

**FAMILY ENVIRONMENT, SELF-ESTEEM, ANXIETY, AND
DEPRESSION AMONG CHILDREN OF ALCOHOLICS AND
NON-ALCOHOLICS**

**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE
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**FAMILY ENVIRONMENT, SELF-ESTEEM, ANXIETY, AND DEPRESSION
AMONG CHILDREN OF ALCOHOLICS AND NON-ALCOHOLICS**

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Submitted

**In partial fulfillment of the requirement of the Degree of Doctor of Philosophy
in Psychology of Mizoram University, Aizawl.**



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CERTIFICATE

This is to certify that the present research work titled, “Family Environment, Self-Esteem, Anxiety, and Depression among Children of Alcoholics and Non-Alcoholics” is the original research work carried out by Ms. Mercy Chingnunhoih under my supervision. The work done is being submitted for the award of the Doctor of Philosophy in Psychology of Mizoram University.

This is to further certify that the research conducted by Ms. Mercy Chingnunhoih has not been submitted in support of an application to this or any other University or an Institute of Learning.

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DECLARATION
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I **MERCY CHINGNUNHOIH**, hereby declare that the subject matter of this thesis is the record of work done by me, that the contents of this thesis did not form basis of the award of any previous degree to me or to the best of my knowledge to anybody else, and that the thesis has not been submitted by me for any research degree in any other University/Institute.

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LIST OF ABBREVIATIONS

AUD	Alcohol Use Disorder
APA	American Psychological Association
BAI	Beck Anxiety Inventory
CAST	Children of Alcoholics Screening Test
CES-DC	Centre for Epidemiologic Studies Depression Scale for children
COAs	Children of Alcoholics
DLHS	District Level Household and Facilities Survey
DSM	Diagnostic and Statistical Manual of Mental Disorders
FES	Family Environment Scale
MLPA	Manipur Liquor Prohibition Act
NIAAA	National Institute on Alcohol Abuse and Alcoholism
Non-COAs	Children of Non-Alcoholics
RSES	Rosenberg Self-Esteem Scale
SD	Standard Deviation
SPSS	Statistical Package for Social Sciences
WHO	World Health Organizations

CHAPTER-I

INTRODUCTION

Alcoholism represents one of the most pervasive health and social challenges globally, with profound implications not only for individuals struggling with alcohol dependence but also for their families, particularly their children. As Gysel (2016) notes, alcoholism is aptly considered a "family disease" due to its far-reaching impact on those close to alcohol-dependent individuals. The World Health Organization (2011) recognizes alcohol misuse as a universal problem and a significant public health concern, with an estimated 208 million people worldwide suffering from alcoholism in 2010 and approximately 3.3 million annual deaths resulting from harmful alcohol use.

Alcohol Use Disorder (AUD), formerly known as alcoholism, is characterized by "problem drinking that becomes severe" (NIAAA, 2017). It is a chronic, relapsing medical condition characterized by compulsive alcohol consumption, loss of control over intake, negative emotional states during periods of abstinence, and continued use despite adverse consequences (Nordqvist, 2018; American Psychiatric Association, 2013). Parsons (2003) further defines AUD as a disease causing physiological problems (e.g., hand tremors, blackouts), psychological issues (e.g., excessive desire to drink), and behavioural problems that disrupt social interactions and work performance. This complex disorder cuts across demographic boundaries including gender, race, ethnicity, age, background, and income level, representing the greatest risk factor for disease and disability in middle-income countries and the third highest cause of death worldwide (WHO, 2011). The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) identifies AUD as existing on a severity spectrum, with diagnosis based on meeting at least two of eleven behavioural and physiological criteria within a 12-month period. Key features include the development of tolerance, withdrawal symptoms upon cessation, and unsuccessful attempts to reduce consumption.

Chronic alcohol misuse induces significant neuroadaptations, particularly in the mesolimbic dopamine system and prefrontal cortical regions, which underlie the transition from voluntary to compulsive use (Koob & Volkow, 2016). These neurological changes coincide with multisystem physiological damage, including

hepatic steatosis progressing to cirrhosis, cardiomyopathy, pancreatitis, and immune system dysfunction. The substance's teratogenic effects can also manifest in intergenerational consequences, particularly through fetal alcohol spectrum disorders.

AUD profoundly impacts social functioning and mental health. Longitudinal studies demonstrate its association with: (1) increased risk of mood and anxiety disorders; (2) occupational instability and financial distress; and (3) disruption of family systems through impaired parenting capacity and marital conflict (Rehm et al., 2017). The disorder frequently generates a self-perpetuating cycle wherein psychosocial stressors exacerbate alcohol use, which in turn compounds existing stressors. Children of Alcoholics (COAs) exhibit a 3-4 fold increased risk of developing the disorder, attributable to: (1) inherited neurobiological vulnerabilities; (2) learned maladaptive coping mechanisms; and (3) exposure to stressful home environments (Sher et al., 2005). This intergenerational transmission underscores the importance of family-centered intervention approaches.

Manipur, India, traditionally regarded as a "dry" or "abstaining" culture Ningombam et al. (2011) has witnessed a significant increase in alcohol consumption. According to the WHO, 2011 report on the Global Information System on Alcohol and Health (GISAH), approximately 30% of India's population consumed alcohol in 2010, with 93% consumed as spirits, 7% as beer, and less than 1% as wine. The WHO's Global Status Report on Alcohol and Health 2018 documented a more than twofold increase in per capita alcohol consumption in India between 2005 and 2016, rising from 2.4 liters in 2005 to 5.7 liters in 2016.

Brief Profile of Churachandpur:

The district of Churachandpur, locally referred to as Lamka meaning a confluence of Tedim Road and Tipaimukh Road between Zenhang Lamka Village and Hiangtam Lamka Village. The hill district is located in the southern part of the Indian state of Manipur. On the State official record, the district which was previously clustered as South West Sub-Division in 1919 derives its name from

Maharaja Churachand Singh, following a feast organized in 1921 by the then Sub-Divisional Officer B.C. Gasper in honour of the return of the France Labour Corps (Neihzial, 1996).

Churachandpur district, located in the southwestern part of Manipur and covering 4,570 square kilometers, has experienced remarkable growth over recent decades. It stands as a significant religious and educational center in Manipur, hosting seven Bible Colleges, two Government Colleges, and numerous higher secondary schools. The district serves as the base for more than 40 denominational groups, with churches visible throughout the town. According to the Census of India 2011, Churachandpur has a population of about 2.74 lakhs, with over 92% belonging to Scheduled Tribes predominantly by the Zo ethnic tribes who belong to the broader Tibeto-Burman ethno-linguistic family. Geographically, Churachandpur is the largest district in Manipur, lying between latitudes 23° 55'N and 24° 30'N and longitudes 92° 59'E to 93° 50'E. It spans over a total area of approximately 4,570 square kilometres, of which about 255 square kilometres (5.57%) constitutes the valley/low lying region (Demography | Churachandpur District, Government of Manipur | India, n.d.). The district headquarters, also known as Lamka, is considered one of the fastest-growing towns in the state and is often described as a "Pentecostal town", reflecting the understanding of more than a dozen language/dialects by its inhabitants (Neihzial, 1996).

However, the district has also been marked by recurring ethnic tensions, intercommunal conflicts, and socio-political instability that have periodically disrupted the social fabric of the community. The region's complex ethnic landscape, involving multiple tribal communities with distinct identities and competing political interests, has historically created an environment of chronic social unpredictability for its inhabitants. Research on youth in conflict-affected environments has demonstrated that such persistent socio-political adversity constitutes an independent risk factor for adolescent psychological distress, operating through mechanisms of chronic threat perception, disrupted sense of safety, and community-level trauma exposure (Betancourt & Khan, 2008). For adolescents growing up in Churachandpur,

this ambient socio-political stress may compound existing family-level stressors, creating cumulative psychosocial vulnerability that operates independently of family structure or parental alcohol use.

Adolescent

Adolescence is a pivotal developmental stage characterized by profound cognitive, emotional, and social transformations. This phase is often associated with increased stress levels, as noted by Colten and Gore (1991), and is accompanied by significant emotional volatility, as discussed by Steinberg (2013). The exploration of adolescents' subjective wellbeing has become a focal point of research, with subjective wellbeing being conceptualized as encompassing high levels of overall life satisfaction and a prevalence of positive emotional experiences that outweigh negative ones, as highlighted by Diener et al., 1999 and further reported in Diener (2013). The growing emphasis on understanding subjective wellbeing within this demographic is understandable, given that a substantial proportion of mental health challenges arise during adolescence. If these issues are left unaddressed, they often continue into adulthood, underscoring the necessity of comprehending the diverse factors that influence the wellbeing of adolescents. Adolescence typically commences with the onset of puberty and is segmented into three distinct phases: early, middle, and late adolescence. While some authorities suggest that this developmental stage concludes at age 19, thereby designating age 20 as the threshold for adulthood, the World Health Organization (WHO) classifies adolescents as individuals aged between 10 and 19 years. There exists some variability in the definition of late adolescence; certain theorists propose that it extends to age 23. For instance, Hall (1904) identified the adolescent period as ranging from ages 12 to 23, while Santrock (2011) defined it as lying between ages 10-12 and 18-22. Specifically, late adolescence is often understood to encompass those aged 18 to 22, as articulated by Newman and Newman (1976).

Family and its Environment

The family environment serves as the cornerstone of human development, providing the primary context within which children acquire their fundamental understanding of relationships, self-worth, and emotional regulation. This developmental foundation becomes particularly critical when examining children raised in households affected by paternal alcoholism, especially within the distinctive cultural landscape of Churachandpur district in Manipur—a region characterized by its predominantly tribal Christian community with intricate familial structures, traditional clan-based kinship networks, and deeply rooted spiritual value systems.

The significance of family environment in shaping children's psychological trajectories has been extensively documented across diverse populations and cultural contexts. However, its examination within indigenous tribal communities presents unique opportunities to understand how cultural values, community support systems, and traditional family structures interact with environmental stressors to influence developmental outcomes. In the context of Churachandpur district, the Zo ethnic tribal communities maintain strong patrilineal extended family systems alongside Christian ecclesiastical frameworks, the family transcends its role as a nuclear unit to become an intricate network of intergenerational relationships, cultural transmission mechanisms, and spiritual guidance systems.

This complex familial architecture assumes critical importance when understanding how paternal alcoholism disrupts traditional family functioning and subsequently impacts children's psychological well-being. The disruption occurs not merely at the individual family level but reverberates through extended kinship networks, community relationships, and cultural continuity processes that are fundamental to tribal identity and child development. These multi-layered effects necessitate a comprehensive examination that considers both the immediate family environment and the broader socio-cultural context within which these families operate.

Research has consistently demonstrated that children of alcoholics (COAs) experience family environments markedly different from their non-COA counterparts, characterized by disrupted intergenerational communication patterns, emotional unpredictability, inconsistent caregiving practices, and compromised family cohesion (Bhatia & Chadha, 1993; Lalnunpuui, 2015). These environmental disruptions manifest through various mechanisms including breakdown in healthy communication patterns, compromised parental functioning, erosion of family unity, and economic instability—all of which can profoundly affect children's psychological development. Alcohol consumption may disrupt normal family tasks, generate conflict, and demand adaptive responses from family members who lack appropriate coping strategies. Alcoholism creates escalating crises in family structure and function, potentially triggering system crises and leading to dysfunctional coping behaviors among family members (Ranganathan, 2004).

Children raised in alcoholic families face distinct life experiences compared to those in non-alcoholic households. These children may experience various conflicting emotions including anxiety, embarrassment, difficulty forming close relationships, confusion, anger, and depression (Gysel, 2016). When seeking emotional support, they face the unique challenge of being unable to turn to their own parents. Families affected by alcoholism report higher levels of conflict and disruption than non-alcoholic families, with drinking serving as the primary factor in family disruption. The environment of children of alcoholics (COAs) is characterized by inadequate parenting, poor home management, and deficient family communication skills, effectively depriving these children of modeling or training in parenting skills or family effectiveness.

Research consistently associates several family problems with alcoholism: increased family conflict; emotional or physical violence; decreased family cohesion and organization; increased family isolation; elevated family stress including work problems, illness, marital strain and financial difficulties; and frequent family relocations. Paternal alcoholism profoundly disrupts family functioning across

multiple dimensions, with research consistently identifying several characteristic patterns in families with alcoholic fathers:

1. Decreased family cohesion and increased conflict
2. Reduced expressiveness and emotional safety
3. Inconsistent rule enforcement and boundary maintenance
4. Role confusion and inappropriate role allocation (parentification)
5. Social isolation and decreased community integration
6. Financial strain and resource instability
7. Communication difficulties, including denial and secret-keeping

These disruptions create what Ranganathan (2004) described as "escalating crises in family structure and function," potentially triggering system crises and leading family members to develop dysfunctional coping behaviors. The family environment in homes with alcoholic fathers frequently becomes organized around the alcoholism rather than healthy developmental needs of family members.

Significant gender differences exist in how COAs perceive their family environments. Female COAs typically report greater sensitivity to family conflict and expressiveness deficits, while male COAs more frequently highlight issues related to control and achievement orientation within alcoholic families. Female COAs also demonstrate greater awareness of emotional undercurrents within the family system, often perceiving higher levels of covert tension than reported by male siblings in the same household.

In the tribal Christian context of Churachandpur, these disruptions occur against the backdrop of strong community support systems, traditional healing practices, and ecclesiastical intervention mechanisms, creating a unique interplay between risk and protective factors. The community's strong ecclesiastical support systems and clan-based kinship networks (Nengkhanpau, 1987) provide important contextual factors that may mediate the relationship between family environment and child outcomes. The community's emphasis on collective responsibility, mutual aid, and spiritual resilience may serve as important buffers against the negative effects of

family dysfunction, while simultaneously being challenged by the stigma and secrecy often associated with alcoholism.

Contemporary research highlights the complex interplay between familial alcoholism and offspring mental health, with particular emphasis on the heightened vulnerability of children of alcoholics (COAs) to internalizing disorders. Adolescent children of alcoholics (COAs) demonstrated significantly poorer psychosocial outcomes compared to non-COAs. Specifically, COAs scored significantly lower on all measures of family/personal strengths ($p < .001$) and school bonding ($p < .001$), while scoring significantly higher on all at-risk factors including temperament, feelings, thoughts, and behaviours (Mylant et al., 2002).

Children of Alcoholics (COAs) face multifaceted psychological and biological risks spanning prenatal development to adulthood. These impacts manifest in personality traits (elevated neuroticism, impulsivity), behavioural disorders (ODD, CD), and psychopathology (depression, substance use disorders). Twin studies estimate AUD heritability at ~50% (Kendler et al., 2011), suggesting COAs inherit neurobiological vulnerabilities (e.g., dopamine dysregulation, prefrontal cortex deficits) that interact with adverse environments (e.g., neglect, chaotic parenting) to amplify risk (Enoch, 2011).

The bidirectional nature of this relationship is further evidenced by studies examining family dynamics. Addiction Center (n.d.) demonstrated that parental alcoholism often disrupts parent-child interactions, fostering an environment of emotional instability that exacerbates children's internalizing symptoms. Conversely, offspring with mental health challenges may inadvertently reinforce problematic drinking behaviours among parents, creating a cyclical pattern of risk. The psychological consequences of environmental disparities extend to core aspects of children's mental health, including self-esteem development, anxiety responses, and depressive symptoms. However, the mediating role of specific family environment dimensions and their interaction with socio-demographic characteristics—particularly within tribal communities—remains insufficiently explored, necessitating targeted investigation within this specific cultural context.

The present investigation employs the Family Environment Scale developed by Dr. Harpreet Bhatia and Dr. N.K. Chadha (1993), a psychometrically robust instrument that has demonstrated exceptional validity in Indian populations with reliability coefficients ranging from 0.82 to 0.91. This scale has proven particularly valuable in tribal contexts, having been further refined to account for indigenous family structures prevalent among the Zomi-Kuki tribes of Churachandpur (Nang, 2007). The theoretical framework underlying this scale recognizes family environment as a multidimensional construct encompassing relationship dynamics, personal growth orientations, and system maintenance characteristics—all dimensions that may be significantly altered in households affected by alcoholism.

The family, as the primary agency of socialization, exerts a profound influence on child development and serves as the fundamental institution of society, encompassing individuals connected through biological, emotional, or legal bonds. Ozcinar (2006) describes the family as a primary socialization setting and a critical factor influencing child development, noting that children who are high achievers and well-adjusted typically come from families with healthy relationships, while those from favorable home environments tend to be warm-hearted, outgoing, and socially more intelligent than children from unfavorable homes (Rani, 1998).

Every family system oscillates between nurturing and dysfunctional atmospheres. Functional or nurturing families promote proper development of members, allowing individual expression, whereas dysfunctional environments create toxic conditions, often associated with maladaptive behaviors or alcohol dependence (Pudussery, 1994). Strong evidence suggests that family dysfunction during childhood can negatively influence later life experiences and adjustment (Werner & Broida, 1991). The theoretical foundations of this study rest upon this understanding of family systems as dynamic entities capable of either fostering healthy development or creating conditions that compromise children's psychological well-being. Within the tribal Christian communities of Churachandpur, the concept of "familism"—a cultural value emphasizing interdependent family relationships characterized by warmth, closeness, and mutual

support—takes on particular significance within the framework of patrilineal extended family systems. Traditional family structures in Kuki-Zomi communities involve intricate arrangements where the eldest son remains with parents as the inheritor, while other sons establish separate households ("inntuan") upon achieving economic independence. When a married son has one or two children and demonstrates the ability to support his own family, only then will they be separated from the parents. Daughters remain within the parental household until marriage, with unmarried women remaining lifelong members of their birth families (Nang, 2007).

This investigation addresses a critical gap in understanding how family environment influences children's psychological well-being within the unique socio-cultural context of tribal Christian communities. The study's significance extends beyond academic inquiry to inform culturally sensitive intervention strategies, community-based prevention programs, and policy initiatives that can better support families affected by alcoholism while respecting and leveraging traditional support systems and cultural values.

The family environment's role in child development becomes particularly complex when examined through the lens of cultural diversity, socioeconomic factors, and community resources. In Churachandpur district, where traditional tribal values intersect with Christian teachings and modern influences, children's development occurs within multiple overlapping systems of influence. Understanding how these systems interact with family environmental factors—particularly in the presence of parental alcoholism—is essential for developing comprehensive models of child development that can inform both research and practice.

The present study seeks to bridge this knowledge gap by providing a systematic examination of family environment patterns among COAs and non-COAs within the tribal Christian community of Churachandpur district. Through comparative analysis of family environments and investigation of their relationships with psychological outcomes, this research aims to contribute both to theoretical

understanding of family environment effects and to practical knowledge for developing culturally appropriate support systems for children and families affected by alcoholism.

Self-esteem

Self-esteem constitutes a fundamental pillar in adolescent psychosocial development, serving both as a protective factor against psychological distress and a foundation for healthy identity formation. During adolescence, characterized by rapid biological changes and evolving social expectations, self-esteem functions as a crucial mediator between environmental influences and personal adjustment (Harter, 2012). The significance of self-evaluation processes becomes particularly pronounced in contexts of familial dysfunction, where adolescents' self-perceptions may become systematically distorted through chronic exposure to adverse circumstances.

Empirical evidence consistently demonstrates that children of alcoholics (COAs) represent a vulnerable population regarding self-esteem development. Berger's (1993) seminal work identified a constellation of self-concept disturbances common among COAs, including pervasive feelings of inadequacy, chronic self-doubt, and impaired self-appraisal. These manifestations often co-occur with affective symptoms such as existential loneliness, inappropriate guilt, and learned helplessness—a pattern suggesting the internalization of familial instability. The consistently lower self-esteem scores observed in COAs across studies reflect not merely transient dissatisfaction but rather a fundamental disruption in self-construal processes, wherein individuals develop negative cognitive schemas about their worth and capabilities (Beck, 1976).

The operational definition of self-esteem as "an individual's judgment of his or her self-worth" (Rosenberg, 1965) encompasses both affective and cognitive dimensions of self-evaluation. As the evaluative core of self-concept, self-esteem functions as a meta-construct that organizes perceptions of competence across various life domains (Harter, 2000). Contemporary conceptualizations emphasize its

multifaceted nature, incorporating: (1) global self-worth (the overall valuation of oneself), (2) contingent self-esteem (domain-specific evaluations), and (3) stability of self-evaluation (the degree to which self-worth fluctuates in response to situational factors) (Kernis, 2003). This tripartite model proves particularly relevant when examining COAs, whose self-esteem may demonstrate unusual volatility due to unpredictable home environments (Tomaka & Blascovich, 1991).

The developmental trajectory of self-esteem in COAs often reflects impaired emotional maturation and compromised interpersonal competence. Clinical observations reveal characteristic patterns including: (a) external locus of evaluation (over-reliance on others' appraisals), (b) perfectionistic tendencies (compensatory overachievement), and (c) emotional dysregulation (difficulty tolerating normal affective states) (Adler & Stewart, 2004). These maladaptive patterns frequently persist into adulthood, suggesting that parental alcoholism may establish lifelong self-concept vulnerabilities through mechanisms such as attachment disruption (Bowlby, 1980) and social learning (Bandura, 1977).

Paternal alcoholism significantly undermines self-esteem development in adolescent children. Madhavi's (2016) comparative study conclusively demonstrated lower self-esteem among adolescent children of alcoholic fathers compared to those with non-alcoholic fathers. This impact occurs through multiple pathways:

1. Direct negative messaging, where alcoholic fathers may exhibit critical, demeaning, or inconsistent communication patterns that undermine children's sense of worth
2. Modeling of maladaptive behaviors that children may internalize as reflections of their own value
3. Social stigma associated with paternal alcoholism that children may absorb into their self-concept
4. Disruption of healthy father-child attachment, which typically serves as a foundation for positive self-regard

Kanus's (2014) research established a strong negative correlation ($r=-0.69$, $p<0.05$) between direct paternal alcohol abuse effects and self-esteem scores,

confirming the substantial impact of fathers' drinking behaviour on children's self-evaluation. This relationship appears particularly pronounced during adolescence, when identity formation and social comparison processes intensify.

Gender differences have been observed in self-esteem among COAs and non-COAs. Research indicates that female COAs typically exhibit lower self-esteem compared to male COAs. Elaine & Robert's (1999) study with African-American adolescents demonstrated that while COAs generally scored lower on self-esteem than non-COAs, females in particular showed significantly lower self-esteem scores than males. This gender disparity may be attributed to different socialization patterns and coping mechanisms between genders, with females often internalizing problems and assuming caretaking roles in alcoholic families, potentially compromising their sense of self-worth.

Cross-cultural research further complicates this picture, indicating that self-esteem manifestations in COAs may vary according to cultural values and socialization practices. Collectivist societies like India may present unique risk factors, where familial shame associated with alcoholism interacts with community expectations to produce distinct self-esteem disturbances (Markus & Kitayama, 1991). The Manipur context, with its recent alcohol policy changes and tribal-cultural diversity, likely creates a particularly complex milieu for adolescent self-concept development—an area demanding urgent empirical attention.

Anxiety

Anxiety ranks among the most common psychological disorders in school-aged children and adolescents worldwide (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003). Studies on the prevalence of behaviour problems among children have shown varying results across different regions. Anxiety represents an uneasy mental state concerning future or anticipated unfortunate circumstances, marked by apprehension, uneasiness, and a sense of helplessness as the anxious individual feels blocked and unable to find solutions to problems.

The adolescent period, characterized by unique challenges and adjustment demands, renders adolescents particularly vulnerable to anxiety. While anxiety represents a normal experience during adolescence, unregulated anxiety can develop into more severe mental health conditions known as anxiety disorders. Research has demonstrated that Children of Alcoholics (COAs) experience higher levels of anxiety and depression compared to their peers. According to Maynard (1997), COAs exhibited higher anxiety levels and lower differentiation of self than non-COAs, with poorly differentiated individuals depending heavily on others' acceptance and approval, adjusting their thoughts, words, and actions to please others.

Paternal alcoholism creates an environment characterized by unpredictability, inconsistency, and potential threat—conditions highly conducive to anxiety development. Eiden et al.'s (2009) study with a community sample conclusively demonstrated that children with alcoholic fathers exhibited significantly higher anxiety scores than children from non-alcoholic homes. Specific anxiety-inducing factors associated with paternal alcoholism include:

1. Unpredictable behavioral changes during drinking episodes
2. Financial instability and associated family stress
3. Anticipatory anxiety related to potential embarrassment or harm
4. Hypervigilance developed as an adaptive response to chaotic home environments
5. Genetic vulnerabilities to anxiety disorders potentially transmitted from alcoholic parents

The research by Mishra et al. (2018) identified an anxiety disorder prevalence of 15% among COAs, substantially higher than rates in general adolescent populations. These findings highlight how paternal alcoholism creates chronic stress conditions that specifically elevate anxiety risk.

Gender differences in anxiety responses to parental alcoholism are well-documented. Female COAs typically report higher levels of anxiety symptoms compared to male COAs. This pattern aligns with broader epidemiological findings

showing higher prevalence of anxiety disorders among females in general populations. However, the anxiety gap between female COAs and female non-COAs appears larger than the corresponding gap between male COAs and male non-COAs, suggesting that females may be particularly vulnerable to anxiety-related outcomes when exposed to parental alcoholism.

The manifestation of anxiety also differs by gender, with female COAs more frequently reporting somatic complaints, worry, and social anxiety, while male COAs more commonly exhibit anxiety through restlessness, irritability, and concentration difficulties. These gender-specific expressions of anxiety among COAs have important implications for assessment and intervention approaches. A recent study among Mumbai school students revealed that symptoms of overall anxiety were present in 10.8% of participants, with older students showing greater odds of experiencing overall anxiety symptoms and obsessions/compulsions. Fears of physical injury emerged as the most common type of anxiety (Karande et al., 2018).

Depression

Depression constitutes a common and serious illness that negatively affects an individual's thinking, feelings, and actions. Unlike protective factors such as high self-esteem, risk factors including depressive symptoms (feeling blue, difficulty completing tasks, irritability) may constrain adolescents, complicating effective decision-making and appropriate actions. Depression can lead to various emotional and physical problems and diminish a person's ability to function effectively.

Research findings indicate that while depression prevalence in children is low (Kessler, et.al.,2001) with no gender differences, it increases significantly during adolescence (Green et al., 2005). This rise in prevalence stems partly from adolescence being a developmental period characterized by pronounced biological and social changes. Numerous studies demonstrate that parental alcoholism increases children's risk of depression, with COAs exhibiting a higher likelihood of depression

and depressive symptoms compared to non-COAs (Thapa, Selya, & Jonk, 2017; Christenson & Bilenberg, 2000).

Paternal alcoholism significantly increases depression vulnerability among adolescent children. Multiple studies confirm that children of alcoholic fathers face approximately double the risk for both major depressive disorder and persistent depressive disorder compared to peers from non-alcoholic homes. This elevated risk stems from several factors:

1. Exposure to negative cognitive models from depressed alcoholic parents
2. Neurobiological vulnerabilities potentially shared between alcoholism and depression
3. Environmental stressors associated with alcoholic households
4. Disrupted attachment relationships that typically buffer against depression
5. Learned helplessness developing from inability to control or predict family circumstances

Ranta & Raitasalo's (2017) research confirmed significantly higher psychiatric disorder rates, including depression, among children whose parents misused substances. The 14.5% depression prevalence found among COAs by Mishra et al. (2018) underscores the substantial impact paternal alcoholism has on mood regulation and emotional wellbeing during adolescence.

Consistent with general population trends, depression symptoms appear more prevalent among female COAs than male COAs. Omkarappa & Rentala's 2019 research confirmed higher depression rates among female adolescents from alcoholic homes compared to their male counterparts. The gender gap in depression appears to widen during adolescence, particularly for COAs, suggesting that this developmental period may represent a time of heightened vulnerability for female children of alcoholics. Male COAs, while still at elevated risk compared to non-COAs, may exhibit depression through different manifestations such as irritability, anger, and risk-taking behaviours rather than the more commonly recognized symptoms of

sadness and withdrawal. These gender differences in depression expression can sometimes lead to underdiagnosis of depressive conditions in male COAs.

A study conducted on COAs by Mishra, Srivastava, Tiwary, and Kumar (2018) found a depression prevalence of 14.5% and anxiety disorder prevalence of 15%. Similarly, Vinnakota and Kaur (2018) reported clinical depression in 12.7% of COAs and subclinical mild depression in 19.3%.

Effects of Parental Alcoholism on Adolescent Children

The effects of harmful alcohol use extend beyond the individual consumer, often impacting family, friends, and colleagues before any negative health consequences become apparent. These effects can be as damaging to the family as to the drinker, with children being the most affected (Klingemann & Gmel, 2011). Consequently, alcoholism is often described as a family disease due to its impact on family members (Bauman, 2008).

Children of Alcoholics (COAs) are defined as individuals under 18 years of age raised by at least one parent diagnosed with Alcohol Use Disorder (AUD). These children are often exposed to familial dysfunction, including inconsistent parenting, emotional neglect, and heightened conflict, which elevate their risk for psychosocial adversities (World Health Organization [WHO], 2018)

In empirical studies, COAs are frequently identified by using screening tools such as the CAST-6 (Children of Alcoholics Screening Test). Adolescents (aged 15–18) scoring ≥ 3 on this scale report behavioural indicators of parental AUD, including neglect, exposure to excessive drinking, or role reversal (e.g., assuming caretaking responsibilities) (Jones et al., 2021).

Children of Alcoholics constitute a substantial population segment and face risks for numerous psychological and developmental problems throughout their lives. These problems range from fetal alcohol syndrome in infancy to emotional problems and hyperactivity in childhood, emotional and conduct problems in

adolescence, and potential alcoholism development in adulthood. Children of alcoholics are defined as any child whose parent uses alcohol in a manner that causes problems in the child's life (Bird & Canino, 1991). Many COAs share common symptoms including low self-esteem, loneliness, guilt, feelings of helplessness, fear of abandonment, and depression (Berger, 1993; Jenefer, 2016; Wong et al., 2018).

Studies by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in 1990 demonstrated that COAs often exhibit increased depression and anxiety compared to non-COAs. Additional emotional and social adjustment problems associated with parental alcoholism include hyperactivity, relationship difficulties, aggression, school absenteeism, and drug use (McWhirter et al., 2007). Bird and Canino (1991) found that children of alcohol-dependent parents manifested higher levels of behavioural under control, neuroticism, and psychiatric distress compared to children of non-alcohol-dependent parents. Pecukonis's (2004) study revealed that COAs reported that parental/caretaker alcohol use could promote negative family relationships, psychologically affecting COAs. Several studies have established a correlation between parental alcohol use and subsequent child maltreatment, leading to both mental and physical problems and somatic symptoms. The psychological problems identified across various research studies may adversely affect COAs through multiple stressors and negatively impact child development, resulting in poor health outcomes.

The dysfunctional family environment created by parental alcoholism has been extensively investigated. Alcoholism generates escalating crises in family structure and function, potentially triggering system crises and leading family members to develop dysfunctional coping behaviours (Ranganathan, 2004). Additionally, children of alcoholics often feel responsible for the alcoholic's problems, wrongly believing they somehow created the problem. They internalize these feelings, ultimately experiencing tremendous guilt, shame, and senses of helplessness and hopelessness. They may attempt to conceal evidence of parental alcoholism, make excuses for parental absence at functions, or lie to friends, school personnel, employers, or others about the parent.

The co-dependent children and spouse of an alcoholic often neglect their own needs and desires, focusing instead on addressing or covering up the alcoholic family member's problems and striving to maintain family cohesion. By denying the existence of the problem (parental alcoholism), COAs and spouses enable the alcoholic to continue drinking without confronting the consequences. COAs may develop beliefs that they are responsible for problems associated with their alcoholic parent, even believing they created the problem. COAs frequently experience high levels of tension and stress, may lack friends, and might fear school attendance. Older COAs may exhibit depressive symptoms such as obsessive perfectionism, social isolation, or extreme self-consciousness.

Two common patterns often emerge among adolescents living with parental alcoholism: development of strong peer relationships kept separate from family, and increasing introspection and social isolation, friendship difficulties (e.g., reluctance to visit or invite friends home, negative interaction style), anxiety, and depression (Velleman & Templeton, 2007).

Theoretical Framework

The complex psychosocial ramifications of parental alcoholism on children require a comprehensive theoretical foundation that can adequately capture the multifaceted nature of this phenomenon. This study employs an integrative theoretical approach, drawing from four distinct yet complementary perspectives to understand how parental alcoholism influences children's self-esteem, anxiety, and depression. The theoretical framework encompasses Family Systems Theory, Developmental Perspective, Stress and Co-dependency Perspective, and Cross-Cultural Perspective, each contributing unique insights into the mechanisms through which familial alcoholism affects child development and psychological well-being.

The selection of these theoretical frameworks is deliberate and strategic, as each addresses different dimensions of the child's experience within an alcoholic family system. Family Systems Theory provides the foundational understanding of how dysfunction permeates family structures, while the Developmental Perspective

illuminates age-specific vulnerabilities and disruptions. The Stress and Co-dependency Perspective explains the physiological and psychological mechanisms underlying observed symptoms, and the Cross-Cultural Perspective ensures the findings are contextualized within the specific sociocultural environment of the study population. Together, these theories create a robust analytical lens through which to examine and interpret the lived experiences of children of alcoholics (COAs).

Family Systems Theory

Family Systems Theory, originally conceptualized by Murray Bowen in 1978 and subsequently refined by numerous scholars including Goldenberg and Goldenberg (2002), serves as the primary theoretical foundation for understanding how alcoholism affects not just the individual drinker but the entire family constellation. This theory posits that families operate as complex, interconnected emotional systems where each member's behaviour, emotions, and experiences ripple throughout the entire unit, creating patterns of interaction that maintain systemic equilibrium, albeit sometimes at great cost to individual members' well-being.

Within the context of alcoholic families, the theory reveals how dysfunction becomes systematically embedded within family structures, creating what Velleman and Templeton (2007) describe as a "new normal" where chaos, denial, and enabling behaviours paradoxically maintain family stability. The alcoholic parent's unpredictable behaviour necessitates constant adaptation from other family members, leading to rigid role assignments and emotional suppression that serve to maintain homeostasis but at the expense of healthy individual development. Children in these systems often find themselves adopting roles far beyond their developmental capacity, such as the "hero child" who excels academically to bring pride to the family, the "scapegoat" who acts out to deflect attention from the alcoholic parent, or the "lost child" who becomes invisible to avoid adding stress to an already overburdened system.

Family Systems Theory views individuals as belonging to subsystems within families where they learn and perform specific skills, with all members becoming interrelated as a whole (Jacobs, 1992). The spousal subsystem, typically characterized by conflict, emotional distance, or co-dependent dynamics, creates an unstable foundation that affects the parent-child subsystem. Children may witness chronic marital discord, domestic violence, or emotional withdrawal, leading to insecure attachment patterns and difficulty trusting intimate relationships. The sibling subsystem may also be disrupted as children compete for limited emotional resources or band together in survival alliances, sometimes creating inappropriate caretaking relationships where older children assume parental responsibilities for younger siblings. However, the family itself is influenced by external factors, including cultural norms and values (Hendershot et al., 2005).

Intergenerational transmission patterns, another crucial component of Bowen's Family Systems Theory(1978), help explain why alcoholism and its associated psychological impacts often persist across generations. Children who grow up in alcoholic families learn maladaptive communication patterns, emotional regulation strategies, and relationship dynamics that they may unconsciously replicate in their own adult relationships and parenting practices. This theoretical understanding is essential for comprehending why COAs may exhibit higher rates of anxiety and depression, as these symptoms often reflect learned patterns of hypervigilance, emotional suppression, and chronic stress adaptation that originated within their family system.

Developmental Perspective

The Developmental Perspective, grounded in Erik Erikson's seminal work on psychosocial development (1963) and enhanced by subsequent research on role regulation and developmental tasks, provides crucial insights into how parental alcoholism disrupts age-appropriate developmental milestones and creates lasting impacts on personality formation and psychological well-being. This theoretical framework emphasizes that children's developmental needs are consistent and universal, but the alcoholic family environment often fails to provide the stability,

predictability, and emotional attunement (the ability of a caregiver (typically a parent) to accurately perceive, understand, and respond appropriately to a child's emotional states and needs) necessary for healthy progression through developmental stages.

During early childhood, typically encompassing Erikson's stages of trust versus mistrust and autonomy versus shame and doubt, children of alcoholics often experience inconsistent caregiving that undermines their ability to develop basic trust in their environment and caregivers. The unpredictable nature of parental availability and emotional responsiveness, influenced by cycles of intoxication and withdrawal, creates an environment where children cannot reliably predict whether their basic needs for safety, comfort, and emotional connection will be met. If alcoholic parents exhibit additional emotional problems, their children may experience greater difficulty achieving normal "role regulation" (Nardi, 1981). This early disruption in attachment formation has profound implications for the child's developing sense of self-worth and their capacity to regulate emotions and form secure relationships later in life.

As children progress into middle childhood, corresponding to Erikson's industry versus inferiority stage, the impacts of parental alcoholism become increasingly evident in academic, social, and emotional domains. Children at this developmental stage are naturally focused on developing competence and mastery in various skills, but the chaos and unpredictability of alcoholic homes often interfere with their ability to concentrate on learning, maintain consistent school attendance, or participate in extracurricular activities that would normally contribute to their sense of industry and accomplishment. Instead, many COAs during this stage become preoccupied with family survival, monitoring parental moods and behaviors, and attempting to maintain some semblance of normalcy in their daily lives.

The adolescent period, characterized by identity formation and the navigation of independence versus dependence conflicts, presents unique challenges for COAs. During this crucial developmental phase, adolescents typically begin to separate from their families and develop their own sense of identity, values, and future

aspirations. However, adolescent COAs often find themselves trapped in parentified roles, caring for younger siblings, managing household responsibilities, or even attempting to control or monitor their alcoholic parent's drinking behaviour((Kelley et al., 2007). This premature assumption of adult responsibilities can lead to what developmental theorists term "pseudomaturity," (Newcomb, 1996) where adolescents appear mature and capable on the surface but have not actually completed the essential developmental tasks of identity formation and emotional individuation.

The concept of developmental arrest is particularly relevant when examining long-term outcomes for COAs. Many individuals who grew up in alcoholic families report feeling "stuck" in childhood patterns of thinking and responding, even well into adulthood. Role development opportunities for children of alcoholics (COAs) can be severely limited, potentially causing problems in accomplishing necessary healthy development stages (Lee, 2003). They may continue to exhibit hypervigilance, people-pleasing behaviours, difficulty setting boundaries, or perfectionist tendencies that originally served as survival mechanisms in their chaotic family environments but become maladaptive in healthy adult relationships and work environments. This perspective highlights how developmental tasks appropriate for specific age periods may be disrupted or delayed due to the unstable environment created by parental alcoholism.

Stress and Co-dependency Perspective

The present study approaches the research primarily from the stress perspective associated with co-dependency. The Stress and Co-dependency Perspective draws from extensive research on trauma, chronic stress responses, and the development of maladaptive coping mechanisms in children exposed to ongoing family dysfunction. This theoretical framework, significantly influenced by the pioneering work of Janet Woititz (1983) on adult children of alcoholics and contemporary research on toxic stress by scholars like Jack Shonkoff (2012), provides crucial insights into the physiological and psychological mechanisms

through which chronic exposure to familial alcoholism creates lasting impacts on children's mental health and emotional regulation.

This perspective hypothesizes that heightened stress from living in an alcohol-complicated family environment can adversely affect adolescent children's personality traits and manifest as deficits in their psychosocial functioning. The chronic stress experienced by COAs often leads to maladaptive coping mechanisms, including assuming parental responsibilities prematurely, becoming enablers, or developing hypervigilance to manage unpredictable home environments.

Cross-Cultural Perspective

The Cross-Cultural Perspective acknowledges that the experience of growing up with an alcoholic parent is significantly shaped by cultural, religious, and societal contexts that influence how alcoholism is perceived, discussed, and addressed within communities. This theoretical framework, informed by cross-cultural psychology and anthropological research on substance use across different societies, recognizes that culture serves as "a system of patterns of belief and behaviour that shape the worldview of the member of a society" (Heath, 1995), and while it is well-established that alcohol and other substance use is shaped by the interplay of psychosocial factors and cultural characteristics, empirical evidence is still rare (Kuntsche et al., 2017). The stigma, support systems, and coping resources available to COAs vary dramatically across cultural contexts, making it essential to understand these influences when examining psychosocial outcomes.

In the Indian context, and particularly within the north-eastern state of Manipur where this study is situated, cultural attitudes toward alcohol consumption and addiction are complex and multifaceted. The collectivist nature of Indian society, which promotes social cohesion and interdependence through traditional joint family systems, can create additional pressures for families to conceal alcoholism, potentially increasing the isolation and shame experienced by COAs, particularly given that more than half of all alcohol drinkers in India fall into criteria for hazardous drinking, making alcohol abuse a major public-health problem

(Prasad, 2009). This perspective is particularly relevant for understanding COAs in Churachandpur district, Manipur, where traditional tribal communities may have historical relationships with alcohol that differ significantly from mainstream Indian attitudes, while colonial influences, Christian missionary activities, and modern urbanization have created layers of cultural perspective that shape how families and communities respond to alcoholism (Neihzial, 1993).

Beyond cultural and religious dynamics, the broader socio-political context of Churachandpur district, characterized by ethnic tensions and periodic communal conflict — introduces an additional layer of environmental stress that shapes the psychological experiences of adolescents in this region. Betancourt and Khan (2008) have specifically demonstrated that youth in conflict-affected environments carry a cumulative psychosocial burden that cannot be fully explained by family-level variables alone, as chronic exposure to community violence and instability fundamentally alters adolescents' cognitive appraisal of safety and threat. This socio-political dimension is therefore an important contextual factor in understanding the psychological outcomes of both COAs and non-COAs within this district

Religious and spiritual frameworks play crucial roles in shaping how alcoholism and its impacts are understood and addressed. In Manipur's predominantly Christian communities, religious teachings about addiction, forgiveness, and family responsibility may influence how COAs interpret their experiences and seek help. Some religious frameworks may provide comfort and community support, while others may contribute to guilt, shame, or fatalistic attitudes about the possibility of change. Traditional spiritual practices and indigenous healing approaches may also offer alternative frameworks for understanding and addressing the psychological impacts of parental alcoholism.

Gender roles and expectations within specific cultural contexts significantly influence how COAs experience and respond to their family situations. In many Indian communities, sons may face pressure to assume responsibility for "fixing" family problems or controlling their parent's drinking, while daughters may be expected to provide emotional caretaking and maintain family harmony. These

gendered expectations can create additional stress and role confusion for COAs, influencing their self-esteem and contributing to anxiety about their ability to fulfill cultural expectations.

Community support systems and extended family networks, which are traditionally strong in many Indian communities, can serve as protective factors for COAs by providing alternative sources of stability, emotional support, and practical assistance. The traditional institutional frameworks in Churachandpur district, Manipur provide additional context for understanding how COAs navigate family dysfunction within established cultural systems. The 'Indongta' a traditional community institution among the Paite and other Zo ethnic community in the pre-colonial period, exemplifies how social norms guide individual behaviour and community responses to family crises (Guite, 2017). Within this framework, individual choice is often subordinated to collective social activities, where services appear selfless but actually reflect deeper obligations between individuals and institutions. The symbolic roles and intercommunication patterns within such institutions are guided by societal norms that extend beyond the institution to the entire village community (Guite, 2017).

For Children of Alcoholics (COAs), however, this institutional framework presents both opportunities and constraints. While the 'Indongta' can provide community-level support for families experiencing alcoholism-related crises, the same system may also pressure families to maintain appearances and handle problems within established hierarchical structures. Cases that disrupt social relationships, such as those caused by parental alcoholism, are typically addressed through these traditional institutions before being referred to higher authorities like the chief's court. This cultural mechanism may either facilitate community support for COAs or reinforce pressures to conceal family dysfunction to maintain social harmony and fulfil cultural obligations even at the cost of their own psychological well-being. This cultural pressure to maintain family dignity can prevent help-seeking behaviours, increase isolation, and contribute to the internalization of shame and responsibility for their parent's addiction. Understanding these cultural dynamics

is essential for developing culturally appropriate interventions and interpreting research findings within their proper sociocultural context.

The present study was attempted against this background primarily from the above perspectives, which hypothesized the heightened stress of living in an alcohol complicated family environment could have adverse consequences on the personality traits of adolescent children and manifest deficits in their psychosocial functioning. The present study is an attempt to explore and highlight the psychosocial correlates of parental alcoholism on children focusing on children of alcoholics and seek to understand the adverse impact of parental alcoholism on their growth and psychosocial functioning and to discuss implications for therapeutic intervention with adolescent COAs and their families in the light of the results obtained.

Review of Literature

The relationship between parental alcoholism and the psychosocial development of children has attracted sustained scholarly attention since the 1970s. Research across this period has progressively refined its focus from broad documentation of psychopathological risk toward systematic investigation of specific psychological outcomes- most notably self-esteem, anxiety, and depression, and the family, cultural, gender-related, and socio-demographic factors that moderate these outcomes. The present review is organized into five thematic sections corresponding directly to the objectives of this investigation: (1) the impact of parental alcoholism on self-esteem, anxiety, and depression in children of alcoholics (COAs); (2) gender differences in these psychological outcomes; (3) the interaction effect of paternal alcoholism and gender; (4) family environment patterns among COAs and non-COAs; and (5) the role of family environment and socio-demographic characteristics on self-esteem, anxiety, and depression. Each section concludes with an identification of the specific gaps in the literature that the present study is designed to address.

Based on the WHO, India's total per capita alcohol consumption (APC) increased significantly from 2.3 litres in 2000 to 5.5 litres in 2018. Alcohol

consumption was higher among males in the north-eastern states than the rest of India (Rastogi et al., 2022). The states with the highest consumption rates were Arunachal Pradesh (53%), Telangana (43%), Sikkim (40%), Manipur (37%), Goa (36%), and Jharkhand and Chhattisgarh (35%).

According to a study by Jyani et al. (2019), alcohol-related deaths would result in the loss of 258 million life years between 2011 and 2050. By contrast, the elimination of alcohol consumption would result in 552 million quality-adjusted life years (QALYs). The cost to the health system of treating these conditions will be INR 3127 billion (US\$ 48.11 billion). The total cost of alcohol to society, including out-of-pocket expenses, productivity losses, and health system costs, is INR 121,364 billion (US\$ 1867 billion). There is a net economic loss of INR 97,895 billion (US\$ 1506 billion) from alcohol consumption, even after accounting for tax revenues from sales. The Indian economy loses an average of 1.45% of its GDP annually as a result.

1. Impact of Parental Alcoholism on Self-esteem, Anxiety, and Depression in COAs

Historical Foundations

The scientific study of children raised in alcoholic households was formally established through a series of foundational works in the 1970s and 1980s that documented, across diverse methodologies, the pervasive psychosocial risk associated with parental alcohol use disorder. **El-Guebaly and Offord (1977)** conducted one of the earliest comprehensive narrative reviews of empirical and clinical literature on COAs, synthesizing findings by child age and focusing on standardized diagnostic criteria for parental alcoholism. A particularly significant contribution of this review was its insistence that research attend not only to the 'casualties' among COAs, those who developed psychosocial disorders, but also to the 'successes': children who demonstrated resilience despite adverse family conditions. This call for a resilience-informed research agenda anticipated what would become a major strand of COA scholarship two decades later.

Building on this foundation, **Clare Wilson and Jim Orford (1978)** employed a qualitative design(in-depth interviews with 11 families containing a confirmed alcoholic parent) to examine how parental drinking shaped family life from the inside. Their finding that emotional distress and fear caused by living with an alcoholic parent were more psychologically harmful to children than physical violence represented an early challenge to the prevailing focus on observable behavioural outcomes, pointing instead toward the invisible but pervasive emotional damage of chronic uncertainty.

Melissa Owings West's (1987) systematic narrative review of a decade of COA research (1975–1985) consolidated these insights across eight outcome domains, including anxiety, depression, social inadequacy, and dysfunctional family interactions, and recommended longitudinal designs, attention to the child's age at exposure, and multi-source data collection as priorities for future research.

While these three foundational studies differ in design, a narrative review, a qualitative family study, and a systematic review, they converge on a shared conclusion: parental alcoholism creates a measurably distinct developmental environment that elevates children's risk for a broad range of psychosocial difficulties. Critically, however, all three were conducted in Western contexts and none disaggregated outcomes by the specific psychological constructs of self-esteem, anxiety, and depression that later became central to the field. These foundational studies thus established the broad contours of COA risk while leaving open the task of systematically examining its specific psychological manifestations- a task that subsequent research began to pursue with greater methodological precision.

Self-esteem in COAs

Among the psychological outcomes most consistently associated with parental alcoholism, self-esteem has received substantial empirical attention, with studies spanning multiple decades and cultural contexts converging on the finding that COAs characteristically exhibit lower self-worth than their non-COA peers. **Berkowitz and Perkins (1988)** were among the first to examine this relationship systematically, surveying 860 college students using standardized personality

questionnaires and finding that COAs reported significantly higher levels of self-deprecation than non-COAs. A notable nuance in their findings was the gender differentiation: the self-deprecation difference was most pronounced among women with alcoholic fathers, while male COAs paradoxically rated their autonomy higher than male non-COAs — a pattern that would be echoed in subsequent research and suggests that gender moderates not only the level but also the expression of self-esteem effects.

In the same year, **Bennett et al. (1988)** extended this work to a younger sample, comparing 80 children from non-alcoholic families with 64 from alcoholic families on 17 developmental measures. COAs performed significantly worse on nine of these measures, with the most pronounced differences in emotional functioning and cognitive achievement, indicating that the self-esteem deficit documented in adolescents and young adults has its origins earlier in development. Together, these two studies established what would become the foundational empirical consensus: COAs are at measurably greater risk for compromised self-worth, and this risk is present across the developmental span.

Indian research has both confirmed this consensus and introduced important cultural nuances. **Kaur Jyothi Jiv (1991)** compared adolescent sons of alcohol-dependent fathers with peers from non-alcoholic households in an Indian sample and found significantly lower self-esteem, reduced assertiveness, and elevated interpersonal family problems among COAs- among the earliest empirical evidence that the self-esteem deficit documented in Western research is replicated in the Indian context. **Selwyn and Vanitha (2008)** reached a similar conclusion using a matched-pairs design with 50 Indian COAs, finding significantly lower self-esteem and poorer adjustment across all domains ($r = 0.68$, $p < 0.01$). More recently, **Madhavi (2016)** confirmed these findings using an Indian community sample, with adolescent children of alcoholic fathers scoring significantly lower on standardized self-esteem measures than those of non-alcoholic fathers. While these studies collectively affirm the cross-cultural robustness of the self-esteem–alcoholism link, they share an important methodological limitation: all rely on purposive sampling from single sites, and their small sample sizes (typically 50–100 participants per

group) constrain the generalizability of findings. None specifically examines tribal communities in northeast India, where the cultural context of alcoholism, its social stigma, and the community resources available to COAs differ substantially from the urban and pan-Indian settings where this research was conducted.

Internationally, **Kanus (2014)** documented a strong negative correlation ($r = -0.69$, $p < 0.05$) between parental alcohol abuse and self-esteem among Kenyan secondary school students, demonstrating that this relationship is not confined to Western or South Asian populations. **John and Godwin's (2014)** survey of 108 Indian school students added ecological validity: 54% reported an alcoholic family member, approximately 75% felt low about themselves relative to peers, and half felt ashamed of their homes. The shame dimension identified here is particularly significant, as it links self-esteem not merely to the direct effects of family dysfunction but to the social and reputational consequences of parental alcoholism — a mechanism likely to be especially potent in collectivist communities where family honour is a central component of personal identity.

Gondolf and Ackermann's (1993) factor analysis of the Adolescent Children of Alcoholics Index identified four core dimensions: rejection, impulsiveness, inconsistency, and deliberation with low self-esteem and mild depression emerging as the outcomes most strongly correlated with these factors, foreshadowing the empirical link between self-esteem and depression in COAs that **Elaine and Robert (1999)** would later confirm. In their community-based survey of 649 African-American adolescents aged 12 to 19, Elaine and Robert found that COAs scored significantly lower on the Rosenberg Self-Esteem Scale than non-COAs, that females scored lower than males overall, and that depression was the strongest predictor of COA status- establishing an empirically important bidirectional relationship between self-esteem and depression that the present study accounts for by measuring both constructs simultaneously.

Anxiety and Depression in COAs

The empirical literature on anxiety and depression in COAs is extensive and methodologically diverse, and its conclusions are strikingly consistent: children

raised in alcoholic households are at substantially elevated risk for both internalizing disorders relative to their non-COA peers.

Ellis, Zucker, and Fitzgerald's (1997) narrative review of multiple cross-sectional and longitudinal studies established this as a foundational empirical claim, while **Abela et al. (2009)** extended it developmentally through a longitudinal community-based study demonstrating that exposure to negative family environments significantly increases vulnerability to depressive symptoms even in young children and early adolescents- indicating that the risk begins well before adolescence and accumulates over time. This developmental trajectory underscores the importance of early identification and intervention, a point that **Mansharamani et al. (2018)** reinforced in an 18-month Indian cross-sectional study comparing 50 COAs and 50 non-COAs aged 4 to 14: COAs showed significantly higher anxiety and depression on the Childhood Psychopathology Measurement Schedule, with no significant differences found for conduct disorder or somatisation, suggesting a degree of outcome specificity that has implications for targeted intervention design.

Methodologically, the most rigorous evidence comes from studies employing structural equation modelling or longitudinal designs to control for confounding factors. **Eiden, Molnar, Colder, Edwards, and Leonard (2009)** used SEM in a community sample of 213 children: 112 with alcoholic fathers, 101 without, and found that paternal alcoholism predicted significantly higher anxiety scores even after controlling for relevant covariates, establishing a degree of causal plausibility that cross-sectional designs cannot provide.

Ranta and Raitasalo's (2017) population-based longitudinal register study in Finland, drawing on national health data for children of substance-abusing parents, found significantly elevated rates of all psychiatric disorder categories compared to matched controls, and **Karen's (2015)** PRISMA-compliant systematic review of 39 peer-reviewed articles confirmed that depression, anxiety, suicidal ideation, and interpersonal difficulties cluster together as a syndrome of internalizing risk among COAs. The consistency of these findings across very different methodological approaches, a national register study in Finland, a structural equation

model in the United States, and a systematic review across international literature, substantially strengthens confidence in the empirical consensus.

Indian research has added both confirmatory evidence and nationally relevant prevalence estimates. **Mishra et al. (2018)** documented a depression prevalence of 14.5% and anxiety disorder prevalence of 15% among Indian COAs (figures substantially exceeding general adolescent population rates) using validated tools (HAM-A and BDI) across hospital and community settings. **Omkarappa and Rentala (2019)**, in a school-based comparative survey in Bangalore, found that 100 COAs showed statistically significant differences from 100 non-COAs across anxiety, depression, self-esteem, obsessive-compulsive symptoms, separation anxiety, and social phobia- demonstrating that the psychological consequences of parental alcoholism in India extend well beyond the three core constructs and encompass a broader internalizing syndrome.

More recently, **Brunda (2023)** documented elevated hopelessness among young adult COAs using the Beck Hopelessness Scale, suggesting that the affective sequelae of parental alcoholism persist into early adulthood, with hopelessness representing a potentially mediating cognitive mechanism linking childhood adversity to adult depression.

In the specific context of northeast India, the psychological dynamics of COAs take on additional complexity. Unlike urban Indian settings where alcohol is typically associated with moral stigma and social deviance, many tribal communities in the northeast integrate traditional fermented beverages into domestic and ceremonial life (**Barooah, 2024; Chaturvedi, 2016**). This cultural normalization may alter the shame dynamics typically reported in Indian COA research: while **John and Godwin (2014)** found that approximately half of urban Indian COAs felt ashamed of their homes, this figure may differ markedly in communities where traditional alcohol production is woven into cultural identity and festive ritual. The near-total absence of empirical studies examining these psychological dynamics specifically in tribal adolescent COAs represents a significant methodological gap,

as interventions designed without cultural grounding risk being both ineffective and alienating to the communities they aim to serve.

Across the literature on self-esteem, anxiety, and depression in COAs, several important research gaps emerge. First, the large majority of studies have been conducted in Western or urban pan-Indian contexts, with very limited research from northeast India, particularly tribal communities in Manipur and Mizoram, where distinct cultural, social, and religious contexts may substantially moderate the relationship between parental alcoholism and psychological outcomes. Second, most Indian studies have focused on adult or mixed-age COA populations, leaving adolescent COAs during the critical developmental window of identity formation comparatively underexamined. Third, the compounding role of COVID-19 as an additional stressor on COA psychological outcomes has not been empirically examined; pre-pandemic prevalence figures such as those reported by **Mishra et al. (2018)** may substantially underestimate the current burden. Fourth, the mechanisms through which community-level protective factors- church-based social support, kinship networks, and traditional cultural practices- buffer or amplify the impact of parental alcoholism on adolescent mental health have not been empirically investigated in the Indian tribal context.

2. Gender Differences in Self-esteem, Anxiety, and Depression

The role of gender in shaping the psychological consequences of parental alcoholism has been a recurring theme in the COA literature, with a broad body of evidence indicating that female adolescents are generally more vulnerable than their male counterparts to internalizing outcomes, particularly anxiety and depression, while males tend toward externalizing responses.

Sher et al. (1991) established an important early reference point with their college-based cross-sectional study of 490 young adults (253 COAs, 237 non-COAs), finding that COAs overall reported higher behavioural under-control, neuroticism, and psychiatric distress than non-COAs, and that women were generally more affected by a family history of alcoholism than men, though few statistically significant Gender $\times$ Family History interaction effects emerged. This finding, i.e.

robust gender differences at the main effect level without strong interaction effects, recurs across the literature and has important methodological implications: it suggests that gender and parental alcoholism may influence psychological outcomes through partially independent rather than strictly interactive pathways, a distinction with implications for statistical modelling decisions in the present study.

Puttler et al. (1998) extended this work developmentally, following 212 children aged 3 to 8 through a longitudinal family study and finding that boys experienced significantly more behavioural problems than girls across all family subtype groups: non-alcoholic, non-antisocial alcoholic, and antisocial alcoholic; while older children showed more internalizing difficulties than younger ones. The interaction between child age, gender, and parental alcoholism subtype identified in this study suggests that the gender dynamics of COA outcomes are developmentally variable: the male externalizing pattern observed in early childhood may not hold into adolescence, when puberty, hormonal change, and the intensification of social-evaluative processes tend to shift girls toward greater internalizing vulnerability (**Hyde et al., 2008**). This developmental re-patterning was documented by **Galambos et al. (2004)** in a multi-year longitudinal study of Canadian adolescents, which found robust gender differences in depressive symptoms emerging during adolescence, with girls significantly more affected than boys—a pattern reinforced by **Afifi et al.'s (2005)** large-scale Canadian epidemiological study attributing the gender gap in adolescent depression to a constellation of sociodemographic health determinants.

Research from non-Western contexts adds important comparative perspectives. **Banga (2016)** found significantly higher anxiety among girls than boys in an Indian sample of 400 senior secondary students in Himachal Pradesh, suggesting that the female vulnerability to anxiety documented in Western research extends to the Indian adolescent population.

Golan (2015) provided a theoretical account through which gender norms, specifically, the cultural positioning of self-confidence as a masculine attribute,

produce higher self-esteem among boys and greater internalizing tendencies among girls.

Gestsdottir et al.'s (2021) pandemic-period survey of university students confirmed that males exhibited fewer anxiety and depression symptoms and higher self-esteem than females, and that female students were disproportionately affected by loneliness and social isolation during COVID-19 restrictions- findings directly relevant to the present study's data collection context.

More recent work by **Barbieri et al. (2024)** in Nepal and **Shawon et al. (2024)** across adolescent populations confirmed that gender differences in anxiety and depression persisted post-pandemic, with family dynamics identified as a significant moderating factor alongside age, education, and economic status.

An important exception to the prevailing pattern is **Mission and Sakthivel's (2024)** Indian study, which found a higher prevalence of low self-esteem among male than female adolescents- a result that challenges the assumption of universal female vulnerability and underscores the importance of cultural context in shaping the direction of gender effects. Similarly, **Mommaerts et al.'s (2024)** qualitative study of female Mexican American adolescents identified cultural navigation, social pressure, and external validation-seeking as key mechanisms through which anxiety and self-esteem interact in minority cultural contexts- a finding with clear resonance for adolescent females in Churachandpur's tribal Christian community, where cultural expectations, religious norms, and family roles intersect in complex ways.

Taken together, the literature establishes that gender is a consistent and significant moderating variable in adolescent mental health outcomes, but that its direction and magnitude are shaped by cultural context, developmental stage, and the specific outcome under examination. Several important gaps persist. Most studies examining gender differences among COAs have been conducted in Western individualistic societies, and their findings may not generalize to the collectivist and patriarchal dynamics of tribal communities in northeast India, where gender role expectations, community support systems, and the social consequences of family dysfunction operate according to different logics. Very few Indian studies have

specifically examined gender differences in psychological outcomes among adolescent COAs, and those available draw on pan-Indian or urban samples that do not capture the lived realities of tribal communities. The specific mechanisms driving female vulnerability in a tribal context, including premature caretaking roles, restricted coping outlets, and differential access to social support, have not been empirically examined. Finally, the moderating role of the COVID-19 pandemic on pre-existing gender differences in mental health, particularly among COAs in rural and tribal settings, remains an understudied area of considerable policy relevance.

3. Interaction Effect of Paternal Alcoholism and Gender on Self-esteem, Anxiety, and Depression

While the preceding sections establish that both parental alcoholism and gender independently shape adolescent psychological outcomes, a more nuanced and theoretically important question concerns whether these two variables interact, i.e. whether the psychological impact of growing up with an alcoholic father is differentially experienced by male and female adolescents in ways that exceed their independent effects. The available evidence on this interaction is mixed and methodologically uneven, but several key studies provide important empirical anchors.

Berkowitz and Perkins (1988) identified a significant gender–alcoholism interaction specifically for self-deprecation, with women reporting markedly greater self-deprecation when the alcoholic parent was the father rather than the mother, suggesting that paternal alcoholism carries a specific psychological cost for daughters that is not reducible to general family dysfunction. **Elaine and Robert (1999)** extended this finding to an African-American adolescent sample, documenting the most pronounced self-esteem and depression effects among female COAs- a pattern indicating that girls experience not merely an additive combination of gender and family risk but a distinctively amplified vulnerability at their intersection. These findings align with the differential susceptibility hypothesis (**Belsky & Pluess, 2009**), which proposes that certain individuals are constitutionally more sensitive to environmental influences in both negative and positive directions-

a framework that may partially explain why female COAs show stronger adverse outcomes than would be predicted from either gender or COA status alone.

However, not all research confirms a significant interaction. **Sher et al. (1991)**, in their large cross-sectional study of 490 college students, found that while women were generally more affected by parental alcoholism than men, few statistically significant Gender $\times$ Family History interaction effects emerged, suggesting that the two variables largely operate through independent pathways. **Puttler et al. (1998)** found that gender interacted with paternal alcoholism subtype: boys showed more behavioural problems across all family categories, but the interaction was domain-specific, present for externalizing but not internalizing outcomes.

Chassin et al. (1999), in a longitudinal study following 454 families from adolescence into early adulthood, found that the effects of maternal versus paternal alcoholism on young adult anxiety and depression were not consistent across subsamples, suggesting that the parent-gender and child-gender combination may jointly determine interaction effects in ways that simple two-way analyses cannot fully capture.

Crum and Harris (1996), studying data from the NIMH Epidemiologic Catchment Area Program, found stronger associations between parental alcoholism and alcohol use disorders in female offspring than male offspring- an intergenerational transmission effect that, while distinct from self-esteem, anxiety, and depression, points to a broader pattern of elevated female vulnerability in the context of paternal alcohol misuse.

The interaction between paternal alcoholism and gender on psychological outcomes in adolescents remains one of the most underexplored areas in the COA literature, and the gaps are particularly pronounced in non-Western contexts. Most studies that examine these interactions do so as secondary or post-hoc analyses rather than as primary research objectives, limiting the statistical power available to detect genuine interaction effects. Available studies have predominantly relied on Western, adult, or non-tribal samples, making it empirically unjustifiable to generalize their

findings to adolescents in culturally distinct settings such as the tribal Christian communities of northeast India, where gender role socialization, the social meaning of alcoholism, and the emotional resources available to young people operate according to substantially different cultural logics. No published study has examined how the COVID-19 pandemic may have differentially intensified the interaction between paternal alcoholism and gender on adolescent mental health outcomes, a gap of particular relevance to the present study, given that data collection occurred during the pandemic period when lockdown measures eliminated access to school-based and community-based protective support systems for both male and female COAs.

4. Family Environment Patterns of Children of Alcoholics and Non-Alcoholics

A substantial body of research has examined the family environment as both the medium through which parental alcoholism harms children and as a potential source of protective factors that can buffer its effects. The foundational insight across this literature, established early and confirmed repeatedly, is that it is not parental alcoholism per se but the quality of the family environment that most directly determines children's psychological outcomes.

Clare Wilson and Jim Orford (1978), in their qualitative family interviews, found that the emotional climate of the household- characterized by fear, unpredictability, and chronic distress- was more damaging to children than the specific behavioural manifestations of parental drinking. **Clair and Genest (1987)** formalized this insight empirically, demonstrating in a comparative study using the Family Environment Scale that when family cohesion and emotional support remained high despite parental alcoholism, COAs did not differ significantly from non-COAs in depression or self-esteem, a finding with profound implications for intervention design, indicating that strengthening family protective factors may be as important as addressing parental drinking directly. **Werner and Broida (1991)** reinforced this conclusion, showing through regression analysis that family dysfunction (not parental alcoholism as an independent variable) was the proximal cause of compromised self-esteem and external locus of control in children.

Subsequent research documented the specific family environment dimensions most disrupted by parental alcoholism. **Narang et al. (1997)**, in one of the earlier Indian studies in this area, found that children of alcoholic parents showed higher psychopathological abnormalities, greater temperamental arrhythmia, and lower mood persistence than children of non-alcoholic parents, with a significant positive correlation between temperamental and psychopathological traits.

Velleman and Templeton (2007) identified two recurrent patterns in adolescents living with parental alcoholism: the development of peer relationships deliberately kept separate from family life, and a progressive withdrawal into social isolation accompanied by anxiety and depression- patterns that function simultaneously as coping strategies and as risk factors for further psychological deterioration.

Hinrichs et al. (2011), in a methodologically sophisticated cluster-analytic study using Q-sort personality data from both adolescent and adult COA samples, identified five distinct personality subtypes: externalizing, inhibited, emotionally dysregulated, high-functioning, and divergent, underscoring that COAs are not a homogeneous population and that subtype-sensitive approaches are essential both for research and for clinical intervention.

An important counterpoint in the literature is provided by **Schuckit et al. (2000)**, who found, after controlling for familial antisocial personality disorder and socioeconomic status, that a family history of alcoholism was not significantly associated with childhood externalizing disorders such as conduct disorder, oppositional defiant disorder, or attention deficit disorder. This finding suggests that the pathways through which parental alcoholism affects children may be more specific than a general elevation of psychopathological risk- confined perhaps to internalizing outcomes (self-esteem, anxiety, depression) rather than externalizing ones, a specificity that aligns with the focus of the present investigation and reinforces the importance of carefully disaggregating outcomes rather than treating COA risk as undifferentiated.

Research from India and the northeast Indian region adds important contextual dimensions. **Lalnunpuii (2015)**, working with Mizo families in Mizoram, found that paternal alcoholism significantly disrupted emotional expressiveness (Cohen's $d = 0.68$) and conflict resolution patterns, while certain traditional kinship support systems were partially preserved- a finding that illustrates both the disruptive power of paternal alcoholism on family functioning and the potential of cultural protective structures to limit its reach. However, as Lalnunpuii's own data suggest, this collectivist protection is not unconditional. In tribal Christian communities such as those of Churachandpur, where the Church functions as the primary arbiter of social conduct, religious institutions can intensify the internalizing symptoms of COAs through strict moral monitoring of family behaviour, creating pressure on children to conceal dysfunction and absorb shame privately rather than seeking help (**War, 2020**).

Jose and Cherayi (2020) found that Indian children of alcoholic parents scored significantly lower on life satisfaction and positive relationships than non-COAs, while **Joseph et al. (2024)**, in a qualitative study with 12 Indian children aged 11–13, found that parental AUD was compounded by social norms of family honour and reputation that actively discouraged disclosure.

AlSaad et al.'s (2023) systematic scoping review of 52 years of international literature documented that COAs were more likely to develop poor coping strategies, hyperactivity in school age, early alcohol initiation in adolescence, and relationship and employment difficulties in adulthood- confirming that the family environment disruptions associated with parental alcoholism cast a long developmental shadow well beyond childhood.

Several important gaps in the family environment literature remain. Most studies have been conducted outside India or in urban and pan-Indian settings, and the few available northeast Indian studies have not specifically examined tribal communities in Manipur, where the interplay of traditional kinship systems, clan-based governance, church institutions, and the specific social meaning of alcohol creates a distinctive family environment context. The protective function of cultural

institutions in moderating the adverse effects of parental alcoholism on family environment has not been empirically quantified in Indian tribal contexts. The specific subscale dimensions of the Family Environment Scale, where conflict, independence, active recreation, and control sub-scales have rarely been compared systematically between COAs and non-COAs in Indian adolescent samples. Finally, the compounding effect of the COVID-19 pandemic on family environment patterns in COA households, including intensification of conflict through prolonged enforced proximity, erosion of independence through lockdown restrictions, and disruption of community-based support systems, represents an entirely unexplored dimension in the Indian literature.

5. Role of Family Environment and Socio-Demographic Characteristics on Self-Esteem, Anxiety, and Depression

Beyond documenting the family environment patterns characteristic of COA households, a distinct strand of research has sought to understand how variations in family environment and socio-demographic characteristics predict self-esteem, anxiety, and depression- both as risk factors that amplify psychological vulnerability and as protective factors that buffer against it. This line of inquiry is directly relevant to the present study, which employs multiple regression to examine the predictive role of family environment dimensions and socio-demographic variables on each of the three psychological outcomes.

Keane (1983) established an early empirical foundation for this inquiry, demonstrating that adolescents who perceived their family environment more positively and who held an internal locus of control adjusted significantly better to parental alcoholism than those with external locus of control and negative family perceptions. This finding positioned the subjective quality of the family environment as a meaningful determinant of psychological adjustment, and prefigured the cognitive-appraisal models of stress and coping later developed by Lazarus and Folkman (1984).

Clair and Genest (1987) confirmed that even under conditions of high family conflict, high family cohesion and independence functioned as protective factors against psychopathology in COAs- indicating that protective dimensions of the family environment can operate independently of its risk dimensions, and that family-level interventions need not wait for the elimination of parental drinking to be beneficial. **Werner and Broida (1991)** reinforced this argument, demonstrating that family dysfunction rather than parental alcoholism per se adversely affected self-esteem and produced an external locus of control.

Indian studies have confirmed the salience of family environment as a predictor of adolescent psychological well-being across non-COA populations. **Rapheal and Varghese (2015)** found a significant linear relationship between home environment and stress, anxiety, and psychological well-being in a stratified random sample of 152 Kerala students, with home environment emerging as the single most significant predictor of psychological well-being in the regression model. **Kaneez (2015)** similarly found that cohesion, expressiveness, acceptance, and active recreation dimensions of the Family Environment Scale were significantly and positively associated with psychological well-being in a sample of 60 Indian adolescents, with gender differences in psychological well-being also documented. These findings from non-COA Indian samples strongly suggest that the family environment–psychological well-being relationship is robust in Indian adolescent populations, but neither study examined this relationship specifically within a COA/non-COA comparative framework, leaving open the question of whether the predictive pathways operate differently for children already burdened by the additional stressor of parental alcoholism.

Park et al.'s (2014) PRISMA-compliant systematic review organized the biological, protective, and risk factors influencing COA development into four levels: social, familial, parental, and individual, providing a multi-level framework that the present study draws upon in designing its analytical approach. At the familial level, factors such as family cohesion, communication quality, and parental warmth emerged as consistently protective, while family conflict and role confusion consistently elevated risk. At the individual level, temperament, coping style, and

self-esteem functioned as both mediating and moderating variables, underscoring the interdependence between the family environment and individual psychological outcomes that the present study seeks to examine.

Ranta (2015) added evidence for the compounding effect of co-occurring risk factors, finding in a Finnish national register study that children of mothers with both substance abuse and psychiatric disorders faced substantially higher psychiatric risk than those with only one of these parental conditions- a finding that parallels the present study's concern with the cumulative risk environment created by the simultaneous presence of paternal alcoholism, family dysfunction, cultural stigma, and pandemic-period stressors.

The socio-demographic determinants of self-esteem, anxiety, and depression in COA populations have received comparatively limited systematic attention, particularly in Indian contexts. Family income, family structure, birth order, family size, and tribal or caste identity are all variables that may interact with family environment to shape psychological outcomes, yet their specific roles in COA populations in northeast Indian tribal communities remain empirically unmapped.

This gap is particularly consequential because the socio-demographic characteristics of the population under study (predominantly Zo tribal adolescents from lower to middle income households in a historically marginalized hill district) may generate risk and protective profiles that differ substantially from those documented in urban Indian or Western samples.

Several gaps persist across this domain. The relationship between family environment and psychological outcomes has not been examined specifically within COA and non-COA adolescent populations in northeast Indian tribal settings. The role of socio-demographic variables, including birth order, family size, and tribal identity, on COA psychological outcomes in India has received very limited empirical attention. Research has rarely examined whether the protective influence of family environment dimensions differs between COAs and non-COAs as a function of socio-demographic characteristics. The COVID-19 pandemic has introduced new socio-demographic stressors- economic disruption, increased

domestic crowding, altered family roles, and the collapse of community support networks- that may significantly interact with family environment to shape psychological outcomes in COA households, yet this intersection remains unexplored in the Indian literature.

Assessment Tools and Methodological Framework

This study employs four validated psychological instruments to assess self-esteem, anxiety, depression, and family environment in adolescent COAs and non-COAs in Churachandpur, Manipur. **The Family Environment Scale (FES; Moos & Moos, 1974), as revised by Bhatia and Chadha (1993)** for Indian populations, provides a standardized measure of family interpersonal and structural characteristics across Relationship, Personal Growth, and System Maintenance dimensions, with reliability coefficients ranging from 0.82 to 0.91.

The Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965) is the most widely used self-esteem measure globally, with strong psychometric reliability (Cronbach's alpha 0.77–0.88) and validated performance in Indian adolescent populations (Joshi & Srivastava, 2009).

The Beck Anxiety Inventory (BAI; Beck et al., 1988) assesses cognitive and physiological symptoms of anxiety and is specifically designed to minimize overlap with depressive symptomatology, with excellent internal consistency (alpha = 0.92).

The Center for Epidemiologic Studies Depression Scale for Children (CES-DC; Weissman et al., 1980) provides a 20-item measure of depressive symptomatology with high internal consistency and cross-cultural validity in South Asian adolescent populations.

Together, these instruments provide a multidimensional, methodologically rigorous, and culturally adaptable framework for capturing the psychological and environmental correlates of adolescents affected by parental alcoholism in the specific Indian tribal context of the present study.

Research Gaps

A comprehensive review of the existing literature across all five domains, i.e. the impact of paternal alcoholism on psychological outcomes, gender differences, interaction effects, family environment patterns, and the role of socio-demographic factors, reveals a consistent and multi-layered set of research gaps that collectively justify the present study.

First, there is a significant lack of Indian studies, particularly from north-east India, directly examining the psychological impact of paternal alcoholism on adolescent self-esteem, anxiety, and depression. The majority of available evidence is drawn from Western or urban pan-Indian contexts, and the few north-east Indian studies available (e.g., Lalnunpuui, 2015, from Mizoram) have not focused specifically on the tribal Christian communities of Manipur, where distinct sociocultural dynamics, including traditional kinship institutions, community governance structures, church-based social networks, and deeply embedded collective values, may substantially modify the relationship between parental alcoholism and adolescent psychological outcomes.

Second, while the literature on COAs is extensive, the focus has predominantly been on adult children of alcoholics, with comparatively limited investigation of adolescent COAs during the critical developmental period of identity formation. Adolescence represents a uniquely vulnerable window during which exposure to parental alcoholism may interact with normative developmental tasks, including identity development, peer relationship formation, and autonomy seeking, in ways that are not captured by studies of adult populations. Research specifically targeting adolescent COAs in India is particularly scarce.

Third, the gender-specific effects of paternal alcoholism on adolescent psychological outcomes have been inconsistently examined, and the interaction between paternal alcoholism and gender as a primary research focus has rarely been studied. Available evidence suggests that females may be particularly vulnerable to anxiety under conditions of paternal alcoholism, yet the mechanisms and cultural

mediators of this vulnerability have not been empirically examined in Indian tribal contexts.

Fourth, Fourth, the cultural and tribal context of Northeast India remains a "black hole" in COA research. While mainstream Indian studies (e.g., Omkarappa & Rentala, 2019) treat alcohol as a deviant substance associated with high moral stigma, tribal communities in states like Manipur, Assam, and Nagaland often view traditional rice-based brews as "holy drinks" or essential ritual components (Bhattacharya, 2023). This normalization of consumption creates a unique psychological environment for COAs that Western "deficit-based" models cannot capture. There is a conspicuous lack of comparative, case-control empirical data specifically measuring the mental health of tribal COAs versus non-COAs. Cultural nuances such as family honour norms that prioritize collective reputation over individual disclosure, and community stigma that may be lower for traditional brewing but higher for "modern" spirit addiction function as volatile risk and protective factors. Without culturally grounded studies, interventions risk being alienating or ineffective.

Fifth, the COVID-19 pandemic introduced an unprecedented layer of stress on already vulnerable populations, yet its compounding effects on COAs, particularly in rural and tribal communities, where disruption of community support systems, intensification of household conflict, and restriction of adolescents' developmental opportunities were most pronounced, have not been empirically examined. The pandemic's role as a mega-stressor (Lazarus & Folkman, 1984) may have substantially altered the psychological landscape for COAs in ways that require urgent investigation.

The present study directly addresses these gaps by examining the impact of paternal alcoholism on adolescents' self-esteem, anxiety, and depression in Churachandpur district, Manipur, with explicit attention to gender differences, interaction effects, family environment patterns, and socio-demographic influences — all within the culturally specific context of a tribal Christian community in north-east India and during the unprecedented conditions of the COVID-19 pandemic.

CHAPTER-II
STATEMENT OF THE PROBLEM

The present investigation aims to comprehensively examine and elucidate the intricate relationships between family environment, self-esteem, anxiety, and depression among children of alcoholics (COAs) in comparison with children of non-alcoholics (non-COAs). This research endeavour is particularly timely and relevant given the concerning prevalence of alcohol consumption within the study region, which is under the total probation of the Manipur Liquor Prohibition Act (MLPA) of 1991. The psychological impact of parental alcoholism on adolescent development represents a critical yet insufficiently explored domain within the Indian context, particularly in Manipur, where cultural and social factors may uniquely influence these relationships.

Alcohol consumption constitutes a significant global health concern, with the World Health Organization (2011) identifying it as "the world's third largest risk factor for disease and disability." In middle-income countries, the situation is even more alarming, as alcohol consumption represents the foremost risk factor for disease burden. Despite extensive research documenting the detrimental effects of alcohol on individual health, comparatively less attention has been directed toward understanding the collateral impact on family systems, particularly on developing children and adolescents within these environments.

The dynamics of alcoholism within family systems create profound ripple effects that extend beyond the affected individual to influence the psychological development and well-being of children. This represents a critical gap in our understanding, as the implications for development and well-being of children. The impact of parental alcohol use on children and adolescents constitutes a pressing social issue that demands immediate research attention, particularly within culturally diverse contexts such as India, and particularly in the Churachandpur district of Manipur, where alcohol-related studies remain limited despite their significant social relevance.

Regional Context: Alcohol Consumption in Manipur: In Manipur, local alcohol is termed "Yu/Zu," which traditionally was used medicinally and prescribed only by traditional medical practitioners and village leaders. Today, however, alcohol has become one of the most widely abused substances in Manipur (Singh,

Kennedy, & Khundongbam, 2018), despite its sale being prohibited under the Manipur Liquor Prohibition Act (MLPA) of 1991.

The paradoxical situation in Manipur presents a compelling case study for examining the effects of parental alcoholism on children. Despite being designated as a "dry state" under the Manipur Liquor Prohibition Act (MLPA) of 1991, alcohol consumption remains pervasive, particularly in Churachandpur district, where prevalence rates reach an alarming 52.5%. According to the District Level Household and Facilities Survey in Manipur (DLHS-4, 2012-13), approximately 25% of adults in Manipur consume alcohol, with consumption rates highest among individuals over 30 years of age (31%) and among Schedule Tribes (30%). The geographical distribution of alcohol consumption across Manipur reveals significant regional variations, ranging from 16% in Bishnupur to 40% in Churachandpur (IIPS, 2014).

Churachandpur district, where the present study is conducted, has long maintained a vibrant tribal culture grounded in oral traditions, and customary law. Before the arrival of Christianity in 1910, an indispensable feature of traditional social life was the ritual consumption of *zu* (a fermented rice beer) which served both as a religious ceremonial and socio-legal function within these communities (*Neihsial*, 1993).

The historical trajectory of Churachandpur changed dramatically with the arrival of Welsh Presbyterian missionaries in 1910, who introduced not only Christian doctrine but also Western education, Roman-script literacy, and modern medical practices. The missionary endeavour was not merely religious, it was re-civilizational, aiming to reshape the moral and cultural landscape of the Zo ethnic tribal people. Among the practices targeted for reform was the communal consumption of *zu*, which missionaries perceived as an emblem of heathenism and a barrier to moral progress. In their view, *zu* encouraged idleness, disorder, and sin which values antithetical to Christian discipline.

As a result, the consumption of *zu* which was once used to solemnize marriages, offer hospitality, and settle disputes was progressively replaced by tea, a

non-alcoholic beverage promoted by the missionaries as both clean and Christian. This cultural substitution was not incidental. It signified a symbolic moral transformation wherein alcohol came to be seen not as a ritual necessity but also as a moral transgression. It can be surmised that the transition from zu to tea presupposed that alcoholic consumption was no longer a matter of cultural practices.

Despite Churachandpur's prominence as a religious-educational centre, the rise of alcohol abuse among its Zo tribal populations (e.g., Zomi, Kuki, Hmar) remains understudied. The MLPA's failure to curb consumption, coupled with the erosion of traditional 'Yu/Zu' practices, demands urgent inquiry into the drivers and impacts of this trend.

Besides, the above alcohol consumption across Manipur statistics underscore the pervasive nature of alcohol use within the region and establish the contextual backdrop against which many children develop. The contradiction between legislative prohibition and widespread consumption creates a unique social environment that may further complicate family dynamics and child development trajectories.

Adolescence represents a period of significant developmental transitions and challenges, globally recognized as a time of turbulence and growth. This developmental stage is characterized by biological transformations (puberty), educational transitions (progression to high school), and social changes (expanded peer networks, emerging partnerships, and developing sexuality). These normative transitions create a foundation of developmental stress that all adolescents must navigate.

The developmental tasks of adolescence include increasing independence and autonomy, which often manifest through decision-making processes that may lead to risk-taking behaviours. When these normative developmental challenges are compounded by dysfunctional family environments related to parental alcoholism, adolescents face additional obstacles in negotiating this already tumultuous phase of development. The domestic environment created by parental alcoholism may

significantly impact adolescents' psychological adjustment and personality development as they attempt to navigate this critical developmental period.

Existing research indicates substantial differences between children of alcoholics and children of non-alcoholics across various domains of functioning. These differences have been observed across all age groups, suggesting pervasive effects of parental alcoholism on child development and well-being. Studies have consistently documented higher rates of learning difficulties, attentional problems, behavioral issues, truancy, absenteeism, and grade retention among COAs compared to their non-COA counterparts (Berger, 1993).

Comparative analyses between these groups have revealed differences across multiple psychosocial domains, with the most pronounced and consistently observed differences in self-esteem and family relationships. These findings suggest that the impact of parental alcoholism may be particularly salient in these areas of functioning. However, as noted by the National Institute on Alcohol Abuse and Alcoholism (1990), methodological limitations and insufficient comprehensive studies preclude the generalization of these findings to all children of alcoholic parents.

Among these consequences, the erosion of self-esteem occupies a foundational position. Self-esteem, defined as an individual's subjective evaluation of his or her own worth (Rosenberg, 1965), functions during adolescence not merely as a psychological trait but as a mediating mechanism between environmental stress and psychological adjustment. A healthy sense of self-worth enables adolescents to navigate social comparison, manage academic challenges, and develop a coherent identity; its absence renders them disproportionately vulnerable to rejection, failure, and psychological disorder. Adolescent COAs characteristically display lower self-esteem than their non-COA counterparts, a deficit rooted in multiple converging experiences: direct negative messaging from a critical or emotionally absent alcoholic father, internalized shame arising from the social stigma of parental alcoholism, disrupted attachment that undermines the child's foundational sense of being valued and loveable, and the social isolation that follows from concealing family dysfunction (Berkowitz & Perkins, 1988; Selwyn & Vanitha, 2008; Madhavi, 2016). Kanus (2014) documented a strong negative correlation between direct

paternal alcohol abuse effects and self-esteem scores ($r = -0.69$, $p < 0.05$), confirming the magnitude of this relationship. In the tribal Christian community of Churachandpur, the cultural imperative to maintain family honour and the collectivist emphasis on communal identity may simultaneously offer partial protection against self-esteem deficits — through clan-based support and religious belonging — while deepening the shame experienced by adolescents whose family reality diverges sharply from community norms. Understanding how self-esteem is shaped by this interplay of family dysfunction and cultural context is therefore a primary concern of the present study.

Closely intertwined with the erosion of self-esteem is the elevation of anxiety among adolescent COAs. Anxiety, a state of persistent apprehension, tension, and physiological arousal in the face of perceived or anticipated threat, is a predictable psychological response to the unpredictable, emotionally volatile home environment created by a parent with Alcohol Use Disorder. Children in such households develop hypervigilance as an adaptive survival strategy, attuning themselves with extraordinary sensitivity to parental mood, intoxication cues, and environmental signals of impending conflict. This chronic activation of the stress response system produces lasting neurobiological changes, disrupting hypothalamic-pituitary-adrenal (HPA) axis functioning and elevating baseline anxiety well beyond what acute stressors would ordinarily generate (Tarullo & Gunnar, 2006; Bellis et al., 2019). Eiden et al. (2009) demonstrated in a controlled community sample that children with alcoholic fathers exhibited significantly higher anxiety scores than those from non-alcoholic homes even after controlling for relevant covariates. In India, Mishra et al. (2018) documented an anxiety disorder prevalence of 15% among COAs, substantially exceeding rates observed in general adolescent populations. Within Churachandpur district, the anxiety burden of adolescent COAs is further amplified by the stigma attached to alcoholism in a deeply religious community, the scarcity of accessible mental health services, and the pressure to conceal family dysfunction in order to protect family and community reputation — all of which compound the isolation in which many COAs manage their distress. Maynard (1997) found that COAs exhibited not only higher anxiety but also significantly lower differentiation of self than non-COAs, creating patterns of chronic people-pleasing and approval-

seeking that persisted well beyond their family of origin. These findings establish anxiety as a primary and clinically significant psychological outcome requiring systematic investigation in the present study.

The third critical psychological domain implicated in the experience of adolescent COAs is depression. Depression, characterized by persistent low mood, anhedonia, impaired concentration, feelings of worthlessness, and functional deterioration across social and academic domains, represents a serious and potentially chronic consequence of growing up in an alcohol-affected household (APA, 2013). Multiple mechanisms underlie this association: exposure to depressed or emotionally dysregulated alcoholic parents provides maladaptive cognitive and affective models; shared neurobiological vulnerabilities between alcohol dependence and major depressive disorder heighten genetic risk; the experience of learned helplessness, rooted in the child's repeated inability to predict or control family circumstances, fosters the hopelessness that is the cognitive hallmark of depression; disrupted attachment deprives children of the relational buffering that normally protects against mood disorders; and the chronic internalization of guilt and responsibility for the parent's drinking generates the negative self-schema central to depressive cognition (Black, 1981; Bowen, 1978; Thapa, Selya, & Jonk, 2017). Mishra et al. (2018) found a depression prevalence of 14.5% among Indian COAs, while Vinnakota and Kaur (2018) reported clinical depression in 12.7% of COAs alongside subclinical depressive features in a further 19.3%. In the context of Churachandpur district, the intersection of intergenerational trauma associated with the historical experiences of Zo tribal communities, the erosion of traditional cultural structures, and the dissonance between a community's deeply Christian moral framework and the reality of alcohol-affected family life creates a distinctive depressogenic environment. At the same time, the community's collectivist values, ecclesiastical support networks, and spiritual coping resources may serve as culturally specific protective factors that moderate the severity of depressive outcomes — a moderating role that remains empirically unexamined. Taken together, the evidence establishes self-esteem, anxiety, and depression as the three primary psychological constructs through which the impact of paternal alcoholism on adolescent development must be understood and measured.

The present investigation also attends specifically to gender as a critical moderating variable in the relationship between paternal alcoholism and these psychological outcomes. Data from the Manipur NFHS-5 (2019–21) confirms that 80% of alcohol consumers in the state are male, making paternal alcoholism the dominant form of household alcohol-related dysfunction and giving particular salience to an examination of its differential effects on sons and daughters. Female COAs have consistently been found to experience lower self-esteem, higher anxiety, and greater depressive symptomatology than their male counterparts, a pattern attributable to gendered socialization processes that encourage girls to internalize distress, assume caretaking roles within dysfunctional family systems, and hold themselves responsible for family harmony (Berkowitz & Perkins, 1988; Elaine & Robert, 1999; Omkarappa & Rentala, 2019). In tribal Christian communities such as those of Churachandpur, patriarchal social structures that constrain female agency and restrict acceptable forms of emotional expression may further amplify the psychological vulnerability of female adolescent COAs. However, gender differences in how COAs experience and express psychological distress are insufficiently examined in Indian tribal contexts, representing a significant gap that the present study directly addresses.

This research aims to address these limitations by implementing a methodologically rigorous comparative study that accounts for cultural context and sociodemographic variables. By matching COAs and non-COAs on key sociodemographic characteristics, this study seeks to isolate the specific effects of parental alcoholism on adolescent psychological functioning.

Despite the scale and urgency of the problem, no empirical study has specifically examined the psychological impact of paternal alcoholism on adolescent COAs within the tribal Christian communities of Manipur. The limited research available from north-east India, most notably Lalnunpuii's (2015) study from Mizoram, confirms the relevance of this regional context but does not capture the specific sociocultural dynamics of Churachandpur district, where the interplay of Zo ethnic tribal identity, Christian ecclesiastical life, traditional kinship institutions such as the 'Indongta', and the paradox of widespread alcohol use within a legally dry and religiously conservative community creates a unique configuration of risk and

protective factors. The existing literature, largely drawn from Western or urban pan-Indian samples, cannot be uncritically applied to this context. There is thus a compelling and urgent need for empirical investigation that is grounded in, and sensitive to, this specific sociocultural reality.

The researcher's own professional experience as a lecturer working with Class XI and XII students in Churachandpur has provided direct observation of the psychological difficulties faced by adolescents from alcohol-affected households, reinforcing the practical as well as academic significance of this inquiry.

This study operates on the premise that any effects of living with alcoholic versus non-alcoholic parent(s) would have already manifested in both groups of respondents. By examining adolescents who have experienced extended exposure to either alcoholic or non-alcoholic parental environments, this research aims to capture the cumulative effects of these different family contexts on psychological development.

The primary objective of this research is to determine and compare the impact of paternal alcoholism on the psychosocial functioning of adolescent children, with particular focus on family environment, self-esteem, anxiety, and depression. By matching participants on key socio-demographic variables, this study aims to isolate the specific effects of parental alcoholism on these psychological outcomes.

This research incorporates psychometric considerations informed by cross-cultural psychology (Witkin & Berry, 1975) to ensure contextual validity and cultural appropriateness of the measurement instruments. This approach acknowledges the importance of cultural factors in shaping psychological experiences and responses, particularly in diverse contexts like Manipur.

The findings from this study will contribute to both theoretical understanding and practical applications. Theoretically, this research will provide empirical evidence regarding the impact of parental alcoholism on adolescent psychological functioning within a specific cultural context. Methodologically, it will demonstrate the importance of culturally sensitive approaches to psychological assessment and research.

Practically, the results will inform the development of targeted intervention strategies for adolescent children of alcoholics and their families. By identifying specific areas of psychological vulnerability, this research will guide the creation of intervention programs that address the most salient issues faced by this population. The findings will also establish a foundation for future research exploring additional dimensions of psychological functioning among children of alcoholics.

The present study addresses a critical gap in our understanding of the impact of parental alcoholism on adolescent psychological functioning within the specific cultural context of Manipur. By examining the relationships between family environment, self-esteem, anxiety, and depression among children of alcoholics compared to children of non-alcoholics, this research will provide valuable insights into the psychological consequences of growing up in alcoholic households.

This study specifically focuses on paternal alcoholism, which is notably prevalent and culturally significant in Manipur. Data from the Manipur NFHS5, 2019-21 indicates that 80% of alcohol consumers are male, with only 20% being female, highlighting the male-dominated patterns of drinking. Furthermore, geographical statistics show considerable variations in alcohol consumption across different regions of the state, with rates ranging from 16% in Bishnupur to 40% in Churachandpur, where male alcohol users account for 47%, far exceeding the 7% for females (IIPS, 2014). Although alcohol use among women tends to rise with age, peaking around 30 years, the overall trend remains predominantly male, reflecting deep-seated gender norms that link drinking with masculinity and stigmatize female drinking. Given that fathers are statistically more likely to be the primary alcohol consumers in families and that paternal alcoholism is associated with instability, economic difficulties, and disrupted child-rearing, this research places a strong emphasis on understanding its unique effects on the mental health of adolescents.

The findings will contribute to both theoretical understanding and practical applications, informing the development of intervention strategies tailored to the needs of this vulnerable population. Given the pervasive nature of alcohol consumption in the region despite legislative prohibitions, this research addresses an urgent social issue with significant implications for adolescent development and well-being.

Through a methodologically rigorous comparative approach that accounts for cultural context and sociodemographic variables, this study aims to isolate the specific effects of parental alcoholism on adolescent psychological functioning. The results will provide empirical foundations for behavioural intervention programs and establish a framework for future research in this critical area of inquiry.

Operational Definitions:

- **Children of Alcoholics (COAs):** "Individuals under 18 years raised by at least one parent meeting diagnostic criteria for Alcohol Use Disorder (AUD), often experiencing familial dysfunction and psychosocial risks" (*WHO, 2018; National Association for Children of Alcoholics, 2020*). For the present studies Adolescents is defined as children between 15-18 years scoring ≥ 3 on the CAST-6 screening tool, indicating paternal alcohol use disorder (AUD) based on child-reported behavioral indicators (e.g., neglect, excessive drinking)
- **Children of Non-Alcoholics:** Non-COAs (Control Group are taken as Age-matched adolescents scoring < 3 on CAST-6, confirming no paternal AUD.
- **Paternal Alcoholism:** "A chronic pattern of alcohol misuse by fathers, leading to impaired parenting capacity and family disruption" (*Sher, 1991; WHO Global Status Report on Alcohol, 2018*).
- **Self-Esteem:** "An individual's overall subjective evaluation of their own worth, encompassing both positive and negative self-appraisals" (*Rosenberg, 1965; Orth & Robins, 2022*)
- **Anxiety:** "A psychological state characterized by excessive apprehension, somatic symptoms (e.g., tachycardia), and avoidance behaviors" (*American Psychiatric Association, DSM-5-TR, 2022; Beck & Steer, 1993*)
- **Depression:** "A mood disorder marked by persistent sadness, loss of interest, and cognitive-behavioral impairments lasting ≥ 2 weeks" (*American Psychological Association, 2020; Weissman et al., 1980*)
- **Family Environment:** "The interpersonal dynamics, emotional climate, and organizational patterns within a family system that influence psychosocial development" (*Moos & Moos, 1994; Bowen, 1978*).

Objectives of the study:

Given the theoretical and methodological foundation pertaining to the research problem, the present study is put forward with the following objectives:

1. To elucidate the impact of ‘paternal alcoholism’ on Self-esteem, Anxiety and Depression on Children of Alcoholics (COAs)
2. To explore ‘gender differences’ on Self-esteem, Anxiety and Depression of the two groups (COAs and non-COAs)
3. To determine the interaction effect of ‘paternal alcoholism x gender’ on Self-esteem, Anxiety and Depression
4. To elucidate the family environment pattern of children of alcoholics and non-alcoholics
5. To determine the role of Family environment and socio-demographic characteristic on Self-esteem, Anxiety and Depression.

Hypotheses of the study:

To meet the objectives of the study, the following hypotheses will be attempted in the study:

1. Children of alcoholics (COAs) will exhibit significantly lower levels of self-esteem compared to children of non-alcoholics (non-COAs).
2. Children of alcoholics (COAs) will report significantly higher levels of anxiety and depression compared to children of non-alcoholics (non-COAs).
3. There will be significant gender differences in self-esteem, anxiety, and depression.
4. There will be a significant interaction effect between paternal alcoholism and gender on self-esteem, anxiety, and depression.
5. The family environment of children of alcoholics (COAs) will differ significantly from that of children of non-alcoholics (non-COAs).
6. Family environment will have a significant positive relationship with self-esteem in both children of alcoholics (COAs) and non-alcoholics (non-COAs).
7. Family environment will have a significant negative relationship with anxiety and depression in both children of alcoholics (COAs) and non-alcoholics (non-COAs).

8. Socio-demographic characteristics (e.g., family income, family structure, tribe/caste) will significantly influence the overall psychosocial functioning of children of alcoholics (COAs) and non-alcoholics (non-COAs).

CHAPTER- III
METHODS AND PROCEDURE

This chapter outlines the research design, sampling procedure, data collection tools, and statistical analyses employed in the study. The study aimed to investigate the impact of family environment and socio-demographic characteristics on self-esteem, anxiety, and depression among children of alcoholics (COAs) and non-alcoholics (non-COAs). This chapter provides a detailed description of the methods used to achieve the study's objectives and test its hypotheses.

Sample:

To achieve the objectives, the present study employed a multistage stratified sampling technique to ensure comprehensive geographic, demographic and institutional representation of higher secondary students (Class XI and XII) across the Churachandpur district of Manipur, India. This approach was selected to minimize selection bias and enhance the generalizability of findings across diverse educational and socioeconomic contexts.

Stage I- School level stratification and selection

All higher secondary schools within the district were systematically through official education department records. Schools were identified and stratified based on geographic regions to ensure that each region was proportionately represented in the sample. From each geographic stratum, schools were selected using purposive sampling criteria to include both government and private institutions, to capture variability in resources and student backgrounds,; Schools with comparable enrolment sizes, to avoid overrepresentation of larger institutions, where feasible. Schools with co-educational policies were prioritized to ensure gender balance.

Stage 2- Student Recruitment and Screening

In the second stage, students from Class XI and XII were selected from the chosen higher secondary schools, age ranging from 15years to 18 years, from Churachandpur District of Manipur, India. The current study sample comprised of 309 adolescents (M=163; F=146). Prior to data collection, a screening test was administered to identify students who qualified as Children of Alcoholics (COAs) – students with paternal alcohol misuse (score ≥ 3) and those who did not (non-COAs) - students without parental alcohol misuse (score of ≤ 3), based on standardized screening tools Children of Alcoholics Screening Test (CAST-6)- a validated 6-item

instrument. CAST-6 was administered as a screening instrument during the sampling phase to identify and classify adolescents into COAs and non-COAs group. Only participants screened using CAST-6 (cut-off ≥ 3) were included in the respective groups, ensuring that group membership was empirically established prior to psychological assessment. Final groups constituted of COAs (n= 162) and non-COAs group (n= 147) with a total of N= 309. The sample was further stratified by gender to examine psychological differences (self-esteem, anxiety and depression).

Socio-demographic data -

To maintain sample homogeneity and control for confounding variables, participants provided sociodemographic information, including: their age, gender, tribe/caste, education, family structure, socioeconomic status, substance use (to assess secondary risk factors), etc to maintain the homogeneity of the sample.

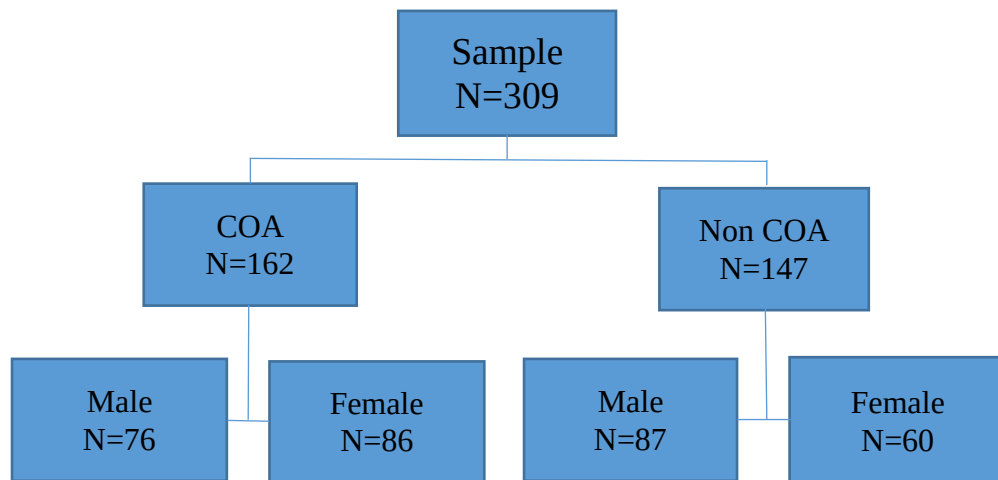
This multistage stratified sampling approach allowed for broad representation across diverse educational and regional contexts, while the screening ensured accurate subgroup identification for the purpose of comparative analysis

Design of the study:

The study incorporated a 2x2 factorial design, which enabled the examination of two key independent variables—paternal alcoholism status (COAs vs. non-COAs) and gender (Male vs. Female). This design allowed for analysis of both main effects, the independent impact of each variable, and their potential interaction effects on the dependent variables (self-esteem, anxiety, and depression). The two levels of paternal alcoholism were:

Figure1: :

Research design of the study



Psychological Tools:

1. The Family Environment Scale (FES-BC) (Bhatia & Chadha, 1993):

The Family Environment Scale (FES-BC) created by Dr. Harpreet Bhatia and Dr. N.K Chadia in 1993, is a revised version of the original family environment scale established by Moos and Moos in 1974. The FES is designed to assess the social and environmental aspects of family life (Bhatia & Chadha, 1993). This scale is comprised of three main dimensions derived from Moo's framework and contains a total of 69 items, which are further classified into eight subscale categories. The Relationship dimension encompasses various aspects, including Cohesion, measured by positive items 1, 9, 24, 37, 43, 55, 60, 63, 66 and 69, and negative items 17, 31, and 49. Expressiveness includes positive items 10, 25, 38, 44, and 56, along with negative items 2, 18, 32, and 50. The Conflict dimension features positive items 11, 19, 39, 51, 61, 67, and negative items 3, 26, 33, 45, 57, and 64. Lastly, the Acceptance and Caring dimension comprises positive items 8, 16, 36, 42, 48, 54, 59, and 62, and negative items 23, 30, 65, and 68. Cohesion reflects the extent of commitment and support among family members, expressiveness pertains to the

encouragement of open emotional expression, conflict measures the level of overt anger and discord, while Acceptance and Caring indicates the degree of unconditional acceptance and the expression of care within the family. The next two subscales assess Personal Growth and Independence, with positive items 4, 27, 46, and 52, and negative items 12, 20, 34, 40, and 58, along with Active Recreational Orientation, which includes positive items 5, 13, 21, 28, and 47, and negative items 35, 41, and 53. The Independence subscale examines how assertive and self-sufficient family members are in making their own choices, whereas Active Recreational Orientation addresses the level of engagement in social and recreational pursuits. The final two subscales, Organization and Control, pertain to System Maintenance. The Organization subscale includes positive item 14 and negative item 6, while the Control subscale consists of positive items 7, 22, and negative items 15 and 29. The Organization aspect focuses on the significance of a well-defined structure for planning family activities and roles, while Control evaluates the limitations established within the family dynamics. To ensure the reliability of each subscale, the Split-Half method was utilized, and the reliability coefficients, calculated using the Spearman-Brown formula, reveal the following values: Cohesion .92, Expressiveness .88, Conflict .84, Acceptance and Caring .86, Independence .70, Active Recreational Orientation .48, Organization .75, and Control .48. Additionally, the scale has undergone Content and Face Validation.

2. Rosenberg Self Esteem Scale (Rosenberg, 1965):

The Rosenberg Self-Esteem Scale (RSES) consists of ten items that utilize a Likert-type format, with responses ranging from Strongly Agree to Strongly Disagree on a four-point scale. The total score is calculated by summing the responses from all 10 items, with higher totals indicating increased self-esteem. Specifically, a score of 20 reflects low self-esteem, a score between 20 and 30 represents moderate self-esteem, and a score above 30 indicates high self-esteem. This scale assesses overall self-worth by evaluating both positive and negative self-perceptions (Rosenberg, 1965). It includes five statements that are phrased positively and five that are phrased negatively. The RSES examines state self-esteem by

prompting respondents to consider their current emotional state. Regarding reliability, the scale has demonstrated strong performance, with an internal consistency rating of 0.77, and a minimum Coefficient of Reproducibility of at least 0.90 (Rosenberg, 1965). Additionally, an Indian study found a test-retest reliability of 0.80 (Joshi & Srivastava, 2009).

3. **Beck's Anxiety Inventory (Beck, Epstein, Brown, & Steer, 1988) :**

The Beck Anxiety Inventory (BAI) is a self-assessment tool designed to evaluate anxiety levels in both adults and adolescents. It looks at the intensity of anxiety by assessing physical and cognitive symptoms while minimizing overlap with other self-report measures for depression. The inventory includes 21 items, each describing a specific anxiety symptom, which respondents rate on a scale from 0 to 3 (Beck, Epstein, Brown, & Steer, 1988). A total score ranging from 0 to 7 is interpreted as indicating minimal anxiety, scores between 8 and 15 suggest mild anxiety, scores from 16 to 25 represent moderate anxiety, and scores from 26 to 63 are indicative of severe anxiety. The BAI demonstrates strong reliability, with an internal consistency measure (Cronbach's alpha) of .92 and a test-retest reliability score of .75.

4. **CES-DC for children (Weissman , Orvaschel , & Padian, 1980):**

This is a revised version of the Center for Epidemiologic Studies Depression Scale created by Laurie Radloff in 1977. The scale consists of 20 items that individuals complete to assess their level of depression, yielding scores that can range from 0 to 60 (Weissman , Orvaschel , & Padian, 1980). Each item is rated as follows: 0 for Not at all, 1 for A little, 2 for Some, and 3 for A lot. However, for items 4, 8, 12, and 16, which are framed positively, the scoring is reversed: 3 for Not at all, 2 for A little, 1 for Some, and 0 for A lot. A higher score on the CES-D indicates greater levels of depression, with a cutoff score of 15 suggesting the presence of depressive symptoms in children and adolescents. Previous research has demonstrated strong internal consistency (0.84) and test-retest reliability ($r = 0.51$) (Betancourt et al., 2012).

5. **Socio-demographic profiles (Chingnunhoih, 2020):**

In order to ensure the homogeneity of the sample characteristics and to manage potential confounding factors, a custom-designed questionnaire was

employed to gather the socio-demographic data. This data included variables such as age, gender, and tribal affiliation to reflect cultural diversity. Additionally, information about family structure, whether nuclear or joint, as well as socio-economic status, parental education, occupation, income, and personal or familial history of substance use was collected to evaluate secondary risk factors.

6. Screening Tool (Jones & Pilat, 1981):

Children of Alcoholic Screening Test (CAST-6) is a concise screening instrument intended to identify individuals who have been raised in environments where one or both parents struggled with alcohol use disorder (AUD). It evaluates the frequency and intensity of parental drinking habits and their effects on the child. This tool features a subset of questions from the COAs screening test, created by Jones and Pilat, specifically designed for screening individuals affected by COAs. Comprised of six items, the CAST6 uses a Likert scale for scoring, ranging from 0 (Never) to 4 (Very Often). If three or more affirmative responses are given, it suggests the presence of COAs (Pilat & Jones, 1985). The internal consistency of this abbreviated version, containing the selected six items, is measured at 0.86.

7. Informed Consent Forms (Chingnunhoih, 2020)

Three informed consent forms were developed and used in this study to ensure ethical compliance and voluntary participation. These forms were designed specifically for this research, tailored to the different stakeholders involved in the data collection process.

- i) **School Consent Form** was addressed to the school principal, seeking institutional permission to conduct the study within the school premises. It outlined the purpose of the study, the school's role in facilitating data collection, and the assurance that no identifying information about the school or its students would be published. The school retained the right to withdraw participation at any time without consequences.
- ii) **Parent/Guardian Consent Form** was provided to parents or guardians of the participating children. It described the nature of participation, including that their child would complete a questionnaire lasting approximately 20–30 minutes covering emotions, family life, and self-perception. Confidentiality and anonymity of responses were assured, and parents were informed of their right to withdraw consent at any time without penalty.

- iii) **3. Student/Child Assent Form** was written in age-appropriate language for the student participants themselves. It explained the study in simple terms, emphasized the voluntary nature of participation, and assured students that their responses would remain confidential. Students were given a clear choice to indicate whether they wished to participate.

All three forms carried the title of the research, the name of the principal investigator, and the supervisor's details, ensuring transparency and accountability throughout the research process.

Procedure for data collection:

Ethical Considerations

The study followed the ethical standards set forth by the American Psychological Association (APA) (2010 & 2017). Approval for the data collection process was secured from the Principal/Head of the relevant selected institutions. The data was collected in group settings within a classroom context, taking into account that this took place during the Covid-19 pandemic in 2020, thus adhering to appropriate safety protocols. Before gathering data, participants were provided with a comprehensive summary and guidelines regarding the study, and informed consent was obtained. For those participants who were under 18, parental or guardian consent was also required in writing. Participants were guaranteed that their responses would remain confidential and anonymous, and they were made aware that they could withdraw from the study at any time without facing any repercussions.

Pilot Testing

Prior to the main phase of data collection, a pilot study was carried out with 60 students to evaluate the clarity and feasibility of the questionnaires and psychological instruments. This preliminary study aimed to identify any issues related to the administration process, including unclear instructions or time limitations, and to assess the reliability and validity of the tools within the cultural and demographic context of the study.

The pilot study revealed that participants mostly understood the instruments, though a few slight adjustments were necessary in the phrasing of specific questions to improve clarity. The research takes into account psychometric factors guided by

cross-cultural psychology (Witkin & Berry, 1975) to guarantee that the measurement tools are contextually valid and culturally suitable. This method recognizes the significance of cultural influences on psychological experiences and reactions, especially in varied settings such as Manipur. Although the results from the pilot study were omitted from the final analysis, they played a crucial role in enhancing the data collection approach.

Statistical Analyses:

To test the hypotheses set forth for the study of Family environment, Self-esteem, Anxiety and Depression among Children of Alcoholics (COAs) and Children of non-Alcoholics (non-COAs), the data were analyzed using SPSS (Statistical Package for the Social Sciences, version 20). The following statistical techniques were employed:

1. Descriptive Statistics

- Frequencies, percentages, means, and standard deviations were calculated to summarize socio-demographic characteristics and psychological outcomes.

2. Inferential Statistics

- Independent t-test: To compare depression levels between COAs and non-COAs; and to compare Family environment among COAs and non-COAs
- Univariate ANOVA: To examine gender differences in psychological outcomes.
- Two-Way ANOVA: To assess the interaction effect of paternal alcoholism and gender on self-esteem, anxiety, and depression.
- Pearson's Correlation: To explore relationships between family environment, socio-demographic factors, and psychological outcomes.
- Multiple regression analyses were conducted to examine the influence of family environment subscales and socio-demographic variables (family structure and birth order) on self-esteem, anxiety, and depression among adolescents

CHAPTER-IV
RESULTS AND DISCUSSION

The present study aims to comprehensively examine and explore the intricate relationships between family environment, self-esteem, anxiety, and depression among children of alcoholics (COAs) in comparison with children of non-alcoholics (non-COAs). Family environment was assessed using the Family Environment Scale (FES; Bhatia & Chadha, 1993). Self-esteem was measured using Rosenberg's Self-esteem scale (Rosenberg, 1965). Anxiety and Depression was measured using Beck's Anxiety Inventory (BAI) (Beck, Epstein, Brown, & Steer, 1988) and modified version of the Centre for Epidemiologic Studies Depression Scale (CES-DC) by Laurie Radloff (Weissman, Orvaschel, & Padian, 1980), respectively. The data was screened for extreme outliers and verified for parametric test assumptions such as normality (skewness and kurtosis), linearity, and homogeneity of variance (Levene's statistic)/homoscedasticity.

Descriptive Statistics of the Scales & Sub-scales

The descriptive statistics include the mean, standard deviation, skewness, kurtosis and standard errors. The descriptive statistics of all scales and subscales associated with gender (male and female) are given in Table 1.1, the descriptive statistics of all scales and subscales associated with paternal alcoholism (COAs and non-COAs) are given in Table 1.2. In accordance with methodological standards for parametric analysis (Curran et al., 1996; West et al., 1995), normality thresholds were established at absolute skewness values exceeding 1.0 and kurtosis values surpassing 2.0. All the implemented scales – Rosenberg's Self-esteem (RSES), Beck's Anxiety Inventory (BAI), Centre for Epidemiologic Studies Depression Scale (CES-DC) and Family Environment Scale (FES) and their constituent sub-scales used to assess the variables exhibited distribution parameters that satisfied these normality criteria. This confirmation of normal distribution further supports the appropriateness of parametric analyses planned for hypothesis testing.

Table 1.1

Descriptive Statistics (Mean, SD, Skewness & Kurtosis) of Each Scale/Sub-scales for Male and Female Adolescents

Variable	Male				Female			
	<i>M</i>	<i>SD</i>	Skewness	Kurtosis	<i>M</i>	<i>SD</i>	Skewness	Kurtosis
RES	24.39	3.69	-0.23	0.49	22.56	3.65	-0.20	-0.06
CES-DC	22.79	9.75	0.45	-0.34	26.83	10.16	0.26	-0.44
BAI	21.04	10.78	0.25	-0.58	27.38	10.88	0.26	-0.93
FES Cohesion	47.46	6.77	-0.54	0.89	45.42	8.14	-0.42	0.00
FES Expressiveness	28.84	4.67	-0.17	0.22	27.58	5.22	-0.45	0.23
FES Conflict	39.16	4.48	-0.35	1.26	37.99	6.05	-0.34	0.04
FES Acceptance	38.32	4.69	-0.48	0.57	36.23	5.52	-0.33	-0.06
FES Independence	27.12	3.26	-0.48	0.23	27.38	3.57	-0.14	0.14
FES Active Recreation	26.50	3.30	-0.37	0.34	25.77	3.51	-0.30	-0.14
FES Organization	7.50	2.18	-0.53	-0.04	6.99	1.69	-0.59	-0.05
FES Control	13.80	2.18	-0.32	0.13	14.68	2.30	-0.25	0.71

Note. RES = Rosenberg Self-esteem; CES-DC = Center for Epidemiologic Studies Depression Scale for Children; BAI = Beck Anxiety Inventory; FES = Family Environment Scale.

Table 1.2

Descriptive Statistics (Mean, SD, Skewness & Kurtosis) of Each Scale/Sub-scale for COAs and Non-COAs

Variable	COAs				Non-COAs			
	<i>M</i>	<i>SD</i>	Skewness	Kurtosis	<i>M</i>	<i>SD</i>	Skewness	Kurtosis
RES	23.16	4.07	-0.26	-0.09	23.93	3.39	0.10	0.23
CES-DC	25.83	10.59	0.30	-0.57	23.45	9.49	0.37	-0.29
BAI	26.19	11.93	-0.02	-0.82	21.66	10.00	0.44	-0.14
FES Cohesion	45.01	7.89	-0.25	0.16	48.14	6.71	-0.84	1.38
FES Expressiveness	27.35	5.39	-0.17	-0.18	29.22	4.27	-0.41	1.40
FES Conflict	37.28	5.15	-0.40	0.56	40.07	5.10	-0.59	1.30
FES Acceptance	36.24	5.51	-0.14	-0.01	38.53	4.55	-0.83	1.26
FES Independence	26.66	3.45	-0.25	0.49	27.88	3.26	-0.30	-0.12
FES Active Recreation	26.04	3.47	-0.14	-0.32	26.29	3.36	-0.60	0.68
FES Organization	7.08	1.74	-0.51	-0.36	7.46	1.42	-0.62	0.65
FES Control	13.86	2.41	-0.26	0.39	14.61	2.06	-0.01	-0.01

Note. RES = Rosenberg Self-esteem; CES-DC = Center for Epidemiologic Studies Depression Scale for Children; BAI = Beck Anxiety Inventory; FES = Family Environment Scale.

Reliability Analysis

The reliability of the scales and sub-scales used was checked using Cronbach's Alpha, a measure of internal consistency where values above **0.70** are generally considered acceptable, while values below **0.60** indicate poor reliability (Nunnally, 1978). Reliability analysis of all the subscales was done without splitting the data in any way. The psychometric properties of the item, scale, and scale were assessed to evaluate the suitability of the behavioural measures in the target population. The reliability analysis of the scales and subscales used in the study are shown in Table 2.

Table2:

Reliability analysis of all the scales and subscales

Scale/Subscale	No. of Items	Cronbach's α
BAI (Beck Anxiety Inventory)	21	.87
RES (Rosenberg Self-esteem Scale)	10	.70
CES-DC (Depression Scale for Children)	20	.82
FES (Family Environment Scale)	69	.90
Cohesion	13	.45
Expressiveness	9	.51
Conflict	12	.81
Acceptance and Caring	12	.67
Independence	9	.80
Active Recreational	8	.80
System Maintenance (Organization & Control)	6	.86

From the above Table 2, we can see that The Beck Anxiety Inventory (BAI), consisting of 21 items, demonstrated high reliability with a Cronbach's Alpha of 0.87, confirming its suitability for measuring anxiety levels in children. The Rosenberg Self-Esteem Scale (RES), with 10 items, showed acceptable reliability at 0.70. The Center for Epidemiological Studies Depression Scale for Children (CES-DC), comprising 20 items, exhibited good reliability with an Alpha of 0.82, making it a reliable tool for assessing depressive symptoms.

The Family Environment Scale (FES) was analysed both as a whole and across its subscales. The overall FES, with 69 items, displayed excellent reliability ($\alpha = 0.90$). However, some subscales showed varying levels of consistency. The Cohesion ($\alpha = 0.45$) and Expressiveness ($\alpha = 0.51$) subscales had poor reliability, indicating potential issues with these measures. In contrast, the Conflict ($\alpha = 0.81$), Independence ($\alpha = 0.80$), Active Recreational Orientation ($\alpha = 0.81$), and System Maintenance ($\alpha = 0.86$) subscales demonstrated strong reliability, making them suitable for assessing family dynamics. The Acceptance and Caring subscale showed moderate reliability ($\alpha = 0.67$), which is borderline acceptable.

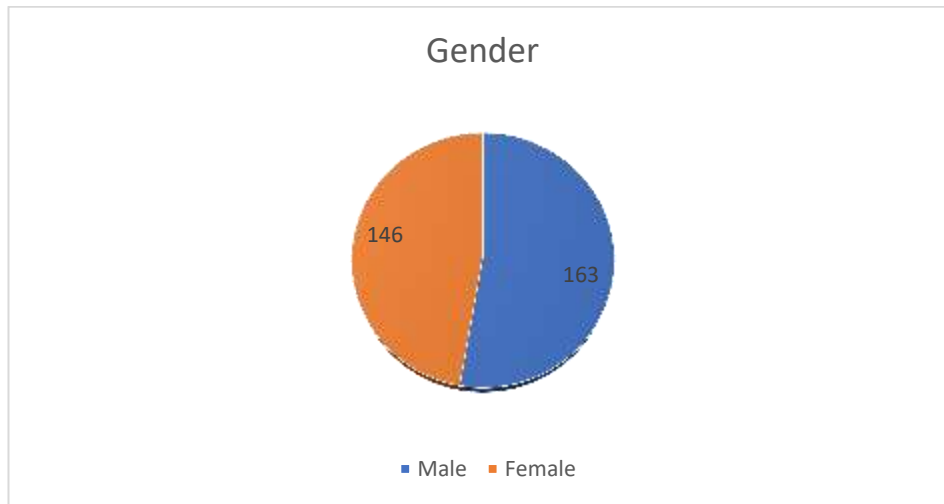
Based on these findings, the study incorporated only those FES subscales meeting the predetermined reliability criterion ($\alpha \geq 0.70$), while excluding the Cohesion, Expressiveness, and Acceptance and Caring subscales from subsequent analyses due to their insufficient internal consistency. This selective approach ensures the methodological rigor and interpretability of findings related to family environment dimensions.

Demographic Information

The sample characteristic of the study as follows:

Figure 2:

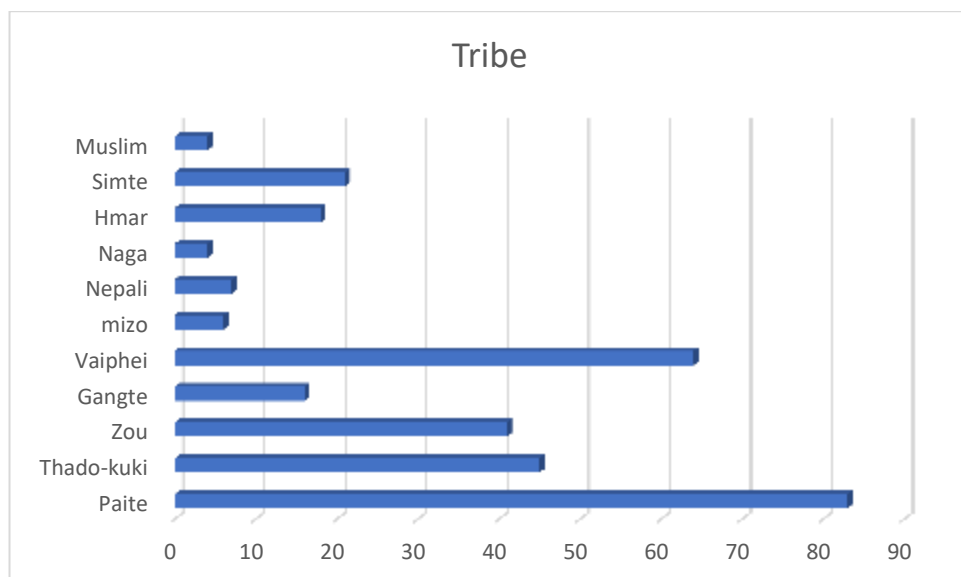
Gender distribution of the sample



The sample is nearly balanced, with **52.8% males and 47.2% females**. This near-equal distribution ensures that gender-based comparisons are feasible.

Figure 3:

Tribe distribution of the sample

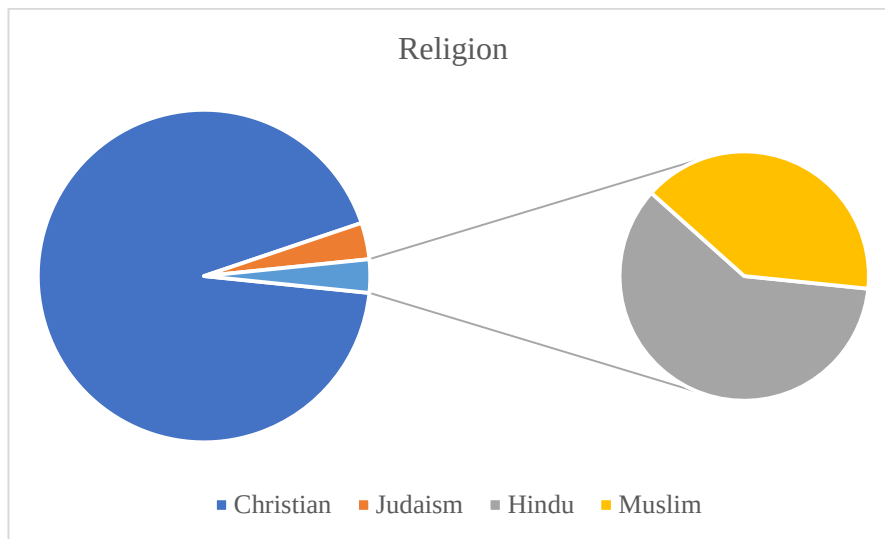


The participants belong to diverse tribal backgrounds, with the **Paite (26.9%)**, **Vaiphei (20.7%)**, and **Thado-Kuki (14.6%)** being the most represented. Other tribes, including **Zou (13.3%)**, **Simte (6.8%)**, and **Hmar (5.8%)**, also form

significant portions of the sample. The least represented groups are **Naga (1.3%)** and **Muslim (1.3%)**, suggesting that certain ethnic groups are underrepresented in this study.

Figure 4:

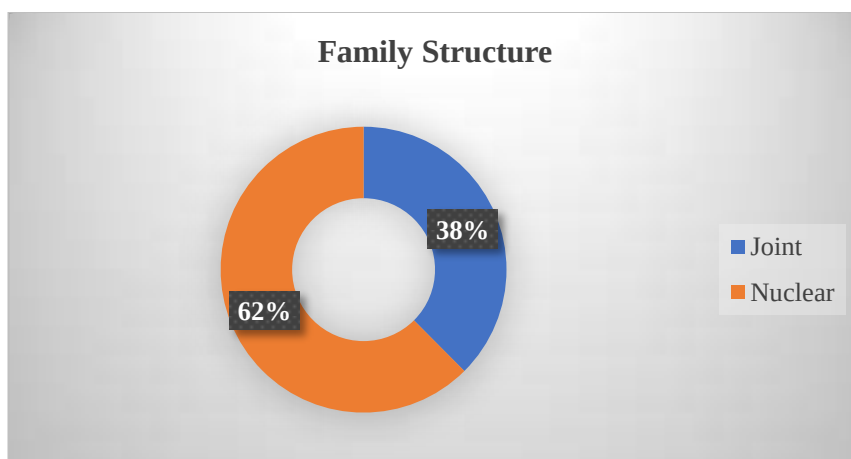
Religion distribution of the sample



In terms of religious affiliation, Christianity dominates the sample, comprising **93.2% of the participants**, followed by **Judaism (3.6%)**, **Hinduism (1.9%)**, and **Islam (1.3%)**. This indicates that the study is conducted in a predominantly Christian demographic.

Figure 5:

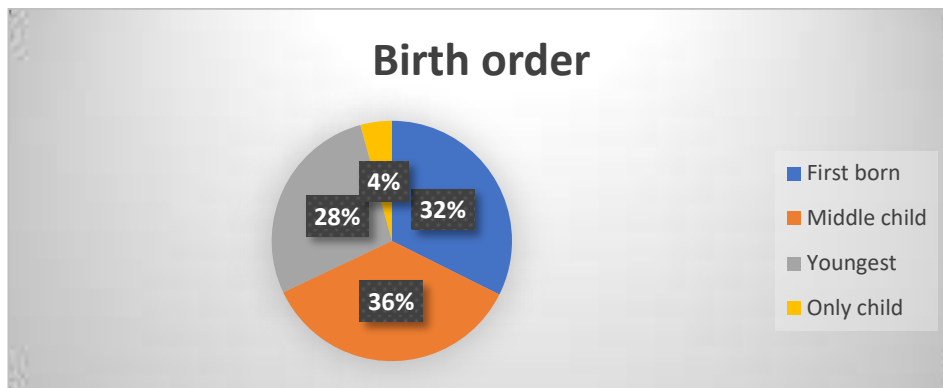
Family structure of the sample



Family structure analysis shows that **nuclear families (62.5%)** are more common than **joint families (37.5%)**, which is in line with modern trends favouring smaller household units.

Figure 6:

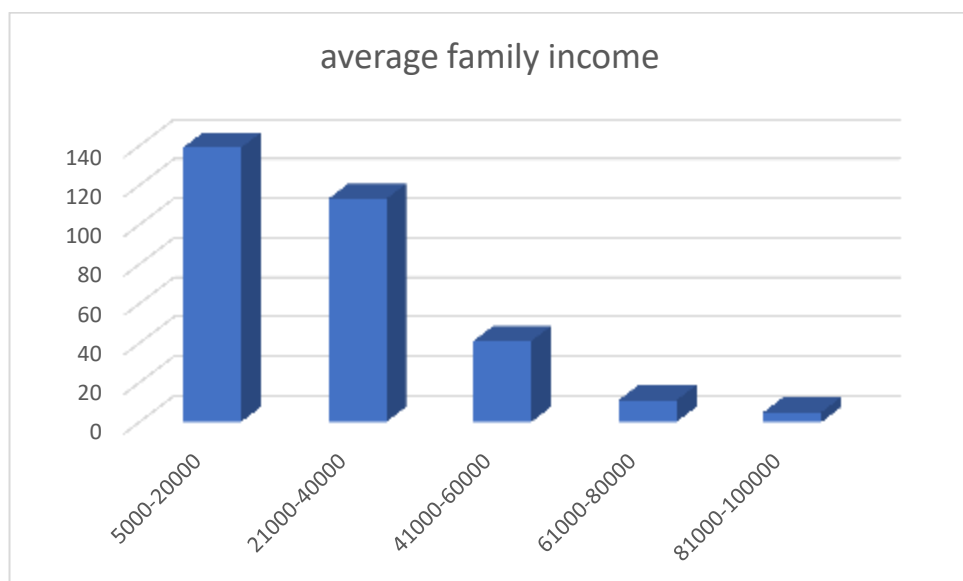
Birth order of the sample



Birth order analysis reveals that middle children (35.6%) form the largest group, followed by firstborns (32.4%) and youngest children (27.8%). Only 4.2% of participants were the only child in their family.

Figure7:

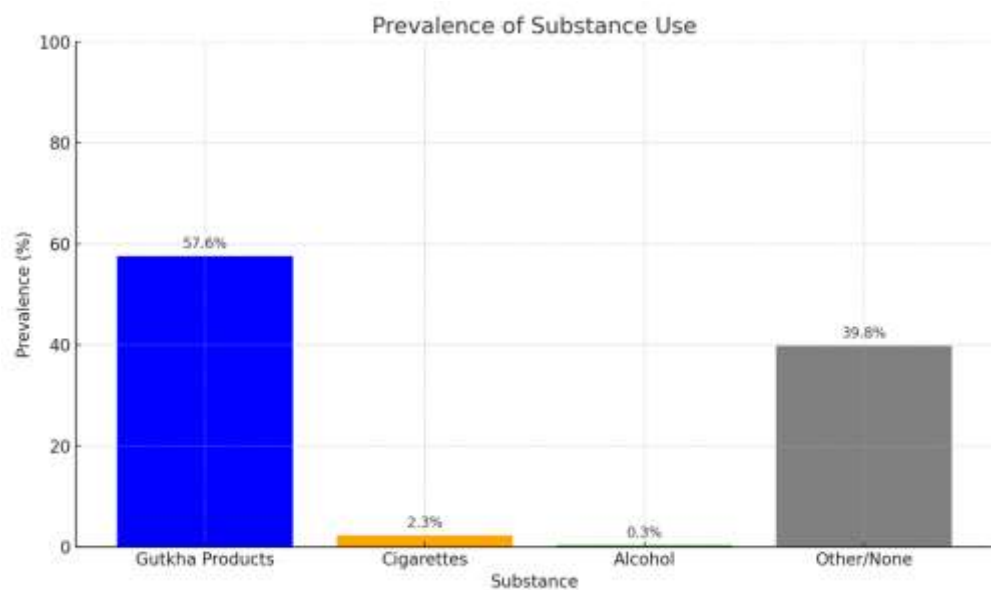
Average Family income of the sample



Family income distribution shows that nearly half (45.0%) of the participants' families earn between ₹5,000–₹20,000 per month, followed by ₹21,000–₹40,000 (36.6%). Higher income brackets are relatively less common, with only 1.6% reporting an income between ₹81,000–₹1,00,000.

Figure 8:

Substance usage of the sample -Children of alcoholics



Among COAs participants, **57.6%** reported **no substance usage**, while **gutkha products (39.8%)** were the most commonly used substance. A small proportion reported using **cigarettes (2.3%)** or **alcohol (0.3%)**.

The substance use patterns observed among Children of Alcoholics (COAs) reveal distinct trends that may reflect both pre-existing risk factors and pandemic-specific influences. The high prevalence of gutkha use (57.6%) could be attributed to multiple factors: on the one hand, the stress of parental alcoholism and pandemic-related anxiety may have driven adolescents toward easily accessible and concealable smokeless tobacco products. On the other hand, lockdown restrictions may have limited access to other substances, making gutkha cheaper and more discreet option, a default coping mechanism.

The strikingly low rates of cigarette smoking (2.3%) and alcohol use (0.3%) also invite dual interpretations: reduced peer interactions due to school closures and social distancing may have decreased opportunities for experimental or social substance use. Alternatively, heightened parental supervision during lockdowns, especially in households with alcoholism, might have suppressed alcohol consumption, despite COAs' increased vulnerability.

These findings suggest that while familial alcoholism remained a key risk factor, the pandemic environment may have altered typical substance use pathways, pushing COAs toward less detectable forms of nicotine rather than alcohol or smoked tobacco. This underscores the need for dual-focused interventions that address both the long-term psychosocial risks of growing up with alcoholic parents and the situational stressors of crises like COVID-19. Future research should explore whether these patterns persist post-pandemic or represent temporary behavioural adaptations.. The findings highlight the need for substance use prevention programs targeting COAs to specifically address smokeless tobacco products, while not neglecting education about other substances.

Psychological Assessment

Figure9:

Self-esteem levels among the overall sample

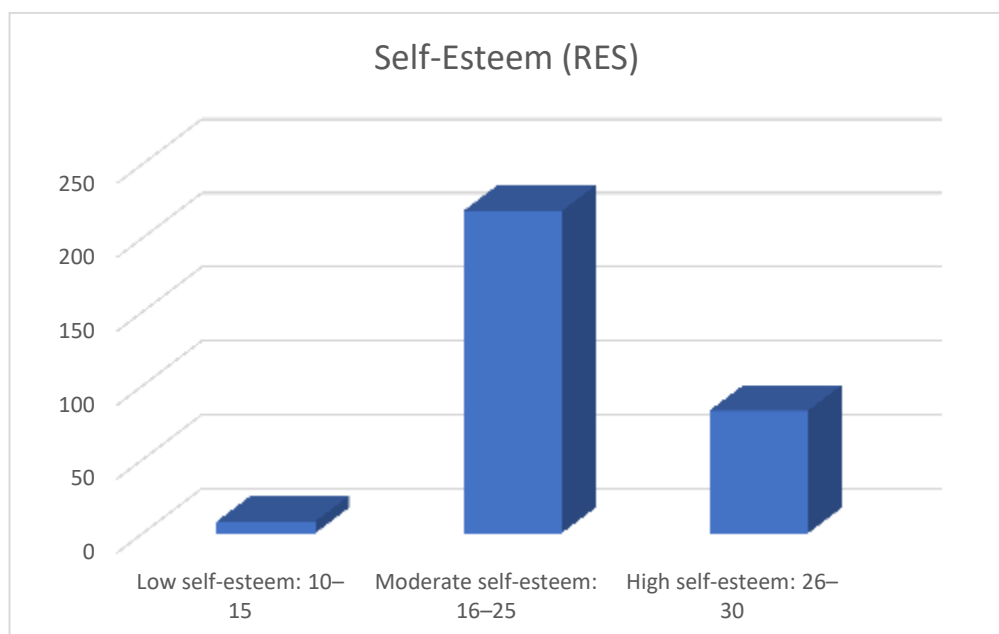


Figure10:

Anxiety levels among the overall sample

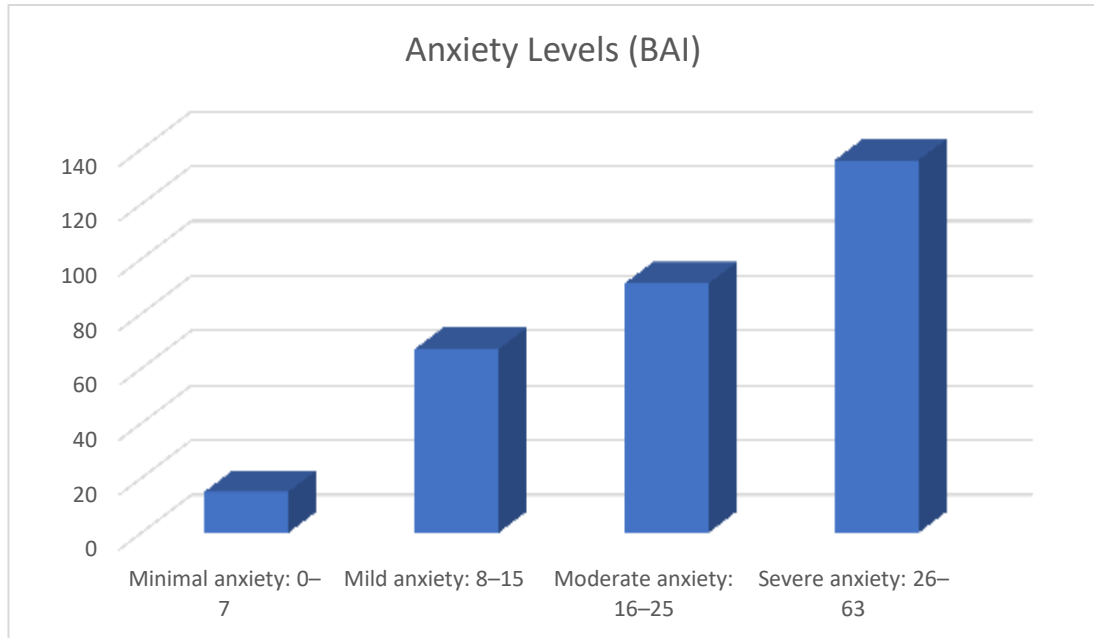


Figure11:

Depression levels among the overall sample

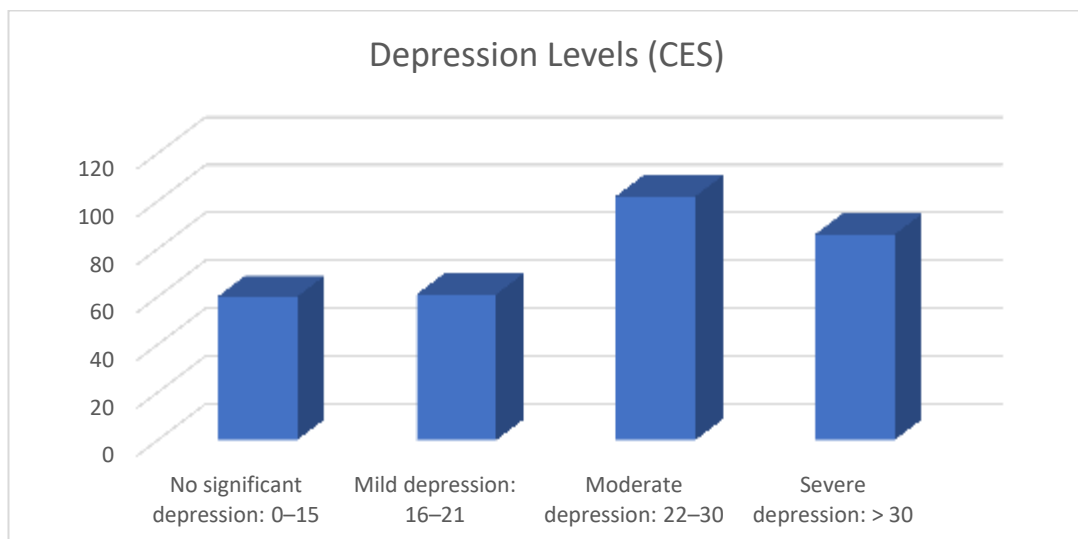
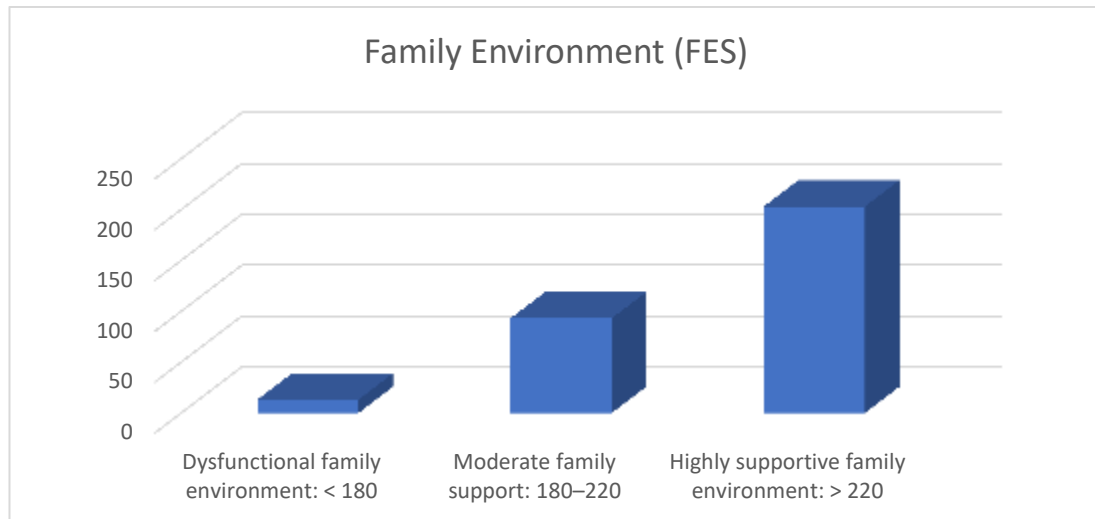


Figure12:

Quality of family environment among the overall sample



The Rosenberg Self-Esteem Scale (RES) categorizes self-esteem levels among participants as low, moderate, and high. As seen in Fig 9, the majority of the participants (70.55%, n = 218) had **moderate self-esteem**, indicating a balanced perception of self-worth. A significant proportion (26.86%, n = 83) exhibited **high self-esteem**, suggesting a strong sense of confidence and positive self-regard. However, a small subset (2.59%, n = 8) reported **low self-esteem**, which may be associated with negative self-perception and emotional distress. These findings suggest that most participants had a healthy level of self-esteem, with only a minor proportion experiencing self-worth issues.

The Beck Anxiety Inventory (BAI) results in Fig 10 revealed a wide distribution of anxiety severity among participants. Nearly half of the participants (44.01%, n = 136) experienced **severe anxiety**, which is concerning as it indicates significant distress and possible functional impairment. **Moderate anxiety** was observed in 29.45% (n = 91) of participants, implying frequent anxiety symptoms that may impact daily life. **Mild anxiety** was seen in 21.68% (n = 67), suggesting occasional but manageable anxiety symptoms. A small proportion (4.85%, n = 15) had **minimal anxiety**, indicating very few or no significant anxiety symptoms. The high percentage of participants with moderate to severe anxiety highlights a potential mental health concern within the study population.

In Fig 11, it displays the result of The Centre for Epidemiologic Studies Depression Scale (CES-DC) which indicate that **33.01%** (n = 102) of participants experienced **moderate depression**, while **27.83%** (n = 86) suffered from **severe depression**, showing that a significant proportion of the population is struggling with depressive symptoms that may require intervention. **Mild depression** was observed in **19.74%** (n = 61), indicating occasional depressive symptoms that may not severely impact daily functioning. On the other hand, **19.42%** (n = 60) showed **no significant depression**, suggesting good emotional well-being. The high prevalence of moderate to severe depression (combined **60.84%**) indicates a pressing need for mental health support and interventions within this population.

The Family Environment Scale (FES) assessed the quality of the participants' home environments. A substantial majority (**65.70%**, n = 203) , as seen in Fig 12, reported a **highly supportive family environment**, suggesting strong family cohesion, positive communication, and emotional support. About **30.10%** (n = 93) experienced a **moderate family environment**, indicating a balanced but potentially fluctuating level of familial support. However, a small but noteworthy **4.21%** (n = 13) described their family environment as **dysfunctional**, meaning they might lack emotional or practical support from their families. The predominance of supportive family environments suggests a generally positive home atmosphere for most participants, which could play a protective role in their mental well-being.

The psychological assessment results reveal a compelling paradox that demands theoretical interpretation through multiple frameworks. Despite the overall sample demonstrating predominantly moderate to high self-esteem (97.41%) and largely supportive family environments (65.70%), the prevalence of severe anxiety (44.01%) and combined moderate-to-severe depression (60.84%) presents a critical finding: both children of alcoholics (COAs) and children of non-alcoholics (non-COAs) exhibited high psychological distress during the conduction of the study, which is during the Covid-19 pandemic. This unexpected result calls into question traditional beliefs or views that prioritize family dysfunction as the primary driver of adolescent distress, which underscore thorough analysis through the integrated theoretical frameworks adopted for this study.

From a family systems perspective, the simultaneous existence of supportive family structures and elevated individual distress presents the complexity of family system dynamics during periods of crisis. As seen in Fig 12, 65.70% of participants reported high supportive family environments which may represent what family systems theorists describe as ‘functional adaptation’. In other words, families who can successfully adapt and reorganize their boundaries, roles, and communication patterns in the presence of external stressors (Bowen, 1978; Minuchin, 1974).

However, during the Covid-19 lockdown it created what can be conceptualized as ‘involuntary family intensification’, which forces families into prolonged proximity at the same time there is an absence of or less external support systems. This involuntary family intensification fostered better communication and understanding in many families, although it also created unprecedented stress loads that even individuals from well-functioning family systems struggled to manage. This finding suggests that external and unseen pressures can overwhelm even resilient and well-functioning family, which in turn can lead to distressing symptoms expression in the most vulnerable members of the family- the adolescents, regardless of family or paternal alcohol status.

Beyond the pandemic context, the socio-cultural and political landscape of Churachandpur district itself warrants serious consideration as an independent contributor to the elevated psychological distress observed among participants across both groups. As noted in the introduction, the district has historically been marked by recurring ethnic tensions, intercommunal conflicts, and socio-political instability that create a chronic and unpredictable threat environment for adolescents regardless of their family background. Unlike discrete or acute stressors, this form of ambient socio-political adversity operates as a persistent background stressor, continuously shaping adolescents' threat perception, emotional regulation, and fundamental sense of safety. Betancourt and Khan (2008) specifically demonstrated that youth living in conflict-affected environments carry a cumulative psychosocial burden that operates independently of immediate family protective factors, as prolonged exposure to community-level violence and instability fundamentally alters adolescents' cognitive appraisal of their environment. They further established that even adolescents embedded within functionally supportive family environments remain significantly

psychologically vulnerable when the broader social environment is characterized by persistent insecurity and ethnic conflict, finding that directly parallels the present study's observation of high distress levels among participants from supportive family backgrounds. This contextual reality offers a compelling explanation for why elevated anxiety (73.46% moderate to severe) and depression (60.84% moderate to severe) were observed across both COAs and non-COAs- the chronic socio-political environment of the district may be exerting a floor effect on psychological well-being, establishing a baseline of distress that neither supportive family environments nor adequate self-esteem levels alone can fully buffer against.

When this chronic socio-political stressor is considered alongside the unprecedented disruptions of the COVID-19 pandemic, the cumulative environmental burden experienced by adolescents in Churachandpur becomes considerably clearer. This dual context, i.e. chronic community-level conflict compounded by a global health crisis provides a powerful explanatory framework for the present study's paradoxical finding of high psychological distress coexisting with predominantly supportive family environments and moderate to high self-esteem, further reinforcing the concept of universal vulnerability wherein distress becomes a normative rather than exceptional response irrespective of paternal alcoholism status.

A crucial insights was also provided by the developmental perspectives on why adolescents regardless of paternal alcohol use still demonstrated such elevated psychological distress. Adolescents is a critical period of identity formation, peer relationship development, and autonomy seeking stage (Erikson, 1968; Steinberg, 2013). The pandemic also contribute in the disruption of these normative developmental tasks, creating what can be termed as 'developmental arrest' or 'crisis-induced regression'.

As seen in Fig 9, the participants display moderate self-esteem levels (70.55%) which may reflect this developmental disruption. During the typical development of the adolescents, self-esteem fluctuation occur as children take in feedback and incorporate in their life they received from multiple social contexts such as from their peers, school, extra-curricular activities, and emerging romantic

relationships. The pandemic restricts these area widely which is likely creating an artificial stabilization of self-esteem at moderate levels, preventing the natural developmental growth that characterize healthy adolescents.

In Fig 10 and 11, the participants display high anxiety (73.46% experiencing moderate to severe levels) and depression (60.84% experiencing moderate to severe levels). Adolescents' neurobiological and psychological needs for novelty, peer connection, and autonomy were fundamentally thwarted by the restrictions during pandemic, which can create a toxic mismatch between developmental requirements and environmental possibilities.

The high anxiety (73.46% experiencing moderate to severe levels) and depression (60.84% experiencing moderate to severe levels), can be seen in Fig10 and 11) rates can be understood through developmental mismatch theory. Adolescents' neurobiological and psychological needs for novelty, peer connection, and gradual independence were fundamentally thwarted by pandemic restrictions, creating a toxic mismatch between developmental requirements and environmental possibilities.

The above psychological assessment of the overall sample shows a contradictory findings. There is a concept called 'universal vulnerability' which explains why adolescents with supportive families and adequate self-esteem still demonstrated significant psychological distress. This perhaps can be best explained using the stress and coping framework (Lazarus & Folkman, 1984). Covid-19 functioned as what the stress theorists term a 'mega-stressors'- an environmental challenge so pervasive and unprecedented that it overwhelmed typical coping mechanisms regardless of individual or family protective factors.

Inferential Statistics

1. Impact of Paternal Alcoholism on Self-Esteem, Anxiety, and Depression

In the present study, two genders were taken into consideration: male and female, and paternal alcoholism was categorized into two: Children of alcoholics (COAs) and Children of non-alcoholics (non-COAs). The first objective is to elucidate the impact of 'paternal alcoholism' on Self-esteem, Anxiety and

Depression on Children of Alcoholics (COAs). To achieve the objectives the following hypothesis are put forth to study:

1. Children of alcoholics (COAs) will exhibit significantly lower levels of self-esteem compared to children of non-alcoholics (non-COAs).
2. Children of alcoholics (COAs) will report significantly higher levels of anxiety and depression compared to children of non-alcoholics (non-COAs).

To assess the impact of paternal alcoholism on self-esteem, anxiety, and depression among children of alcoholics (COAs) and non-COAs, an independent samples t-test was conducted. The data was scrutinized to see if the samples or group score met the requirements for parametric test assumptions such as skewness, kurtosis, (ref:table2) and homogeneity of the samples or group score (Levene's test of equality of variances) on each scale.

Levene's test for Equality of Variances was conducted for Rosenberg's Self-Esteem Scale (RES), Beck's Anxiety Inventory (BAI), and Center for Epidemiologic Studies Depression Scale (CES-DC) to assess the homogeneity of variances assumption. The test was significant for Rosenberg's Self-Esteem Scale, RES ($F=4.389$, $p=.037$) and Beck's Anxiety Inventory, BAI ($F=7.319$, $p=.007$), indicating unequal variances between groups. Despite significant Levene test for some variables, parametric t-test was still used due to the robustness of the test to variance homogeneity, approximate normality of data and availability of Welch's correction for unequal variances (Delacre et. al, 2019). Thus, for these variables, Welch's t-test was used. For Center for Epidemiologic Studies Depression Scale (CES-DC), the test was not significant ($F=2.442$, $p=.119$), suggesting equal variances and validating the use of the standard independent t-test. Given that the data met normality assumptions, based on skewness and kurtosis (Table 1.1 and Table 1.2), and the sample sizes were sufficiently large ($N > 30$ per group) the use of Welch's t-test in cases of unequal variances is both appropriate and statistically reliable (Delacre et al., 2017).

Table3:

Levene's Test of Equality of Error Variances and independent sample t-test of self-esteem, anxiety and depression (COAs vs Non-COAs)

Scale	Levene's Test	t-Test					
	<i>F</i>	<i>p</i>	<i>t</i>	<i>df</i>	<i>p</i>	Mean Difference	SE Difference
RESTOT							
Equal variances assumed	4.389	.037	-1.801	307	.073	-0.771	0.428
Equal variances not assumed	—	—	-1.816	304.87	.070	-0.771	0.425
BAITOT							
Equal variances assumed	7.319	.007	3.600	307	<.001*	4.531	1.259
Equal variances not assumed	—	—	3.631	305.12	<.001*	4.531	1.248
CESTOT							
Equal variances assumed	2.442	.119	2.071	307	.039**	2.378	1.148
Equal variances not assumed	—	—	2.082	306.96	.038**	2.378	1.142

*significance at $p < 0.001$ level **significance at $p < 0.005$ level

Independent sample t-test as displayed in Table 3 revealed that Children of Alcoholics (COAs) had significantly higher anxiety (Welch's $t(305.12) = 3.63$, $p < .001$, $d = 0.41$) and depression ($t(307) = 2.07$, $p < .005$, $d = 0.24$) than Children of Non-alcoholics (Non-COAs). Self-esteem differences were not significant ($p = .070$)

- **Self-Esteem (RES):** The mean self-esteem score for COAs ($M = 23.16$, $SD = 4.068$) was slightly lower than for non-COAs ($M = 23.93$, $SD = 3.391$). However, the difference was not statistically significant, $t = -1.816$, $p = .070$.
- **Anxiety (BAI):** The mean anxiety score for COAs ($M = 26.19$, $SD = 11.925$) was significantly higher than for non-COAs ($M = 21.66$, $SD = 9.996$), $t = 3.631$, $p < .001$. This suggests that children of alcoholics exhibit higher levels of anxiety compared to non-COAs.
- **Depression (CES):** The mean depression score for COAs ($M = 25.83$, $SD = 10.585$) was significantly higher than for non-COAs ($M = 23.45$, $SD = 9.491$), $t = 2.071$, $p = .039$, indicating a significant impact of paternal alcoholism on depressive symptoms.

As seen in table 3, the results revealed that COAs had slightly lower self-esteem scores compared to non-COAs; however, no statistically significant difference in self-esteem was found between COAs and Non-COAs ($p = 0.070$), contradicting Hypothesis 1 and challenges prevailing Western-centric theoretical frameworks. This finding diverges substantially from established literature documenting diminished self-worth among COAs in predominantly individualistic societies (Sher, 1991; Windle & Searles, 1990; Elaine & Robert, 1999; Madhavi, 2016). The non-significant result may be attempted to explain in the unique sociocultural context of Churachandpur's tribal Christian community, where collectivist family structures, community & peer support, and robust church-based social support systems potentially function as protective mechanisms against self-esteem deficits (Ungar, 2012).

The theory of Indigenous resilience offers a framework for interpreting these results, indicating that cultural traditions, spiritual beliefs, and a strong sense of community can act as psychological shields against family dysfunction (Kirmayer et al., 2011). Additionally, developmental factors reveal that during adolescence, the importance of peer acceptance and social connection outside the family increases as

key influences on self-worth, which could help offset household instability (Erikson, 1968). The slightly non-significant result ($p = 0.070$) implies that although paternal alcoholism might have some impact on self-esteem, the extent of this influence is notably reduced within this cultural setting in comparison to findings in western studies.

The Cross-Cultural Perspective is essential for interpreting these findings within Manipur's specific sociocultural context. The traditional institutional frameworks, such as the 'Indongta' among Paite communities, demonstrate how cultural norms guide both individual behaviour and community responses to family crises (Guite, 2017). While these traditional systems can provide community support for families experiencing alcoholism, they may also create pressure to maintain family honour and conceal dysfunction, contributing to the complex pattern of results observed in this study where self-esteem preservation occurs despite family-level challenges. The slightly non-significant result ($p = 0.070$) implies that although paternal alcoholism might have some impact on self-esteem, the extent of this influence is notably reduced within this cultural setting in comparison to findings in western studies.

COAs demonstrated significantly higher levels of anxiety compared to Non-COAs, with a significance level of $p < 0.001$, which supports Hypothesis 2. This finding is particularly important as it aligns well with stress-co-dependency theories. These theories propose that individuals who are chronically exposed to unstable home environments and emotional neglect within families affected by alcoholism face a greater risk of developing lasting hypervigilance and various anxiety symptoms. The works of Mansharamani et al. (2018) have elaborated on these ideas, emphasizing the significant influence that family dynamics can exert on mental health. Furthermore, the calculated effect size of $d = 0.41$ not only indicates a statistically significant difference between the two groups but also highlights a clinically meaningful distinction. This effect size implies that the variation in anxiety levels between COAs and Non-COAs is not simply a statistical coincidence, but has real-world implications for the mental health of individuals in the COA group, underscoring the necessity for tailored interventions.

Neurobiological studies support these behavioural findings, showing that early exposure to prolonged stress significantly interferes with the functioning of the hypothalamic-pituitary-adrenal (HPA) axis. This disruption makes children of parents with mental health issues more susceptible to increasing anxiety throughout their development (Bellis et al., 2019; Tarullo & Gunnar, 2006). The ongoing activation of stress response mechanisms within unstable family settings leads to neurological weaknesses that continue into later stages of life, resulting in generalized anxiety, social anxiety, and patterns of anticipatory worry (Anda et al., 2006).

In Churachandpur, the complex interaction of sociocultural elements profoundly elevates anxiety levels among individuals, especially among children of alcoholics (COAs). The stigma attached to alcoholism, particularly within tribal Christian groups, creates distinct pressures for these young people. This stigma frequently fosters feelings of shame and secrecy, pushing COAs to handle their emotional difficulties in solitude (Room, 2005). The social fallout from being linked to an alcoholic parent can lead to a strong sense of social disconnection, hindering their ability to seek support from friends or family. Additionally, the scarcity of mental health resources in the area exacerbates these issues. When families attempt to access psychological support, they often face cultural obstacles that may dissuade them from seeking help or cause them to distrust available services. The insufficient number of mental health professionals further worsens the situation, leaving many anxiety symptoms overlooked and unacknowledged. Under these circumstances, there is a pressing need for innovative, community-based strategies for intervention. These strategies should aim to incorporate traditional healing methods that align with local cultural values while also integrating evidence-based practices rooted in modern psychological research.

The challenges for COAs are made even more complicated by the COVID-19 pandemic, which has added a new dimension to the mental health issues they face. Data gathered during this time reveals significant mental health disparities between COAs and their peers who are not affected by alcoholism. The pandemic has correlated with rising levels of anxiety and depression among children and teenagers,

with adolescent females particularly experiencing an increase in these issues due to their heightened vulnerability in crises. World Health Organization in 2022 highlights the harsh reality that vulnerable groups, including those from dysfunctional family backgrounds, faced more pronounced mental health impacts due to the pandemic. The stressors presented by the pandemic, such as isolation, uncertainty, and disruptions to everyday life, have likely exacerbated the psychological difficulties encountered by COAs, demonstrating an urgent need for focused mental health initiatives in these communities.

Several pandemic-specific mechanisms likely exacerbated pre-existing vulnerabilities among COAs. Social distancing and stay-at-home orders could lead to loneliness and isolation among children – known risk factors for poor mental health (Panchal et al., 2023). For COAs, mandatory confinement within dysfunctional household environments potentially intensified exposure to parental drinking behaviours, family conflict, and domestic instability. Unlike their non-COA peers who might have found refuge in school environments or peer relationships, COAs faced prolonged entrapment within problematic family dynamics.

The pandemic also contributed to increased substance use patterns among adults, including those with pre-existing alcohol use disorders. Studies suggest many people increased their use of alcohol and other substances in the early stages of the pandemic, especially people with clinical anxiety and depression (Lardier et al., 2022). This escalation in parental drinking behaviours likely created additional stressors for COAs, including increased family conflict, financial strain, and unpredictable home environments.

Furthermore, the disruption of traditional support systems during lockdown measures may have disproportionately affected COAs. School closures eliminated access to counsellors, teachers, and peer support networks that often serve as protective factors for at-risk youth. Adolescents had perceived high rates of low to moderate social support during the pandemic, which contributed to increases in anxiety and depression (Loades et al., 2020). For COAs, who may already experience limited social support due to family dysfunction and stigma, these

pandemic-related restrictions likely created additional barriers to emotional regulation and coping.

Depression scores were significantly elevated in COAs ($p = 0.039$), though with a small effect size ($d = 0.24$) which suggests that while depression represents a legitimate concern for COAs, the magnitude of difference is relatively small, indicating potential protective factors operating within this population. Similarly, research by Brunda in 2023 reported increased levels of hopelessness among COAs, assessed using the Beck Hopelessness Scale. In a school-based sample, a study by Omkarappa and Rentala (2019) showed significantly elevated anxiety and depression levels, along with diminished self-esteem in COAs compared to their non-COA counterparts, and found that anxiety and social phobia comorbid among COAs indicate that depression often occurs alongside other internalizing symptoms. This underscores the importance of comprehensive mental health screening in future research, as gaining a deeper understanding of the range of mental health issues that COAs encounter could facilitate more effective interventions and support systems.

Additionally, Family Systems Theory provides an insightful framework for comprehending how depression can be transmitted within families where alcohol dependency is present. This theory underscores the way children absorb maladaptive coping strategies and dysfunctional communication styles from their alcoholic parents (Bowen, 1978; Minuchin, 1974). In this environment, children may develop a tendency to suppress their emotions, assume inappropriate responsibilities, and cultivate negative thought patterns about themselves and their surroundings. These learned behaviors significantly increase their vulnerability to experiencing depression (Black, 1981).

The concept of intergenerational trauma further deepens this understanding, especially in the context of the sociocultural dynamics prevalent in Manipur. Tribal communities in this region have faced historical marginalization, political strife, and cultural upheaval, leading to a cumulative stress that can worsen family dysfunction (Brave Heart, 2003; Sotero, 2006). This compounded stress can create a cycle in which the struggles of parents perpetuate challenges for their children, reinforcing maladaptive behaviours and emotional difficulties. Despite the complex interplay of

these factors, the relatively modest effect size found in the present study may suggest the existence of protective factors, like familial support or community resilience, which might lessen the intensity of psychological distress in COAs in Manipur. Potential protective mechanisms include the role of religiosity and spiritual coping strategies that are prevalent in Christian tribal communities. This contrasts with the more significant differences in hopelessness observed in Brunda's 2023 sample, possibly reflecting variations in cultural settings or research methods, such as the employment of CAST6 versus modified screening instruments. Research indicates that these spiritual practices can provide individuals with a sense of meaning, foster social support networks, and instil a sense of hope, all of which can play a crucial role in alleviating symptoms of depression (Pargament, 2011).

Furthermore, the collectivist cultural values inherent in these communities, which emphasize collective responsibility and community support, could also offer alternative pathways for emotional affirmation and practical assistance. Such cultural dynamics may help counterbalance the dysfunction observed at the family level, enabling children to navigate their challenges in a more resilient manner. By fostering community resilience and highlighting shared responsibility, these cultural traits may provide essential support that helps shield COAs from the adverse effects of their familial circumstances.

2. Gender Differences in Self-Esteem, Anxiety, and Depression

The second research objective focused on elucidating 'gender differences' in self-esteem, anxiety, and depression among adolescents in Churachandpur. The hypothesis is for the objective is that there will be significant gender differences in these outcomes. The results of Levene's test indicated homogeneity of variance (Table 4), and the skewness and kurtosis (Tables 1.1) does not violate the demands for a normal distribution, justifying the use of parametric tests.

The univariate analysis of variance (ANOVA) approach was methodologically appropriate given that Levene's test confirmed homogeneity of variance across groups, and the skewness and kurtosis values fell within acceptable parameters for normal distribution. This statistical foundation justified the use of

parametric testing procedures, ensuring robust and reliable inference regarding gender-based differences in psychological outcomes.

Table4:

Levene's Test of Equality of Error Variances and result of ANOVA of self-esteem, anxiety and depression by Gender

Scale	Gender	<i>n</i>	Mean Square	<i>F</i>	<i>p</i>	Levene's <i>F</i>	Levene's <i>p</i>
RES	Male	163	225.565	16.842	< .001	0.069	.792
	Female	146	—	—	—	—	—
BAI	Male	163	1221.483	21.691	.001	0.090	.764
	Female	146	—	—	—	—	—
CES	Male	163	1026.077	10.500	.001	0.164	.685
	Female	146	—	—	—	—	—

Note: Dashes (—) indicate values identical to the row above (results apply to both genders).

The decision to employ ANOVA rather than multiple independent t-tests was statistically sound, as it controls for Type I error inflation that would occur with multiple comparisons while providing comprehensive examination of gender effects across all three dependent variables simultaneously (Field, A. 2013). This approach aligns with contemporary best practices in psychological research methodology and enhances the interpretability of findings.

The univariate ANOVA revealed significant gender differences in self-esteem, anxiety, and depression among adolescents in Churachandpur.

- **Self-Esteem (RES):** The results indicated a significant effect of gender on self-esteem, $F = 16.842$, $p < .001$. Males had significantly higher self-esteem scores ($M =$

32.45, SD = 5.67) compared to females (M = 29.21, SD = 6.12). This suggests that males tend to have a more positive self-concept and higher confidence levels than females.

- **Anxiety (BAI):** A statistically significant effect of gender was observed on anxiety, $F = 21.691$, $p < .001$. Females reported significantly higher anxiety levels (M = 21.78, SD = 7.34) compared to males (M = 18.32, SD = 6.89). This finding highlights that females are more prone to experiencing heightened anxiety compared to their male counterparts.
- **Depression (CES):** The analysis also revealed a significant effect of gender on depression, $F = 10.500$, $p = .001$. Females had significantly higher depression scores (M = 19.87, SD = 6.21) compared to males (M = 17.45, SD = 5.78). This suggests that depressive symptoms are more prevalent among females, indicating potential gender-based vulnerabilities in mental health.

The significant gender difference in self-esteem ($F = 16.842$, $p < .001$) revealed males reporting substantially higher self-esteem scores compared to females, a pattern that demonstrates remarkable consistency with cross-cultural research findings. This pattern demonstrates remarkable consistency with cross-cultural research findings, including Bleidorn et al.'s (2016) comprehensive analysis across 48 nations showing that males consistently report higher self-esteem than females, indicating that this gender disparity transcends cultural boundaries and suggests fundamental differences in socialization processes and social structural influences.

The present findings align with prior findings (Berkowitz and Perkins', 1988; Gestsdottir et al., 2021) that male COAs rated their own autonomy significantly higher than their male peers, suggesting that even within challenging family environments, males maintain or develop protective self-perceptions. This finding is particularly noteworthy given that Sher et al. (1991) found that while both male and female COAs experienced similar effects from family history of alcoholism, women were more affected by family history overall, yet males still maintained higher self-esteem levels.

Within the context of Churachandpur's tribal Christian community, these findings likely reflect deeply embedded patriarchal social structures that systematically privilege male autonomy, competence, and social status while constraining female agency and self-determination. Traditional gender role expectations within tribal societies often emphasize male leadership, decision-making authority, and economic responsibility, creating multiple opportunities for positive self-concept development and social validation (Eagly, 2012). Conversely, females may encounter restrictive gender norms that limit their perceived competence domains and reduce opportunities for achievement-based self-esteem enhancement.

The magnitude of this gender difference is particularly noteworthy given that some collectivist cultures demonstrate reduced gender gaps in self-esteem due to emphasis on communal values and interdependence over individual achievement (Schmitt & Allik, 2005). The pronounced gender disparity observed in this study suggests that localized gender dynamics in Manipur may reflect more hierarchical social structures than typically found in collectivist societies, potentially influenced by historical patterns of male dominance and contemporary socioeconomic pressures.

Conversely, females exhibited significantly higher anxiety ($F = 21.691, p < .001$) with scores of $M = 21.78, SD = 7.34$ compared to males ($M = 18.32, SD = 6.89$). This finding aligns closely with Elaine & Robert's (1999) research among African-American adolescents, which found that females generally experienced higher levels of psychological distress regardless of parental alcoholism status, though these gender differences were more pronounced among COAs. The present results support epidemiological data showing women's heightened vulnerability to internalizing disorders (Kessler et al., 2005). Girls and female adolescents more frequently develop cognitions and emotions related to internalizing problems (e.g., sadness, anxiety, anger inhibition), while boys and male adolescents develop cognitions and emotions related to externalizing problems (e.g., aggressiveness).

From a developmental psychopathology perspective, adolescent females face a confluence of biological, psychological, and social stressors that increase anxiety vulnerability. The onset of puberty introduces hormonal fluctuations that affect mood regulation and stress reactivity, while simultaneously increasing social-evaluative concerns and body image pressures (Hyde et al., 2008). Additionally, females demonstrate greater sensitivity to interpersonal stressors and social rejection, creating heightened vulnerability to anxiety symptoms during the socially complex adolescent period.

The stress-co-dependency framework provides additional explanatory power for understanding these gender differences. Girls within alcoholic families are often socialized into caretaking roles earlier than boys, absorbing family dysfunction more directly and assuming inappropriate responsibility for household emotional regulation (Jester et al., 2005). This premature caretaking burden may create chronic anxiety patterns that persist beyond the immediate family context (Barbieri et al. 2024).

Within Churachandpur's cultural context, restrictive gender norms may further amplify anxiety among females by limiting acceptable coping mechanisms and emotional expression outlets. While males may be permitted or encouraged to externalize distress through physical activity, risk-taking behaviors, or aggressive responses, females may face societal pressure to internalize emotional difficulties, leading to rumination and anxiety escalation (Nolen-Hoeksema, 2012).

The analysis as shown in Table 4 also revealed a significant effect of gender on depression ($F=10.500$, $p=.001$), with females reporting higher depression scores ($M= 19.87$, $SD= 6.21$) compared to males ($M= 17.45$, $SD = 5.78$). This finding aligns with the established epidemiological pattern showing the emergence of gender differences in depression during adolescence, when the male-to-female ratio shifts from approximately 1:1 in childhood to 1:2 by late adolescence, a pattern that persists throughout adulthood (Hankin & Abramson, 2001).

These results are consistent with Elaine & Robert's (1999) findings among African-American adolescents and support Crum & Harris's (1996) observation that

the association between parental alcoholism and psychological distress was stronger in female offspring than in male offspring. The present findings also align with Berkowitz and Perkins' (1988) research showing that women with alcoholic fathers were substantially more likely to report higher levels of self-deprecation compared to women with alcoholic mothers.

Several theoretical frameworks explain this gender disparity in depression vulnerability. The response styles theory suggests that females are more likely to engage in rumination when experiencing negative emotions, leading to prolonged and intensified depressive episodes (Nolen-Hoeksema, 2000). Additionally, females demonstrate greater sensitivity to interpersonal stressors and relationship difficulties, creating vulnerability to depression when social connections are disrupted or conflictual.

Cognitive vulnerability models indicate that females develop more negative cognitive schemas about themselves, their world, and their future during adolescence, partially due to socialization processes that emphasize appearance, social approval, and relational success over achievement and autonomy (Hankin & Abramson, 2001). These cognitive patterns create susceptibility to anxiety and depression when faced with stressors or negative life events.

The timing of data collection during the COVID-19 pandemic introduces crucial contextual factors that may have exacerbated pre-existing gender differences in mental health outcomes. Adolescent females have experienced increased feelings of hopelessness and sadness compared to their male peers during the pandemic. Research confirms that children and adolescents are experiencing significant anxiety and depression during the COVID-19 pandemic, with adolescents at greater risk, particularly females.

The pandemic's disproportionate impact on female mental health can be attributed to several gender-specific mechanisms. Recent data indicate that females are at increased risk of loneliness, depression and anxiety during Covid-19, potentially due to greater reliance on social connections for emotional regulation and coping. School closures and social distancing measures may have particularly

affected females, who typically maintain more extensive and intimate peer relationships compared to males.

Furthermore, the increased domestic responsibilities and caregiving burdens that emerged during lockdown periods may have disproportionately affected female adolescents, who are often expected to assume additional household duties and childcare responsibilities. This increased domestic burden, combined with academic pressures and social isolation, may have created a perfect storm for anxiety and depression escalation among female participants.

The pandemic also disrupted traditional gender role expectations and future planning processes, potentially creating additional stressors for female adolescents who may face uncertain educational and career prospects. Economic insecurity within families during the pandemic may have disproportionately affected plans for female education and empowerment, contributing to hopelessness and depressive symptoms.

The pronounced gender differences observed in this study must be interpreted within the specific sociocultural context of Churachandpur's tribal Christian community. While the patterns align with global research findings, the magnitude of these differences may reflect particular cultural dynamics that amplify gender-based vulnerabilities and protective factors.

Traditional tribal societies often maintain distinct gender role expectations that may contribute to differential mental health outcomes. The emphasis on male leadership and economic responsibility may provide multiple pathways for positive self-concept development among males, while restrictive female roles may limit opportunities for competence-based self-esteem enhancement. However, these same traditional structures may also provide protective factors, such as clear social expectations and community support systems.

The Christian religious context adds another layer of complexity to gender role expectations and mental health outcomes. While Christian theology emphasizes equality and dignity for all individuals, practical implementation within traditional societies may perpetuate gender hierarchies that affect psychological well-being. The

interplay between traditional tribal values and Christian teachings may create unique challenges for female adolescents navigating identity development and future planning.

These findings underscore the need for gender-sensitive mental health interventions in Churachandpur district, Manipur and similar tribal Christian communities. Schools and community programs should prioritize psychoeducation for girls on anxiety and depression management, while simultaneously working to challenge patriarchal norms that suppress male emotional expression and help-seeking behaviour. Future research should explore how religiosity and tribal identity mediate these gender disparities, potentially offering culturally adaptive protective factors.

3. Interaction Effect of Paternal Alcoholism and Gender on Self-Esteem, Anxiety, and Depression

The third objective of the study is to determine the interaction effect of 'paternal alcoholism x gender' on Self-esteem, Anxiety and Depression. For this, the hypothesis lay forth is that there will be a significant interaction effect between paternal alcoholism and gender on self-esteem, anxiety, and depression. The results, however, revealed differential effects across the three domains, highlighting the complex interplay between familial alcoholism and gender in shaping mental health.

A two-way ANOVA was conducted to assess the interaction between paternal alcoholism and gender in relation to self-esteem, anxiety, and depression. This analysis helps determine whether the combined effect of these two variables influences emotional and psychological outcomes.

Table5:

Results of ANOVA (2 gender X 2 paternal alcoholism-CAST) on the self-esteem, anxiety and depression

Interaction Effect	Mean Square	F	p
RES	22.643	1.691	.194
BAI	698.829	6.237	.013*
CES	283.644	2.903	.089

**significance at $p < 0.05$ level*

- **Self-Esteem (RES):** The interaction between paternal alcoholism and gender was not significant, $F(1, 305) = 1.691$, $p = .194$. Although paternal alcoholism and gender individually influence self-esteem, their combined impact does not lead to significant variations. Males from alcoholic households had a self-esteem mean score of 30.92 (SD = 5.83), while females had a mean score of 27.84 (SD = 6.40). In contrast, males from non-alcoholic households had a higher self-esteem score of 33.21 (SD = 5.54), and females had a mean score of 30.02 (SD = 6.03). This indicates that while paternal alcoholism slightly lowers self-esteem, gender differences remain consistent.
- **Anxiety (BAI):** A significant interaction effect was observed, $F(1, 305) = 6.237$, $p = .013$, suggesting that the impact of paternal alcoholism on anxiety differs by gender. Males from alcoholic households had an anxiety mean score of 19.65 (SD = 7.12), while females had a much higher score of 23.41 (SD = 7.89). Conversely, males from non-alcoholic households had lower anxiety levels (M = 17.92, SD = 6.64), while females had an anxiety mean score of 20.48 (SD = 7.10). This suggests that paternal alcoholism exacerbates anxiety, particularly among females, underscoring the need for targeted psychological interventions for this group.
- **Depression (CES):** The interaction effect for depression was not statistically significant, $F(1, 305) = 2.903$, $p = .089$. However, a trend was observed where females from alcoholic households had the highest depression scores (M = 21.04, SD

= 6.45), followed by males from alcoholic households ($M = 18.63$, $SD = 5.92$). Non-alcoholic household males had a depression mean score of 16.92 ($SD = 5.54$), whereas non-alcoholic household females had a mean score of 18.72 ($SD = 6.10$). These results suggest that while paternal alcoholism increases depression levels, its interaction with gender does not produce a significant statistical difference.

From the findings, first, it was revealed the non-significant interaction effect ($F = 1.691$, $p = .194$) indicates that while both gender and paternal alcoholism independently affect self-esteem, their combined influence does not create additional psychological impact. This suggests that the detrimental effects of growing up with an alcoholic father and the well-documented gender gap in self-esteem operate through separate pathways. The finding aligns with social identity theory by Tajfel & Turner, 1979, which posits that “multiple social identities (e.g., gender, family background) may influence self-concept additively rather than interactively in certain cultural contexts”. The consistent gender difference across both COAs and non-COAs (with males scoring higher) supports existing literature on gender socialization in tribal societies (Elaine & Robert, 1999; Beyers & Goossens, 2008), where boys may receive more consistent reinforcement of self-worth regardless of family circumstances.

Second, the significant interaction for anxiety ($F = 6.237$, $p = .013$) reveals a crucial gender-specific vulnerability. Females from alcoholic households displayed markedly higher anxiety levels ($M = 23.41$) compared to their male counterparts ($M = 19.65$), suggesting that girls may be particularly sensitive to the stressful home environment created by paternal alcoholism. This observation aligns with, yet expands on, the gender-specific effects identified by Berkowitz and Perkins in 1988. While their study mainly concentrated on self-deprecation as an outcome, the current research highlights anxiety as a particularly vulnerable area for female children of alcoholics (COAs), thereby enriching the understanding comprehension of gender-specific reactions to familial alcoholism.

This finding supports the differential susceptibility hypothesis (Belsky & Pluess, 2009), which offers a theoretical basis for understanding why females might be more sensitive to the chronic stress associated with paternal alcoholism. This

finding raises concerns when viewed alongside research by Chassin et al. (1991), which pointed out varying effects of parental alcoholism on anxiety across different groups, hinting at possible gender interactions. The present study provides empirical backing for these suspected interactions, revealing that the connection between paternal alcoholism and anxiety is indeed influenced by gender, with females facing a greater burden. The heightened anxiety levels among female COAs may be indicative of their inclination to take on caretaking responsibilities within dysfunctional family structures, as supported by studies on parentification in families with alcohol issues (Chassin et al., 1991). This assumption of a caretaking role, coupled with the erratic and often unstable home environment typical of alcoholic families, may create an ideal scenario for anxiety development in adolescent girls.

Third, Although the interaction effect for depression was not statistically significant ($F = 2.903$, $p = .089$), the observed trend where females from alcoholic households showed the highest depression deserves careful examination in light of existing research. The finding that females from alcoholic households exhibited the highest levels of depression supports theoretical expectations rooted in the gender intensification hypothesis (Hill & Lynch, 1983), which suggests that cultural pressures during adolescence may lead girls to internalize family stressors more deeply than boys. The distinct pattern emerging- where paternal alcoholism impacts depression but not through a significant gender interaction- hints that cultural and community influences could play crucial moderating roles. Aspects such as traditional support systems, religious coping strategies, and extended family networks (Wills & Yaeger, 2003) may offer some level of protection against the severe depressive outcomes commonly linked to growing up in alcoholic families. Furthermore, the heightened anxiety. Future research with larger samples might clarify whether this trend represents a meaningful clinical pattern.

4. Family Environment Pattern Among COAs and Non-COAs

The fourth objective is to elucidate the family environment pattern of children of alcoholics and non-alcoholics. The hypothesis to achieve this objective is that the family environment of children of alcoholics (COAs) will differ significantly from that of children of non-alcoholics (non-COAs).

To examine the family environment pattern among children of alcoholics (COAs) and non-COAs, descriptive statistics were analysed using the Family Environment Scale (FES-69). The findings indicate that COAs experience a significantly more adverse family environment than non-COAs.

Table 6.1:

Result of Independent t-test of Family environment (overall scale) of COAs and non-COAs (overall scale)

CAST Group	n	M	SD	Mean Difference [95% CI]	t	p
COAs (Yes)	162	221.87	26.715	-13.05 [-18.49, -7.61]	-4.721	< .001*
Non-COAs (No)	147	234.92	21.236			

*significance at $p < 0.01$ level

Note. COAs = Children of Alcoholics; FESTOT = Family Environment Scale Total Score; CI = Confidence Interval. Negative mean difference indicates lower scores for COAs. Degrees of freedom = 307.

- The mean total family environment score (FESTOT) for COAs was 221.87 (SD = 26.715), whereas for non-COAs, it was significantly higher at 234.92 (SD = 21.236). This suggests that COAs generally report more negative perceptions of their family environment compared to non-COAs.
- An independent samples t-test showed a significant difference in FESTOT scores between COAs and non-COAs, $t = -4.721$, $p < .001$. The mean difference was 13.048 (95% CI: -18.487 to -7.609). The findings demonstrate that COAs experience substantially poorer family environments overall (FESTOT: COAs = 221.87 vs. non-COAs = 234.92, $p < .001$), characterized by heightened conflict, reduced independence, and chaotic control structures. These results align with family systems theory (Bowen, 1978), which posits that addiction disrupts family equilibrium,

creating dysfunctional patterns that persist across generations. Below is a detailed discussion of the key findings:

Analysis of Independent Samples t-Test for Family Environment Subscales

Table 6.2:

Levene's Test of Equality of Error Variances and independent sample t-test of FES subscales among COAs and non-COAs

Subscale	Variance Assumption	Levene's <i>F</i>	Levene's <i>p</i>	<i>t</i>	<i>df</i>	* <i>p</i> * (2-tailed)	Mean Difference	SE Difference
Conflict	Equal	0.005	.941	-4.778	307	< .001*	-2.790	0.584
	Unequal	—	—	-4.780	304.72	< .001*	-2.790	0.584
Independence	Equal	0.109	.742	-3.181	307	.002*	-1.217	0.383
	Unequal	—	—	-3.189	306.49	.002*	-1.217	0.382
Active Recreational	Equal	1.049	.307	-0.639	307	.523	-0.249	0.389
	Unequal	—	—	-0.640	305.63	.523	-0.249	0.389
Control	Equal	2.334	.128	-2.916	307	.004*	-0.747	0.256
	Unequal	—	—	-2.938	305.81	.004*	-0.747	0.254

*significance at $p < 0.01$ level

Note. SE = Standard Error. Negative mean differences indicate lower scores for COAs. Dashes (—) indicate identical Levene's test values as above.

The Family Environment Scale (FES-69) comprises eight subscales that assess various dimensions of the family environment. These subscales provide insight into the differences between children of alcoholics (COAs) and non-COAs in

terms of family dynamics, communication, structure, and values. However only 4 subscales -the Conflict ($\alpha = 0.81$), Independence ($\alpha = 0.80$), Active Recreational Orientation ($\alpha = 0.81$), and System Maintenance (control subscale) ($\alpha = 0.86$) gave high reliability as shown in Table 2 are taken into consideration.

The results of Levene's test indicated homogeneity of variance (Table 6.2), and the skewness and kurtosis (Tables 1.1 and Table 1.2) does not violate the demands for a normal distribution, justifying the use of parametric test.

The independent samples t-test was conducted to assess the differences between the two groups (children of alcoholics and children of non-alcoholics) across various family environment subscales. The results for each subscale are discussed below:

1. Conflict Subscale

The t-value for this subscale is -4.778, p-value is < 0.001 . This indicates a statistically significant difference between the two groups. Specifically, children of alcoholics (COAs) reported significantly higher levels of family conflict than children of non-alcoholics, with a mean difference of -2.79 (95% CI: -3.94 to -1.64). This suggests that the family environment of COAs is characterized by higher conflict compared to non-COAs.

COAs reported significantly higher conflict ($t = -4.778, p < .001$) than non-COAs, consistent with prior research linking alcoholism to familial discord (Moos & Moos, 1984; Jacob, 1992; Lalnunpui, 2015). The research consistently demonstrates that "children of alcoholics (COAs) tend to show negative outcomes while they are growing up, such as depression, anxiety, suicidal ideation, substance abuse or interpersonal difficulties" (Park & Schepp, 2015). However, the implications of this finding become particularly complex when viewed through the lens of Churachandpur's tribal Christian community.

Through Bowen's (1974) family systems framework, the elevated conflict in alcoholic families can be understood as a systemic dysfunction where parent-child and sibling subsystems become strained due to the instability of the drinking parent's

behaviour. The family system becomes reactive rather than responsive, creating communication patterns that are either confrontational or avoidant, ultimately escalating conflicts over time. The pandemic likely intensified these conflict patterns, as families spent unprecedented time together during lockdowns while facing additional stressors including economic uncertainty, health concerns, and disrupted routines. For families already dealing with alcohol-related dysfunction, these pandemic stressors may have created a "perfect storm" of increased conflict and reduced coping resources.

Within the Cross-Cultural Perspective, the impact of conflict takes on particular significance in the tribal Christian context of Churachandpur. Community and clan networks traditionally buffer family disputes, but the stigma associated with alcoholism may cause families to withdraw from these support systems, leading to heightened isolation and unresolved internal family tensions (Kumar et al., 2020). During the pandemic, when traditional community support mechanisms were further limited by social distancing requirements, this isolation likely became even more pronounced.

2. Independence Subscale

The t-value for this subscale is -3.181, with 307 degrees of freedom, and the p-value is 0.002. This result is statistically significant. Children of alcoholics (COAs) had significantly lower scores on the independence subscale ($M = -1.22$, 95% CI: -1.97 to -0.46), meaning that they likely reported a less independent family environment compared to children of non-alcoholics.

COAs scored lower on the independence subscale ($t = -3.181, p = .002$), suggesting restrictive or enmeshed family dynamics. Alcoholic families often oscillate between neglect and overcontrol, inhibiting adolescents' autonomy (Werner, 1986). In tribal Christian communities, where interdependence is valued, paternal alcoholism may distort healthy boundaries, forcing children into premature caregiving roles (co-dependency) or stifling their decision-making agency. This aligns with cross-cultural studies showing that COAs in collectivist cultures may

experience *role confusion*—balancing traditional family loyalty with personal growth needs (Ranganathan, 2004).

From a developmental perspective, adolescence represents a critical period for cultivating independence. However, parental alcoholism often forces adolescents into premature caretaker or peacekeeper roles, depriving them of the developmental space necessary for exploring self-identity. This limitation contributes to stunted psychosocial growth and difficulties in forming a stable sense of self (Erikson, 1968).

The COVID-19 pandemic created additional challenges for adolescent autonomy development, as lockdowns and restrictions already limited opportunities for independent exploration. For COAs, who were already experiencing restricted independence, these pandemic limitations may have been particularly detrimental to healthy identity development.

3. Active Recreational Subscale

The t-value for this subscale is -0.639, with 307 degrees of freedom, and the p-value is 0.523, which is not statistically significant. There is no significant difference between COAs and non-COAs in terms of the active recreational activities in the family environment. Both groups reported similar levels of engagement in active recreational activities. This may reflect cultural resilience—despite dysfunction, families in Manipur’s tribal communities may prioritize communal events (e.g., church gatherings, festivals) as a normative coping mechanism (Nang, 2007). Alternatively, it could indicate that alcoholism’s impact is more pronounced in emotional dimensions (conflict, control) than in behavioural ones (recreation).

4. Control Subscale

The t-value for this subscale is -2.916, with 307 degrees of freedom, and the p-value is 0.004. This result is statistically significant, suggesting that COAs report significantly lower levels of perceived control in their family environment (mean

difference = -0.75, 95% CI: -1.25 to -0.24) compared to non-COAs. Children of alcoholics perceive their family environment to be less controlled or more chaotic compared to children of non-alcoholics.

The significantly lower control subscale scores among COAs ($t = -2.916$, $p = .004$) reflect unpredictable, disorganized home environments. Alcoholic households frequently lack consistent rules or routines, leaving children vulnerable to anxiety and insecurity (Jacob & Leonard, 1994; Avenevoli et al., 2005). In Churachandpur, where tribal norms emphasize hierarchical family structures, paternal alcoholism may destabilize this order, eroding adolescents' sense of safety. This disruption creates an incongruence between cultural expectations of family order and the disordered reality of their home life, affecting both individual psychological well-being and broader cultural values regarding family governance. Again, the Covid-19 pandemic likely intensified the chaos experienced in alcoholic households, as the additional stressors of health concerns, economic uncertainty, and confined living spaces further compromised already fragile family control systems. This may have been particularly destabilizing for adolescents who rely on predictable family structures for emotional security.

5. The Role of Family Environment and Socio-Demographic Characteristics on Self-Esteem, Anxiety, and Depression

The last and final objective is to determine the role of Family environment and socio-demographic characteristic on Self-esteem, Anxiety and Depression. For this, the hypothesis are as follow:

1. Family environment will have a significant positive relationship with self-esteem in both children of alcoholics (COAs) and non-alcoholics (non-COAs).
2. Family environment will have a significant negative relationship with anxiety and depression in both children of alcoholics (COAs) and non-alcoholics (non-COAs).
3. Socio-demographic characteristics (e.g., family income, family structure, tribe/caste) will significantly influence the overall psychosocial functioning of children of alcoholics (COAs) and non-alcoholics (non-COAs).

Role of Family Environment on Self-Esteem, Anxiety, and Depression

The family environment plays a crucial role in shaping an individual's self-esteem and mental health. The study found a significant positive correlation between family environment (FESTOT) and self-esteem (RESTOT) ($r = 0.292$, $p < 0.001$), as seen in Table 7.1, suggesting that individuals who perceive their family as supportive and nurturing tend to have higher self-esteem. A strong and cohesive family environment fosters a sense of security and belonging, contributing to better emotional regulation and confidence. Conversely, a negative family environment can lead to diminished self-worth and increased psychological distress (Bowen, 1978). The strength of this correlation reflects the collectivist values typical of tribal communities, where individual identity is deeply intertwined with family belonging (Neihisial, 1993).

Table 7.1:

Correlation coefficient of the scales measuring the variables under study

Variable	<i>M</i>	<i>SD</i>	<i>n</i>	<i>r</i>	<i>p</i>
RESTOT	23.53	3.78	309	.102	.073
BAITOT	24.04	11.26	309	-.201**	< .001
FESTOT	228.08	25.09	309	.260**	< .001
CESTOT	24.70	10.13	309	-.117*	.039

** .Correlation is significant at the 0.01 level (2-tailed).

* .Correlation is significant at the 0.05 level (2-tailed)

Additionally, family environment was negatively correlated with both anxiety (BAITOT) ($r = -0.281$, $p < 0.001$) and depression (CESTOT) ($r = -0.439$, $p < 0.001$). This indicates that individuals from supportive families are less likely to experience anxiety and depressive symptoms, highlighting the protective effect of a positive family atmosphere. Research which suggests that "children of parents with

alcohol use disorders are at increased risk for mental health problems" (National Center for Biotechnology Information, n.d.). During the pandemic, families that maintained cohesion, communication, and emotional support provided the consistent positive environment necessary to buffer against the depressive effects of social isolation, uncertainty, and disrupted routines. This distinction has important implications for understanding how family environment operates as a protective factor during extended crisis periods. The stronger correlation with depression suggests that family environment may play a more significant role in preventing depressive symptoms compared to anxiety.

Furthermore, family structure did not show a direct correlation with self-esteem, anxiety, or depression, but family size exhibited a weak positive correlation with anxiety ($r = 0.113$, $p = 0.046$). This suggests that individuals from larger families may experience slightly higher anxiety, possibly due to increased familial responsibilities or interpersonal conflicts. However, the effect size remains small, indicating that other factors may play a more substantial role in determining anxiety levels.

The robust correlation result given in Table 7.1 between overall family environment (FESTOT) and self-esteem ($r = 0.292$, $p < 0.001$) strongly supports the fundamental premise of family systems theory (Bowen, 1978). This finding suggests that in this cultural context, the family unit serves as the primary crucible for identity formation and self-worth development. The negative correlations with anxiety ($r = -0.281$) and particularly depression ($r = -0.439$) indicate that the family's influence extends beyond self-concept to emotional regulation.

From a developmental perspective, these results align with Erikson's (1968) emphasis on the adolescent need for psychosocial stability during identity formation. The stronger correlation with depression versus anxiety may reflect that depressive symptoms are more sensitive to chronic familial stressors, while anxiety might be more influenced by immediate environmental factors. This distinction has important implications for intervention strategies.

Table 7.2:*Correlation coefficient of the FES sub- scales measuring the variables under study*

FES Subscale	With Anxiety (BAITOT)	With Self-Esteem (RESTOT)	With Depression (CESTOT)
Conflict	-.238**	.153**	-.344**
Active Recreation	-.237**	.246**	-.381**
Independence	-.179**	.186**	-.260**
Control	.043	.030	-.041

**Correlation is significant at the 0.01 level (2-tailed).

Family Conflict was found to be negatively correlated with anxiety ($r = -0.238$, $p < .01$) and depression ($r = -0.344$, $p < 0.01$); and positively correlated with self-esteem ($r = 0.153$, $p < .01$). This suggests that greater levels of conflict within the family are associated with increased anxiety, depression and lower self-esteem. This finding aligns with previous literature indicating that a hostile or conflict-ridden home environment can contribute to psychological distress and diminished self-worth (Grych & Fincham, 1990) while adding cultural nuance. In this community, where familial harmony is typically prioritized, conflict may be particularly disruptive due to its relative rarity. This aligns with the stress-co-dependency framework, suggesting that unexpected discord in generally cohesive families may be more psychologically damaging than in high-conflict environments where children develop coping mechanisms. In addition, in collectivist tribal societies, family disputes may be more openly expressed yet also more readily resolved through communal support, possibly moderating self-esteem impacts (Triandis, 1995).

Active Recreation also demonstrated significant correlations in the expected direction. It was negatively associated with anxiety ($r = -0.237$, $p < .01$); Depression

($r = -0.381$, $p < 0.01$) and positively associated with self-esteem ($r = 0.246$, $p < .01$). This implies that families engaging more frequently in shared recreational activities may provide a buffer against anxiety and foster higher self-esteem in children or adolescents. In this cultural context, recreational activities likely extend beyond leisure to include communal work and religious event. This supports family systems theory, which emphasizes the importance of positive family interactions in the development of emotional resilience (Minuchin, 1974).

Independence within the family structure showed a modest negative correlation with anxiety ($r = -0.179$, $p < .01$) and depression ($r = -0.260$, $p < 0.01$) and a positive correlation with self-esteem ($r = 0.186$, $p < .01$). The moderate correlations suggest that balanced autonomy-granting is crucial, even in collectivist cultures. This challenges stereotypes about tribal societies being uniformly interdependent and underscores the universal adolescent need for developing personal identity (Erikson, 1968). The findings suggest that families who successfully navigate the tension between cultural expectations of interdependence and developmental needs for autonomy foster better psychological outcomes. Encouraging independence could help individuals develop a stronger sense of self, which may be protective against anxiety and promote self-confidence.

In contrast, the Control subscale was not significantly correlated with either anxiety ($r = 0.043$, $p = .455$) or self-esteem ($r = 0.030$, $p = .596$). The null findings may reflect measurement issues or cultural specificity. In hierarchical tribal families, certain forms of control may be normative and thus less psychologically impactful. Alternatively, as Rotenberg (1999) suggests, the distinction between benevolent and authoritarian control may be more important than control itself. Also, in tribal Christian families, control may reflect structured guidance rather than intrusion, perceived neutrally (Rudy & Grusec, 2006)

Role of Socio-Demographic Characteristics on Self-Esteem, Anxiety, and Depression

The examination of socio-demographic factors such as age, birth order, and family income were examined for their influence on self-esteem, anxiety, and depression

among children of alcoholics (COAs) and non-COAs during the Covid-19 pandemic reveals a complex landscape where traditional predictors show unexpected patterns. These findings challenge the conventional assumptions about how demographic variables influence mental health and highlight the paramount importance of family environmental factors over structural characteristics.

Table 7.3:

Correlation coefficient of the socio-demographic details and the variables under study

Variable	1	2	3	4	5	6	7	8	9	10
1. RESTOT (Self-Esteem)	—									
2. BAITOT (Anxiety)	-.26**	—								
3. FESTOT (Family Env.)	.29**	-.28**	—							
4. CESTOT (Depression)	-.36**	.54**	-.44**	—						
5. CAST	.10	-.20**	.26**	-.12*	—					
6. Age	.08	-.02	.01	-.01	-.02	—				
7. Family Structure	.02	-.02	.09	.02	.03	-.07	—			
8. Family Size	-.06	.11*	-.06	.05	.07	-.02	-.54**	—		
9. Birth Order	.00	-.08	.10	-.07	.02	.01	-.02	.01	—	
10. Family Income	-.08	.13*	-.01	.12*	.02	-.06	-.06	.21**	-.04	—

** .Correlation is significant at the 0.01 level (2-tailed).

* .Correlation is significant at the 0.05 level (2-tailed)

Note: Dashes indicate self-correlations.

The results as seen in Table 7.3 revealed that there is an absence of significant correlations between age and psychological outcomes such as with self-

esteem ($r = 0.084$, $p = 0.140$), anxiety ($r = -0.015$, $p = 0.789$), or depression ($r = -0.006$, $p = 0.910$), indicating that within the study population (mean age = 16.72 years), age does not play a significant role in shaping psychological well-being. The results presents several important implications for developmental theory and clinical practice.

The narrow age range (mean age= 16.72 years) suggests that participants are within a relatively homogenous developmental period (middle to late adolescence). This finding aligns with developmental psychopathology literature suggesting that within specific developmental windows, chronological age may be less predictive of psychological outcomes than qualitative developmental experiences (National Center for Biotechnology Information, n.d.). The stability of psychological functioning across this age range may reflect the consolidation of identity and coping mechanisms that typically occurs during mid-adolescence.

In many indigenous and tribal communities, and in this particular tribal Christian communities of Churachandpur, Manipur, the transition from childhood to adulthood is marked by cultural milestones rather than chronological age alone. Research on tribal studies in 2004 demonstrates that "puberty and initiation rites are more than cultural practices; they are transformative journeys that prepare individuals for adulthood" and represent "an important stage that is celebrated at birth, the transition from childhood to adulthood, and during more stages." The non-significant age effects observed may reflect a cultural context where psychological maturity and resilience are developed through community involvement, traditional practices, and family responsibilities (Yale Human Relations Area Files, 2017) rather than age-related developmental trajectories emphasized in Western psychological literature.

Family income was weakly but significantly correlated with anxiety ($r = 0.127$, $p = 0.026$) and depression ($r = 0.115$, $p = 0.043$). Research indicates that "levels of parent-adolescent conflict were higher among low-income families who were more likely to work in hourly and essential service sector jobs, and more vulnerable to job loss, infection, and financial stress during the pandemic" (National Center for Biotechnology Information, n.d.), however, the present study findings suggest that individuals from higher-income families may experience slightly greater

psychological distress. This finding may reflect pressures related to maintaining social status or heightened expectations. On the other hand, family income did not significantly correlate with self-esteem ($r = -0.078$, $p = 0.171$), implying that financial stability alone does not directly influence self-worth.

The absence of significant birth order effects (self-esteem: $r = 0.004$, $p = 0.950$; anxiety: $r = -0.077$, $p = 0.179$; depression: $r = -0.068$, $p = 0.236$) contrasts with classical birth order research and becomes particularly noteworthy in the context of pandemic-related family stress. Recent research has consistently found that "earlier born children score slightly higher on average on measures of intelligence, but has found zero, or almost zero, robust effect of birth order on personality" (Lejarraga et al., 2024). This traditional birth order research, largely conducted in Western nuclear family contexts, may not apply directly to tribal communities where extended family systems and collective child-rearing practices are common (Lejarraga et al., 2024). In such contexts, children may receive attention and resources from multiple adult figures, reducing the competition and differential treatment that typically characterize birth order effects in nuclear families. The pandemic may have further highlighted these protective community factors as extended family networks provided additional support during times of crisis. The lack of birth order effects may reflect more egalitarian resource distribution within families during the pandemic, where emotional support, educational opportunities, and family responsibilities were shared more equally among siblings. This pattern could be particularly pronounced in communities with strong collective values and traditional child-rearing practices, where pandemic challenges were met with collective family responses rather than individualized coping strategies.

Overall, Table 7.3 revealed that the socio-demographic characteristics (e.g., family income, family structure, tribe/caste) did not significantly influence the overall psychosocial functioning of children of alcoholics (COAs) and non-alcoholics (non-COAs). The findings emphasize the crucial role of family environment in shaping self-esteem and protecting against anxiety and depression. A supportive and cohesive family setting enhances self-worth and reduces psychological distress. Among socio-demographic factors, family income and family

size showed weak but significant correlations with mental health outcomes, while age and birth order had minimal impact.

These results support family systems theory, which emphasizes that family functioning (how families operate) is more predictive of child outcomes than family form (how families are structured). The relative unimportance of demographic characteristics highlights the centrality of family environmental quality in promoting psychological well-being, particularly during crisis periods when "mental health effects of the COVID-19 pandemic on children and adolescents" have been extensively documented (National Center for Biotechnology Information, n.d.). These results highlight the importance of fostering a positive family environment to promote psychological well-being, irrespective of socio-demographic factors.

Chapter-V
SUMMARY AND CONCLUSION

The present study examined the complex interplay between family environment, self-esteem, anxiety, and depression among adolescents children with alcoholic parents (COAs) compared to children of non-alcoholics (non-COAs). The research holds particular urgency in Manipur, where despite alcohol prohibition laws, consumption rates remain alarmingly high. The psychological consequences of parental alcoholism on adolescent development remain critically understudied in the Indian context, especially within Manipur's unique sociocultural landscape where traditional values may mediate these effects.

‘Alcohol-use disorder (AUD)’, encompassing ‘alcohol misuse and dependency’, is recognised as one of the most perilous health risk factors globally, as reported by the WHO in 2011, particularly in poor countries where it constitutes a significant contribution to serious diseases. Although the severity impact on health has been widely studied, its impact on the family systems specifically in relation to child development however was inadequately explored. Parental alcoholism creates cascading familial disruptions that can profoundly alter children's psychological trajectories, yet these dynamics are poorly understood in culturally diverse settings like India.

To achieve the objectives, the present study employed a multistage stratified sampling technique to ensure geographic and demographic representation of higher secondary students across the district. The current study sample comprised of 309 adolescents (M=163; F=146). Prior to data collection, a screening test was administered to identify students who qualified as Children of Alcoholics (COAs) and those who did not (non-COAs), based on standardized screening tools Children of Alcoholics Screening Test (CAST-6). The study adopted a cross-sectional, comparative research design to examine the differences in self-esteem, anxiety, and depression between children of alcoholics (COAs) and children of non-alcoholics (non-COAs).

The Beck Anxiety Inventory (BAI) by Beck, Epstein, Brown, and Steer (1988), the Rosenberg Self-Esteem Scale (RES) created by Rosenberg (1965), the Center for Epidemiological Studies Depression Scale for Children (CES-DC) developed by Weissman, Orvaschel, and Padian (1980), and the Family Environment

Scale (FES) by Dr. Harpreet Bhatia and Dr. N.K. Chadha (1993) were utilized for the psychological assessment and the study itself.

Diagnostic assumptions for parametric tests, including linearity, normality, skewness, kurtosis, and the homogeneity of variance as measured by Levene's statistic, were evaluated and deemed acceptable. Consequently, parametric analyses were conducted for further exploration. The reliability of all scales and subscales was examined, revealing satisfactory reliability overall. Any scales and subscales that scored below a reliability of 0.6 were excluded from the analysis.

The study engaged a sample of 309 adolescents from Churachandpur District, Manipur, with an average age of 16.73 years (ranging from 15 to 18), predominantly consisting of 17-year-olds (73.5%). The gender distribution was fairly even, with 52.8% male and 47.2% female, allowing for meaningful gender comparisons. Participants hailed from various tribal backgrounds, primarily Paite (26.9%), Vaiphei (20.7%), and Thado-Kuki (14.6%), with a significant majority identifying as Christian (93.2%). Most respondents came from nuclear families (62.5%) and belonged to middle-income households (45%) earning between 5,000 to 20,000 rupees per month. Middle children represented the largest portion in the birth order distribution (35.6%). Among children of alcoholics (COAs), gutkha usage was notably high at 57.6%, while the use of alcohol and cigarettes remained low at 3%. The demographic characteristics of the sample highlight the unique sociocultural landscape of Manipur while still offering adequate diversity for subgroup analyses. The balanced distribution of age, gender, and tribal representation contributes to the internal validity and generalizability of the study findings within the region. The prominence of Christian nuclear families with moderate income levels provides a crucial context for interpreting the psychosocial outcomes explored in this research.

The study uncovered significant insights across four essential psychological dimensions among the adolescent participants. Concerning self-esteem, a majority (70.55%) exhibited moderate levels, while 26.86% reported high self-esteem, and only 2.59% indicated low self-worth, reflecting generally positive self-perceptions among the individuals studied. However, anxiety levels raised concerns, with 44.01% experiencing severe anxiety symptoms, and 29.45% reporting moderate anxiety, suggesting widespread distress within the population. Patterns of depression

echoed these findings, with 60.84% of participants showing moderate to severe symptoms, highlighting considerable mental health challenges. In contrast, assessments of family environments yielded more favorable outcomes, as 65.70% characterized their home environments as highly supportive, although 4.21% indicated dysfunctional family dynamics. Collectively, these findings present a nuanced picture of adolescent well-being in the region, wherein a generally favorable self-concept and family support are juxtaposed with alarmingly high rates of anxiety and depression. This may point to external stressors or developmental pressures impacting mental health, even in the presence of protective factors. These results highlight the dual strengths and vulnerabilities of this population, signifying the necessity for targeted mental health interventions that address the evident contradictions in psychological functioning.

1. Impact of Paternal Alcoholism on Self-Esteem, Anxiety, and Depression

The first objective is to elucidate the impact of ‘paternal alcoholism’ on Self-esteem, Anxiety and Depression on Children of Alcoholics (COAs). To achieve the objectives the following hypothesis are put forth to study:

1. Children of alcoholics (COAs) will exhibit significantly lower levels of self-esteem compared to children of non-alcoholics (non-COAs).
2. Children of alcoholics (COAs) will report significantly higher levels of anxiety and depression compared to children of non-alcoholics (non-COAs).

The study presented detailed insights into the effects of paternal alcoholism on adolescents within the tribal Christian community of Churachandpur. Unexpectedly, COAs displayed only slightly lower self-esteem than non-COAs, with no significant statistical difference ($p = 0.070$). This finding calls into question Hypothesis 1 and indicates that certain cultural protective factors, such as collectivist family dynamics, support from church communities, and validation from peers, may mitigate the self-esteem challenges often linked with parental alcoholism seen in Western settings.

The study provided strong support for Hypothesis 2, indicating that children of alcoholics (COAs) experience significantly greater levels of anxiety compared to

non-COAs, $p < 0.001$. This finding is consistent with theoretical frameworks that propose that chaotic home environments and emotional neglect in families affected by alcoholism contribute to ongoing stress responses. Additionally, neurobiological evidence connects early-life stress with dysregulation of the HPA axis. In terms of depression, COAs had notably higher scores than their non-COA counterparts, $p < 0.039$, though the effect size was relatively small. This implies that while parental alcoholism raises the risk of depression, factors rooted in cultural resilience, such as religious beliefs and community connections, might mitigate its severity. The results emphasize both the susceptibility of COAs to internalizing disorders and the protective influence of cultural context within this group.

These findings are crucial for creating culturally informed interventions that not only meet the mental health needs of COAs but also capitalize on the strengths present in their communities. The study highlights how cultural context influences the psychological effects of parental alcoholism, showing particularly strong repercussions on anxiety, while having a more limited impact on self-esteem within this demographic.

2. Gender Differences in Self-Esteem, Anxiety, and Depression

The second objective is to elucidate ‘gender differences’ on Self-esteem, Anxiety and Depression. The hypothesis is for the objective is that there will be significant gender differences in these outcomes.

The study revealed significant gender-based psychological differences with males reporting substantially higher self-esteem than females ($p < .001$). This aligns with patriarchal norms that typically reinforce male confidence through greater autonomy and social affirmation, while restrictive gender roles appear to undermine girls' self-worth. Notably, this pattern contrasts with some collectivist cultures where communal values minimize such disparities, suggesting Manipur's gender dynamics reflect more hierarchical structures.

Conversely, female adolescents exhibited markedly higher levels of both anxiety ($p < .001$) and depression ($p = .001$), consistent with global trends showing women's greater vulnerability to internalizing disorders. Multiple factors likely

contribute to this pattern in the Churachandpur context: heightened social and academic pressures on girls, earlier development of social-evaluative anxiety, and cultural norms that encourage emotional internalization in females while promoting externalizing behaviors in males. The stress-codependency framework further suggests that girls' traditional caregiving roles may intensify their absorption of household dysfunction.

These findings highlight the critical need for culturally-attuned, gender-sensitive mental health approaches in Manipur. Recommended interventions include school-based anxiety management programs for girls coupled with initiatives challenging patriarchal norms that restrict emotional expression in boys. Future research should investigate how local cultural factors like religiosity and tribal identity might mitigate these gender disparities, potentially revealing important protective mechanisms unique to this population. The study underscores how cultural context shapes gender differences in psychological outcomes while emphasizing the importance of developing mental health strategies that address both biological and sociocultural influences on adolescent wellbeing.

3. Interaction Effect of Paternal Alcoholism and Gender on Self-Esteem, Anxiety, and Depression

The third objective of the study is to determine the interaction effect of 'paternal alcoholism x gender' on Self-esteem, Anxiety and Depression. For this, the hypothesis lay forth is that there will be a significant interaction effect between paternal alcoholism and gender on self-esteem, anxiety, and depression.

The analysis revealed three key patterns regarding how gender and paternal alcoholism jointly influence psychological outcomes:

1. Self-Esteem: No significant interaction was found ($F=1.691$, $p=.194$), indicating that gender and parental alcoholism independently affect self-esteem through distinct pathways. This additive rather than multiplicative effect aligns with social identity theory, suggesting that male adolescents maintain higher self-esteem regardless of

family circumstances, likely due to consistent gender-role reinforcement in tribal societies.

2. Anxiety: A significant interaction emerged ($F=6.237$, $p=.013$), highlighting female COAs' particular vulnerability. Girls from alcoholic homes showed substantially higher anxiety ($M=23.41$) than boys ($M=19.65$), supporting the differential susceptibility hypothesis. This likely reflects both biological sensitivity to stress and culturally-assigned caregiving burdens that amplify girls' emotional distress in dysfunctional families.
3. Depression: While the interaction was non-significant ($F=2.903$, $p=.089$), the trend of elevated depression among female COAs suggests possible gender-specific impacts that may become statistically significant with larger samples. The marginal effect could indicate protective cultural factors buffering depression, or measurement limitations in capturing boys' externalizing symptoms

4. Family Environment Pattern Among COAs and Non-COAs

The fourth objective is to elucidate the family environment pattern of children of alcoholics and non-alcoholics. The hypothesis to achieve this objective is that the family environment of children of alcoholics (COAs) will differ significantly from that of children of non-alcoholics (non-COAs).

The study found significant differences in family environments between children of alcoholics (COAs) and non-COAs. COAs reported substantially poorer overall family functioning, characterized by higher conflict, less independence, and more chaotic control structures. These findings align with Family Systems Theory, demonstrating how parental alcoholism disrupts family equilibrium through financial strain, emotional volatility, and inconsistent parenting.

A notable discovery was COAs' significantly restricted autonomy, suggesting these adolescents often face either neglect or overcontrol in their family dynamics. Many are forced into premature caregiving roles, creating role confusion as they balance cultural expectations of family loyalty with their own developmental needs. Interestingly, while emotional and structural aspects of family life were clearly impacted, active recreational activities remained unaffected - possibly indicating

these communal practices serve as a cultural buffer against complete family dysfunction.

These findings highlight the need for targeted interventions addressing conflict resolution and healthy boundary-setting in COA households. The preservation of recreational activities despite other family disruptions suggests community-based approaches leveraging existing cultural strengths may be particularly effective. Future research should further explore how traditional tribal support systems might be mobilized to mitigate the negative effects of parental alcoholism on family functioning and adolescent development.

5. The Role of Family Environment and Socio-Demographic Characteristics on Self-Esteem, Anxiety, and Depression

The last and final objective is to determine the role of Family environment and socio-demographic characteristic on Self-esteem, Anxiety and Depression. For this, the hypothesis are as follow:

1. Family environment will have a significant positive relationship with self-esteem in both children of alcoholics (COAs) and non-alcoholics (non-COAs).
2. Family environment will have a significant negative relationship with anxiety and depression in both children of alcoholics (COAs) and non-alcoholics (non-COAs).
3. Socio-demographic characteristics (e.g., family income, family structure, tribe/caste) will significantly influence the overall psychosocial functioning of children of alcoholics (COAs) and non-alcoholics (non-COAs).

The family environment plays a crucial role in shaping an individual's self-esteem and mental health. The study found a significant positive correlation between family environment (FESTOT) and self-esteem (RESTOT) ($r = 0.292$, $p < 0.001$), suggesting that individuals who perceive their family as supportive and nurturing tend to have higher self-esteem. A strong and cohesive family environment fosters a sense of security and belonging, contributing to better emotional regulation and confidence. Conversely, a negative family environment can lead to diminished self-worth and increased psychological distress.

Additionally, family environment was negatively correlated with both anxiety (BAITOT) ($r = -0.281, p < 0.001$) and depression (CESTOT) ($r = -0.439, p < 0.001$). This indicates that individuals from supportive families are less likely to experience anxiety and depressive symptoms, highlighting the protective effect of a positive family atmosphere. The stronger correlation with depression suggests that family environment may play a more significant role in preventing depressive symptoms compared to anxiety.

Furthermore, family structure did not show a direct correlation with self-esteem, anxiety, or depression, but family size exhibited a weak positive correlation with anxiety ($r = 0.113, p = 0.046$). This suggests that individuals from larger families may experience slightly higher anxiety, possibly due to increased familial responsibilities or interpersonal conflicts. However, the effect size remains small, indicating that other factors may play a more substantial role in determining anxiety levels.

Analysis of the data revealed that socio-demographic variables—including family income, structure, and tribal/caste affiliation—did not exhibit significant influence on overall psychosocial functioning when comparing children of alcoholics (COAs) with their non-alcoholic counterparts (non-COAs). The research underscores the fundamental importance of family environment as a critical determinant in developing healthy self-esteem and providing protection against anxiety and depression. Children raised in cohesive, supportive family units demonstrated enhanced self-worth and reduced psychological distress. While most socio-demographic factors showed minimal impact, family income and size did demonstrate weak yet statistically significant correlations with mental health outcomes, whereas age and birth order position showed negligible effects. These findings emphasize that cultivating positive family dynamics remains essential for promoting psychological well-being across diverse socio-demographic backgrounds.

Limitations and Implications of the study

The study has several limitations that should be acknowledged. First, its cross-sectional design restricts the ability to establish causality between parental alcoholism and psychological outcomes. While associations were identified, longitudinal research would better clarify how these dynamics evolve over time.

Additionally, reliance on self-report measures may introduce biases, such as social desirability or underreporting due to stigma, particularly in a conservative cultural setting like Manipur. Adolescents might hesitate to disclose family struggles or emotional distress, potentially skewing results.

Another limitation is the study's restricted geographical and cultural scope. The sample was drawn exclusively from Churachandpur District, primarily comprising Christian tribal communities. While this provides valuable insights into a specific population, findings may not generalize to non-tribal, non-Christian, or urban Indian adolescents. Furthermore, the study focused solely on paternal alcoholism, excluding cases where mothers were alcoholics. Maternal drinking patterns could have distinct effects on family dynamics and child mental health, warranting future investigation.

The study also did not deeply explore protective cultural factors, such as religiosity or community cohesion, that may buffer psychological distress in COAs. While these were acknowledged, their specific mechanisms remain unclear. Additionally, confounding variables like domestic violence, financial instability, or parental mental illness were not controlled for, which could independently influence adolescent well-being. Finally, some psychological scales had suboptimal reliability, leading to their exclusion, which may have omitted relevant dimensions of mental health.

The findings contribute to theoretical frameworks by highlighting how cultural context mediates the effects of parental alcoholism. Unlike Western studies, which often report significant self-esteem deficits in COAs, this research suggests that collectivist cultural norms—such as extended family support and church involvement—may mitigate some negative psychological impacts. This challenges universal assumptions about COAs and calls for culturally adapted models of resilience and risk.

Additionally, the study reinforces gender socialization theories by demonstrating how patriarchal norms exacerbate anxiety and depression in girls, particularly those from alcoholic households. The significant interaction between gender and parental alcoholism suggests that cultural expectations shape emotional expression and coping mechanisms in distinct ways for boys and girls. These

insights underscore the need for gender-sensitive theoretical approaches in developmental psychology.

Given the high rates of anxiety and depression among COAs, school-based mental health programs should be prioritized. Cognitive-behavioral therapy (CBT) workshops, peer support groups, and gender-sensitive counseling could help adolescents manage stress and emotional distress. Schools in Churachandpur, Manipur could collaborate with local mental health professionals to implement early intervention programs, particularly for at-risk students.

Community and religious institutions also play a crucial role. Churches and tribal councils could organize parental awareness campaigns on the consequences of alcoholism and provide support groups for affected families. Since the study found that recreational family activities remained intact despite dysfunction, community-based programs that foster positive family interactions could be particularly beneficial.

Family-focused interventions are another critical need. Conflict resolution training, parenting skills workshops, and economic support initiatives could help stabilize households affected by alcoholism. Given the correlation between low family income and poorer mental health, policies that address socioeconomic disparities may indirectly improve adolescent well-being.

At the policy level, the study highlights the need for stricter enforcement of alcohol prohibition laws in Manipur, where consumption remains high despite legal restrictions. Additionally, mental health funding should be directed toward rural and tribal adolescent populations, who often lack access to psychological services. Schools could integrate COA screening into routine health check-ups to identify at-risk students early.

Future research should expand on these findings through longitudinal studies tracking COAs into adulthood. Qualitative approaches, such as in-depth interviews, could provide richer insights into lived experiences, while neurobiological studies might explore stress-related biomarkers in this population. Further investigation into maternal alcoholism and the specific mechanisms of cultural resilience would also enhance understanding of this complex issue.

APPENDICES

APPENDIX-I

Informed Consent Form- School

(Chingnunhoih, 2020)

Title of the research: Family Environment, Self-Esteem, Anxiety and Depression among Children of Alcoholics and Non-Alcoholics

Principal Investigator: Mercy Chingnunhoih, Ph.D Research Scholar, Dept. of Psychology, Mizoram University.

Supervisor: Prof. Zoengpari, Professor, Dept. of Psychology, Mizoram University.

Purpose of the Study:

This study aims to understand the relationship between family environment, self-esteem, anxiety, and depression in children of alcoholics compared to non-alcoholics. The findings will help in developing better support systems for affected children.

Participation Details:

- The study involves voluntary participation of students (with parental consent).
- Data will be collected through questionnaires in a confidential manner.
- No identifying information about the school or students will be published.

School's Role:

- Grant permission for researchers to approach parents/students.
- Provide a suitable time/space for data collection.

Voluntary Participation:

The school has the right to withdraw participation at any time without consequences.

Consent:

By signing below, I confirm that I have read and understood the study details and grant permission for the research to be conducted in this school.

Principal's Name : _____

Signature : _____

Date : _____

School Stamp (if applicable)

Informed Consent Form- Parent/Guardian

(Chingnunhoih, 2020)

Title of the research: Family Environment, Self-Esteem, Anxiety and Depression among Children of Alcoholics and Non-Alcoholics

Principal Investigator: Mercy Chingnunhoih, Ph.D Research Scholar, Dept. of Psychology, Mizoram University.

Supervisor: Prof. Zoengpari, Professor, Dept. of Psychology, Mizoram University.

Purpose of the Study:

This study aims to understand the relationship between family environment, self-esteem, anxiety, and depression in children of alcoholics compared to non-alcoholics. The findings will help in developing better support systems for affected children.

What Participation Involves:

- Your child will complete a questionnaire (approx. 20-30 mins).
- Questions will relate to emotions, family life, and self-perception (age-appropriate).
- Participation is voluntary—your child can withdraw anytime.

Confidentiality:

- Responses will be anonymous—no names or personal details will be shared.
- Data will be stored securely and used only for research purposes.

Voluntary Participation:

You may withdraw consent anytime without penalty.

Consent:

By signing below, I confirm that I understand the study and voluntarily allow my child to participate.

Parent/Guardian Name: _____

Child's Name (optional): _____

Signature: _____

Date: _____

Informed Consent Form- Student/Child

(Chingnunhoih, 2020)

Title of the research: Family Environment, Self-Esteem, Anxiety and Depression among Children of Alcoholics and Non-Alcoholics

Principal Investigator: Mercy Chingnunhoih, Ph.D Research Scholar, Dept. of Psychology, Mizoram University.

Supervisor: Prof. Zoengpari, Professor, Dept. of Psychology, Mizoram University.

Purpose of the Study:

This study aims to understand the relationship between family environment, self-esteem, anxiety, and depression in children of alcoholics compared to non-alcoholics. The findings will help in developing better support systems for affected children.

What You'll Do:

- Answer questions (like a survey) about your thoughts and family.
- It's **your choice**—you can say no or stop anytime.
- Nobody will know it's you—your answers are secret.

Your Rights:

- ☐ You don't have to answer anything you don't want to.
- ☐ You can ask questions anytime.

Do You Want to Participate?

- **Yes, I want to.**
- **No, I don't want to.**

Name (optional): _____

Signature (if old enough): _____

Date: _____

APPENDIX-IV

Socio-demographic profiles: - (Chingnunhoih, 2020)

Name:

CODE no.

Age:

Gender:

Tribe/ Caste:

Religion:

Family structure: Joint/ Nuclear

Size of the family:

No.of siblings:

Birth order: first born/ middle child/ youngest/ only child

Any substance usage (including gutkha products):

Parents age: Mother_____ Father_____

Tribe/caste: Mother_____ Father_____

Occupation: Mother_____ Father_____

Average monthly income of the family:

Substance usage of Parent (including gutkha products):

Average amount spent on alcohol:

CAST-6
(Screening tool)
(Jones & Pilat, 1981)

Answer the following questions in YES or NO

1. Have you ever thought that one of your parents had a drinking problem? Yes/No
2. Did you ever encourage one of your parents to quit drinking? Yes/No
3. Did you ever argue or fight with a parent when he or she was drinking? Yes/No
4. Have you ever heard your parents fight when one of them was drunk? Yes/No
5. Did you ever feel like hiding or emptying a parent's bottle of liquor? Yes/No
6. Did you ever wish that a parent would stop drinking? Yes/No

Rosenberg Self-Esteem Scale (RSE)

(Rosenberg, 1965)

Please record the appropriate answer for each item, depending on whether you Strongly agree, agree, disagree, or strongly disagree with it.

1 = Strongly agree

2 = Agree

3 = Disagree

4 = Strongly disagree

- _____ 1. On the whole, I am satisfied with myself.
- _____ 2. At times I think I am no good at all.
- _____ 3. I feel that I have a number of good qualities.
- _____ 4. I am able to do things as well as most other people.
- _____ 5. I feel I do not have much to be proud of.
- _____ 6. I certainly feel useless at times.
- _____ 7. I feel that I'm a person of worth.
- _____ 8. I wish I could have more respect for myself.
- _____ 9. All in all, I am inclined to think that I am a failure.
- _____ 10. I take a positive attitude toward myself.

APPENDIX-VII

Beck Anxiety Inventory ***(Beck, Epstein, Brown & Steer, 1988)***

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not at all 0	Mildly but it didn't bother me much 1	Moderately – it wasn't pleasant at all 2	Severely – it bothered me a lot. 3
Numbness or tingling				
Feeling hot				
Wobbliness in legs				
Unable to relax				
Fear of worst happening				
Dizzy or lightheaded				
Heart pounding/racing				
Unsteady				
Terrified or afraid				
Nervous				
Feeling of choking				
Hands trembling				
Shaky / unsteady				
Fear of losing control				

Difficulty in breathing				
Fear of dying				
Scared				
Indigestion				
Faint / lightheaded				
Face flushed				
Hot/cold sweats				
Column Sum				

APPENDIX-VIII

Center for Epidemiologic Studies Depression Scale for Children (CES-DC)

(Weissman, Orvaschel & Padian, 1980)

Below is a list of the ways you might have felt or behaved. Please tell me how often you have felt this way during the past week.

During the Past Week

	Rarely or none of the time (less than 1 day)	Some or a little of the time (1-2 days)	Occasionally or a moderate amount of time (3-4 days)	Most or all of the times (5- 7 days)
1. I was bothered by things that usually don't bother me.				
2. I did not feel like eating; my appetite was poor.				
3. I felt that I could not shake off the blues even with help from my family or friends.				
4. I felt I was just as good as other people.				
5. I had trouble keeping my mind on what I was doing.				
6. I felt depressed.				
7. I felt that everything I did was an effort.				
8. I felt hopeful about the future.				
9. I thought my life had been a failure.				
10. I felt fearful.				
11. My sleep was restless.				

2. I was happy.				
3. I talked less than usual.				
4. I felt lonely.				
5. People were unfriendly.				
6. I enjoyed life.				
7. I had crying spells.				
8. I felt sad.				
9. I felt that people dislike me.				
10. I could not get "going."				

APPENDIX-IX

Family Environment Scale (FES – BC)

(Bhatia & Chadia, 1993)

Sr. No	STATEMENTS	RESPONSES					
		Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree	Score
1.	We enjoy doing things together.						
2.	Family members often do not express their feelings.						
3.	Breaking things in anger is quite common in our family.						
4.	Making decisions independently is strongly encouraged in our family.						
5.	In our family everyone is encouraged to play and interact with neighbors.						
6.	Responsibilities are not taken seriously in our family.						
7.	All members of the family are expected to be together for at least one meal in a day.						
8.	Affection is expressed openly, quite often in our family.						

9. Togetherness is the basic feeling of our family.						
10. Our feelings of happiness are shared openly in our family.						
11. Beating up people in anger is not seen in our family.						
12. There are lots of restriction in our family.						
13. Friends and guests are always welcome in our family.						
14. Everyone in our family is well aware of their responsibilities.						
15. Nobody in our family is bothered about rules of my kind.						
16. Everyone in our family listens to what each one of us has to say.						
17. Whenever any work comes up, everyone tries to get out of the situation.						
18. It is difficult to express ourselves openly for fear of someone reacting to it angrily.						
19. Everyone tries to sort things out if there is disagreement in the family.						

20. Thinking for ourselves is not encouraged in our family.						
21. We often go out together for movies in our family.						
22. Going for programmes without informing at home is not acceptable in our family.						
23. Nobody bothers to look after anyone else in our family.						
24. Any new situation that arises is discussed openly in the family in order to get ideas and suggestions from the family.						
25. We talk about our personal problems to each other in our family.						
26. When members are angry, they do not talk to each other for days together.						
27. In our family, members ask for what they need, quite openly.						
28. Having hobbies is encouraged in our family.						
29. Quite often members of our family stay out without informing						

at home.						
30. Only when we do something well, we get praise and attention from others in our family.						
31. Family members do not get along with each other.						
32. Complaining about something that we don't like is not accepted in our family.						
33. Finding faults with each other is quite common in our family.						
34. It is difficult to do something on your own in our family, without some- one feeling rejected or left out.						
35. Watching T.V. is our only form of entertainment.						
36. There is plenty of time and attention for everyone in our family.						
37. Everyone comes together to sort out any new situation that may arise in our family.						
38. At home we feel free to anything we want to.						

39. Shouting in anger is not common in our family.						
40. Everyone is expected to accept all decisions made in the family, whether they like it or not.						
41. Our family members are just confined to either work or school.						
42. We are careful not to hurt anyone in the family by making thoughtless remarks.						
43. Whenever something needs to be done in the house, everyone joins in, happily.						
44. When any member is feeling upset, he/she talks to someone in the family.						
45. The members of our family constantly keep bickering over small matters.						
46. Whenever a marriage takes place in our family the person concerned is asked his/her views.						
47. We go out often to visit friends or relations.						

48. In our family if anyone is upset, there is always someone to comfort them.						
49. There is no sense of closeness in our family.						
50. Family Members often keep their feelings to themselves.						
51. Whenever anyone in our family is angry with another member he makes sure to sort out things with him.						
52. The decision to take on or continue a particular job is taken by the family members concerned in consultation with other family members.						
53. Joking and laughing is not encouraged in our family.						
54. When things get laugh there is always someone in the family whom we can turn to.						
55. When someone is sick in our family everyone participates after the person. looking.						
56. Expressing an opinion about matters at home is strongly						

encouraged in our family.						
57. Whenever a family member does something well, the other members feel upset about it.						
58. All major decisions in our family are taken by the elders in our family, without asking anyone else's opinion.						
59. There is a lot of affection amongst our family members.						
60. When a family vacation is planned, we all give our suggestions.						
61. Our family believes in not letting differences continue unsorted out.						
62. If any member gets into trouble he/she gets help and sympathy from other family members.						
63. When in trouble, all of us stand up for our family member.						
64. Quite often members of our family fail to arrive at a mutually acceptable solution.						

65. When anyone makes a mistake, the other members ridicule him.						
66. In our family, we enjoy sitting together and talking to each other.						
67. Showing anger by banging doors is rarely seen in our family.						
68. Members of our family are very critical of each other.						
69. All of us participate together in family functions/programmes.						

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- Mercy Chingnunhoih, Lalngaihawmi & Zoengpari (2022). A comparative study of mental health impact among children of alcoholics and non-alcoholics. *Contemporary Social Scientist (A National Referred Journal)* 14 (2), 78-85.
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- Chingnunhoih, M., Lalnunhlmi, & Zoengpari. (2019). Occupational stress among staff nurses in Aizawl City. *Mizoram University Journal of Humanities & Social Sciences*, 5(1)
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ABSTRACT

FAMILY ENVIRONMENT, SELF-ESTEEM, ANXIETY, AND DEPRESSION AMONG CHILDREN OF ALCOHOLICS AND NON-ALCOHOLICS

**AN ABSTRACT SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF
PHILOSOPHY**

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DEPARTMENT OF PSYCHOLOGY

SCHOOL OF SOCIAL SCIENCES

MARCH, 2026

**FAMILY ENVIRONMENT, SELF-ESTEEM, ANXIETY, AND DEPRESSION
AMONG CHILDREN OF ALCOHOLICS AND NON-ALCOHOLICS**

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Submitted
In partial fulfilment of the requirement of the Degree of Doctor of Philosophy in
Psychology of Mizoram University, Aizawl

Introduction

Alcoholism represents one of the most pervasive health and social challenges globally, with profound implications extending far beyond the individual struggling with alcohol dependence. The World Health Organization (2011) recognizes alcohol misuse as a universal problem and significant public health concern, with an estimated 208 million people worldwide suffering from alcoholism in 2010 and approximately 3.3 million annual deaths resulting from harmful alcohol use. Alcohol Use Disorder (AUD), characterized by compulsive alcohol consumption, loss of control over intake, and negative emotional states during periods of abstinence, cuts across all demographic boundaries. This complex disorder represents the greatest risk factor for disease and disability in middle-income countries and stands as the third highest cause of death worldwide.

Manipur, India, traditionally regarded as a "dry" or "abstaining" culture, has witnessed a significant increase in alcohol consumption despite legislative prohibitions. The WHO's Global Status Report on Alcohol and Health 2018 documented more than a twofold increase in per capita alcohol consumption in India between 2005 and 2016, rising from 2.4 liters to 5.7 liters.

Churachandpur district, the focus of this study, presents a compelling paradox. Despite being governed by the Manipur Liquor Prohibition Act (MLPA) of 1991, alcohol consumption remains widespread, with prevalence rates reaching 52.5%. This district, covering 4,570 square kilometers in southwestern Manipur, serves as a significant religious and educational center, hosting seven Bible Colleges, two Government Colleges, and numerous higher secondary schools. The district's demographic composition includes 274,143 people belonging to various tribes including Kuki, Zomi, Hmar, and Mizo, with 93.30% residing in rural areas. This predominantly Christian tribal community (93.2% Christian according to our study) provides a unique cultural context for examining the impact of paternal alcoholism on adolescent development.

Research consistently demonstrates that the effects of harmful alcohol use extend beyond the individual consumer, often impacting family members before any negative health consequences become apparent to the drinker. Children bear the brunt of these effects, experiencing what many researchers describe as a "family disease" due to alcoholism's pervasive impact on family systems.

Children of alcoholics constitute a substantial population segment worldwide, facing risks for numerous psychological and developmental problems throughout their lives. These challenges range from emotional problems and hyperactivity in childhood to emotional and conduct problems in adolescence, with potential for developing alcoholism in adulthood.

Adolescence represents a pivotal developmental stage characterized by profound cognitive, emotional, and social transformations. This phase, typically defined as ages 10-19 by the World Health Organization, is associated with increased stress levels and significant emotional volatility. The exploration of adolescents' subjective wellbeing has become a focal point of research, as a substantial proportion of mental health challenges arise during this period.

When normative adolescent developmental challenges are compounded by dysfunctional family environments related to parental alcoholism, adolescents face additional obstacles in negotiating this already tumultuous phase. The domestic environment created by parental alcoholism may significantly impact adolescents' psychological adjustment and personality development.

Early research on children of alcoholics emerged in the 1970s, with pioneering studies by El-Guebaly and Offord (1977) reviewing the effects of parental alcoholism on children's emotional disturbances. These foundational studies established the groundwork for understanding how parental drinking patterns substantially impact children over time, with the alcoholic parent's gender serving as another significant factor.

Wilson and Orford (1978) conducted seminal research examining familial relationships in families where one parent was alcoholic, concluding that alcohol consumption by parents disturbed the emotional climate of everyday family life. Their findings revealed that fear and emotional distress caused by living with an alcoholic parent were often more harmful than physical violence.

West's (1987) comprehensive review of studies published between 1975 and 1985 organized substantive findings across eight outcome domains: hyperactivity and conduct disorder; substance abuse, delinquency, and truancy; cognitive functioning; social inadequacy; somatic problems; anxiety and depressive symptoms; physical abuse; and dysfunctional family interactions. This review substantiated the argument that parental alcoholism was linked to higher prevalence of psychopathology symptoms in children.

Self-esteem constitutes a fundamental pillar in adolescent psychosocial development, serving both as a protective factor against psychological distress and a foundation for healthy identity formation. Empirical evidence consistently demonstrates that children of alcoholics represent a vulnerable population regarding self-esteem development. Berger's (1993) seminal work identified a constellation of self-concept disturbances common among COAs, including pervasive feelings of inadequacy, chronic self-doubt, and impaired self-appraisal. These manifestations often co-occur with affective symptoms such as existential loneliness, inappropriate guilt, and learned helplessness—patterns suggesting the internalization of familial instability.

Research by Berkowitz and Perkins (1988) revealed that COA respondents reported higher levels of self-deprecation compared to their peers, with women experiencing greater differences in self-deprecation between COAs and their peers. Madhavi's (2016) comparative study conclusively demonstrated lower self-esteem among adolescent children of alcoholic fathers compared to those with non-alcoholic fathers.

Anxiety ranks among the most common psychological disorders in school-aged children and adolescents worldwide. The adolescent period, characterized by unique challenges and adjustment demands, renders adolescents particularly vulnerable to anxiety. Research has consistently demonstrated that Children of Alcoholics experience higher levels of anxiety compared to their peers. Paternal alcoholism creates an environment characterized by unpredictability, inconsistency, and potential threat—conditions highly conducive to anxiety development. Eiden et al.'s (2009) study conclusively demonstrated that children with alcoholic fathers exhibited significantly higher anxiety scores than children from non-alcoholic homes.

Specific anxiety-inducing factors associated with paternal alcoholism include unpredictable behavioral changes during drinking episodes, financial instability and associated family stress, anticipatory anxiety related to potential embarrassment or harm, hypervigilance developed as an adaptive response to chaotic home environments, and genetic vulnerabilities to anxiety disorders potentially transmitted from alcoholic parents.

Depression constitutes a common and serious illness that negatively affects thinking, feelings, and actions. Research findings indicate that while depression prevalence in children is generally low with no gender differences, it increases significantly during adolescence. Numerous studies demonstrate that parental alcoholism increases children's risk of depression, with COAs exhibiting higher likelihood of depression and depressive symptoms compared to non-COAs.

Multiple studies confirm that children of alcoholic fathers face approximately double the risk for both major depressive disorder and persistent depressive disorder compared to peers from non-alcoholic homes (Omkarappa & Rentala, 2019; Mansharamani et al., 2018; Abela, et al., 2009). This elevated risk stems from exposure to negative cognitive models from depressed alcoholic parents, neurobiological vulnerabilities potentially shared between alcoholism and depression, environmental stressors associated with alcoholic households, disrupted

attachment relationships that typically buffer against depression, and learned helplessness developing from inability to control or predict family circumstances.

The family, as the primary agency of socialization, exerts profound influence on child development. Functional families promote proper development of members, allowing individual expression, whereas dysfunctional environments create toxic conditions often associated with maladaptive behaviours or alcohol dependence. Research consistently associates several family problems with alcoholism: increased family conflict; emotional or physical violence; decreased family cohesion and organization; increased family isolation; elevated family stress including work problems, illness, marital strain and financial difficulties; and frequent family relocations.

Paternal alcoholism profoundly disrupts family functioning across multiple dimensions, including decreased family cohesion and increased conflict, reduced expressiveness and emotional safety, inconsistent rule enforcement and boundary maintenance, role confusion and inappropriate role allocation, social isolation and decreased community integration, financial strain and resource instability, and communication difficulties including denial and secret-keeping.

This study employs several theoretical perspectives to understand the impact of parental alcoholism on children's psychosocial development:

Family Systems Theory views the family unit as the source of dysfunction because alcoholism becomes intertwined with family operations. The theory posits that different subsystems—couple, parent-child, and sibling subsystems—are each affected by alcoholism in distinct ways.

Developmental Perspective emphasizes how parental alcoholism significantly impacts both young children and adolescents. Role development opportunities for COAs can be severely limited, potentially causing problems in accomplishing necessary healthy development stages.

Stress and Co-dependency Perspective hypothesizes that heightened stress from living in an alcohol-complicated family environment can adversely affect adolescent children's personality traits and manifest as deficits in their psychosocial functioning.

Cross-Cultural Perspective recognizes that while certain impacts of parental alcoholism may be universal, manifestations and coping mechanisms vary significantly across cultures. This perspective is particularly relevant for understanding COAs in Churachandpur district, where tribal identities, religious influences, and community structures create unique contexts.

Objectives

Given the theoretical and methodological foundation pertaining to the research problem, the present study is put forward with the following objectives. The study aims to elucidate the impact of paternal alcoholism on self-esteem, anxiety and depression among children of alcoholics (COAs). Additionally, it seeks to explore gender differences on self-esteem, anxiety and depression between the two groups (COAs and non-COAs), while also determining the interaction effect of paternal alcoholism and gender on these psychological variables. The research further endeavours to elucidate the family environment patterns of children of alcoholics compared to non-alcoholics, and to determine the role of family environment and socio-demographic characteristics in influencing self-esteem, anxiety and depression outcomes.

Hypotheses

To meet the objectives of the study, the following hypotheses will be attempted in the study:

1. Children of alcoholics (COAs) will exhibit significantly lower levels of self-esteem compared to children of non-alcoholics (non-COAs).
2. Children of alcoholics (COAs) will report significantly higher levels of anxiety and depression compared to children of non-alcoholics (non-COAs).

3. There will be significant gender differences in self-esteem, anxiety, and depression.
4. There will be a significant interaction effect between paternal alcoholism and gender on self-esteem, anxiety, and depression.
5. The family environment of children of alcoholics (COAs) will differ significantly from that of children of non-alcoholics (non-COAs).
6. Family environment will have a significant positive relationship with self-esteem in both children of alcoholics (COAs) and non-alcoholics (non-COAs).
7. Family environment will have a significant negative relationship with anxiety and depression in both children of alcoholics (COAs) and non-alcoholics (non-COAs).
8. Socio-demographic characteristics (e.g., family income, family structure, tribe/caste) will significantly influence the overall psychosocial functioning of children of alcoholics (COAs) and non-alcoholics (non-COAs).

Research Design

This study adopted a cross-sectional, comparative research design to examine differences in self-esteem, anxiety, and depression between children of alcoholics (COAs) and children of non-alcoholics (non-COAs). The design allowed for comparison of psychological outcomes across the two groups at a single point in time, while controlling for key socio-demographic variables.

For enhanced data analysis, the research employed a 2x2 factorial framework that permitted investigation of two primary independent variables: paternal alcohol dependency status (COAs versus non-COAs) and gender (male versus female). This analytical approach enabled examination of both main effects—the individual influence of each variable—and their possible interactive effects on the outcome measures of self-esteem, anxiety, and depression.

Sample

To accomplish the research objectives, this study utilized a multistage stratified sampling method to ensure thorough geographic, demographic and institutional coverage of senior secondary students (Classes XI and XII) throughout Churachandpur district in Manipur, India. This sampling strategy was chosen to reduce selection bias and improve the applicability of results across varied educational and socioeconomic settings. The research implemented a cross-sectional comparative framework to investigate differences in self-esteem, anxiety, and depression between children from alcoholic families (COAs) and those from non-alcoholic families (non-COAs). This methodology facilitated comparison of psychological measures between both groups at one time point, while accounting for important socio-demographic factors including age, gender, family composition, and tribal affiliation. The study also examined how family environment and socio-demographic variables influence these psychological outcomes.

Psychological Tools

The study utilized several psychological assessment tools to evaluate various aspects of family dynamics, mental health, and socio-demographic factors. The **Family Environment Scale (FES)**, developed by Bhatia and Chadha (1993) as an adaptation of Moos and Moos' (1974) original scale, measures social and environmental family characteristics. It consists of 69 items categorized into three dimensions—Relationship (Cohesion, Expressiveness, Conflict, Acceptance & Caring), Personal Growth (Independence, Active Recreational Orientation), and System Maintenance (Organization, Control)—with reliability coefficients ranging from 0.48 to 0.92. The **Rosenberg Self-Esteem Scale (RSES; Rosenberg, 1965)** assesses self-worth through 10 Likert-scale items, with scores classifying self-esteem as low (<20), moderate (20–30), or high (>30), demonstrating strong reliability ($\alpha = 0.77$). Anxiety levels were measured using the **Beck Anxiety Inventory (BAI; Beck et al., 1988)**, a 21-item self-report tool with scores indicating minimal (0–7), mild (8–15), moderate (16–25), or severe anxiety (26–63), showing high internal consistency ($\alpha = 0.92$). Depressive symptoms in children were

evaluated via the **CES-DC (Weissman et al., 1980)**, a 20-item scale with reversed scoring for positive items; scores ≥ 15 suggest depression, supported by strong reliability ($\alpha = 0.84$). A **custom socio-demographic questionnaire** captured variables like age, family structure, and socio-economic status to control for confounding factors. Lastly, the **Children of Alcoholics Screening Test (CAST-6; Pilat & Jones, 1985)** identified parental alcohol use disorder's impact using six Likert items (score ≥ 3 indicating risk), with an internal consistency of 0.86.

Procedures

Data collection adhered to APA ethical guidelines (2017) with appropriate institutional approvals. Participants provided informed consent, with parental consent obtained for those under 18. The study ensured confidentiality and participants' right to withdraw at any point.

A pilot study with 60 students tested instrument clarity and feasibility, leading to minor wording adjustments for cultural appropriateness. Data were collected in group classroom sessions with comprehensive instructions provided.

Statistical Analyses

Data analysis employed SPSS with multiple statistical techniques: descriptive statistics (frequencies, percentages, means, standard deviations), independent t-tests for group comparisons, univariate ANOVA for gender differences, two-way ANOVA for interaction effects, Pearson's correlation for relationship exploration, and multiple regression analyses for examining family environment and socio-demographic influences.

Results and Discussion

The study sample consisted of 309 participants, with a nearly equal gender distribution: 52.8% males and 47.2% females. The tribal composition reflected the region's diversity, with the largest groups being Paite (26.9%), Vaiphei (20.7%), Thado-Kuki (14.6%), Zou (13.3%), Simte (6.8%), and Hmar (5.8%).

Religiously, the majority identified as Christian (93.2%), followed by Judaism (3.6%), Hinduism (1.9%), and Islam (1.3%). In terms of family structure, 62.5% came from nuclear families, while 37.5% belonged to joint families. Household income distribution showed that 45.0% of families earned between ₹5,000–₹20,000 per month, and 36.6% earned ₹21,000–₹40,000.

The psychological assessment revealed concerning mental health patterns among participants. Using standardized cut-off scores, the majority showed moderate self-esteem (70.55%), while anxiety levels were alarmingly high with 44.01% experiencing severe anxiety and 29.45% moderate anxiety. Depression was similarly prevalent, with 33.01% showing moderate depression and 27.83% severe depression. Despite psychological challenges, 65.70% of participants reported highly supportive family environments, suggesting the presence of protective factors that may buffer against complete psychological deterioration.

The present study results revealed no significant difference in self-esteem between COAs ($M=23.16$, $SD=4.068$) and non-COAs ($M=23.93$, $SD=3.391$), $t=-1.816$, $p=.070$. This unexpected finding challenges Western and previous literature (Sher, 1991; Windle & Searles, 1990; Kanus, 2014; Madhavi, 2016) and suggests collectivist cultural structures and church-based support may buffer against self-esteem deficits (Ungar, 2012). However, COAs exhibited significantly higher anxiety ($M=26.19$, $SD=11.925$ vs. $M=21.66$, $SD=9.996$; $t=3.631$, $p<.001$) and depression ($M=25.83$, $SD=10.585$ vs. $M=23.45$, $SD=9.491$; $t=2.071$, $p=.039$), though the modest depression effect size indicates potential protective factors at play. These findings are supported by similar research findings (Abela, et al., 2009; Mishra, et al., 2018; Mansharamani et al. 2018; Brunda 2023).

Gender analysis revealed significant disparities: males showed higher self-esteem ($F=16.842$, $p<.001$) while females reported greater anxiety ($F=21.691$, $p<.001$) and depression ($F=10.500$, $p=.001$), reflecting cultural gender norms that restrict girls' coping mechanisms (Elaine & Robert, 1999; Andrade et al., 2003; Bromet et al., 2011). Notably, a significant interaction effect ($F=6.237$, $p=.013$)

showed females from alcoholic households experiencing markedly higher anxiety ($M=23.41$ vs. males' $M=19.65$), supporting differential susceptibility hypotheses.

Family environment analysis showed COAs reporting significantly poorer family functioning ($M=221.87$, $SD=26.715$ vs. $M=234.92$, $SD=21.236$; $t=-4.721$, $p<.001$), with specific deficits in conflict resolution ($t=-4.778$, $p<.001$), independence ($t=-3.181$, $p=.002$), and control ($t=-2.916$, $p=.004$). These findings are in consistent with prior research linking alcoholism to familial discord (Moos & Moos, 1984; Jacob, 1992; Lalnunpui, 2015). However, active recreation showed no difference ($t=-0.639$, $p=.523$), suggesting cultural resilience in maintaining communal activities (Nang, 2007).

Correlation analyses revealed strong relationships between family environment and psychological outcomes, particularly for depression ($r=-0.439$, $p<.001$). These findings suggest a complex cultural mediation effect where collectivist structures protect self-esteem but not internalizing disorders. The tribal Christian context appears to provide alternative validation sources through extended family and religious community, buffering against self-worth erosion while anxiety and depression manifest through universal stress pathways. Gender differences highlight how cultural norms may amplify vulnerability for girls in alcoholic households, particularly regarding anxiety. The family environment emerges as a crucial mediator, with conflict and unpredictability being especially disruptive in this harmony-valued culture. These results underscore the need for culturally-grounded interventions that leverage existing community strengths while addressing universal developmental impacts of parental alcoholism.

Conclusion

This comprehensive study provides crucial insights into the psychological impact of paternal alcoholism on adolescent children within a specific cultural context. The research challenges Western-centric assumptions about children of alcoholics while confirming universal vulnerabilities in anxiety and depression domains.

The findings demonstrate that cultural factors—including tribal community support, religious involvement, and collectivist family structures—can buffer against certain negative psychological outcomes, particularly self-esteem deficits commonly observed in Western populations. However, the elevated anxiety and depression among COAs suggests that some psychological impacts transcend cultural boundaries, likely reflecting universal neurobiological and developmental processes.

Limitations

The study's findings should be interpreted in light of several methodological constraints. First, the cross-sectional design precludes causal inferences, necessitating longitudinal research to track the temporal relationships between paternal alcoholism and psychological outcomes. Second, reliance on self-reports risks social desirability bias, particularly in conservative settings where stigma may lead adolescents to underreport family dysfunction or distress. Third, the exclusive focus on Churachandpur District's tribal communities limits generalizability to urban or non-tribal populations in India. Fourth, by examining only paternal alcoholism, the study overlooks potential differential effects of maternal drinking patterns on family dynamics. Fifth, unmeasured confounders—such as domestic violence, parental mental illness, or financial instability—may independently influence outcomes but were not accounted for. Finally, the exclusion of less reliable subscales in the Family Environment Scale might have omitted salient dimensions of family functioning. These limitations highlight the need for future studies with longitudinal designs, broader geographical and cultural sampling, inclusion of maternal alcoholism, and rigorous control of confounding variables to strengthen the evidence base.

Implications and Suggestions

The present study finding has important implications for prevention and intervention efforts, highlighting the need for gender-sensitive approaches that address cultural expectations and coping limitations faced by girls in traditional societies. The study's family environment findings illuminate the mechanisms

through which alcoholism affects children, revealing patterns of increased conflict, reduced independence, and chaotic control structures that disrupt normal adolescent development. These insights provide clear targets for family-based interventions.

Perhaps most importantly, this research underscores the necessity of culturally adapted approaches to understanding and addressing the needs of children affected by parental alcoholism. The protective factors identified in this tribal Christian community suggest that effective interventions must build upon existing cultural strengths rather than imposing external models of treatment.

The high prevalence of anxiety and depression among all adolescents in this study, regardless of parental alcoholism status, points to broader mental health concerns requiring community-level attention. The findings call for immediate implementation of school-based mental health programs, community prevention initiatives, and improved access to culturally appropriate psychological services.

As alcohol-related problems continue to affect families worldwide, research like this provides essential guidance for developing effective, culturally sensitive approaches to supporting one of society's most vulnerable populations—children growing up in alcoholic households. The resilience demonstrated by many participants offers hope while the documented psychological impacts demand urgent action.

The ultimate goal of this research is not merely to document problems but to inform solutions—solutions that recognize both the universal aspects of human development and the particular ways in which culture shapes resilience, vulnerability, and recovery. In this regard, the study succeeds in providing a foundation for more effective, culturally grounded approaches to supporting adolescents affected by parental alcoholism in similar communities throughout India and beyond.

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