INTRODUCTION
Alcohol affects each member of the family from the unborn child to the alcoholic’s spouse. Its far-reaching affects result in not only physical problems for the alcoholics, but also may result in physical and psychological problems for other members of the family. Alcohol addiction is defined as a behavior over which an individual has impaired control with various harmful consequences and negative implications. (Cottler, 1993, Rounsaville, Bryant, Babor, Kranzler, & Kadden, 1993). Individuals with alcoholic and substance abuse problems recognize that the behavior is harming them and others whom they care about and find themselves unable to stop engaging in the behavior when they try to do so with or without help (Heather, 1998).

Jellinek offered the following definition for alcohol problems: “Alcohol addiction is an uncontrollable craving for alcohol (i.e. physical dependence), while “chronic alcoholism is referred to “the mental or physiological changes associated with prolonged use of alcohol” (Jellinek, 1947).

In Psychiatry and psychological studies and treatment, the International Classification of Diseases, 10th revision (ICD-10), published in 1992 is used as it is the definitive international system of diagnosis, classification and coding of diseases and related health problems. It is used worldwide to classify and record diagnoses in clinical practice and in hospital settings to capture disease occurrence for statistical monitoring. The International Classification of Diseases defines “alcohol abuse as repeated use despite recurrent adverse consequences; further (WHO, 1992) defining alcohol dependence as alcohol abuse combined with tolerance, withdrawal, and an uncontrollable drive to drink”.

Alcohol use and abuse are health hazards and the problems of addiction are not limited to individuals in certain social strata but appear to affect people in all the levels of the society. (Murthy, Manjunatha, Subodh, Chand, & Benegal, 2010) has
rightly remarked that “Substance use patterns are notorious for their ability to change over time”.

In our country both licit and illicit substance use cause serious public health concerns. National level prevalence has been calculated for many substances but in the studies and surveys regional variations are quite evident. Often in the studies of addiction, short questionnaires such as the Michigan Alcoholism Screening Test (MAST), (Selzer, 1971) and Cutting down Annoyance by criticism, Guilty- feeling, and Eye-opener (CAGE), (Ewing, 1984) are used to screen alcohol use and dependence in the population.

In the national prevalence studies, alcohol use/ abuse prevalence in different regions is found to be varied from 167/1000 to 370/1000. Alcohol addiction for chronic alcoholism range from 2.36/1000 to 34.5/1000. In a meta analysis by (Reddy & Chandrashekar, 1998) it is seen that in India, an overall substance use prevalence is 6.9/1000 and urban and rural rates vary and it is found to be 5.8 and 7.3/1000 population. The rates of men and women were found to be different i.e. 11.9 % and 1.7% respectively. Among women, alcohol consumption is reported to be less in comparison to men in India though alcohol use among women is found to be increasing as seen in epidemiological research. Various regional studies between 2001 and 2007 continue to reflect this variability. In a study conducted in southern India by (John et al., 2009) showed that 14.2 % of the population surveyed had hazardous alcohol use on the AUDIT. Again a similar study by (Sampath, Chand, & Murthy, 2007) in the tertiary hospital showed that 17.6 % admitted patients in the hospital settings had hazardous alcohol use. National Family Health survey (2007), India, indicates daily use to be 4-13% and out of that 32% was found to be dependent on alcohol.

In a study on alcohol use from Delhi by (Mohan, Chopra, & Sethi, 2002) found that annual incidence of non dependent alcohol use and dependent alcohol use among men was 3 and 2 per thousand persons in a total cohort of 2937 households. Among the national level studies the national house hold survey of drug use in the country by (Ray, 2004) is the first systematic effort to document the nationwide prevalence of drug use. In his study it was found that alcohol (21.4%) was the primary substance
used apart from tobacco followed by cannabis (3%) and opioids (0.7%). In the findings, 17 to 26% of alcohol users qualified for ICD 10 diagnosis of dependence, translating to an average prevalence of about 4%. In a study by (Murthy et al., 2010) a marked variation in alcohol use prevalence was found in different states of India, current use ranged from a low of 7% in Gujarat (officially under prohibition act) to 75% in Arunachal Pradesh which is situated in the North-east part of India.

According to the drug abuse monitoring system, 2004 which evaluated the primary substance of abuse in patient treatment centres found that the major substances were Alcohol (43.9%), Opioids (26%) and Cannabis (11.6%). In the National Family Health survey (2005-06) it was found that 124,385 females and 74,369 males aged 15 to 54 in 29 states have prevalence of substance abuse.

In a retrospective study of emergency treatment in Sikkim between 2000 and 2005 by (Bhalla & Chakraborti, 2006) substance use emergencies constituted 1.16% of total psychiatric emergencies. The commonest cause of emergency was alcohol withdrawal which was reported to be 57.4% among group of patients in the in-patient setting. In Assam, a study reported by (Hazarika, Biswas, Phukan, Hazarika, & Mahanta, 2000) alcohol users were 37% in rural Assam and a prevalence rate of 365/1000 population which was greater than the national prevalence.

In Bhagabati and his colleague's research study conducted in Assam during 2009, depicted that alcohol use among below 18yrs is 22.2% and the earliest use is 11yrs. The intake of alcohol in Assam is higher than the national prevalence and children as well as adolescence population is found to be using and abusing alcohol which is a serious public health issue (Bhagabati, Das, & Das, 2013). In Assam, there is no study done so far on children of alcoholics and on parents of alcohol dependence though the prevalence rate of alcohol is reported to be high.

The prevalence of substance/alcohol related problems is more than twice as high among children of alcoholic parents than among children of normal drinking parents (Goodwin, 1985). The adverse impact of parental drinking on children has clearly been established in various studies. (Adler & Raphael, 1983). Genetic and environmental factors are involved in the familial association of alcoholism...
Factors such as maladaptive communication and parenting abilities, personality factors, parent-child relationships conflict and rejection, lack of family cohesion may mediate the impact of parental disorder and alcoholism.

Children of Alcoholic (COAs) is a general term used to describe children or individuals with one or more alcoholic parents. Although the ramifications of living in a family with addicted, alcoholic parent are variable, nearly all children from alcoholic families are at risk for behavioral and emotional difficulties and live with physical and psychological scars as a result of parental alcoholism (Seixas, 1982).

From prenatal influences leading to learning and memory problems to vulnerabilities in behavioral and emotional control and aggression in adulthood (Jacob & Leonard, 1986, Jacob, Krahn, & Leonard, 1991) a significant number of COAs exhibit physical, psychological, and/or interpersonal difficulties. Parental alcoholism could also instill a legacy which affects the development of both individual and family members and the habitual patterns are often carried forward from one generation to the next.

Various genetic studies indicate that alcoholism tends to run in families, generation after generation; hence a genetic vulnerability for alcoholism exists (Kaij, 1960, Goodwin, Schulsinger, Hermansen, Guze, & Winokur, 1973, Cloninger, Michael, & Soren, 1981, Kumpfer, 1986). Often children of alcohol dependents (COAD’s) are reported to have an elevated risk for externalizing disorders, attention problems, aggression & delinquency (Martin & Sher, 1994) & conduct as well antisocial personality disorder (Bukstein, 1989b, Bukstein, 1989a, Hesselbrock & Hesselbrock, 1992).

Sons of alcoholic fathers are at fourfold risk compared with the male offspring’s of non-alcoholic fathers as reported by (Goodwin, 1983) in their studies on alcoholism. Though there are strong genetic causes for alcoholism in children of alcohol dependent fathers (CADF) as reported by the genetic studies not all children from alcohol dependent fathers (ADF) become alcoholics. Hence, environmental and family studies gained importance in the early part of the 20th century which still continues.
From early 1970’s research work on alcoholism had undergone a massive transition from only genetic studies to interactional studies /family and from children of alcohol dependent parents to women with alcohol use and abuse. Of late there has been an increasing focus on children of alcoholic parents (COA) seeking to understand the adverse impact of parental alcoholism on their personality growth and psychosocial functioning. Research by (Bennett, Wolin, & Reiss, 1988) suggests that these children are at risk for a range of affective, cognitive, emotional, and behavioral problems. Longitudinal research suggests that these behavioral problems are predictors of future alcohol-dependency or other addiction-disorders (Clark, Parker, & Lynch, 1999). Several studies have also shown that children from alcohol dependent families report higher levels of depression & anxiety and exhibit more symptoms of generalized stress (i.e. low self-esteem) than do children from non-alcohol dependent families (Anderson & Quasi, 1983, Prewett, Spence, & Chaknis, 1981). But some investigators also stated that many children from alcohol dependent homes develop neither any forms of psychopathology nor alcoholism (Miller & Jang, 1977).

The effects of parental alcoholism can vary with a child's developmental stage (Harter, 2000). A sampling of developmental research conducted on COAs at different ages and stages of their growth and development reveals that pre-school and young children have demonstrated behavior problems, vulnerabilities to aggressive and delinquent behavior, and difficulties in such areas as academic achievement and cognitive functioning, and they are at-risk for abuse, eating disorders, conduct disorders, alcoholism, communication problems, relational deficits, and problems with intimacy (Jacob & Leonard, 1986, West & Prinz, 1987, Chassin, Regosch, & Barrera, 1991, Fitzgerald et al., 1993, Fitzgerald, Zucker, & Moos, 1995), adolescents have demonstrated negative academic performances in English and math, as well as negative psychological and substance abuse outcomes (Chassin et al., 1991, West & Prinz, 1987); depression has been noted in an elevated level in college samples (Sher, Walitzer, Wood, & Brent, 1991) and increased marital conflict, decreased family cohesion, mal-adaptive communication and role distress has been reported in a middle-aged sample (Domenico & Windle, 1993, Black, 1979, Woititz, 1983, Black, Bucky, & Wilder -Padila, 1986, Jacob & Leonard, 1986
Hence, in studies from early childhood till late adulthood, there has been variety of dysfunctions noted among children of alcoholic parents that could have a deep impact upon their psyche and well-being.

The most common explanation for the adverse effects of parental alcoholism has been characterized as by the general environmental mechanism (Tellegen et al., 1988, Pandina, Johnson, & La Bouvie, 1992, Henderson, Galen, & Deluca, 1998). According to this explanation, parental alcoholism is believed to produce disturbed family relationships and dynamics that has a deep negative impact on the personality and psychosocial well-being of children who grow up in such environments.

"Temperament" or "Personality" typically refers to characteristic ways of thinking, feeling and behaving or acting out that show some consistency when measured across situations and over time. Personality is defined by Gordon Allport (1937) as "dynamic organization within the individual of those psychophysical systems that determines his unique adjustment to his environment". The belief that personality plays a role in alcoholism and it may even be one of the major causes has a long tradition. Among studies in alcoholism, role of personality is one of the most common with respect to alcohol use. There has been a lot of discussions linking personality traits and addictive behaviors which are commonplace in the psychosocial literature.

Sleisinger commented that "by definition a personality disorder underlies the habitual use of alcohol" (Sleisinger, 1985). Personality and parental alcoholism interact differentially to influence an individual's risk of becoming an alcoholic. Studies have thrown favourable insight about how similar personality or temperament can lead either to alcoholism, or to other behaviors, such as drug abuse, overeating, and anti-social criminality (Tarter et al., 1984). Tarter and his colleagues have mentioned about the model of an impulsive personality. The model explains a person born with such an impulsive temperament may engage in any of a range of excessive behaviors either as an expression of this impulsiveness, or else as a way of trying to modulate or control their impulsive temperaments.
Some research findings are also suggestive of an interaction between a personality trait called "novelty seeking" and parental alcoholism which increase the risk of, or protect against, developing individual alcoholism. High novelty seeking is a strong risk factor for alcoholism among children of alcoholics. Some factors have been identified as "Disinhibitory personality traits" which refers to risk-taking, extraversion, and exploratory, thrill-seeking and sometimes impulsive personality characteristics. Some studies have also reported that children, especially boys, who exhibit these characteristics have a high likelihood of becoming alcoholics as adults.

Furthermore, evidence also suggests that maladaptive personality traits improve after successful substance abuse treatment. This again supports the interpretation that these maladaptive "personality" traits may be at least in part acquired from the environment especially from one's family. Hence, family system plays a significant role in developing or moderating a child's behavior disorders which may or may not lead to alcohol use and abuse.

Johnson and Leff have reported that families play the most important role in determining how children handle the temptations to use alcohol, cigarettes, and illegal drugs. The family plays an important role in shaping a child's future drinking behavior and attitudes toward alcohol, both through the parents' behavioral example and through the ways in which the parents filter and interpret societal norms and values regarding alcohol use (Johnson & Leff, 1999). The risk factors include alcohol-specific influences, which selectively predict alcohol problems, and alcohol-nonspecific influences, which predict a variety of mental health dysfunctions. Alcohol-specific family influences include modeling of parental drinking behavior or learning, development of alcohol expectancies, and the family's ethnic/cultural background. A child's first exposure to and experiences with alcohol are likely to be in the context of family system. It is commonly known that alcohol problems run in families i.e. alcoholic parents are much more likely than those without alcohol problems to have children who develop alcoholism in later life (Cotton, 1979). It is seen that with a family history of alcoholism, the process of becoming an alcoholic has been characterized (Zucker & Gomberg., 1986) as occurring in a social world and being influenced by a bio-psychosocial process. Baer and his colleagues reported
that "family attachments, or bonds, feelings of closeness and intimacy, perceived monitoring communication and joint activities are associated negatively with substance use, even after taking into account peer influences" (Baer, McLaghlin, Pokorny, Garmezy, & Wernick, 1987). Parental psychopathology or psychiatric illness, parent's chronic physical illness, the family's socioeconomic status, parent-child relationship and general family psychopathology are examples of alcohol-nonspecific risk factors, which increase the COA's risk of behavior disorders as well as of alcoholism.

One of the most reasonable theories for conceptualizing the problem of treating alcoholic population is by views alcoholism as a systemic process in which the entire family is affected. Family systems theory is based on the idea that a feedback mechanism exists that is seen to be continuously monitoring the family state. In adolescents who are brought up in alcoholic family environments, alcoholics said to enter through several receptor sites, fills many gaps left over from the development period prior to separation. Their parents--either the alcoholic parent, or the partner living with him/her in co-dependency, are themselves filled with distress, depression, and anxiety, so usually cling to their children while at the same time manifesting overt signs of resentment and rejection indicating anxious-ambivalent or insecured attachment styles.

In this state of pathological ambivalence, they may both reject their children and try to tie them to themselves, thus seriously hindering their separation leading to insecure attachment. As a result, many children of alcoholic parents develop defensive aggression or passive resistance, or take recourse to some other inappropriate patterns of inappropriate behaviour. Their negative self-image, is rendered even more somber by the feeling of insecurity and shame caused by the alcoholism of their parents, which adds to their loneliness and low sense of well-being.

And in this state they have no opportunity to learn how to cope with anxiety and depression. Thus, children who grow up in alcoholic homes learn early in life to monitor the family climate and engage in behaviors designed to minimize the conflicts and chaos that are a part of the alcoholic family environment. When this
occurs, the child may engage in behaviors designed to re-establish contact with the
attachment figure as reported by (Woititz, 1983) in his study. Once contact is
regained, the child modifies his or her behavior to ensure his/her well being and
maintain the proximity with the caregiver. Hence, in recent studies styles of
attachment are found to be significantly related to alcohol use and dependence.

One of the most common claim made with regard to ACOAs is that they experience
significant difficulties in interpersonal relationships particularly with the
establishment and maintenance of intimate relationships (Seixas, 1982), possibly
because of the parenting practices of alcoholic parents (Woititz, 1983). For example,
Woititz (1983) has noted that “alcoholic parents are often inconsistent with the
affection they give to their children, vacillating between demonstrations of love and
warmth at certain times and rejection at other times”. Hence, COAs learn from an
early age not to trust people and experience persistent fears of abandonment or
rejection. Due to this, although ACOAs may desire love and intimacy, they are
likely to be afraid that relationships in their adult lives will be as hurtful as their early
relationships in their family of origin (Woodside, 1983).

Attachment theory is based on the premise that the nature of one’s childhood
attachments with primary caregivers shapes an individual’s attachment orientation in
later life (Bowlby, 1969, Bowlby, 1973, Ainsworth, Blehar, Waters, & Wall, 1978,
Ainsworth et al., 1978, Bowlby, 1980). Primary caregivers who in the childhood
years meet the young child’s needs for comfort and protection foster the child’s
development of a model of self as valued and self reliant. While in contrast, children
whose needs are not met are more likely to develop an internal model of self as
unworthy or incompetent (Bowlby, 1973). More specifically, attachment theory
proposes that, through repeated interactions with the primary caregiver, children
form some internal representations or “working models” of both the self and of the
attachment figure (Bowlby, 1969). Children who experience available and responsive
attachment figures will likely develop expectations that they are worthy of love and
support and that others are generally trustworthy and available (secure attachment).
Alternatively, children who do not have responsive attachment figures will develop
expectations that they are not worthy of the love and support of others and that
people are generally unreliable and rejecting (insecure attachment). Attachment representations show predictive associations with a wide-range of pathological behavior including personality disorder(s), mood disturbance, affective instability, substance dependence and psychopathy. There is an inverse relationship which exists between addiction and healthy interpersonal relationships attachment (Bowlby, 1980). Specifically, in a large pool of items designed to assess the principal themes of infant and adult attachment, (Feeney, Noller, & Hanrahan, 1994) it is found that attachment groups were best described in the following terms: anxiety over relationships (defined by preoccupation with relationships, need for approval, and lack of confidence) and discomfort with closeness (defined by anxiety with closeness and relationships as secondary).

A key factor that has been associated with the difficulties observed in ACOAs is parenting received in one's family of origin i.e., by their own biological parents compared to primary caregivers. Children of alcoholics are often exposed to inappropriate and inadequate parenting and negative parent–child interaction patterns (Jacob & Johnson, 1997, Gallant, Gorey, Gallant, Perry, & Ryan, 1998) found that couples in which at least one parent was alcohol-dependent then the parent demonstrated lack of empathy for their children's needs, advocated physical punishment, and often created an environment that facilitated parent–child role reversal i.e. the child functions as parents by assuming a lot of parental responsibilities.

It has been argued in many studies that alcohol-dependent parents are emotionally unavailable to their children and may be less able to provide the nurturance and consistency necessary to form a secure parent–child attachment (Tweed & Ryff, 1996). In the review article, (Harter, 2000) argued that inconsistent nurturance in combination with parents who regard their own needs as most important, leads to difficulties trusting others, being intimate, and having reasonable boundaries or interpersonal space.

Flores reported that “addiction as an attachment disorder because for better or worse an increasing number of individuals in the present day society rely on psychoactive substances to help manage their fear and difficulties in interpersonal relationships.”
(Flores, 2001). Again it is highly noticed that most of them use substances in ways that do not cause any prolonged harm or dire consequences. These are social drinkers who take alcohol occasionally without causing any harm on their health physical or psychological. But there are certain individuals due to various biological, sociological, interpersonal and personality factors develop disabling dependence to substances.

Attachment theory also holds true that it is impossible for individuals to completely regulate their affective states easily as it becomes a disease. Consequently until substance abusers relinquish their dysfunctional attachment styles which they have developed from early childhood (e.g. insecure, avoidant) and develop the capacity for healthy interpersonal relationships, affect regulation (secure attachment and mutuality) they will forever remain vulnerable to substitute one obsessive addiction (e.g. drugs, alcohol, etc) for another. In the last decade, relationships between substance abuse and the quality of parenting have led researchers to call for various longitudinal studies that examine variables, such as parenting behavior received in one’s family of origin, which may explain the relationship between parental substance abuse and outcomes in their offspring (Luthar, Cushing, Merikangas, & Rounsaville, 1998).

Several studies based on attachment theory have found a greater proportion of insecure attachment styles among ACOAs, mirroring the findings with respect to infant COAs (Rina, Ellen, & Kenneth, 2002) leading to the belief that one’s attachment style could contribute to alcohol use. And insecure attachment style characterized by anxious-ambivalent and avoidant attachment is reported in most studies of alcoholism (Burge et al., 1997, Ognibene & Collins, 1998, Mc Nally, Palfai, Levine & Moore 2003, Doumas, Blasey, & Mitchell, 2007, Kassel, Wardle, & Roberts, 2007).

Family studies in children of alcohol dependent fathers (ADF) are very few in India and absent in Assam, hence the focus of our study was on psychosocial factors contributing to the pathogenesis of alcoholism and its impact on both fathers of alcohol dependence and their sons. Earlier research has indicated that in order for alcoholism or psychosocial mal-adaptation to develop in children of alcoholics, a
combination of certain personality traits, parent-child bond and their interaction, typical patterns of attachment as well as the family systems are contributory factors. Indian literature from this perspective is scanty and there is a need for more comprehensive investigation to explore the consequences of parental alcoholism particularly on adolescent and adult children of alcohol dependent fathers (CADF). Hence, this inter-generational study was carried out keeping in view of the explanations cited above.