The key findings of the study reveal that ACOAs compared to non ACOAs demonstrate certain behaviours. The study findings reveal that ACOAs report that father’s alcoholism affects them both overtly as well as covertly. The table below presents the key findings by linking the objectives, tools used and the findings.

Table 8.1: Linking Objectives, Tools and Findings of the study

<table>
<thead>
<tr>
<th>Key Objectives</th>
<th>Tools used in the Study</th>
<th>Findings and Implications: ACOA in comparison to Non ACOAs</th>
</tr>
</thead>
<tbody>
<tr>
<td>To explore the effects of alcoholism on the adult children of alcoholics (ACOAs).</td>
<td>ACOA index-Alcohol and its effects on ACOA</td>
<td>The areas of perceived isolation, fear of failure and self-condemnation do not differ for ACOAs and Non-ACOAs. ACOAs demonstrate problems in the area of intimacy, and report more inconsistency. ACOAs also report higher approval needs and demonstrate more rigidity than non-ACOAs.</td>
</tr>
<tr>
<td>To explore the effects of EI on the adult children of alcoholics (ACOAs)</td>
<td>ESAP - EI of ACOAs</td>
<td>Empathy in ACOAs was found lower than non ACOAs. Assertion, leadership, drive strength, time management was higher in non-ACOAs. In this scale Self Esteem was reported higher in ACOAs than non ACOAs. The skill of stress management was reported as equal for both.</td>
</tr>
</tbody>
</table>
To explore the psycho-social factors that affect the ACOAs in Mumbai, a Socio demographic Schedule – Explored the following in ACOAs

1. Drinking behaviours
2. Smoking behaviours
3. Drug use behaviours
4. Gambling use behaviours
5. Exercise
6. Working Patterns
7. Marital Status
8. Community invitations
9. Socialisation Patterns

- 42% of ACOAs reported that they do not drink as compared to 72% of non ACOAs who drink.
- 28% ACOAs reported that they smoke as against 8% non ACOAs
- All 6% of those who do drugs were ACOAs
- Of the 6% who reported gambling, 4.5% were ACOAs were ACOAs.
- 60% ACOAs don’t exercise whereas non ACOAs at 60% are exercising.
- 12% of ACOAs work more than 12 hours as compared to 4% non ACOAS who work more than 12 hours
- About 41% of ACOA are single compared to 30% non ACOAs who are single. About 31% of ACOAS were married as compared to 42% non ACOAs who were married.
- 16% ACOAs reported not receiving community invitations. Overall of the 84% who receive community invitations are more non ACOAs. –not clear
- 21% ACOAs reported that they partied more than 3 times a week and an equally larger number- 23% did not
The above findings reveal that the ACOAs as a group are less likely to use alcohol as compared to non-ACOAs. Non-ACOAs report higher drinking and are seemingly unaware of the consequences of the disease of alcoholism. As a group it is observed that whether there is a parental alcoholism or not the risk to be alcoholic is present for both ACOAs and non-ACOAs.

With regard to the other basic demographic areas the following were key findings of the study. Gender differences between men and women ACOAs were not significant. This could probably be explained by groups similar educational profiles and that all of them were from the upper middle class.

Overall the socio economic differences between the groups were ranging from those who did not earn at all to those who earned high salaries.

Education was found to be related to alcoholism as few ACOAs in the lower socioeconomic strata dropped out of school or college or did not complete education. The reasons ranged from financial problems to lack of interest. This was not found in the higher socioeconomic strata. Thus the vulnerability to effects of alcoholism is higher in the lower socioeconomic strata. This link between educational attainment and poverty needs to be researched further.
The above table reveals that the emotional intelligence of ACOAs is affected by their father’s alcoholism and resulted in two different trajectories. The ACOAs had experienced a protected childhood if the father was affectionate, available, caring and present whilst they were growing up. However if the father was drinking and had characteristics of being emotionally absent, controlling, immature, irresponsible, egocentric and unconcerned then the following outcomes of a lost childhood were likely to be reported.

**Parental Relationships**

![Figure 8.1: Trajectories of ACOAs due to Differences in Father’s Personality](image-url)
Relationship with father ranged from close to estranged. Many ACOAs reported seeing father in split personality kind of roles. He was a different person when drunk and when sober. Those who were estranged had not seen the father since some time and in some cases for some years also as he was drinking and did not come to meet them. Some ACOAs reported that they did not wish to meet the father. As one ACOA remarked that she had no “father memories”. It was observed that there was “Father Hunger” (Maine 1991). Father hunger is a term that is used to describe women who had fathers who were emotionally unavailable. Though Maine’s work connects this to the area of eating disorders which is on the similar spectrum of compulsive behaviours seen like alcoholism. This was found in many children as alcoholism could affect the ability to be emotionally close. In girls, it was found that from falling in love at younger age to wanting to be rescued by someone. In boys it was expressed in the absence of role modelling behaviours in boys. Data reveals that relationship with father influenced the self-esteem especially for women.

Variation in responses were found in certain responses like many children described difficult relationship with father but on questions related to father, they responded saying they were having close or very close relationship. This dichotomy was found in certain other areas too like reporting stigma and discrimination. This mixed response were found especially in the group that had alcohol problems themselves with respect to their perception on their life problems, there was denial, minimization, as also changing facts.

Relationship with mother was also difficult for both the ACOAs men and women. Many of the ACOAs reported not having a good relationship with the mother especially if she was drinking too. It emerged that the women ACOAs who were sexually abused felt let down and mistrust towards the mother as she knew about the abuse and yet did not intervene or protect the child. This lack of protection by the mother from the abuse that ACOAs faced at the hands of the father was reported by both men as well women ACOAs.

Relationships with grandparent were reported by many as nurturing and caring and a great support when parental problems got unmanageable. ACOAs have reported that they have spent early part of their lives with their grandparents or other close family member like an aunt or an uncle which seems to act as a buffer and enhance coping.
Those ACOAs who were parents reported certain problems in managing their children. The areas were educational disinterest, hyperactivity, experimentation with alcohol or drugs, emotional distance with the child. A few of those who were also alcoholics reported that the child did not grow up with them but with mother or in laws as they were unable to be around and care for the child.

**Deprivation, Abuse and Violence**

Deprivation, abuse and violence were key areas that ACOAs reported. The deprivation ranged from those who were deprived of basic needs such as food, clothing, shelter to those who were deprived of taking up hobbies or further education as there was a dearth of money. Some reported being emotionally deprived of love, affection and care as the parents were too preoccupied in their own problems. Financial deprivations are also present and at times were acute enough to push the child to start work from a younger age, earliest ages are 10 for girls and 12-13 for boys as reported by ACOAs. (Refer to figure 8.1)

Abuse was reported as even sadistic when father was drunk and parental immaturity present. The nature of the abuse differed as some were verbally abusive, some emotionally, some were physically abusive. Those who were in higher socioeconomic strata tended to use more emotional and verbal abuse and those in lower socio demographic were not only physically abusive but also used other forms of abuse like verbal violence and emotional abuse.

A key finding was sexual abuse in ACOAs females which was found across different instruments of data collected. The likely reason could be lack of monitoring and accountability in the family system as the alcoholic is the centre of attention. There is neglect and this increases vulnerability of the girl child in the family. Of the 6% who reported abuse only one ACOA was a man the rest were all women. In this study the deprivation, abuse and violence when snowballed resulted in trauma. If one viewed this on a scale then deprivation lead to abuse which then lead to violence. Given below is a step up demonstration of the violence.
Many male ACOAs reported that as they reached adolescents they reacted to the violence by “hitting back”. Age reported varied from 16 years and up. Thus the cycle of violence and abuse is initiated due to the alcoholism in the father and is perpetuated by the sons as they grow up. Thus intergenerational transmission of abuse can be seen. This was seen in the problem area of EI, men ACOAs report more aggression than women ACOAs. This was reflected in the quality of intimate relationships and the selection of partners.

**Love Relationships**

Intimacy was a problem area for many ACOAs. They found it difficult to find partners who were appropriate and some of them found it difficult to sustain relationships. A large number were single. Emotionally the area of trust emerged as a factor for breakdown in relationship. There were major issues regarding trusting the partner either too much or not at all.

Boundaries in intimate relationship were found to be problematic, parallel relationships, extra marital affairs, flings are present in both parents and affect the ACOAs. The relationships that ACOAs have later, one observed are role modelled on these relationship that they witness their parents having and are more likely to marry alcoholics or high risk persons or persons who may be compulsive. Another form of assortative mating(adult daughters of alcoholics marry alcoholics) is observed in the case of arranged marriages where alcoholic fathers marry the daughter to other alcohol drinking friend’s sons.
Women as well men both had partners who drank or smoked but this was not a reason why break ups took place. This means that though alcoholism is one of the causes of relationship break downs one cannot conclude people broke up only because partner drank or smoked. Court statistics show that the rate of divorce due to alcoholism is about 6.3 and the incidence of alcoholism in partners seeking divorce is about 29%. (Chavan 2012 ). Thus divorce due to alcoholism is not significant, people continue to live with the partner`s alcoholism or drinking habits even when they may have a choice. This means as a society it is acceptable if people drink. Cultural sanctions are present thought there are no overt sanctions in religious groups such as Muslims. One cannot speculate on the number as there are no studies to check the prevalence of drinking religion wise. The number of people who drink could be high, but no permissions are present to seek help.

The non ACOAs and the ACOAs both drank as much and high functioning alcoholics (HFA) was emerging trend in youth and young adults. These are individuals who drink regularly but are also productive at work. They seem to be unaffected by alcoholism and may not seek treatment till health is affected.

**Social Support**

The role of social support is high among ACOAs in this study and therefore the perceived isolation or the self-condemnation is lower as help is given and received by the family. In the absence of a clear social security measures the joint family in a psychological sense does take care of many of the needs of the growing child. (Kakar 1978.) In this case it is alcoholism. Neighbours and relatives were also good social support but if violence is more, then even they withdraw or hesitate to reach out. Thus violence is treated as a private issue, covered up or trivialised by outsiders and people in general keep out perceiving it as an internal issue.

The surprising finding was sexual abuse in women ACOAs was reported in both phases of data collected in the larger group as well as in indepth interviews. The likely reasons could be lack of monitoring and accountability in the family system as the alcoholic is the centre of attention which results in neglect and high vulnerability for others in the family.

As such researcher observed that ACOAs who were in or had been exposed to support group programs did better than ACOAs who had not been to one. The ACOAs who knew it was a
disease had better outcomes than those who looked at it as problem or poor control or will power.

**Effects of Alcoholism**

Drinking was found commonly in both ACOAs and non ACOAs, overall 53.7 % of respondents drank. Not everyone who drank have parental alcoholism, in fact in this study those who came from homes where there was no alcoholism drank more (72%) compared to ACOAs where only 42 % drank. Today drinking with friends is the most common activity and pastime. Drinking as such is not frowned upon and is means to establish contact, rather than as a means to separate. This means drinking and alcoholism is more accepted and the problems associated with it are not taken seriously by groups who have not seen alcoholism at all. This key finding suggests that the risk to become an alcoholic is not restricted to parental alcoholism, vulnerability is equal regardless of family history.

About 20% ACOAs also smoked and more ACOAs than non ACOAs smoked and were regularly addicted to nicotine. ACOAs in this study were also likely to experiment or take drugs recreationally compared to non ACOAs at 6%. This affected the EI and this was found in the ACOAs who had a history of alcohol use disorders.

**Emotional Intelligence**

The EI scale did not yield significant differences though non ACOAs had slightly higher EI scores. Due to the sample size, this finding cannot be generalized. Further the sampling method was purposive and sample was not from general population it is recommended to do further studies in the Indian context to generalize these findings.

In subsections of the ESAP there were differences that emerged in both EI skills and EI Problem areas. The major areas of differences are in empathy, assertion, leadership, drive strength, time management. The areas where there is very marginal or no difference is comfort, decision making, stress management. The two areas that are problem areas show ACOAs males being more aggressive and females more submissive. ACOAs also report wanting a change in their present life situation. The areas where ACOAs seem to do better than non ACOAs are commitment ethic and self-esteem. It does raise unanswered questions
as a researcher on the scores of self-esteem. If a group has high self-esteem then why do other areas show the lower scores? This needs to be further studied using other measures of self-esteem like Rosenberg’s Self-Esteem Scale.

The reasons could also range from any of the following. Perhaps ACOAs are better able to manage EI as they are growing up, facing and managing more problems than children from non-alcoholic homes. It may also be that they do not want to acknowledge the problems caused by alcoholism as the pain is too much, so for many, there maybe masking of pain. Case studies reveal that some children were so disengaged with both the alcoholism in the family and the drinking father that they were mentally and emotionally absent and it did not matter to them. Some children maybe resilient and have worked through their mental health issues and thus may have higher self-esteem.

Alexithymia needs to be further investigated as this clinical construct is similar to EI and could be a reason that these differences may not have showed up. Studies in the area of EI report alexithymia as affecting the emotional areas like lack of self-awareness, lack of insight, poverty of inner experiences, concrete thinking and externalized behaviours. These individuals were likely to develop psychosomatic symptoms like binge eating, alcohol abuse and other compulsive behaviours.

In this study this finding of the area of self-esteem is reported differently and triangulation of data reveals that self-esteem reported as higher by ACOAs in the scales section, was found to be much lower in the in-depth case studies, with low self-esteem being reported.

Management of Emotional Intelligence

Emotional effects are seen in the cases as isolation, intimacy problems, relationships with people emerge as problem areas for ACOAs. EI was managed by ACOAs by adapting roles, and following unspoken rules like not talking or thinking about the alcoholism or feeling the pain or problems due to fathers alcoholism. Thus the link between alcoholism and EI is that the ACOAs adapts as s/he faces a problem. They may use confrontation or withdrawal depending on how the solved the problem or then escape the problem by fantasy or drinking or other maladaptive behaviours. The women ACOAs tend to become caregivers and play placator roles which enhances their sense of control on their lives. Men ACOAs were found
to take on the role of family heroes. Given below is schematic representation of the effects of alcoholism on the management of EI.

**Figure 8.3: Management of EI**

Some characteristics that were found in ACOAs were feeling alone, doing things on their own. Self-centeredness was reported by key informants as one characteristics of ACOAs today. Self-centeredness and focus on self was observed as there is a feeling that there is no
one around to take care of them. ACOAs reported that they did not take parents as role models compared to non ACOA who report father or mother as role models.

The alcoholism not only left overt impacts like educational dropout but other areas such as parenting issues (one ACOAs reported that he was considering counselling for his child as he was hyperactive and they were getting tired) relationships, love and family were affected covertly.

**Coping and Emerging Roles**

Spirituality emerged as a coping mechanism for ACOAs. Waiting for God to solve or intervene or having God on one’s side were most commonly used methods of coping reported in the study. ACOAs used both task focussed(doing something) as well emotion focussed coping (talking about feelings), though withdrawal was the most common way that they coped with the problem across both the sexes.

It was observed by the researcher that roles taken by ACOAs were not fixed and the role changed as there was insight. As such it was observed that there were a higher number of family heroes who were a part of the study and were responsible and mature individuals, though the other clear role was of the family scapegoat. The mascot and the lost child did not emerge as clearly. A large number were found to be placator or adjuster especially in women. The table highlights the roles adopted by the ACOAS in the present study.

**Table 8.2: Roles adopted by ACOAs in the study**

<table>
<thead>
<tr>
<th>Role</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family hero</td>
<td>Responsible, financial head, replaces the fathers role.</td>
</tr>
<tr>
<td>Family scapegoat</td>
<td>Is more likely than other roles to use self-sabotaging behaviours like drinking, smoking, overeating, internet overuse, sex addiction or exercise addiction.</td>
</tr>
<tr>
<td>Mascot</td>
<td>Happy go lucky and unaware and not in touch with the family alcoholism.</td>
</tr>
<tr>
<td>Lost child</td>
<td>Disconnected and disengaged. Maybe in</td>
</tr>
</tbody>
</table>
abusive relationships. Lacks focus and direction. Confusion and indecisiveness present.

| Placator/Adjuster | The family peacemaker, keeps the family homeostasis. This is more likely to be taken on by women ACOAs. |

The possibility of drinking behaviour is as likely for the family hero as well as the placator, mascot and lost child as reported by Black (1981), in this study the scapegoat was more likely to have drinking problems. It was also found that roles were not fixed and with insight and maturity ACOAs moved in the role that they adopted. One ACOA adopted the role of the scapegoat and then became the family hero once he gained insight.

The structure of the family as system seems to have affected the findings. The ACOAs were a part of the larger joint family system. Here the joint family does not mean individuals who stay together but rather a psychological understanding of people who reach out to one another in case of a crisis. They may live apart but are there to support or help one another, in this case it was grandparents who were around. The children were not as unprotected or vulnerable as reported in European or American studies on alcoholism in the family. (Black 1981, Weghscheider-Cruse 1981)

The emotional intelligence of the ACOA is affected by and affects various areas like needs, roles to other behaviours.

The needs of the ACOAs in this study was reported as approval, attention, acceptance. They wanted validation at times for the being like self, feelings and behaviour. ACOAs report feeling insecure and unprotected especially when they were growing up and they witnessed the violence in the home. The ones who were sexually abused expressed the lack of protection they felt.

These needs gave rise to some feelings like that of confusion, anger sometimes at self, some expressed anger towards the drinking father and others to the mother. ACOAs also held on to
resentments towards parents especially mother. Some felt uncared for, neglected, others felt rejected. These feelings in turn gave rise to behaviours that affected emotional growth.

Thus some “acted out” the behaviours while other “acted in”. Acting out behaviours were expressed as drinking, smoking, lying, stealing, sexual promiscuity, eating disorders and internet and gaming overuse. Acting in behaviours were expressed as depression, cutting wrists, and attempting suicide. Gender differences in behaviour were observed with men ACOAs reporting more aggression and women ACOAs reporting more submissive behaviour patterns. ACOAs also reported care taking behaviours with regard to younger siblings and later with partners. It was observed that ACOAs also overadapted and were likely to indulge in people pleasing behaviour. This came as a direct result of the ambiguity experienced in the household. ACOAs reported that they were unsure of what would maintain peace and this behaviour helped to keep equilibrium. At times this may result in idealisation of the home situation and the parents in order to avoid incongruence with the world outside. ACOAs both men and women reported taking on more responsibility and also becoming more mature than peers their age. The consequence was losing out on childhood and some reported that they were aware of it and felt sad about it.

The behaviour that they adapted influenced the kinds of roles that they were more likely to play in the family. Some played the hero and were high achievers. Some enabled the alcohol in the family and became placators. A few became rescuers trying to help the parents and siblings from alcohol related effects. Detachment was also reported where no contact was made with the father for years to emotional detachment where though they stayed together they did not interact. ACOAs role modelled the parents in two ways one was becoming like the father who drank or then becoming like the mother who either suffered or fought the addiction.

The major barriers to EI was lack of communication in the household between parent and children or between partners. EI was affected by the nondrinking parents compulsive behaviour of obsessing about the drinking parent. This was reported in the form of discounting behaviours like not addressing the sexual abuse in women ACOAs, minimizing the violence in home, discounting expression of feelings by not talking about them or clarifying or explaining to the ACOAs.
If one had to summarize the study the following were the factors that emerged in the context of ACOAs in Mumbai. Given below is a visual representation of intrapersonal EI of the ACOA.

Figure 8.4: Intrapersonal EI of ACOA

- **Major Barriers**
  - Lack of Communication
  - Non alcoholic parent’s compulsive behaviour
  - Discounting Behaviours
  - Mixed Messages
  - Lack of Attunement

- **Needs**
  - Approval
  - Attention
  - Acceptance
  - Validation of Self feelings and behaviour
  - Need for Security
  - Need for Protection

- **Roles Played to Manage EI**
  - Hero
  - Enabler
  - Rescuer
  - Detachment
  - Role Modelling either Parent

- **Feelings**
  - Confusion
  - Anger
  - Shame
  - Resentments
  - Fear, Insecurity
  - Neglect
  - Deprivation
  - Uncared and Rejection

- **Behaviours and Expression of Emotional Growth**
  - Acting out behaviours e.g. drinking, smoking, stealing, sexual promiscuity, lying, eating disorders.
  - Care taking behaviour
  - Acting in behaviours withdrawal, depression
  - Aggression in boys, submissive behaviours in girls
  - Over adaptation and people pleasing
  - Idealisation
  - Responsibility
  - Maturity before age

**Figure 8.4: Intrapersonal EI of ACOA**
Difficulties in the Study

The sample of ACOAs is self-reported. This self-reported technique has barriers. If an ACOA reports having an alcoholic parent then he or she was included in the sample. So those who did not report or did not reveal the alcoholism, could not be accessed.

The access to ACOA was largely dependent on support groups, treatment centres and homes where ACOAs could be contacted through their parents in treatment as there is no active network of ACOA in Mumbai. This resulted in a smaller sample than anticipated. The sample was accessed using multiple ways so as to have a representative sample of ACOAs and avoid a facility based/clinical sample of ACOAs.

The tools used in the study were limited in their understanding as they were developed for higher income country populations. Thus tools from an Indian perspective need to be developed in the area of EI. Further, cross cultural studies need to be undertaken in the area of EI and its understanding in the Indian context. Certain factors that have emerged as different in the current study maybe because of contextual factors which are not measured by the western tools like perceived isolation in India will be less as the large network of social support are there in the form of family, friends and neighbours.

Another finding during data collection was that follow up and motivating ACOAs to give interviews was like motivating the alcoholic to go for treatment, a difficult process as they are reluctant to talk about the effects that alcohol has had on them. This “bottling up” was reported by key informants as well members of support group when they were helping out the researcher in the sampling process.

Confounding Factors

Overall awareness was found to be significant as there was lack of awareness about self and alcoholism in some of the ACOAs. This lack of awareness coupled along with a dichotomy in responses made data analysis a demanding task. This is significant as researcher cannot conclude with surety as similar questions have yielded different results in the different methods.
Sample size is a confounding variable as this could not be controlled due to respondents moving over to ACOA group as this was not anticipated when planning the study.

**Emerging Conceptual Understanding:**

ACOAs are not viewed as a high risk group in the Indian context but the present study highlights that ACOAs are vulnerable and need to be addressed to break the intergenerational cycle of addiction. The key factors that emerged in the study were in the areas of self, work, relationships, personal lifestyles, emotional lives and EI that affect the ACOAs perspective on growing up with alcoholism in the family.

The key findings that emerged in the study were in the areas of intrapersonal, interpersonal and management of EI. Within the intrapersonal area the ACOA sense of identity was affected due to being a child of an alcoholic which gave rise to certain emotions. The emotions that ACOAs experienced were anger, fear, shame and insecurity. These emotions also affected the self-esteem which emerged as a core area as ACOAs reported that being a child of an alcoholic did affect their self-esteem and overcompensation was a way that some reported that they coped.

In the interpersonal area the relationship with the father was significant and ranged from very close to non-communicative. The father’s role varied from him being an abuser to being dependent on the ACOA. The relationship with the mother varied but was reported as difficult as mother was pre-occupied with the father. The quality of the parental relationship also affected the ACOAs with most damage to those who experienced violence and abuse. With respect to love relationships it was found that women ACOAs had at times married partners who were drinking and even men ACOAs had partners who drank or smoked. Multiple relationships, dual or parallel relationships, live in relationships were reported by both men and women. ACOAs reported witnessing deprivation, abuse and violence in differing forms from deprivation of basic necessities to verbal, emotional, sexual and physical abuse. Other significant findings reveal that grandparents emerged as the source of support and nurturance for ACOAs.

In the management of EI, the ACOAs managed stress in different ways. From pretending that the problem did not exist, withdrawal, detachment, lying and joining support groups were
other behaviours observed. It was seen some used yoga, to accept whatever was happening in their life. Others used religion and spirituality. The second way that EI was managed was by following unspoken rules in the house. These were “don’t talk”, “don’t feel” and “don’t trust”. This meant that ACOAs did not talk about the alcohol or its related problems to those outside the family and protected the family secret. Expression of feelings was either not encouraged or when expressed not addressed satisfactorily and mixed messages were present. Trust was a problem area especially for those who reported sexual abuse. The third way they managed the EI was adopting different roles like family hero, lost child or placator or mascot. Though the roles were not fixed and varied for the same ACOAs at different times in his/her life.

The final emerging conceptual understanding of the study has revealed that the paradigm of this research, based on the ontology and the epistemological route synergised into a methodology that resulted in findings which were at some level synonymous to other research findings in the field but at the same time some of the findings were unique to the ACOAs in Mumbai. An emblematic understanding of the study is presented in the following emerging conceptual map.
Figure 8.5: Emergent Conceptual Map

ACOA

**GROWING UP**
- Deprivation
- Relationship Abuse
- Violence
- Nurturing
- Mentoring roles

**INTERPERSONAL**
- Relationship with father
- Relationship with mother
- Parental Behaviour
- Behaviour with others
- Love relationships
- Deprivation, abuse, violence

**EMOTIONAL INTELLIGENCE**
- Intrapersonal
  - Identity
  - Emotions
  - Self Esteem
  - Personal Lifestyle
  - Characteristics of ACOAS
- Stigma
  - Anger, fear, shame, insecurity

**STRESS MANAGEMENT / RULES /ROLES**
- Higher in ACOA’s
  - Inconsistency
  - Control needs
  - Approval needs
  - Rigidity
- Marginal/No Difference
  - Isolation
  - Fear of failure
  - Self-condemnation

**MANAGEMENT OF EI**
- HIGHER in ACOA’s
  - Commitment ethic
  - Self-esteem
- LOWER in ACOA’s
  - Empathy
  - Assertiveness
  - Leadership
  - Drive strength
  - Time management
- MARGINAL/NO DIFFERENCE
  - Comfort
  - Decision making
  - Stress management
- PROBLEM AREA higher in ACOAs
  - Aggression
  - Deference
  - Change in life

**DEPRIVATION, ABUSE, VIOLENCE**

**POORER THE QUALITY, MORE THE EFFECTS**

**INTIMACY A PROBLEM AREA**
- Less expectations
- Poor Selection of partners
- Assortative mating is arranged

**VERBAL, EMOTIONAL PHYSICAL, SEXUAL ABUSE REPORTED**
Suggestions and Recommendations

Individual and Family

The role of the parent emerges as an important deterrent in alcohol use. Construction of fatherhood in India is that fathers are considered as important authority figures as well as the “karta” (head) of the family. Thus if the parent is introducing alcohol then the permission to drink begins at home and this cannot be then reversed. Thus suggestion is to delay the onset of drinking behaviour if not abstinence. Age of first tasting was reported as six years in those who had alcohol problems and by the time the child was 10-11 even non ACOAs had experimented with alcohol as there was accessibility, availability and acceptance of drinking alcohol.

Parental awareness of alcoholism and its effects should be covered in parenting workshops.

At the family level it emerges that physical distance from the alcoholic father is better for mental health outcomes than living with the alcoholism as comorbidity maybe triggered. It was revealed that the father’s drinking pattern and the behaviour thereafter was unpredictable and at times ACOAs found it traumatic but did not know how to deal with parent. Fathers lack of awareness when drunk results in language or behaviour which seems to scar the ACOA and result in long term emotional or intimacy problems.

Social Work Level

The findings in the study indicate that not only ACOAs but also non ACOAs are at high risk to become alcoholics poses a serious public health threat. Due to the rapid changes in society today, courses on substance abuse need to be taught and social workers trained to work with high risk groups. The area of emotional intelligence could also be used as a framework to work with individuals, groups, and communities.

The ACOAs that social workers may encounter in clinical or treatment centres are those who have experienced some levels of difficulty due to the parental alcoholism. ACOAs who do not come for clinical treatment and maybe living high quality lives can also contribute to the positive psychology movement as they are the ones who coped in spite of the alcoholism. These ACOAs cannot be reached due to the secrecy and stigma around being an ACOA.
coupled with the reluctance to talk or share by these hardy group. This research was also an attempt to understand the non-clinical sample of ACOAs and it is recommended that further research with ACOAs and areas that maybe affected due to alcoholism needs to be undertaken.

Social Workers need to be trained in working with alcoholism and recognising high functioning alcoholics (HFA). They need to be trained in interventions that break the family secret and work with denial so that professional help is received without stigma.

When working with an alcoholic, the emotional needs of the children need to be focussed on so that they can be addressed and high risk for future compulsive behaviour in other areas is discussed and prevention is highlighted and psycho-education imparted especially in the areas of management of EI.

Trained professionals like social workers, counsellors and family therapist are a dearth as the field is dominated by recovered and recovering substance abusers who may need to deal with their own emotional and psychological issues too.

A strong suggestion is to have centres that are professionally managed as is the case with other diseases and relook at the concept of only employing peer counsellors. An urgent shift is required in importance given to treatment services in Mumbai from peer based to professional based services.

Suggestions to government and non-government initiatives on introducing a diploma or an advance degree in the area of addictive behaviours as this is likely to emerge as a public health issue in the near future with the breakdown of the joint family system and increasing role of media. Bollywood movies have been showing an increasing trend of associating alcohol with friendship, love and loss. (eg. Dostana, Yeh Jawaani Hain Deewani, Devdas,) and there has to be active lobbying in this area to make filmmakers aware of their influence on youth and tweens.

Ingram describes emotional intelligence as being at the “heart of social work practice” (Ingram, 2013) as all work that is done with people requires skills of empathy, and perceiving the emotions in the opposite person and understanding these emotions. Social workers deal
with people who are distressed and who are unable to manage their emotions and need support and guidance in regulating and managing the same. Thus the importance of EI in social work cannot be much forcefully emphasized.

**Counselling and Therapy**

Emotional Intelligence being a psychological construct, its importance in the field of human resources is valued. However its application to therapy cannot be ignored. Having counselled and worked with substance abusers and their families, researchers observation is that this group lacks the ability of management of emotions which is crucial to prevent relapse. The teaching of EI is a core skill that counsellors and therapist can empower clients and thus provide tools to resolve challenges faced. Further one can argue that emotional problems are at the core of human experience and once this core is worked upon with a therapist then the external reality is managed by the client in a fruitful manner.

A short course on EI for counsellors as a part of their training can be beneficial.

Some of the suggestions made in the section on Social Work hold true for Counselling also as the fields are overlapping.

**Governmental Level**

Schools need to be trained in recognising children at high risk and counselling support be provided to such vulnerable ACOAs who may be subject to abuse and violence.

Government needs to have an initiative like educational support, scholarships to ACOA which is recommended by teachers so that they do not drop out of the education system. This will prevent the cycle of alcoholism as these ACOAs do not have an opportunity to study further and therefore have less skills to enter job markets and this results in continuing the cycle of poverty and unemployment.

Social care systems need to be set up which provide help to women and children who are abused in the alcoholic family through an exclusive telephone services to reach out. It also should have an authority to admit alcoholic partners who are a danger to the family or themselves due to drinking.
Stigma needs to be reduced and fear needs to be addressed both in lay public minds towards the alcoholic as well as the family.

A public health approach on the link between poverty and the consequences of alcoholism needs to be addressed. This is true in the case of services available for the treatment of alcohol use and substance use disorders. Currently the services have not been able to address cultural and context specific interventions. The models are largely adapted from centres in America and Europe and do not address the context specific problems that is faced both in urban as well as rural areas. This needs to re-evaluated and a new strategy evolved.

**Support Group Level**

There was a motivated group of ACOAs who initiated ACOAs meeting in the western suburb. This was started with a few members when data collection was in progress but due to lack of sustainability it was discontinued. Newer methods of running support group programs are recommended like using a Skype group or internet based groups. Since time is an important factor in Mumbai this option is more feasible and will result in fewer dropouts.

Another suggestion is to have these meetings fortnightly or monthly which can be feasible for ACOAs to attend.

Changing the interface of meeting to online or Skype needs to be tried out as many of the group that were visited were having very few members. The common reasons were managing work and commuting in Mumbai was difficult so many did not end up coming for meeting at all.

**For the ACOA**

It is paramount to break this secret if one wants to make a choice to live a healthy, happy and fulfilling life. The ACOA needs to reach out and seek help so that he or she can deal with the trauma of living with an alcoholic father or mother.

The ACOA should seek a trained professional in understanding the impact of the trauma and the areas of life that are affected.
ACOAs should come together and lobby for educational support and build a pressure group which will lobby for reforms that are beneficial for children’s growth like educational support.

**Methodological Suggestions**

Alcoholism is methodologically one of the most difficult areas to study as the severity of drinking is underreported by both the alcoholic and the family. Often the periods of sobriety and active drinking are fluid and one drink also affects this categorisation from the research perspective. The parameters of who is an alcoholic needs to be redefined as the newer generation looks at alcohol as the earlier generation looks at “chai” (tea). Thus high functioning alcoholic (HFA) as a category should be included in assessments and treatment protocols be developed.

EI as an issue needs to be reviewed and refined. Researchers do not have clarity even after more than two decades and are having divergent views on what can constitute EI. Researcher community needs to arrive at a consensus on the variables which can be categorised as EI. Methodologically the area of EI is overlapping with personality and other similar constructs, which makes it difficult to derive how EI is not just repackaged as new wine in old bottle (pun unintended). Too many constructs overlap and this poses a challenge to study this variable. The other disturbing factor as a mental health professional is that EI is like a “cottage industry” (Deiner et al 2009) with the number of tests that have been brought into the market to derive EI. The conferences that are held in the human resource industry are numerous where as the theoretical basis is yet not clearly defined. This means EI training as a panacea for all those who are emotionally challenged and this training will help them to reach the dusty corners of their EI using it to become truly powerful managers needs to be researched further scientifically. Whilst some research in this area shows that people can be trained to recognise and decode emotional cues, the base of this trainings are on theoretical grounds that combine many other psychological constructs together like in some it is happiness, in others it is stress management. Each of these areas has a substantial body of research work and it is difficult to extract the EI component from it. One cannot ignore that EI overlaps with personality tests and this raises questions on what is EI and what emerges
because of personality differences. (Zeidner et al 2012). The study highlights the need to develop an indigenous scale of EI measuring the concepts that fit in with the Indian culture.

**Emotional Intelligence – Future Vision**

It is recommended that a centre of Emotional intelligence be established in colleges or university to develop EI in children, youth and adults. Just recently, Harvard University has started a centre for EI.

It is also recommended to study EI in Indian context as this area influences all other areas like educational, industrial, social work, counselling and therapy and any work with groups and people cannot do away with the emotions that one brings along with the self. How many of us can say that we enjoy working with people who are grumpy or sad? (Brackett 2013)

EI studies in healthy lifestyles and behaviour in India needs to be undertaken and documented. Much of literature is focussing on EI at workplace and improving competency or predicting work performance. (Zeidner et al 2012)

EI in counselling is important as raising empathy is related to better outcomes in therapy and Bar-on proposes that EI can be used with children, with couples in therapy and even when they plan to have children (Bar-on 2008).

EI in schools can be taught as a component along with life skill education programs as research is validating the benefits of developing EI in children. Researchers in EI are of the common opinion that due to the neuroplasticity of the brain it is possible to teach EI. (Baron 2008)

**Future Research on ACOAs and EI**

Last but not the least the new trend of high functioning alcoholics (HFA) (Benton 2008) which is a growing trend in the youth needs to be studied further as the common image of a “skid row alcoholic” seems to be less visible now especially in certain classes of society.
In this study one is observing the trend that drinking is common in the younger generation and this dangerous escalation from fun to addiction is not predictable as alcoholism is known to be a democratic disease, it can happen to anyone, at any age and whatever be ones caste, class or gender the results are damaging to the individual and the family and society. (Anonymous speaker, Source Public Address attended by the researcher in 2004)

**Conclusion**

The case study on the life of Ronald Reagan, reiterates that the legacy of being an ACOA lingers on even when that ACOA occupies the highest office in a country, that of a President. Therefore being an ACOA can be a stigma or can be used as gift to attain higher goals, both choices are possible depending on the context of how the ACOAs brackets this phenomenon.

To conclude the “focus” should be on what “choices” the ACOAs makes, looking at the ruin (here the alcoholism) or finding the treasure (hidden gifts) : thus in Rumi’s words

**“Where there is ruin there is hope for a hidden treasure”**

Mawlavi Jalal-ud-din Rumi .

**Comments and Feedback**

The reader can write to the researcher at rizwana.nulwala@gmail.com or rizwana.nulwala@tiss.edu or then post a tweet at @rizwanaghadiali . Feedback and suggestions are welcome as the areas EI, ACOA and substance abuse are potentially rich and relatively under explored from the health dimension in India.