but have an inner experience which can be understood using the humanistic perspective.

Positive psychology believes that human beings make decisions based on choices for which they are responsible, thus the human experience is at the core of the psychological enterprise. (Resnick, Warmoth and Serlin, 2001) Further positive psychology proposes that focusing on what is right is as important as focusing on what is wrong in people. (Shane and Snyder, 2007)

The attempt of the thesis is to understand the deepened subjective experience compared to objectification found in empirical studies.
Phenomenology

Further the lived experiences of the individual make greater sense when viewed in the context of his/her life. Thus there are no generalised answers but only particular answers in relation to the community, society and environment one is embedded in. The framework thus used is qualitative and embedded in the lived experiences of having grown up in a family which witnesses the phenomenon of alcohol abuse. Phenomenology typically understands the phenomenon by using the process of understanding rather than concluding on the phenomenon. Phenomenology also has as one of its aims to contextualize empirical scientific investigation and clarify “essence”. Such essence says Husserl (1952) is important as humans are different from animals and therefore one cannot treat them according to the methods of natural sciences.

In this study it was important to understand the “intentionality” (Husserl 1952) that is the experiences of growing up with alcoholism in the parent and the way the ACOAs relates to this experience. This intentionality of consciousness maybe different from ACOA to ACOA and there may be some common thread that ties the lived experience of the ACOAs as a whole. Here the intentionality was relational as the objective experience of fathers drinking and the consciousness of this constitute one irreducible reality. Thus within the same context each ACOA unfolded finding their own ways of understanding and thus making their own world (Eigen welt) by finding meaning and relevance.

Phenomenology consists of four discernable moments; formulation of research questions to intuitive contact with phenomenon, reflective analysis of data and psychological description. (Churchill and Wertz 2011) This was used by researcher from formulating the research question (researchers knowledge was limited and inadequate as to why some children were thriving and why some were affected) to intuitive contact with the phenomenon (intuitive here means in direct consciousness of the researcher here by way of verbal descriptions, observations of behaviours and gestures and researchers own experience of research which was also recorded.) the researcher invited the respondents to share their experiences of the phenomenon of growing up with alcoholism and its effects. The data analysed used empathic intuition though it was hard to keep the clinical judgement
and bracketing (epoche) helped substantially. Using phenomenology means describing the situation in such a manner that one “re-experiences” this phenomenon as it is. The third moment of reflective analysis was allowing the bracketing and focusing on the meaning of the situation as experienced by the ACOA. The fourth of structural and psychological description was also used and presented in the chapters as insight and integrated into the larger themes and cross cases analysis that were written. This “imaginative” variation allowed for divergent perspectives and divergent frames of reference to emerge within the present research study. Given below is step wise representation of the approach followed in the research process.

**Figure 2.2 Steps in Phenomenological Research**

- **formulating the research question**
  - Researchers knowledge was limited and inadequate as to why some children were thriving and why some were affected

- **intuitive contact with the phenomenon**
  - Intuitive here means in direct consciousness of the researcher, here by way of verbal descriptions, observations of behaviours and gestures and researchers own experience of research which was also recorded.

- **reflective analysis of data**
  - Empathic intuition and bracketing (epoche) helped substantially. 
  - Describing the situation in such a manner that one “re-experiences” this phenomenon as it is.
  - The third moment of reflective analysis was allowing the bracketing and focusing on the meaning of the situation as experienced by the ACOA.

- **psychological and structural description**
  - Structural and psychological description used and presented in the chapters as insight and integrated into the larger themes and cross cases analysis that were written.
In conclusion, the philosophical underpinning of the paper was directed on the understanding of the experience of emotional intelligence on the broader canvas of mixed methodology. There was a reality out there which could be understood by examining the breadth of the phenomenon through quantitative enquiry and the depth of the experience through qualitative enquiry.

**Research Design**

The review of the current literature and research question indicated that if one was required to understand how alcoholism impacts emotional intelligence, one needs to compare with adult children who were from non-alcoholic homes. This was but a logical derivative of the research question, if the claim is that alcoholism affects EI then not having alcoholism should affect it differently. This kind of comparison would help to understand if alcoholism mediates the experience of emotional frontiers. Initially the research was planned keeping the comparative group design in mind. This design underwent some modification as finding an exact match proved difficult. Though a quasi-experimental design was conceived it was not practical to execute and some factors like respondents moving from non ACOA group to ACOAs group was not anticipated and this resulted in having two groups with unequal numbers. Though this was the research design planned, once data collection began it emerged that the field reality was that there was a difficulty to access the ACOAs as well non ACOAs as the topic of alcohol drinking and the problems caused due to it had stigma and people did not want to talk about it, be they those who had problems or those who did not have any problems. This lead to some revisions and though the use of comparative method is used the focus was on ACOAs in the study.

**Methods**

**Combined / Mixed**

The mixed methods approach proved to be a pragmatic way of approaching the problem and though a relatively new area in research it was most appropriate. Since there was no clear paradigm or theory in spite of several authors creating taxonomies, the framework to explain the design used was based on the taxonomy by Tashkkori and Charles (1998). The
dominant –less dominant design was used, which means the basic approach was qualitative, data was gathered through both qualitative and quantitative means with qualitative being the more dominant and quantitative the less dominant. The mixed methods in this study refer to not only the way in which data was gathered but also in the way it was analysed and synthesized. (Tashkkori and Charles, 1998)

The focal method that was adopted to study the research question was qualitative but the approach to study the research question involved the use of a comparative or an ex post facto experiment. The premise was that this quasi experimental method used would help to unravel the impact of alcoholism on the emotional health of the children. Epidemiology studies questions of this nature using the framework of the case control method. In this a certain amount of retrospection was used. The cases are selected on the basis of the disease which was also the case in this present study. (Bonita et al, 2006, Merrill and Timmreck, 2006) The important exercise in this design was to have strict diagnostic criteria and ensure the cases are as homogenous as possible. The crucial task was determining the choice of controls. In this study the controls were difficult to enlist. One of the methods used was that ACOAs were asked to refer to friends they knew who came from homes where there was no alcohol related problems. The other method was accessing one non ACOAs and asking him or her to provide references of one or more friends with similar non-alcoholic backgrounds who would be interested to share their experiences with the researcher. Snowballing was used by researcher to arrive at the control group.

Though the researcher started with a certain understanding, the field realities had to be taken into account and modifications had to be made on the field. The ACOAs were difficult to access due to the lack of any visible differentiating characteristics which makes them recognisable. This is a group that is not accessible in a hospital, centre or homes clearly demarcated for them. Further in India there are a few or no associations or foundations working with this group of children and adults. In Mumbai only one support group for ACOAs was running at the time of collecting data. As reported by other members this group was not regular. Further some of the persons shared that it was due to the time and distance taken by working people in Mumbai, which resulted in poor attendance at meetings and lack of regularity.
Snowballing technique was used to access more persons who could be part of the study. The research design had to be changed as many of the identified participants were unwilling to talk about alcoholism across both samples groups. This required extensive explanation on why the research was being undertaken and how their participation would be helpful. Treatment centres were not the sole areas for recruitment. Multiple ways of accessing the same group was deliberately planned exercise by researcher. Many ACOAs were reluctant to share, some were afraid to share and some were disengaged and did not agree to be a part of the study. It was observed that some women ACOAs who were married were the most reluctant to share and wanted their identity to be anonymous. Many of these women had not shared with their husbands or their marital home about the alcoholism in their natal home. Thus the stigma of having an alcoholic parent is experienced not only in the family of origin but also in the family of marriage.

Some of the ACOAs were identified through support group meeting attended by the researcher regularly. Meetings across Mumbai were attended and researcher made short presentations at the meeting to inform about the study and explore if there were any ACOAs who they knew would be willing to talk. On an average about 2-3 meetings per week were attended over a period of 18 months. The researcher observed during support group meeting there were clear gender demarcations with men more prominent in the alcohol dependent group and women more common in the co-dependents group. Some of the group members were approached to contact the ACOAs known to them. A few also tried to arrange meetings with their children. Some of the ACOAs were not willing to talk and some avoided the researcher.

Yet at other times researcher made presentations on the research to groups at de-addiction centres and homes and those who volunteered and reported to have had a parent with alcoholism problems were interviewed.

The researcher took a conscious decision to include all profiles of individuals instead of only interviewing those in treatment centres. This was to increase diversity and generalizability of the results.
This meant accessing people from all walks of life and not only those in homes or treatment centres. The figure below represents the different methods used by the researcher to access ACOAs and non ACOAs.

**Figure 2.3: Range of Methods Used to Identify ACOAs**

- Attending and presentations in Support group meetings
- Phone calls to key support group members for contacts to ACOAs
- Directly approaching families who were in public domain and had lost family members to alcoholism
- Contacting professional like psychiatrists, counsellors who would be aware of ACOAs
- Contacting ex patients and recovering alcoholics and addicts who could provide contacts
- Presentations in treatment centres /homes

ACOA
One of the premises when you undertake research is that you are “seeing through the eyes of” (Bryman 1988) the persons researched. It is important to have voices which need to be heard. Further, since the researcher had to adopt a flexible approach, changes according to the needs of the research were possible. This was important as the field of alcohol dependency is methodologically challenging and though a respondent may agree to meet the next day, the night before he or she may experience some violence which may then affect the decision to talk to the researcher itself. The entire exercise on part of the researcher was to understand the meaning of what was to be studied and to draw interpretations. There was no fixed or rigid method to study what you wish to understand. The search for truth was to arrive at coherence.
The pragmatic approach guided the researcher’s ontological stand. The belief was that reality (here the experience of parental alcoholism on emotional intelligence in the context of ACOA) though different for different individuals and contextualized in their background differences of sex, socioeconomic status, availability of social supports and social exclusion because of the alcoholism, emotional relationship with the non-alcoholic parent and myriad of other factors there was a common ground where it would be same. The warranted assertion that the research was seeking was realism and therefore the method was mixed.

The interest as a researcher was to understand emotional intelligence. The belief was that the EI was not a fixed concept like IQ and was subject to change due to life experiences. Children were therefore not passive spectators and did not just manage their EI but actively influenced how it will evolve.

The researcher’s belief was that human beings are dynamic and live and exercise reflexivity. (Concept from Notes Prof N. Jayaram). This belief was in keeping with the qualitative ideology of focus on meaning and process. (Nakkeran, 2006). Further, the qualitative inquiry acknowledges that reality is complex and dynamic (Hoepl, 1997)

Thus the researcher’s basic paradigm was that reality is multiple, subjective, and interpretive. (Nakkeran, 2006; Edwards, 1967). At the same time the researcher had chosen to use the quantative method to study this reality along with the qualitative. The logic is that though there are different ways that realities can be studied with respect to the management of EI, one requires a common ground on which they can be compared so that the differences can be highlighted.

**Tools**

After analysing the kinds of tools available to understand the two key concepts, ACOAs and also EI, researcher listed several tools which were in use by practioners and researchers. Keeping in mind the objectives of the study the researcher selected and shortlisted a few but practical availability steered the decision. The selection of tools was made after research on appropriate tools and ease of accessibility of the tool to the researcher. Since MSCEIT is commonly used and one of the oldest in the field it was shortlisted. A close second was Bar-
on. Schuttes et al was suggested by Prof Emerling (2008 EITRI, TISS) at one of the conferences when researcher briefly met him but this too could not be used due to logistic reasons.

The tools that were originally shortlisted were MSCEIT and second option Bar-on EQi were both paid tools obtained through a corporate office that sold these tools. The researcher wrote directly to the test formulators but was yet again directed to the corporate office.

Though the researchers who have formulated the tools are well known academicians they were unable to provide support to the researcher. It was a clear business transaction for them. Baron EQi did not give the researcher an open access to the key for scoring. All the raw data had to be sent to the test company which would score the tests and then send a comprehensive report as compiled by them. Further the researcher did not have access to all the reports and could cite only a stipulated percentage of the findings in her study. Though the same is available in the grey market the researcher did not exercise this option.

After much deliberation and using an ethical framework it was decide to use the ESAP as the test formulators were helpful, available and had given access to the test scoring. Though there were drawbacks too. The test has not been used as much the other tests like MSCEIT, Bar On or Schuttes. A comparison of the scales was undertaken by the researcher initially when shortlisting the tools and this is presented in the table below. The ideal tool was the MSCEIT but due to non-accessibility, the ESAP was finally selected.

**Table 2.1: Comparison of Different Scales of Emotional Intelligence**

<table>
<thead>
<tr>
<th>CRITERIA /SCALE</th>
<th>Emotional Quotient Inventory (EQi)</th>
<th>Mayer, Salovey, Caruso Emotional Intelligence Test (MSCEIT)</th>
<th>Emotional Skills Assessment Process (ESAP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rationale</td>
<td>High, clear rationale</td>
<td>High, clear rationale</td>
<td>Fair, overlapping concepts</td>
</tr>
<tr>
<td>Applicability</td>
<td>Very high, clinical, preventive, educational and corporate</td>
<td>Education, Mental health, health communications and corporate</td>
<td>Education, health and related areas, also corporate</td>
</tr>
<tr>
<td>Administration</td>
<td>30-40 min</td>
<td>45 min</td>
<td>55 min</td>
</tr>
<tr>
<td>time</td>
<td>Administrative procedure</td>
<td>Administrators expertise required</td>
<td>Analysis</td>
</tr>
<tr>
<td>------</td>
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<td>----------------------------------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>Simple</td>
<td>Simple</td>
<td>NA</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Consensus scoring and Expert scoring</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Descriptive statistics</td>
</tr>
</tbody>
</table>

Thus the final tools selected were as follows. The tools are presented in order of the way they were administered after a consent form (attached in appendix) was signed are as follows:

1. ACOA index
2. ESAP
3. Socio demographic profile
4. In-depth interviews
5. Key informant interviews

The order of administration of the tools was pre decided. For the first two scales (ACOA index and ESAP) the researcher wanted to rule out social desirability effect. This was possible if no previous information about respondent was obtained and no prior memories about their lives were triggered by way of conversation with the researcher. Therefore the
socio-demographic was administered last as it involved engaging with the researcher and research understanding was that some bias may influence answers if this engagement occurred prior to the scales administration, thus researcher wanted the individuals to begin on a clean slate.

The following table depicts the tool and the objectives. The objectives appear in the order that were studied by the tool. The philosophical base of the tool is also enunciated as this was also analysed as an integral component of selection of the tools.

**Table 2.2: Tool and Objectives Studied**

<table>
<thead>
<tr>
<th>S.No</th>
<th>TOOL</th>
<th>OBJECTIVES</th>
<th>PHILOSOPHICAL BASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>ACOA Index</td>
<td>To explore the effects of alcoholism on the adult children of alcoholics.</td>
<td>Humanistic</td>
</tr>
<tr>
<td>2.</td>
<td>ESAP</td>
<td>To explore the effects on EI of Adult children of alcoholics</td>
<td>Humanistic and Positive Psychology</td>
</tr>
<tr>
<td>3.</td>
<td>Socio demographic profile</td>
<td>To explore the psychosocial factors that affects the ACOAs in Mumbai.</td>
<td>Phenomenological, Humanistic and Positive Psychology</td>
</tr>
<tr>
<td>4.</td>
<td>In-depth interviews</td>
<td>To explore the effects on EI of Adult children of Alcoholics.</td>
<td>Phenomenological, Humanistic and Positive Psychology</td>
</tr>
<tr>
<td></td>
<td></td>
<td>To explore the effects of alcoholism on the adult children of alcoholics.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>To explore the psychosocial factors that affects the ACOAs in Mumbai.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Key informant interviews</td>
<td>To explore the effects on EI of Adult children of Alcoholics</td>
<td>Biological, Sociological, Psychological, Disease Models, Humanistic</td>
</tr>
</tbody>
</table>
1. ACOA Index:
The ACOA Index (Refer Appendix) was used for assessment of ACOA and for identifying and assessing ACOA symptoms. This was an index which had been developed by Gondolf and Ackerman (1993). This measures the seven major attitudinal and behavioural characteristics of ACOAs like self-condemnation, perceived isolation, approval needs, control etc. These scales helped to assess a ACOAs on several characteristics which could be described as coming under the purview of the emotional dimension of managing emotions like isolation (which includes difficulty in intimacy or feeling left out due to social ostracism), condemnation etc. The index comprised of 21 Likert questions, answers to which were self-reported. This index was administered to both the ACOAs and non ACOAs to provide a comparative analysis. This index was obtained from the test formulators and author Dr. Ackerman through his foundation MAATI. (Mid-Atlantic Addiction Training Institute).

The tool was easy to administer and almost all the participants understood the statements and responded appropriately. The group of ACOAs were more vocal about their feelings and some did share how they were hypercritical or how they were unable to be balance priorities. Most questions were asked for clarification of meaning like deferred gratification. This was uniformly explained as ability to delay satisfaction of some need. One of the questions that came up was question on “I guess at what is normal”. Most people were unsure and since not much lead could be given by interviewer, people answered based on their understanding.

The strength of this tool is that it correctly identifies the feeling that majority of ACOAs had and was able to focus on it. The kind of questions asked related to the effects of parental alcoholism and characteristics that emerge because of dealing with alcoholic parents.

The drawback of this tool is that it does not provide examples of the sentences it asked persons to rate. Many people may not be able to understand words like gratification or affirmation. In the Indian context this tool would benefit if examples were given alongside
the sentences. It would further be beneficial to adapt it to the Indian context. The other drawback was that this tool can be understood and answered by individuals who had a good degree of self-awareness and are able to report the same.

2. Emotional Skills Assessment Process (ESAP)©:
The ESAP is a 213 item self-assessment instrument providing scale specific measures of: (1) Assertion, (2) Comfort, (3) Empathy, (4) Decision Making, (5) Time Management, (6) Commitment Ethic, (7) Self Esteem, and (8) Stress Management. The ESAP takes 30 (online) - 55 (paper) minutes to complete. The paper-pencil version was administered. This has been developed by Nelson Darwin and Gary Low and has been used for the assessing EI skills. (1999). This was used to facilitate in understanding what are the EI skills of the ACOAs and non-ACOAs.

The researcher had obtained a certification in the Emotional Intelligence Skills Assessment and a permission to use it for the research project. A copy of the same is attached as Appendix. (See Appendix IV). Low and Nelson report that the ESAP is a “crude and imperfect” tool like other all other tests subject to changes. It has been used in eastern countries like Taiwan and in the west in America.

The strength of this tool was that it measures EI over many different areas. The limitations of the tool are that it is quite long, it also time consuming for people especially for those who read slowly. The second limitation of the tool is that it does not have an index to check for social desirability.

3. Socio-demographic Questionnaire

This initially was envisaged as a short tool to gather basic demographic information. It was later elaborated to include features such as educational history, parenting history, relationship history, social inclusion experienced, other compulsive behaviours and also the relationship with parents and critical incident techniques. The tool was developed using the researcher’s experience in the field of addiction and was more specific in the questions explored.
4. In-Depth Interview:

In order to explore the research question more intensively, in depth interviews was proposed with ACOAs. The rationale to select the in-depth interview was that individual differences in interpretation of emotional intelligence and the variety of meanings attached to being ACOAs would be more likely to emerge through intensive and self-reflexive dialogues with the ACOAs. The questions were based on the work experience of the researcher and the understanding of alcoholism in the field and contextualisation of these experiences in the Indian context with respect to EI. Since both the tools used were from American perspective, it was important to understand the experiences from Indian standpoint as the scales may miss measuring some unique features which could be captured in the in-depth interview.

5. Interview Schedule for Other Key Informants

A tool was developed by the researcher in order to understand the experience of alcoholism in the context of those who had provided care and support to families of alcoholics. A small number of professionals like social worker, psychiatrist, counsellor, peer counsellor and medical professional and a member of support group were interviewed. The key areas explored were professional observations of characteristics of ACOAs, the effects on EI and the impact of alcoholism.

The table below provides an overview of the tools used to meet the research objectives and the proposed analysis of the collected data. Lastly, the findings from the above tools were used to analyse differences and similarities between ACOAs and non-ACOAs facilitating the answers to the research question which was as follows:

**What is the effect of alcoholism on the emotional intelligence of adult children of alcoholics?**
<table>
<thead>
<tr>
<th>No.</th>
<th>RESEARCH OBJECTIVES</th>
<th>TOOL</th>
<th>METHOD</th>
<th>ANALYSIS</th>
<th>FINAL OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>To explore the effects of alcoholism on the adult children of alcoholics.</td>
<td>1. ACOA index</td>
<td>Quantative +</td>
<td>Thematic case studies cross case analysis</td>
<td>The data was analysed to explore growing up with alcoholism through thematic analysis</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Indepth interview</td>
<td>Qualitative</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Interview with key informants</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>To explore the effects on EI of ACOAs</td>
<td>1. ESAP</td>
<td>Quantative</td>
<td>Adapted from the authors guidelines and modified and re-categorized with permission from authors. The overall group scores, mean and SD obtained were used to categorize scores into high, low and medium EI.</td>
<td>A score of emotional skills of the group. This was combined to make group frequencies by ESAP. The two groups were compared to ascertain the effects of Alcoholism on EI</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Interview with key informants</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To explore the psychosocial factors that affect the ACOAs in Mumbai.

1. Sociodemographic tools
2. In-depth interview
3. Interview with key informants

Quantitative + qualitative

1. Tables 2
2. Descriptive Analysis

The two groups were compared on the different factors that were affected.

The table above depicts the process that was followed to analyse the strength of each objective. The objective informed the method that was most appropriate. The method guided the decision on the tests used. The tests gave further emphasis on the analytical framework and expected outcomes.

**Data Collection**

Initially it was planned to administer only 2 tools to all respondents ACOAs and non-ACOAs. Some were selected based on the divergence they provided to the study. Later in the study a third component the socio demographic interview schedule was expanded and some more data was gathered. The scales were analysed for gaps that were then addressed in socio-demographic profile which captured the local contextual and cultural specificities. Thus data was gathered both qualitatively and quantitatively. This meant that the time required to do an interview increased substantially. The interview time varied from 1 hour and 30 minutes to 3 hours 30 minutes in total. It was observed that fluency in English was an important area that affected the time taken to complete the interview. This toolkit was administered to both the respondents, ACOAs and Non ACOAs.

**Sites of Interview**

The places of interview varied on the comfort of the ACOAs. Very few invited the researcher to their home especially if father was actively drinking. The researcher consciously proposed that they could meet at the home of the alcoholic but some ACOAs refused giving various reasons that they would not be able to share or it was more comfortable to meet outside. Thus a substantial number of interviews were completed...
outside the house. Some of the places where the interview was conducted were, workplace, schools, colleges, churches, treatment centres, homes, gardens, restaurants, family court, on the railway station and in the train while travelling to work as the distances were long. Non ACOAs interviews were conducted in similar places and home was comfortable place for them. Homes it was observed was preferred by woman and men preferred workplace meeting.

**Timings of Interviews**

The timings that interview were to be executed was pre-decided as last interview should be at 7 pm. The reason was to avoid fatigue and lack of concentration. Over the process of data collection it was observed that some people were not available till 8 pm. The last time was shifted till 8 pm but this too did not work as most people in Mumbai in this study were willing to give interview only after work and this meant that a rare few interviews were conducted at 9 pm and went on till 11:30 pm.

The in-depth interviews were only conducted as phase two of the qualitative section and case study was used to understand the experience of growing up in an alcoholic family. The sample size was smaller as saturation was used to arrive at the number. The time taken from pilot study to completing all the phases of data collection was a period of two years from May 2011 to June 2013. This was interspersed with a period of data analysis before the in-depth interviews were conducted.

**Setting and Sample Characteristics**

**Sampling Procedures**

The sample selected used judgment sampling based on researcher’s clinical experience in the field of alcohol and drug dependency. The researcher used non-probability sampling, which is criterion based and combined it with snowball technique.

**Anticipated Sample Profile**

Using the epidemiological concept of restriction certain categories were identified and certain were not chosen. The sample of both ACOAs and non ACOAs had their own set of
obstacles and problems. The profile had to be changed to accommodate the field reality. The table below presents the anticipated profile which was planned in the proposal and the obtained sample highlights the actual sample obtained for the research.

Table No 2.4: Anticipated and Obtained Profiles of Respondents

<table>
<thead>
<tr>
<th>Sr. No</th>
<th>Criteria</th>
<th>Anticipated Sample</th>
<th>Sample Obtained</th>
<th>Anticipated Sample</th>
<th>Obtained Sample</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Group ACOA</td>
<td>Group ACOA</td>
<td>Group non ACOA</td>
<td>Group non ACOA</td>
</tr>
<tr>
<td>1</td>
<td>Alcoholism</td>
<td>Present in father</td>
<td>Heavy Drinkers</td>
<td>Teetotallers Absent</td>
<td>Fathers were Social Drinkers</td>
</tr>
<tr>
<td>2</td>
<td>Age</td>
<td>18 and above</td>
<td>18-70</td>
<td>18 and above</td>
<td>18-70</td>
</tr>
<tr>
<td>3</td>
<td>Religion</td>
<td>No consideration</td>
<td>Christians and Hindu</td>
<td>No consideration</td>
<td>Hindus and Christians</td>
</tr>
<tr>
<td>4</td>
<td>Sex</td>
<td>Males and Females</td>
<td>Same as plan</td>
<td>Males Female</td>
<td>Same as plan</td>
</tr>
<tr>
<td>5</td>
<td>Socio economic</td>
<td>No consideration</td>
<td>Same as plan</td>
<td>No consideration</td>
<td>Same as plan</td>
</tr>
<tr>
<td>6</td>
<td>Occupation</td>
<td>Varied</td>
<td>Same as plan</td>
<td>Varied</td>
<td>Same as plan</td>
</tr>
</tbody>
</table>

Sample Definition:

All individuals who had a parent who had an alcohol problem were defined as Adult children of alcoholics (ACOAs). This was a self-reported definition i.e. all children who report that their parents were alcoholic were accepted as ACOA. This was also used by the ACOA index which was developed by Edward Gondolf and Ackerman (1993) for
identifying and assessing ACOA. The limitation of this definition was that it was self-selected, many times there were people who had parents who drank regularly but they never perceived their parents as alcoholics. So the question at each point was who can be defined as alcoholics as most people in today’s time are growing with parents who drink regularly and clinically many of these persons could be categorised as Alcohol dependent. In the case of non ACOAs it was decided to access those who did not have alcoholic parents. In the initial stage the researcher had tried to access a group of persons who had teetotaller parents. A number of people around 12-15 were asked for the purpose of interview. It was learnt that finding a parent who was a teetotaller was like finding needle in a haystack. The number of people having parents who did not drink at all or had never tasted alcohol was not found. Though there were few persons whose religion did not permit and so they did not drink, this group could not be selected. This meant that in society people drank at least socially and thus teetotallers reflected as a rare category. Since the religious back ground in two groups would become different and comparison not possible the individual from these groups were not selected. The definition was then extended to include those whose fathers drank but had not been admitted for treatment or had no problem with law or had not inflicted any harm to self or others. Since all the above criteria’s are associated with heavy drinking and resulting high risk behaviour and would be categorised as alcohol use disorders (DSM V) . The DSM IV TR classification of substance abuse was retained as framework to check that the non ACOA actually did not have parents who demonstrated dependence or abuse.

Another drawback of this self-reported definition is awareness of the person who is reporting the alcohol use. Some adults were not aware and had more relaxed parameters of drinking and they themselves drank. This resulted in the tendency to underplay or discount the effects or fallouts of drinking.

The effects of fathers alcoholism on the ACOAs were selected as research documents that the effects of mothers alcoholism has different effects and father’s alcoholism has different effects on identity, parenting, relationships and other areas. (Ackerman 1986).

Sample Size:
For the in depth interviews the sampling decision was to ensure a mix of adult sons and adult daughters, about at least till saturation is reached or no new facts emerge, in each.

For the ACOA index and ESAP a minimum of 30 in each group was proposed as this would ensure some statistical reliability. Since the numbers were few in each group due to the nature of the problem, overall sample size interviewed were 73. Of the 73, 6 were dropped after the interview as they either had mother who was primary alcohol dependent or then more than one member was alcohol dependent in the house besides the father. The reason that alcoholic mother was not selected was that the sex of the problem parent affects the psychological and emotional development in different ways for boys and for girls. (Ackerman 1989, refer to literature review section on gender). In all about 193 persons were contacted for the interview. A large number of persons were reluctant to talk and did not agree to do the interviews. The reasons cited were as follows:

1. Lack of time, or
2. Lack of inclination,
3. Not having anyone who had problem so could not talk on it.
4. Many persons were defensive about their fathers and felt that though their fathers drank they were not alcoholics.
5. Some persons were offended by the topic and did not want to share.
6. Some shared that they themselves drank and there was nothing wrong with drinking.
7. Some initially agreed but on seeing the questionnaire backed out and said they were not able to read so much in English.
8. A particularly frustrating group was the one that promised to give the interview and stood the researcher up after making appointments and not keeping them up.

The researcher had to sometimes follow up ACOAs for weeks before they finally agreed to be interviewed. Due to the nature of the problem and the complexity of the topic, this option was acceptable and procrastination was understandable. Here the technique used was similar to the motivational interview done with the alcohol dependent for admission to treatment program. Rapport was built and individuals were taken from pre-contemplation to action, in this case to do the interview.
The reasons for this is that even today alcoholism is a secret disease and denial is common (refer to literature review). It is very difficult to get ACOAs who have an alcoholic parent and are comfortable to acknowledge it publicly.

**Figure 2.5: Taxonomy of Sample Group.**

- contacting ngos and treatment centres and support groups

- calling up all the persons who could be interested

- only those who could understand and read and write English

- making presentations to different persons or groups

- interviewing those who said yes

- final group size was 67, 6 were dropped as more than one member had alcoholism problem in the home or only mother was alcoholic.

An interesting trend observed was that as the data collection progressed and the non-ACOAs were accessed, some moved themselves to the other group of alcoholic parent as they realised that probably they did have a parent who had an alcohol problem. This lead to smaller size of adults who did not have parents with drinking problem, thus an uneven ratio of sample emerged in each group. Some of these were identified by researcher as drinking everyday according to the DSM category meant that there was dependence in clinical terms. Some of the adults accepted that their parents could be dependent. Many people asked questions on who was an alcoholic and how does one define alcoholism.

There were gender differences in response to the interview. Initially it was difficult to reach out to women and overall the group of women spoke if their friends convinced them or if someone they trusted gave them a referral. Men on the other hand did not have as much difficulty but the number of men who wanted to talk about alcoholism was not as high,
simply because many men shared that they drank and did not want to answer any questions on drinking as they felt uncomfortable. This was found more in non ACOAs. There was averting behaviour and a reluctance to engage in the research itself. There was one non ACOAs who left the interview midway for attending a phone call and did not return at all. In the non ACOAs they equated giving the interview as an acceptance of alcoholism in the family or in self. Thus the answer to the question was, “No one is an alcoholic in my family. Thank you”

**Site Selection**

There is also shame and stigma associated with being a part of an alcoholic family. The researcher attended numerous AA, Al-Anon and ACOA meetings for contacting ACOAs. This proved to be beneficial and quite a few children were contacted through this support group. The potential sites were all in Mumbai. De addiction and Rehabilitation Treatment centres were also contacted and Kripa as well as National Addiction Research Centre(NARC) were willing and immediately provided support. The other centres contacted were not as forthcoming and felt that they did not have as many English speaking clients. One of the centres did not respond at all. This one can observe maybe due to several reasons , many of the centres may not have positive views to the process of research , a few are manned by recovering alcoholics and addicts themselves and at times are providing poor quality of care . A recent newspaper article has even published a report on the quality of care provided by recovering alcoholics who had no professional staff and were still treating people for substance abuse.

**Analysis**

The overall analysis was done at multiple levels, the first level was when raw data was entered in SPSS and tables were made. The findings were reported on what could be analyzed from the quantative variables. The second layer of the analysis was of the qualitative data by coding, using matrixes and decision trees which culminated in themes and subthemes. At the third level the research involved triangulation of quantative data and qualitative data from the same study. The fourth layer was when findings were plotted against other researcher’s findings and the fifth level was merging and synthesizing these findings
across the different data sets. The last was to arrive at an overarching understanding of the findings and prioritizing the way that the data was to be presented. A break up of how each of the tools was analyzed is given below for clearer understanding.

The analytic strategies used were as follows:

**Tool ACOA Index**

The two groups were compared on the scores in the index highlighting both the differences and similarities. The overall seven characteristics as outlined by Ackerman were compared and analyzed. In the second layer of analysis some data from the qualitative section was also merged. In the third layer other researcher’s findings were used to support or contradict the findings.

**Tool ESAP**

The scores were compared and analyzed according to the authors guidelines. The ten skills and 3 problem areas were discussed in context of the findings. In the second layer of analysis some data from the qualitative section was also merged. In the third layer other researcher's findings were used to support or contradict the findings.

**Socio-demographic Tool**

The analysis of the ACOAs and non ACOAs groups was done using descriptive statistics. In the second layer of analysis some data from the qualitative section was also merged. In the third layer other researcher’s findings were used to support or contradict the findings.

**Tool in Depth Interviews with the ACOA and Key Informant Interviews**

The In-depth interviews were transcribed using the express scribe software and later analyzed using matrices and based on this, key themes which had emerged helped to piece the puzzle of the ACOAs in India. The case history method was used and within case as well as cross case analysis undertaken. Data from the Sociodemographic scale was used to further enhance the findings in this section.
All throughout the research period an iterative process was used to enhance the linkages and to arrive at coherence.

**The process of research was envisaged in a simple manner of the following stages**

**Stage 1**

**Identify ACOAs. And non ACOAs. Administer the two scales to the two groups.**

The ACOA index was administered to both ACOAs and non ACOAs, in order to ascertain the similarities and differences. The decision to administer the ACOA index has been based on the understanding that it could become an important point of advocacy if no differences in scores. On the other hand if there were differences in EI scores then it could become a focus around which one could design interventions as it has clearly demarcated areas. This stage was most challenging due to the stigma attached to alcoholism. Since alcoholism is a taboo and families prefer not to engage in talk on alcoholism, even families where there is no alcoholism are reluctant to engage in any dialogue on alcoholism assuming it will be on consumption patterns.

Since the researcher wanted to access community settings using snowball it proved more challenging. Treatment centres were still more accessible. Most people it was observed drink socially and almost all persons who the researcher spoke to tried alcohol had accepted or refused alcohol and had some encounter with alcohol at some point in their lives.

**Stage 2**

**Analyse the results.**

The analysis was undertaken using descriptive statistics. The ESAP was used to understand the different dimensions of EI. The rationale to undertake this dimension first was to understand the breadth of the emotional intelligence and to take an experimental decision on who could be then asked to volunteer for in-depth interviews so a range of individual on both ends of the continuum were to be included in the study. The analysis was based on non-parametric parameters. Only descriptive analysis was possible and non-
parametric tests were not used. Emails were exchanged with the researchers and based on this a decision was taken on analysis of the data. Mean and standard deviation was used by the researcher as by the test makers too. Descriptive statistics was used. The group statistics were divided into mean and 3 groups formed one which was on the mean, one above the mean and one below the mean were categorised. The criteria of low, medium and high EI was re formulated based on the data obtained after permission from test formulators. The findings were then presented from this perspective. The reason the decision was taken was only as non-parametric assumptions were used for sampling (purposive and snowballing), parametric measures could not be used for analysis.

Stage 3

Indepth interview with ACOAs and interview Professionals working in the field

Few cases (10)were selected for in-depth interviewing. Since the study sought to understand the depth of the phenomenon as well as the breadth, an in-depth interview gave an inside view of the emotional experience. Here process of data collection involved the researcher sending the ACOAs a message and phone calls were made based on the responses from the messages received. Those who had not responded in the affirmative or the negative were followed up and the ones who responded positively were selected for in-depth interviews. This was continued till saturation was reached. At this stage the additional area that was undertaken was, understanding the role of professionals who had worked with the ACOAs or alcoholics. An interview with 6 professionals and support group leaders was undertaken.

This enhanced the research gaze of looking at children of alcoholics and emotional intelligence from multiple professional perspectives. It also assisted in triangulation of data.

Stage 4

Analyse data from the stage 3

Analyse the data from stage 3. All interviews were transcribed. These were then coded into themes and matrices were drawn. Finally a case study was formulated and lastly cross cases
analysis was undertaken. The conceptual framework that was used was that of pragmatism and mixed methods were used.

**Stage 5**

Data was analysed across the two different data for comparisons and differences. This is the most critical area of research as it highlighted the diversity and an Indian perspective on alcoholism. Since the groups were not as neat and made to order in the real world as it was envisaged in the proposal the findings were contextual and understanding was from the perspective of the multiple realities that presented them in the study. This was used in all the chapters to enhance the differences and similarities which were observed by researcher.

**Quality of Data**

The quality of data was assured at the outset by clarity in the area of study, how (methods) and what was to be studied, and clear plan of analysis of the obtained data. Though the field was not as unpretentious as it was envisaged the changes at each stage were made upholding the quality.

One of the ways used to assess the quality of data was to use **triangulation.** Triangulation refers to use of multiple data, methods and analysis procedures. (Teddlie and Tashkkori 2009). Further the data was verified using theory triangulation, three different perspectives of the ACOAs and the non ACOAs plus professionals interview which reinforced data triangulation.

The data used followed the construction theory of truth-how far had I been able to construct the effects of alcoholism on the emotional intelligence of the ACOAs from their view. Questions that were self-reflexive were asked at each stage. They were, was there coherence or not and was the research a reflection of the lived experiences captured by the researcher?

**Ethical and Political Guidelines**
The following ethical guidelines were adhered and kept in cognizance during the research

**Rule of Beneficence**

Researcher had undertaken a responsibility to undertake research in this area as there was hope that it would be able to contribute to greater understanding and empathy and bring the issue of ACOAs in the forefront. Researcher had to ensure that the self-esteem of the respondents who participated in the study would not be affected.

Since researcher was studying the emotional health and there was contemplation on how could this be shared with the ACOAs without it affecting the research objectives and not stimulating social desirability.

**No Harm to the Subject**

Rule of non-maleficence was followed when the ACOAs were reluctant to share the details of their alcoholic parent. The questions were likely to trigger emotional problems they may have experienced but may have repressed since many years. This was addressed in the consent form. The intention was to ensure that in no way was intentional injury or harm occurred in the process of data collection.

Due to the nature of the questions there was a chance that the ACOA may be affected emotionally. The ACOAs relation with the alcoholic parent would or could be affected for the better or for the worse. They were informed about this so that they could reveal as much as they wanted and a list of counsellors was provided if they needed therapeutic support.

Further, for the researcher it was important to establish role differentiation. The roles in the process were that of a researcher and not of a counsellor and researcher had to use clinical discretion that the research interview did not catapult into a counselling session.

**Anonymity**

Many of the children in the support group knew each other and it was foreseen that anonymity within/among subjects might be difficult to maintain. All names used in the study are pseudo-names and certain details minor details were changed as they would be detrimental for the individual if identity was revealed. Further even in the group of non
ACOAs there was a reluctance and a need to be secretive as the issue of alcoholism aroused embarrassment for the non ACOAs and their anonymity was equally important.

Confidentiality

The notes and the transcriptions in the qualitative data were coded and computer information was secured with double passwords. All data was treated with utmost confidentiality.

Conclusion

Overall the methods were followed with strong underpinning on ethical understanding of beneficence and non-maleficence. Some of what had been decided was amended keeping in mind a pragmatic approach of what was workable was used. The research process was both satisfying as well as challenging as the ground realities were different from the ones envisaged on paper.