IMPACT OF PATERNAL ALCOHOLISM ON ACHIEVEMENT MOTIVATION, SELF-EFFICACY AND PSYCHOLOGICAL WELLBEING OF ADOLESCENTS

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Certificate

This is to certify that the present dissertation titled, 'Impact of Paternal Alcoholism on Achievement Motivation, Self- efficacy and Psychological Well-being of Adolescents' is the bonafide research conducted by C. Lalnunpuii under my supervision. She worked methodologically for her dissertation which is submitted for the Master of Philosophy in Psychology under Mizoram University.

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DECLARATION

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

This is being submitted to Mizoram University for the Degree of Master of Philosophy in Psychology.

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Abbreviations

COA	-	Children of Alcoholics
nCOA -	-	Children of non-Alcoholics
NACOA	-	National Association of Children of alcoholics
AUDIT	-	Alcohol Use Disorder Identification Test
n-Ach-	-	Deo- Mohan Achievement Motivation Scale
GSES-	-	Generalized Self-efficacy Scale
GHQ 12	-	General Health Questionnaire 12
NIAA	-	National Institute on Alcohol Abuse and Alcoholism
GISAH	-	Global Information System on Alcohol and Health
PIATR	-	Peabody Individual Achievement Test-Revised
NIAAA	-	National Institute on Alcohol Abuse and Alcoholism
M	-	Mean
SD	-	Standard Deviation
Sig.	-	Significant

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INTRODUCTION

Alcohol has a long history of use and misuse throughout recorded history. Excessive alcohol misuse and drunkenness were recognized as causing social problems even thousands of years ago. However, the defining of habitual drunkenness as it was then known as and its adverse consequences were not well established medically until the 18th century. Today, alcohol and its adverse consequences have been well researched and documented. The World Health Organization estimates that there are 140 million people with alcoholism worldwide and alcohol use disorders resulted in 139,000 deaths in 2013 up from 112,000 deaths in 1990. The Global Information System on Alcohol and Health (GISAH), an essential tool for assessing and monitoring the health situation and trends related to alcohol consumption, alcohol-related harm, and policy responses in countries stated that the harmful use of alcohol results in the death of 2.5 million people annually. There are 60 different types of diseases where alcohol has a significant causal role. It also causes harm to the well-being and health of people around the drinker. Alcohol abuse is one of the main killers of young men in India today.

According to GISAH, around 30% of the total population of India consumed alcohol in the year 2010 and that 93% of alcohol was consumed in the form of spirits, followed by beer with 7% and less than 1% of the population consumed wine. However, its real impact is on the social and family dynamics that underlie its communities. Domestic violence and an exacerbation of poverty have made alcohol abuse the single most important problem for women in India. Also with one in three people in India falling below the poverty line, the economic consequences of expenditures on alcohol attain special significance. Besides money spent on

alcohol, a heavy drinker also suffers other adverse economic effects. These include reduced wages (because of missed work and lowered efficiency on the job), increased medical expenses for illness and accidents, legal cost of drink-related offences, and decreased eligibility of loans.

Alcoholism, also known as alcohol use disorder, is a broad term for problems with ethanol (commonly referred to as alcohol), and generally refers to alcohol addiction, which is the compulsive and uncontrolled consumption of alcoholic beverages, usually to the detriment of the drinker's health, personal relationships, and social standing. It is medically considered a disease, specifically an addictive illness. There are two main types of alcohol abuse, alcohol dependence and alcohol misuse has the potential to damage almost every organ in the body, including the brain (Hasin, Deborah, 2003). The effects of chronic alcohol abuse can cause both medical and psychiatric problem and one who has alcoholism is called an alcoholic (Caan, Woody; Belleroche, Jackie de, eds., 2002). Diagnosis of alcohol misuse, problem use, abuse, and heavy use refer to improper use of alcohol which may cause physical, social, or moral harm to the drinker. In professional and research contexts, the term "alcoholism" sometimes encompasses both alcohol abuse and alcohol dependence, and sometimes is considered equivalent to alcohol dependence. Alcoholism in the classical disease model follows a progressive course: if a person continues to drink, their condition will worsen and this will lead to harmful consequences in their life, physically, mentally, emotionally and socially. (Thombs, Dennis L,1999).

The consequences of substance abuse and addiction are profound and depredating. Out of the many significant costs alcoholism exacts upon society, one of its most detrimental may be its negative effect upon the children that grow up with alcoholic parents. Since the turn of the century, many reports have described the deleterious influence of parental alcoholism on children. More than 20 years ago, researchers first noted that children of alcoholics (COA's)

appeared to be affected by a variety of problems over the course of their life span. Such problems include fetal alcohol syndrome, which is first manifested in infancy; emotional problems and hyperactivity in childhood; emotional problems and conduct problems in adolescence; and the development of alcoholism in adulthood. Children of Alcoholics (COAs) is a general term used to describe individuals with one or more alcoholic parents. Although the ramifications of living with an addicted, alcoholic parent are variable, nearly all children from alcoholic families are at risk for behavioral and emotional difficulties (Christensen and Bilenberg 2000), and live with scars—psychological or physical—as a result of parental alcoholism (Seixas and Youcha 1985). From prenatal influences leading to learning and memory problems (Coles and Platzman 1993) to vulnerabilities in behavioral control and aggression in adulthood (Jacob and Windle 2000), a significant number of COAs exhibit psychological and/or interpersonal difficulties. In fact, COAs can be differentiated from non-distressed and psychiatric comparison groups in regard to such factors as personality characteristics, depressive symptomatology, and educational attainments, as well as patterns of alcohol and drug use (Jacob et al.1999).

Although much has been learned over the ensuing two decades, a number of controversial research areas remain. In particular, debate stems from the fact that despite a common interest in COA's, clinically focused literature and research-focused literature have resulted in two distinct bodies of knowledge. At least two important constituencies have generated interest in the psychological characteristics of children of alcoholics (COAs). One is the community of clinicians, consisting of mental health and addiction workers and, to some extent, the general public. A number of influential clinicians (Black 1982), have described COA's as victims of an alcoholic family environment characterized by disruption, deviant parental role models, inadequate parenting, and disturbed parent-child relationships. These family related variables are

thought to undermine normal psychological development and to cause distress and impaired interpersonal functioning, both acutely and chronically. Most of the descriptions of COA's, however, have been based primarily on anecdotal reports of people seeking help for any number of psychological or behavioral problems. A second constituency studying COA's is the research community, which is seeking to understand the causes of alcoholism. COA's are at substantially increased risk for becoming alcoholic themselves, and this elevated risk appears to be a function of both genetic and environmental factors. Of late there has been an increasing focus on children of alcoholics seeking to understand the adverse impact of parental alcoholism on their growth and psychosocial functioning. Indian literature from this perspective is scanty and there is a need for more comprehensive investigation to explore the consequences of parental alcoholism particularly on adolescent children (Heath 1995). Various studies have put forward different perspectives on the impact and challenges brought about by parental alcoholism and two such perspectives in line with the present study are the Developmental Perspective according to which Parental alcoholism has been reported to have a significant impact on both young children and adolescents in the family. If alcoholic parents have other emotional problems, the children may be more likely to have difficulties in achieving normal "role regulation" (Nardi, 1981). The opportunities for role development for children of alcoholics (COA) can be severely limited, so COAs may have problems accomplishing the necessary stages for healthy development (Lee, 2003).For instance, if the father is an alcoholic, the son may have no have any positive male role model in the family, and the daughter might have long-term problems making and maintaining intimate relationships as a result of negative experiences with the alcoholic father (Hussong&Chassin, 2004; Scharff, Broida, Conway, &Yue, 2004). And the Cross-Cultural Perspective which opines that according to family systems theory, individuals who belong to

subsystems within a family learn and perform specific skills, and all these members become interrelated as a whole (Jacobs, 1992). However, the family itself is by external factors, including cultural norms or values (Hendershot, MacPherson, Myers, Carr, & Wall, 2005).This view lends support to the general environmental mechanism hypothesis (Velleman, 1992) and suggests that the distress within alcoholic families creates a state of chronic stress for COA's, thereby hindering their development.

The American Academy of Child and Adolescent Psychiatry, (2012), has put forward a framework for impact of alcohol use by parents and according to this alcoholism runs in families, and children of alcoholics are four times more likely than other children to become alcoholics themselves. Compounding the psychological impact of being raised by a parent who is suffering from alcohol abuse is the fact that most children of alcoholics have experienced some form of neglect or abuse. A child being raised by a parent or caregiver who is suffering from alcohol abuse may have a variety of conflicting emotions that need to be addressed in order to avoid future problems. They are in a difficult position because they cannot go to their own parents for support and some of the feelings can include guilt (The child may see himself or herself as the main cause of the mother's or father's drinking), The emotional turmoil that a COA experiences may include Anxiety-the child may worry constantly about the situation at home and he or she may fear the alcoholic parent will become sick or injured, and may also fear fights and violence between the parents, Embarrassment -Parents may give the child the message that there is a terrible secret at home. The ashamed child does not invite friends home and is afraid to ask anyone for help, Inability to have close relationships - Because the child has been disappointed by the drinking parent many times, he or she often does not trust others, Confusion - the alcoholic parent will change suddenly from being loving to angry, regardless of the child's

behavior. A regular daily schedule, which is very important for a child, does not exist because bedtimes and mealtimes are constantly changing, Anger- the child feels anger at the alcoholic parent for drinking, and may be angry at the non-alcoholic parent for lack of support and protection, Depression - the child feels lonely and helpless to change the situation.

Various studies have documented the personality, academic, and social deficits which COAs have been found to exhibit in different stages of their development. COAs first face the risk of Fetal Alcohol Syndrome when their mothers abuse alcohol during pregnancy. This prenatal alcohol exposure can cause physical malformation, growth deficiency, functional deficits, disorganized attachment, and in some cases, death (O'Connor, Sigman, &Kasari, 1992; Murray, 1989; O'Connor, Sigman, & Brill, 1987). Following infancy, many COAs begin to exhibit personality and psychological maladjustment. The multitude of research on this topic clearly demonstrates that COAs are at a greater risk for exhibiting a variety of negative outcomes throughout their life span. However, an examination of these studies also reveals that the research to date concentrates mainly on describing the COAs' social and cognitive difficulties rather than exploring the possible causes of their problems. Nevertheless, the few studies that have begun to explore the family environment of COAs have produced several hypotheses that attempt to account for the variables which contribute to COAs' deficits. These hypotheses have focused mainly on genetics and the general environmental mechanism hypothesis as reviewed by Velleman (1992), according to him an explosion of recent genetic research has established that heredity does play a significant role in the transmission of alcoholism (Schuckit, 1993; Cook &Winokur, 1993), and may even contribute to other deficits exhibited by COAs. The general environmental mechanism hypothesis contends that problems of COAs are transmitted through factors not specific to alcoholic families. In other words, problems evident in alcoholic families may result from family dysfunction and not specifically from alcohol abuse. Thereby, a violent family with alcohol abuse would

have the same problems as a violent family without alcohol abuse. The importance of this hypothesis lies within the understanding that mediating variables in the family exist and are significant contributors to the dysfunction of COAs. Thus, the general environmental mechanism hypothesis shifts the responsibility of COA deficits from parental alcoholism per se to broader environmental factors within the family. Various studies to date have supported the position of the general environmental mechanism hypothesis. Two studies in particular compared the personal and family functioning of recovered and relapsed alcoholics to the functioning of matched controls (Callan& Jackson, 1985; Moos & Billings, 1982). In these studies, no significant differences were found between the personal and family functioning of children from families with recovered alcoholics and that of matched controls. However, the same was not true for families with relapsed alcoholics; such families were less cohesive, less expressive, less likely to promote independence and achievement, and less likely to agree about their family environment Thus, the environmental impact of alcoholism may be of a current and dynamic problem, rather than reflecting a fixed and irreversible effect on the COA's functioning.

The dysfunctional family environment created due to the presence of parental alcoholism has been the focus of several investigations. Marital conflict and a lack of coping mechanisms were more frequent in these families and children of alcoholic (COAs) fathers represent a group at risk for the early onset of psychiatric problems observe Furtado et al.(2002). However, one can conclude that through much effort in fleshing out previous literature on the topic of alcoholism in the family and academic attainment, drinking does negatively influence children's academic experiences. Children of alcoholic parents are at a greater disadvantage than are children who come from families of non-alcoholic parents in completing school successfully with superior or above average marks. The validity of this research comes from the abundance of previous research and studies that have been conducted in efforts to collect reliable data on the

subject. The Family systems theory offers a possible explanation for these contrasting results. This theory states that the family unit is the source of dysfunction because alcoholism becomes so intertwined with family operation that it cannot be separated from the rest of family functioning. Conclusively, the evidence in the literature review as well as the aims of this research project effectively illustrate that the hypothesis that children of alcoholic parent(s) are related to children's psychosocial functioning. (Wolin, Bennett & Noonan, 1979)

Living with alcoholic parents is particularly devastating on young children. Youngsters often show symptoms of depression and anxiety such as being afraid to go to school, bed-wetting, having nightmares, crying, and not having friends. Also, during adolescence which has been globally accepted to be a period of turbulence and a significant developmental milestone. Parental alcoholism could further compound and create a not so conducive domestic environment significantly impacting the adjustment and personality of the adolescent as he tries to come to grips with this tumultuous phase in his developmental career. Adolescent COAs may stay in their rooms for extended periods of time, become secretive, and have difficulty relating to other children or say that they have no one to talk to. Studies have indicated that Teen COAs may begin to show depressive symptoms such as perfectionism, hoarding, isolation, and becoming extremely self-conscious and some teen COAs may start to develop phobias.

Studies also show that total healthcare costs for COAs is 32 percent greater than for children from non-alcoholic families that inpatient admission rates for COAs are triple that of other children and that inpatient admission rates for COAs with mental disorders are almost double that of other children. Further studies have also indicated psychosocial factors are impacted by parental alcoholism. Obot and Anthony (2004), found evidence to favour the hypothesis that adolescent children living with an alcohol dependent parent have more

delinquency problems than other adolescents. Mylant et al. (2002) found that adolescent COAs scored significantly lower on all psychosocial factors of family/personal strengths and school bonding and significantly higher on all factors of at-risk temperament, feelings, thoughts, and behaviours than non-COAs and that they were at risk for depression, suicide, eating disorders, chemical dependency, and teen pregnancy. Hart et al. (2003) interpreted their results as providing partial and preliminary support for the contention that living in an alcoholic environment during childhood and adolescence plays a role in the manifestation of serious medical problems in adulthood. Not only is there a heritable basis for alcoholism running in families, but the children of alcoholics form their beliefs about drinking from perception of their parents' drinking patterns — how much they drink and how often. It is no surprise, then, that COAs often emulate this drinking pattern when they begin to experiment with alcohol themselves. According to Williams and Corrigan (1992), growing up in a household with alcoholic parents is more likely to produce emotional disorders, increases the child's risk of health problems, physical abuse and neglect. The single most potent risk factor is their parent's substance-abusing behaviour and this can place children of substance abusers at biologic, psychological, and environmental risk (Johnson and Leff, 1999). Menees and Segrin (2000) observe that COAs are characterised as an at risk population because of the dysfunctional family environment that disrupts their psychosocial development. Children first learn about alcohol by watching their parent drink. When drinking to excess becomes an everyday phenomenon, children perceive this is the norm. They begin to formulate their expectations about alcohol at a very early age. In other words, they see what alcohol does to their drinking parent or parents. They cannot, however, escape the influence, since it is all around them. They often lack guidance and positive role modeling and live in an atmosphere of stress and family conflict. There is

strong evidence to suggest that family dysfunction during childhood can negatively influence later life experiences and adjustment. This can be very damaging to children, especially younger children and adolescents(Werner and Broida, 1991).

Drinking behavior may interrupt normal family tasks, cause conflict and demand adjustive and adaptive responses from family members who do not know how to appropriately respond. In brief, alcoholism creates a series of escalating crises in family structure and function, which may bring the family to a system crisis. As a result, the members may develop dysfunctional coping behaviors observes Ranganathan (2004). Additionally children of alcoholics often feel responsible for the problems of the alcoholic, believing, wrongly, that they somehow created the problem. They internalize these feelings, ultimately suffering tremendous guilt, shame, and sense of helplessness and hopelessness. They may try to hide the evidence of their parent's alcoholism, or make excuses to others for parental absence at functions, lie to friends, school, employer or others about the parent. They may either serve the alcoholic parent drinks or try to get rid of the stash of alcohol. Both are attempts to stave off the problems that may ensue from an alcoholic parent getting out of control, erupting into violence — or to just keep the family together. The co-dependent children and spouse of an alcoholic soon forget about their own needs and desires. They're too busy looking out for or covering up the problems of the alcoholic family member. COAs learn how to tiptoe around their alcoholic parent. Fearing reprisals, they try hard to please the parent in a never-ending and fruitless attempt to get the parent to stop drinking. By denying the problem exists (parental alcoholism), the COAs and spouses enable the alcoholic to continue his or her drinking and not face up to the troubles such drinking causes. Findings from a longitudinal study by Andreas & O'Farrell (2007) show that fathers' heavy drinking patterns and children's psychosocial problems appear to be closely

related to one another over time, waxing and waning in meaningful patterns, such that children's adjustment was improved during times of parental alleviated drinking and was worsened during times of parental exacerbated drinking. Their results thus add additional support to the hypotheses of causal linkages between problematic parental and problematic child functioning. Of late there has been an increasing focus on children of alcoholics seeking to understand the adverse impact of parental alcoholism on their growth and psychosocial functioning. Indian literature from this perspective is scanty and there is a need for more comprehensive investigation to explore the consequences of parental alcoholism particularly on adolescent children.

Achievement motivation

Achievement motivation, also referred to as the need for achievement (and abbreviated n Achievement), is an important determinant of aspiration, effort, and persistence when an individual expects that his performance will be evaluated in relation to some standard of excellence and such behavior is called achievement-oriented(McClelland 1961). Motivation to achieve is instigated when an individual knows that he is responsible for the outcome of some venture, when he anticipates explicit knowledge of results that will define his success or failure, and when there is some degree of risk, i.e., some uncertainty about the outcome of his effort. The goal of achievement-oriented activity is to succeed, to perform well in relation to a standard motive to achieve of excellence or in comparison with others who are competitors (Atkinson 1964). Individuals differ in their strength of, and various activities differ in the challenge they pose and the opportunity they offer for expression of this motive. Thus, both personality and environmental factors must be considered in accounting for the strength of motivation to achieve in a particular person facing a particular challenge in a particular situation. The very same person

may be more strongly motivated at one time than at another time, even though in most situations he may generally tend to be more interested in achieving than other people. (Murphy, O'Farrell, Floyd, & Connors, 1991; Sher, Walitzer, Wood, & Brent, 1991; von Knorring, 1991).

Ervin and her colleagues found that Full IQ, performance (a measure of abstract and conceptual reasoning), and verbal scores were lower among a sample of children raised by alcoholic fathers than among children raised by nonalcoholic fathers. Gabrielli and Mednick (7) reported similar results for verbal and Full IQ tests, but not for performance tests. In a study comparing COAs and nonCOAs whose families were educated and whose parents lived i n the home, Bennett and colleagues (8) found that children from alcoholic families had lower IQ, arithmetic, reading, and verbal scores. Despite the lower scores, however, COAs performed within normal ranges for intelligence tests in each of these studies.(Julia Dehn,2009). The academic performance of COAs has been found to be relatively poor (Miller and Krop, 1985) and Casas-Gil and Navarro-Guzman (2002) have identified five variables on which performance by children of alcoholic parents was poorer: intelligence, repeating a grade, low academic performance, skipping school days, and dropping out of school. COAs also demonstrate adjustment problems in academics, where they exhibit learning difficulties, reading retardation, conduct and aggressive behavior problems, poor school performance, and loss of concentration (Velleman, 1992). They also are more likely to repeat grades, attend special classes, or get referred to a school counsellor or psychologist (von Knorring, 1991). Furthermore, objective indices of academic performance indicate that COAs repeatedly score lower on verbal scales, reading and writing tasks, and standardized college test scores while also having lower GPAs and class rank than control children whose parents were non-alcoholic (Murphy, O'Farrell, Floyd, & Connors, 1991; Sher, Walitzer, Wood, & Brent, 1991; von Knorring, 1991).Sons of

addicted parents performed worse on all domains measuring school achievement, using the Peabody Individual Achievement Test-Revised (PIATR),including general information, reading recognition, reading comprehension, total reading, mathematics and spelling. In general, children of alcoholic parents do less well on academic measures. They also have higher rates of school absenteeism and are more likely to leave school, be retained, or be referred to the school psychologist than are children of nonalcoholic parents. Studies have indicated that COAs are more likely to be truant, to drop out of school, repeat grades, or be referred to the school counselor or psychologist. In one study, 41% of addicted parents reported that at least one of their children repeated a grade in school, 19% were involved in truancy, and 30% had been suspended from school. Children of addicted parents compared to children of non-addicted parents were found at significant disadvantage on standard scores of arithmetic.(www.nacoa.org/ www.nacoa.net).This may not be due to intellectual ability, but may be more because of performance-related anxiety, difficulty bonding with teachers and peers, fear of failure, or other reasons yet to be determined. What is known is that COAs often feel they will be a failure – even if they do well in school. Raised in an environment lacking stimulation, and with alcoholic parents, who may themselves have poor cognitive or verbal skills, affects COAs in measurable and predictable ways. For example, pre-school COAs exhibit poorer reasoning and language skills than non-COA children. Poorer quality of stimulation at home predicts poorer performance among COAs versus non-COAs. Later on, COAs have difficulty with abstract concepts, and may require specific instructions and concrete explanations. Lower cognitive and verbal skills — Tests of COAs show a lowered cognitive ability and poor verbal skills. They may find their ability to express themselves is impaired, which can, in turn, affect school performance, peer relationships, the ability to develop and sustain intimate relationships, and

hinder their performance at job interviews. This does not imply that COAs lack intellectual ability – just that their ability to express themselves suffers. There is an abundance of literature on the topic of parental alcoholism and poor academic performance of children. Pioneers and researchers of this topic such as Barnes & Farrell (1992, 1986), Casas-Gil & Navarro Guzman (2002), Chassin et al. (1992), Crespi&Sabatelli (1997), Farrell & Barnes (1995), Kandel (1990), MaGrath et al. (1999), Roberts &Bengtson (1993), Schwartz (1992), Tein et al. (1994), and Wolin& Bennett (1984), cover a variety of material including school characteristics among children of alcoholic parents, parental involvement in children's school activities, traumatic childhood experiences, family systems, and mental health. These are all aspects of children's educational success that coincide with their school performance and achievement motivation.

Self-efficacy

Self-efficacy is the extent or strength of one's belief in one's own ability to complete tasks and reach goals(Ormrod,J.E.,2006). Psychologists have studied self-efficacy from several perspectives, noting various paths in the development of self-efficacy; the dynamics of self-efficacy, and lack thereof, in many different settings; interactions between self-efficacy and self-concept; and habits of attribution that contribute to, or detract from self-efficacy. This can be seen as the ability to persist and a person's ability to succeed with a task. Self-efficacy affects every area of human endeavor. By determining the beliefs a person holds regarding his or her power to affect situations, it strongly influences both the power a person actually has to face challenges competently and the choices a person is most likely to make. These effects are particularly apparent, and compelling, with regard to behaviors affecting health. According to Judge et al., (2002), the concepts of locus of control, neuroticism, generalized self-efficacy (which differs from Bandura's theory of self-efficacy) and self-esteem measured the same, single

factor and demonstrated them to be related concepts. High self-efficacy can affect motivation in both positive and negative ways. In general, people with high self-efficacy are more likely to make efforts to complete a task, and to persist longer in those efforts, than those with low self-efficacy. The stronger the self-efficacy or mastery expectations, the more active the efforts. However, those with low self-efficacy sometimes experience incentive to learn more about an unfamiliar subject, where someone with a high self-efficacy may not prepare as well for a task.

The period of adolescence is an especially challenging phase (Eccles and Midgley 1989) when youth have to adapt to biological (e.g.,puberty), educational (e.g., passing into high school), and social (e.g., broadened peer network,partnerships, sexuality) transitions. Adolescence is also a time of growth in independence, which can resultin decision making that leads to involvement in risky behaviors (Bandura 1997). Adolescents create a belief in efficacy in relation with their personal outcomes from familial, peer, educational, and socioeconomic influences (Bandura et al.1996, 2001). Therefore, there is an emphasis on the role of self-efficacy and opportunities to use alcohol during adolescence. Research has consistently shown that adults, students, and adolescents with low self-efficacy confidence have higher consumption rates than those with high self-efficacy expectations (Aas et al.,1995).Bandura (1986) found that people with low self-efficacy are less likely to resist alcoholic drinks, whereas people with high self-efficacy are more likely to resist the pressures. This suggests that, aside from parental and peer influences, self-efficacy plays a strong role in determining the choices that an individual makes regarding alcohol. Adolescents with lower self-efficacy are at a greater risk of consumption than those with higher self-efficacy; however, low self-efficacy is not the direct problem, rather that it is the low alcohol refusal efficacy that is associated with low general self-efficacy."It has been found that self-esteem is strongly negatively correlated with distress and depression (Rosenberg,

1985), while individuals with high perceptions of self-worth and self-esteem are thought to cope better with stress and conflicts in relationships (Pearlin et al., 1981). The availability of an adequate social network is a significant factor impacting the development of both high self-esteem as well as adaptive coping (Sarason&Sarason, 1986; Williams & Corrigan, 1992). The adolescent children of ill parents have been found to have lower scores on all the dimensions of self-esteem compared to the well parents (Nielson & Mehta, 1994).

Psychological well-being

Psychological well-being refers to both a theory and measurement scales designed and advocated primarily by Carol Ryff. Roosa et al., (1990) reported that COA status was related to higher levels of negative and lower levels of positive events. Psychological health is defined as a state of being in which a student is balanced both emotionally and intellectually. A psychologically healthy person is capable of thinking clearly, developing socially and learning new skills with ease. However, as adolescents are at a crucial stage of development, they are more prone to experience mental illnesses in the transition from being an adolescent to an adult (Giugliano, 2004).

It is well established that children of problem drinkers have an increased risk of developing mental health problems, not only during childhood but also when they grow up into adolescents and adults observe Cuijpers et al., (2006). Children of alcoholic fathers are at high risk for psychopathology and gender-related differences also seem to exist contend Furtado et al. (2006). According to Lambert, (2006), Depressed individuals may feel sad, uneasy, or unmotivated and do not enjoy usual activities. The negative impact of having depression is tremendous in that it involves the body, mood, thoughts and affects the way a person eats and sleeps, feels about the self, and thinks about things. Depression and anxiety are recurring themes

in the literature on COAs (e.g. Callan and Jackson, 1986; Williams and Corrigan, 1992; Steinhausen, 1995; Kelley, 1996; Deborah,1997). However, Reich et al. (1993), report that though children of alcoholics exhibit high rates of psychopathology and may be at risk specifically for oppositional and conduct disorders, they may be not so for depression. Behavioral problems in adolescence have been shown to be associated with the presence of a positive family history of alcoholism and negative parenting practices (Barnow et al., 2004). Jacob and Windle (2000) are of the view that risks for COAs might relate specifically to parental alcoholism and its impact on offspring development and not to the combined effects of various parental psychopathologies and/or extreme forms of family instability. Exposure to marital conflict is associated with children's adjustment problems, including internalization and externalization (Cummings et al., 2000) and the results of Keller et al. (2005) indicate that problem drinking may harm children through its association with marital and parenting difficulties. Stanley S &Vanitha C.,(2008). Sher et al., (1991), found that COAs reported more alcohol and drug problems, had stronger alcohol expectancies, higher levels of behavioural under-control and neuroticism, and more psychiatric distress in relation to nCOAs. Bird and Canino (1991), also found that children of alcoholics when compared to those of non-alcoholics manifested higher levels of behavioural under control, more neuroticism and greater psychiatric distress. Hall et al., (1994) report that adult COAs had lower life satisfaction scores and significantly lower levels of locus of control than nCOAs. The impact on adolescent COAs is particularly important, since adolescence is a transitional period in life, involving significant unpredictability, stress, and often adversity (Gemelli, 1996; Jessor, 1998). Even though most adolescents normally experience fear, anger, confusion, guilt, embarrassment, and shame during adolescence, COAs may experience these emotions more severely in terms of depth, intensity,

and frequency (Robinson & Rhoden, 1998). Robinson and Rhoden (1998) claimed that the severity of COAs' lives can be compared with those of psychologically wounded war veterans. Other scholars in trauma research also support this claim (e.g., Agaibi& Wilson, 2005). Because of the high likelihood of a dysfunctional family environment for alcoholic families, the adolescent COAs are at risk of having more depressive symptoms (Lease, 2002).COAs experience barriers to achievement of adolescent developmental tasks, such as establishing positive self-identity (Gemelli, 1996; Hollinger-Smith, 2004; Lerner & Steinberg, 2004; Nurmi, 2004).Experiencing significant conflict within the family can drive adolescents to take risks with their health, for example, by starting to use alcohol, tobacco, and other drugs (Mylant et al., 2002). In addition, a lack of autonomy may lead COAs to suffer from depression or depressive symptoms, especially in relation to repeated failure in coping with familial stressors (Harter, 2000; Lease, 2002).

Further, Obot and Anthony (2004), found evidence to favour the hypothesis that adolescent children living with an alcohol dependent parent have more delinquency problems than other adolescents. Also according to Mylant et al. (2002) adolescent COAs scored significantly lower on all psychosocial factors of family/personal strengths and school bonding and significantly higher on all factors of at-risk temperament, feelings, thoughts, and behaviours than non-COAs. Additionally, that they were at risk for depression, suicide, eating disorders, chemical dependency, and teen pregnancy.(Stanley S &Vanitha C.,2008).Hall and Webster (2002) found that adult COAs had more self-reported stress and more difficulty initiating the use of mediating factors in response to life events. More COAs than comparison offspring were experiencing serious problems in the areas of drinking, personality and psychopathology (Casas-Gil and Navarro-Guzman, 2002) and Harter (2000), notes that adult COAs appear at increased

risk for a variety of negative outcomes, including substance abuse, antisocial or under-controlled behaviors, depressive symptoms and anxiety disorders. Adolescent COAs typically display high levels of anxiety and depression, and they receive twice as much psychiatric treatment for anxiety and depressive symptoms and conduct disorders than their non-COA peers (Workman & Beer, 1992) Adolescent COAs are also at high risk for drug and alcohol abuse. Parental alcoholism is correlated with increased adolescent drug and alcohol abuse (Chassin, Pillow, Curran, Molina, & Barrera, 1993; Chassin, Rogosch, & Barrera, 1991), with adult COAs also reporting elevated drug and alcohol problems (Sher, Walitzer, Wood, & Brent, 1991). Although researchers have examined the possible relationship between family history of alcoholism and its effects on the adaptation of offspring since the beginning of this century (MacNicholl 1905), widespread interest in the problems of COA's did not appear to gain much momentum until the 1960's. By the mid-1970's, how- ever, a sufficiently large number of empirical findings permitted El- Guebaly and Offord (1977) to document a wide range of problems encountered by COA's across the life span, including fetal alcohol syndrome (FAS),2 which is first manifested in infancy; emotional problems and hyperactivity in childhood; emotional and conduct problems in adolescence; and alcoholism in adulthood. In the past 20 years, research has advanced on several fronts and has helped to clarify the nature and extent of problems facing COA's as well as the numerous variables that must be considered when attempting to make generalizations about this group (Sher 1991; Windle and Searles 1990). In fact, perhaps the most significant revelation about COA's that the research community has established is how difficult it is to make valid generalizations. A number of reasons exist for this situation. Most significantly, alcoholics do not represent a homogeneous class of people. Many other psychological disorders coexist (i.e., are comorbid) with alcoholism. These disorders include other forms of sub- stance use

disorders (i.e., drug use disorders), anxiety disorders, mood disorders, and personality disorders (National Institute on Alcohol Abuse and Alcoholism [NIAAA] 1993). Thus, some COA's also are children of depressives, children of agoraphobics, children of people with antisocial personality disorder, and so forth. Given the many forms of psycho- pathology that are possible in parents of COA's, difficulties often arise in attributing any apparent COA characteristic specifically to parental alcoholism. Moreover, even in the absence of significant comorbidity, considerable differences (i.e., heterogeneity) exist among alcoholics. Researchers have proposed numerous approaches to conceptualizing heterogeneity among alcoholics, incorporating a range of dimensions such as age of onset, drinking pattern, extent of antisociality, severity of dependence, personality traits, and even family history (Babor et al. 1994). Although no consensus exists on the optimal classification of alcoholics or even on whether such heterogeneity is best conceptualized as a number of distinct "subtypes" or as a number of interacting dimensions, researchers generally agree that alcoholics vary widely along almost any clinically relevant variable. As demonstrated by Winokur and colleagues (1971), parental characteristics above and beyond alcoholism are important determinants of features observed in the alcoholics' offspring. Al- though it is reasonable to simply ask whether COA's differ from non- COA's, the answer to this question does not reveal whether COA's are unique compared with the children of parents with other major psychological or behavioral problems. Indeed, accu- mulating evidence reveals that children from families with a range of problems show a number of similar deficits. Additionally, many methodological complexities exist, including the way in which alcoholism is measured in the parent(s), how extensively alcoholism is assessed in other family members, whether parental alcoholism is "active" or in recovery, the way in which subjects are sampled.(Sher J, Kenneth,1997).

The results of several studies have shown that children from alcoholic families report higher levels of depression and anxiety and exhibit more symptoms of generalized stress (i.e., low self-esteem) than do children from nonalcoholic families . In addition, COAs often express a feeling of lack of control over their environment. A recent study by Rolf and colleagues (16) noted that COAs show more depressive affect than nCOAs and that their self-reports of depression are measured more frequently on the extreme end of the scale. Moos and Billings found that the emotional stress of parental drinking on children lessens when parents stop drinking. These investigators assessed emotional problems in children from families of relapsed alcoholics, children from families with a recovering parent, and children from families with no alcohol problem. Although the children of relapsed alcoholics reported higher levels of anxiety and depression than children from the homes with no alcohol problem, emotional functioning was similar among the children of recovering and normal parents. (National Institute on Alcohol Abuse and Alcoholism, 1990)

Children from homes with alcoholic parents often demonstrate behavioral problems. Study findings suggest that these children exhibit such problems as lying, stealing, fighting, truancy, and school behavior problems, and they often are diagnosed as having conduct disorders . Teachers have rated COAs as significantly more overactive and impulsive than nonCOAs . COAs also appear to be at greater risk for delinquency and school truancy. Several investigators have reported an association between the incidence of diagnosed conduct disorders and parental alcohol abuse. However, other problems associated with alcoholism (e.g., depression among the alcoholic parents and divorce) also may contribute to conduct problems and disorders among COAs (National Institute on Alcohol Abuse and Alcoholism, 1990)

The alcoholic family's home environment and the manner in which family members interact may contribute to the risk for the problems observed among COAs. Although alcoholic families are a heterogeneous group, group common characteristics have been identified. Families of alcoholics have lower levels of family cohesion, expressiveness, independence, and intellectual orientation and higher levels of conflict compared with nonalcoholic families. Some characteristics, however, are not specific to alcoholic families: Impaired problem-solving ability and hostile communication are observed both in alcoholic families and in families with problems other than alcohol. Moreover, the characteristics of families with recovering alcoholic members and of families with no alcoholic members do not differ significantly, suggesting that a parent's continued drinking may be responsible for the disruption of family life in an alcoholic home .The family environment also may affect transmission of alcoholism to COAs. Children with alcoholic parents are less likely to become alcoholics as adults when their parents consistently set and follow through on plans and maintain such rituals as holidays and regular meal times. Current research findings suggest that these children are at risk for a range of cognitive, emotional, and behavioral problems. In addition, genetic studies indicate that alcoholism tends to run in families and that a genetic vulnerability for alcoholism exists. Yet, some investigators also report that many children from alcoholic homes develop neither psychopathology nor alcoholism. While research findings suggest that some children suffer negative consequences due to parental alcoholism, a larger proportion of COAs function well and do not develop serious problems. In a longitudinal study of COAs born on the island of Kauai, Werner (2005) reported that, although 41 percent of the children developed serious coping problems by 18 years of age, 59 percent did not develop problems. These resilient children shared several characteristics that contributed to their success, including the ability to obtain positive attention from other people,

adequate communication skills, average intelligence, a caring attitude, a desire to achieve, and a belief in self-help. (Julia Dehn,2009)

However, there is also a contention within the alcoholism literature pertaining to children of alcoholics that hold that they manifest no significant differences in terms of psychopathology or other behavioural and personality deficits when compared to children of non-alcoholics. Segrin and Menees (1996), opine that children may exhibit undisturbed psychosocial functioning despite having an alcoholic parent and found no differences between adult children of alcoholic's and controls. Baker and Stephenson (1995), suggest that parental alcoholism does not necessarily result in personality differences in adult children. Morey (1999), found that COAs and nCOAs demonstrate no significant differences on measures of social support and shame while Reich et al. (1993), report few differences between children of alcoholics and controls with respect to self-esteem and achievement tests.

STATEMENT OF THE PROBLEM

Of late there has been an increasing focus on children of alcoholics seeking to understand the adverse impact of parental alcoholism on their growth and psychosocial functioning. There is a vast body of literature both in India and the West devoted to understanding the dynamics involved in alcoholism and ascertaining the deleterious impact that alcoholism could have on the personality and functioning of the family. Indian literature from this perspective is scanty and there is a need for more comprehensive investigation to explore the consequences of parental alcoholism particularly on adolescent children. As of date no research on children of alcoholics (COA) has been conducted on the population under study, the Mizo. And there is a strong need for doing research on this topic as many families are being influenced by the problem made by the parental alcoholism, and many families are being devastated by alcoholism in the family. The present study is an attempt to explore and highlight the psychosocial correlates of paternal alcoholism and their children. To focus and seek to understand the adverse impact of paternal alcoholism on their growth and psychosocial functioning and to explore implications for therapeutic intervention with adolescent COAs and their families in the light of the results obtained.

Alcoholism is a disease that affects millions of individuals from every social class and racial background. It discriminates against no one and unfortunately those who suffer the worst are the family, friends, and relatives that surround themselves around the alcoholic individual, especially the children. Parental alcoholism can have a legacy, which impacts the development

of both individual family members and the patterns carried from one generation to the next. Children growing up in alcoholic families, rarely learn the combination of roles, which mold healthy personalities. Rather, they have been locked into roles based on their perception of what they need to survive and bring stability into their lives (Crespi & Sabatelli 1997). "Many children of alcoholics (COAs) bring from their family of origin ways of coping that may interfere with their ability and capacity for intimacy, the ability to make healthy commitments to adult roles and responsibilities as well as achieve in an academicsetting (Crespi&Sabatelli 1997: 411)."

In terms of behavioral problems and mental health disorders children of alcoholics are at a greater risk than other children for developing attention deficit hyperactivity disorder, anxiety, depression, conduct disorders, and other mental health problems (Barnes & Farrell 1992). School problems are also a concern and are common in children of alcoholics. Compared with children of non-alcoholics, children of alcoholics have higher rates of learning difficulties, decreased attention, misbehavior, truancy, absenteeism, and grade retention (Barnes & Farrell 1992). In addition, cognitive deficits and decreased academic performance in COAs as compared to their non-COA peers have been noted, although both groups perform within normal limits on achievement tests (Crespi&Sabatelli 1997). If COAs do show lowered academic achievement, this has potentially important implications for their outcomes in a variety of domains. Difficulties in school may lead to peer rejection; lower self-esteem and association with deviant peer associates have been linked to antisocial behavior and substance abuse (Kandal 1990). Poor school performance may lead to school failure and to limited educational and vocational opportunities. Thus, lowered academic achievement among COAs is a potentially important mediator of their negative outcomes (Kandal 1990).

Research on COAs is still in its infancy because the concept of COA is focused on the child rather than the parent, and the definition of a COA is any child whose parent (or parental caregiver) uses alcohol or other drugs in such a way that it causes problems in the child's life. Many studies suggest that a variety of differences exist between children of alcoholics and children of non-alcoholics and these differences occur at all ages. However, because of the limitations of the methodology and the inadequate number of comprehensive studies, research findings cannot be generalized to all children who grow up with alcoholic parents. (National Institute on Alcohol Abuse and Alcoholism, 1990). Studies comparing COAs and nonCOAs have suggested that, although the two groups differ in a variety of psychosocial areas, differences in cognitive performance are observed most frequently. Cognitive function in COAs has been examined by many researchers because it is an important element needed for adaptation at all stages of development; it can be measured uniformly across developmental stages; and it often is associated with the symptoms of alcoholism. Adolescence has been globally accepted to be a period of turbulence and a significant developmental milestone. The period of adolescence is an especially challenging phase (Eccles and Midgley 1989) when youth have to adapt to biological (e.g., puberty), educational (e.g., passing into high school), and social (e.g., broadened peer network, partnerships, sexuality) transitions. Adolescence is also a time of growth in independence, which can resulting decision making that leads to involvement in risky behaviors. Parental alcoholism could further compound and create a not so conducive domestic environment significantly impacting the adjustment and personality of the adolescent as he tries to come to grips with this tumultuous phase in his developmental career. (Bandura, 1997).

The impact on adolescent COAs is particularly important, since adolescence is a transitional period in life, involving significant unpredictability, stress, and often adversity

(Gemelli, 1996; Jessor, 1998). Even though most adolescents normally experience fear, anger, confusion, guilt, embarrassment, and shame during adolescence, COAs may experience these emotions more severely in terms of depth, intensity, and frequency (Robinson & Rhoden, 1998). Robinson and Rhoden (1998) claimed that the severity of COAs' lives can be compared with those of psychologically wounded war veterans. Other scholars in trauma research also support this claim (e.g., Agaibi& Wilson, 2005).

The consequences of substance abuse and addiction are profound and depredating. The desolation is incalculable in estimating the psychological damage and trauma inflicted on the children of addicted parents. These children are prone to extensive social, psychological, educational, medical and future socio-economic struggles. The children of addicted parents are at a higher risk of developing addiction. The remedies and solutions for these children must include intensive counseling and programs focused on the healing of these traumatic events to safeguard their future well being, independence and self- efficacy. If not helped, these children often carry their sadness and insecurities into adulthood. (Denh Julia,2009)

Mizoram is a small north-eastern state in India with an area of 21,087 sq. kms. It extends from 21°56'N to 24°31'N, and 92°16'E to 93°26'E. The tropic of cancer runs through the state nearly at its middle. It shares borders with three of the "eight-sister" states, namely Tripura, Assam and Manipur. The state also shares a 722 kilometer border with the neighboring countries of Bangladesh and Myanmar. The name 'Mizoram' has been derived from Mi (people), Zo (Highland or Hills) and Ram (land), and thus Mizoram implies "land of the hill people". Mizoram is a land of rolling hills, valleys, rivers and lakes. Hill ranges or peaks of different heights run throughout the length and breadth of the state, with plains scattered here and there.

Mizoram has a population of 1,091,014 with 552,339 males and 538,675 females (2011 census). It is the second least populous state in the country with majority of its inhabitants Christians (87%). The sex ratio of the state is 976 females per thousand males, higher than the national ratio of 940. The density of population is 52 persons per square kilometer. The literacy rate of Mizoram in 2011 was 91.33 per cent, higher than the national average 74.04 per cent, and second best among all the states of India. About 52% of Mizoram**'s** population lives in urban areas, much higher than India's average. Over one third of the population of Mizoram lives in Aizawl district, which hosts the capital.

The origin of the Mizos, like those of many other tribes in North Eastern India is shrouded in mystery. It is generally accepted that they were a part of a great Mongoloid wave of migration from China who later moved out to India to their present habitat. The earliest documented records of Mizoram were from the British military officers in the 1850s, when they encountered a series of raids in their official jurisdiction in Chittagong Hill Tracts from the neighboring natives. Back then they referred to the land as the Lushai Hills. As a consequence of relentless tribal encroachment often resulting in human mortality, British rulers were compelled to subjugate the tribal chiefdoms. Punitive British military expeditions in 1871 and 1889 forced the annexation of the entire Lushai Hills. After India's independence from the British Empire in 1947, the land became Lushai Hills District under the Government of Assam. In 1972, the district was declared a Union Territory and was given a more culturally inclusive name 'Mizoram'. Ultimately Mizoram became a full-fledged federal state of the Indian Union in 1986.

The ancestors of the Mizos were without any form of written language before the advent of the British. They were anthropologically identified as members of the Tibeto-Burman ethnicity. They worshipped all sorts of objects and natural phenomena. The land is now inhabited

by a mixture of people from Chin Hills and Bangladesh and its history is therefore largely reflected by those of Lusei, Hmar, Lai, Mara and Chakma tribes. Following religious, political and cultural revolutions in the 19th century majority of the people agglomerated into a super tribe, Mizo. Hence, the officially recognized settlement of the Mizos became Mizoram. The Mizos are a distinct community and the social unit was the village. Around it revolved the life of a Mizo. A typical Mizo Village was usually set on the top of a hill with the Chief's house at the centre. In a way the focal point in the village was the Zawlbuk, a dormitory where all the young bachelors of the village slept. Zawlbuk was the training ground, and indeed, the cradle wherein the Mizo youth was shaped into a responsible adult member of the society.

The Mizos came under the influence of the British missionaries in the ninth century, and now most of the Mizos are Christians. They have been enchanted to their faith in Christianity with so much dedication that their entire social life and thought-process has been transformed and guided by the Christian church and their sense of values has also undergone drastic change. Their perception of what is right or wrong is based on Christian beliefs, as is their judgment of what is moral and immoral. This is reflected in their behavior towards those in their community.

Mizos are fast giving up their old customs and adopting the new mode of life which is greatly influenced by the western culture. Many of their present customs are mixtures of their old tradition and a western pattern of life. Contemporary people of Mizoram celebrate Christmas, Easter and other Christian festivals replacing many of old tribal customs and practices. However, the Mizo society is still a close-knit one, with no class distinction and no discrimination on grounds of gender. Birth of a child, marriage and death of a person in the village or community are important occasions in which the whole community is involved. The entire society is knitted together by a peculiar code of ethics, 'Tlawmngaihna' an untranslatable term meaning on the part

of everyone to be hospitable, kind, unselfish and helpful to others. Tlawmngaihna as a cultural concept incorporates behavior that is self-sacrificing, self-denying, doing what an occasion demands unselfishly and without concern for inconvenience caused. Thus, for example, after a fire or landslide damage, the Mizo culture shows spontaneous humble social work without demands or expectations, with members of the whole community helping out.(https:en.m.wikipedia.org)

Historically, alcohol (different varieties of rice beer) has been very much a part of our Mizo culture. Back during the days when we were warring tribes fighting amongst ourselves under different clans, when we were Animists long before the missionaries came, we drank at every village festival, danced around the bonfire under the crystal blue light, drunk and care free with no regard for the future. There were different types of alcohol for every occasion. Some types of alcohol like Zupui were served only on special public occasions such as weddings, a successful hunt, or a successful raid on another village. Others like Zufang were consumed at home(even the kids got the drinks) and served to visiting guests. And there were special Zufang served to important guests such as the chieftain of the village or a pasaltha(a warrior who had proven his courage during a hunt or a raid). Other types like Rakzu were consumed for leisure within the village.

All that changed when the Welsh missionaries arrived in Mizoram in 1894 during British colonization. Along with Christianity, they gave us a script, taught us how to read and write, educated us and abolished some social evils such as the practice of slavery, animal sacrifice, raiding villages and the tradition of proving one's bravery by beheading somebody from a rival clan in order to become a pasaltha. The missionaries also made us do away with other practices such as our consumption of alcohol (terming it a sin). Census data indicates in 2001, around

close to 90% of the population of Mizoram was Christian. Consumption of alcohol continues to be considered a grave sin.

Church pressure on the government to enforce prohibition has been tremendous: it was church influence that resulted in the Congress government passing the MLTP bill. While all church denominations are for prohibition, the Mizoram Presbyterian Church Synod, which has the largest followers, has been the most vocal about it. The same Congress government became abolished the MLTP act then passed a new law MLPC act to legalized the sale and consumption of alcohol with stringent restrictions after a five-hour debate involving two-thirds of all members to end 18 years of prohibition in the state in 10th July 2015.

In Mizoram, from observation and anecdotal reports many children under the age of 18 years live in households with at least one alcoholic parent. These children are seen to be at risk for a range of cognitive, emotional, and behavioral problems and the alcoholism in a family contributes to different kind of problems in a family one of which seems giving psychological problems to the effected children. It is also seen that many children are placed in homes for shelter because of their parental alcoholism and separation. (https://in.news.yahoo.com)

As of date no research on children of alcoholics (COA) has been conducted on the population under study. And there is a strong need for doing research on this topic as many families are being influenced by the problem brought about by the parental alcoholism, and many families are being devastated by alcoholism in the family. Alcoholism affects not only the individual it also has far-reaching effects on the entire family. Although children act and react as individuals, many children of alcoholics share some characteristics in their personalities, such as issues with stress, self-esteem, depression, anxiety and social issues.

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. The overall consideration would not only help satisfy to achieve the theoretical and methodological considerations but would provide foundations for behavioral intervention programs and further extended studies. For this purpose, the present study was designed with the following objectives.

OBJECTIVES

Given the theoretical and methodological foundations pertaining to the research problem, the present study has put forward the following objectives:

1. To explore the impact of parental alcoholism on psychosocial functioning.
2. To elucidate study and compare the achievement motivation, self-efficacy and well being in adolescent children of alcoholics and those of non-alcoholics.
3. To explore the relationship between the measures in the study i.e. self-efficacy, achievement motivation and well being
4. To highlight the relationship of socio-demographic characteristics and the variables under study i.e. achievement motivation, self-efficacy and well being.

HYPOTHESIS

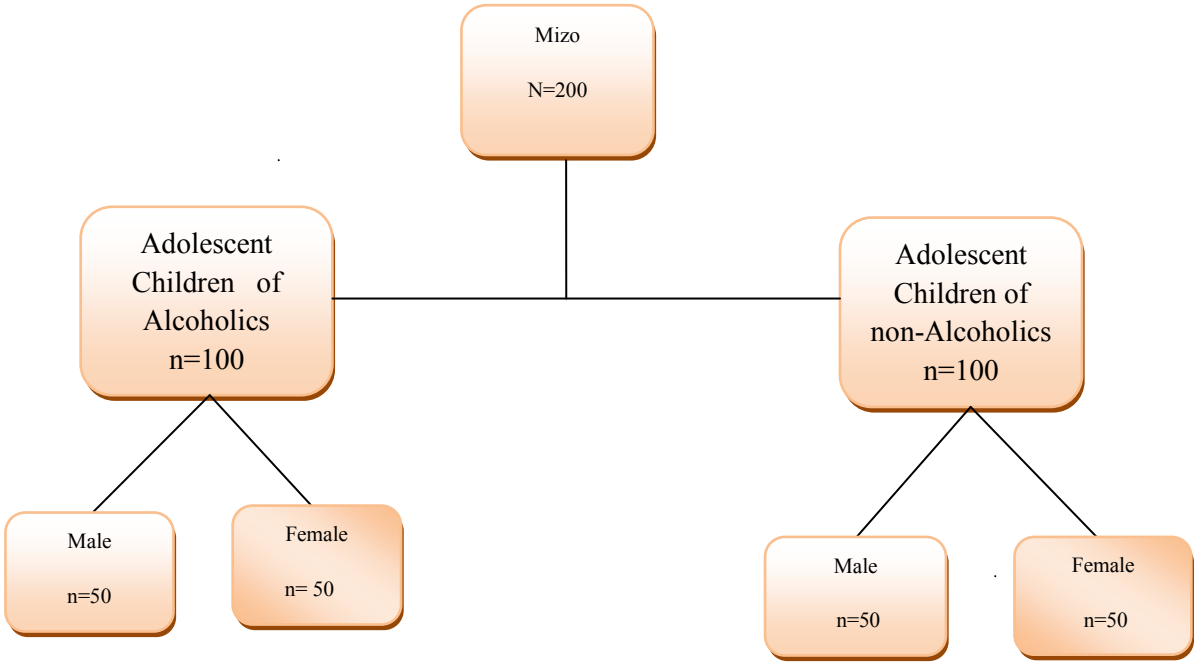
Following the review of literature pertaining to psycho- social correlates in adolescent children of alcoholics and the research objectives put forward, it is hypothesized that:-

1. It is expected that adolescent children of alcoholics (COAs) will have lower achievement motivation, self-efficacy and well being as in comparison to adolescent children of non-alcoholics (nCOAs).
2. There will be significant differences between adolescent children of alcoholics (COAs) and adolescent children of non-alcoholics (nCOAs) on the overall psycho-social functioning.
3. There will be significant gender differences on the dimensions under study.
4. There will be significant relationship between achievement motivation and self-efficacy in adolescent children of alcoholics.
5. There will be significant relationship between achievement motivation and well being in adolescent children of alcoholics.
6. There will be significant relationship between self-efficacy and well being in adolescent children of alcoholics.
7. There will be significant relationship between achievement motivation, self-efficacy and well being in adolescent children of non- alcoholics.

METHODS AND PROCEDURE

Sample:

To achieve the objectives, 200 (M= 100; F= 100) Mizo adolescents with age ranging between 14 to 20 years from Aizawl city served as subjects for the present study. Paternal alcoholic status was determined by AUDIT (Alcohol Use Disorders Identification Test) and the two groups –i) children of alcoholics (50M and 50 F= 100) and ii) children of non- alcoholics (50M and 50 F= 100) were thus categorized for the conduct of the study. The socio-demographic background information of the subjects like age, gender, education, occupation, permanent residence, , family structure etc. were recorded to match the subjects in order to maintain the homogeneity of the sample. The sample characteristics are depicted below:



DESIGN OF THE STUDY

The study incorporated a 2X2 factorial design as depicted above to highlight the impact and relationship of parental alcoholism on psychosocial dimensions such as achievement motivation, self efficacy and psychological well being.

PROCEDURE

The Alcohol Use Disorders Identification Test, AUDIT (Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG) 2001, was implemented to identify paternal alcoholism following which the subjects were categorized into two groups "the alcoholics and non-alcoholics groups" and sample for the study was randomly selected from the two groups. This is a comparative study based on the presumption that the effect if any, of living with an alcoholic (study group) or non-alcoholic (reference group) father would have already manifested itself on both groups of respondents. The groups being matched on key socio-demographic variables, the study is only an attempt to determine and compare the achievement motivation, self-efficacy and mental health in these children at the point of data collection. After obtaining the necessary consents and careful explanations of instructions for completing the questionnaires, subjects filled out the questionnaires. The background demographic sheets were also filled up by each subject who was assured confidentiality. Each response session lasted for approximately 30 minutes.).

PSYCHOLOGICAL TOOLS USED

1)Deo-Mohan Achievement Motivation Scale (Deo, P & Mohan, S.,2002):The Deo-Mohan Achievement Motivation Scale(n-Ach) is a questionnaire consisting of 50 items where responses are to be made to one of the five categories ranging from (1) always, (2)frequently (3)sometimes, (4) rarely, (5)never. It is a self administered test designed to measure achievement motivation including academic areas, general and social interests. The range of scores is from a minimum of 50 to a maximum score of 250. High score indicates high achievement motivation and low score indicates low achievement motivation.

2) General Health Questionnaire -12 (GHQ-12;Goldberg, D.,1992): The General Health Questionnaire -12(GHQ-12) is a 12- item self-report measure of psychological well-being. The scale asks whether the respondent has experienced a particular symptom or behavior recently. Each item is rated on a four-point Likert-type scale with scores of 0-1-2-3 for response choices of 'less than usual' respectively; The scores may range from 0 to 36with lower scores indicating psychological well-being and vice versa for high scores.

3) Generalized Self-Efficacy Scale(R. Schwarzer and M. Jerusalem,1995**):** The GSE is a 10-item scale designed to assess optimistic self-beliefs used to cope with a variety of demands in life. The scale was designed to assess self efficacy, i.e., the belief that one's actions are responsible for successful outcomes. The scaled score for each question ranges from 1 to 4. Higher scores indicate stronger patient's belief in self-efficacy. The scale was originally developed by Jerusalem and Schwarzer in 1981 in Germany and has been translated into manylanguages. Studies have shown that the GSE has high reliability, stability, and construct validity (Leganger et al. 2000; Schwarzer, Mueller, &Greenglass 1999). The scale was found to

be configurally equivalent across 28 nations, and it forms only one global dimension (Leganger et al 2000.;Scholz et al. 2002). Cronbach alpha ranges from 0.75 to 0.94 across a number of different language versions (Rimm and Jerusalem 1999; Luszczynska et al. 2005). Relations between the GSE and other social cognitive variables (intention, implementation of intentions, oucome expectations, and self-regulation) are high and confirm the validity of the scale (Luszczynska et al. 2005). The GSE has been translated into numerous languages and tested in populations around the world. The reliability and validity of these translations are also very high. Sholz et al. (2002) found that the GSE is configurally equivalent across cultures and confirm that it corresponds to only one globally consistent underlying dimension. Consisting of only 10 items, the GSE is easy to administer and interpret. The scale measures one global dimension of self-efficacy with high reliability and validity.

4)Alcohol Use Disorders Identification Test (AUDIT),Babor TF, Higgins-Biddle JC, Saunders JB, Monteiro MG; The Alcohol Use Disorders Identification Test, Guidelines for Use in Primary Care, Second Edition, Department of Mental Health and Substance Dependence, World Health Organization, CH-1211 Geneva 27, Switzerland. It has been developed by the World Health Organization as a simple screening tool to pick up the early signs of hazardous and harmful drinking and identify mild dependence.It is a very reliable and simple screening tool which is sensitive to early detection of risky and high risk (or hazardous and harmful) drinking. It has three questions on alcohol consumption (**1 to 3**), three questions on drinking behaviour and dependence (**4 to 6**) and four questions on the consequences or problems related to drinking (**7 to 10**).

DATA COLLECTION

Each participant received a booklet containing the demographic information (age, educational qualification, and socioeconomic status, family type, substance use profile, etc.), Deo-Mohan Achievement Motivation Scale (Deo, P & Mohan, S.,2002)General Health Questionnaire -12 (GHQ-12;Goldberg, D.,1992) and Generalized Self-Efficacy Scale (R. Schwarzer and M. Jerusalem,1995) and the booklet was completed in the presence of the researcher.

STATISTICAL ANALYSIS

1. Descriptive statistics, graphical methods and inter-correlations will be examined to highlight the nature of participants and the pattern of relationships among the variables.
2. The assumptions underlying the univariate, bivariate and multivariate statistics shall be looked into and where necessary permissible transformation and standardization of the scores will be performed. Alternatively, if required, non-parametric statistics maybe employed.
3. Following such data screening, univariate, bivariate and multivariate statistics will be applied as called for to delineate the relationships between the variables.

RESULTS AND DISCUSSION

The Present chapter presents in a sequential manner the outcomes of the results and the discussion of the results over the level of analysis. The analysis of the data had been carried out as per the design of the study and the tables and the interpretations of the data are presented in that sequence. Descriptive as well as inferential statistics were employed to see the difference if any in the socio-demographic variables, depicting the demographic profile of the subjects - gender, age, birth order, living arrangement, education of father and mother, occupation of father and mother and the family monthly income. The background information of the subjects which are considered significant by the researcher is presented in graph format with the objective to see if some of the extraneous variables are heavily loaded. The background information of the students were recorded with the help of a ' Socio-demographic Information Schedule'.

The psychometric adequacy of the measures used in the study was aimed in the light of the experiences of cross-cultural psychology. Psychological test(s) of proven psychometric adequacy for a given population, if transported and employed for measurement purposes in another cultural milieu, may not carry their identical psychometric properties, and unless preliminary checks are made, may not be accepted as the reliable measure(s) of the theoretical construct (Witkin& Berry, 1975; Eysenck&Eysenck, 1985). Stated otherwise, efforts were made to adapt the behavioral measures, and to find empirical bases for comparability of the test scores (the findings of the present study).

Results revealed that the total coefficient of correlation of the subjects emerged to be satisfactory over the levels of analysis for the whole sample, indicating the trust-worthiness of

the scales, such as, (i)Deo- Mohan Achievement Motivation Scale(Deo, P & Mohan, S.,2002); (ii) General Health Questionnaire -12 (GHQ-12;Goldberg, D.,1992)and (iii) Generalized Self-Efficacy Scale(R. Schwarzer and M. Jerusalem,1995)were prepared for the whole samples-adolescent children of alcoholics and those of non-alcoholics.

Table- 1: Reliability co-efficient of the scales .

SCALES	CRONBACH'S ALPHA
n- Ach Scale	.85
GSES	.74
GHQ 12	.50

The reliability and predictive validity of the scales namely Deo-Mohan Achievement Motivation Scale (n-Ach), Generalized Self- efficacy Scale and General Health Questionnaire (GHQ 12) Scales were ascertained by the Cronbach's Alpha for each of the scales to ensure the psychometric adequacy of the scales. The scores of coefficient of correlation of the test scales used for the study using Cronbach's Alpha are presented in table 1. The overall internal consistency (Cronbach's Alpha) for the entire ns-Ach scale was .85. The overall internal consistency (Cronbach's Alpha) for the entire Generalized Self-efficacy scale was .74. The overall internal consistency (Cronbach's Alpha) for the entire GHQ 12 scale was .50. The results revealed that total coefficient of correlation and reliability coefficient of the scales emerged to be satisfactory over the levels of analysis for the whole sample.

Table- 2: Inter scales correlation.

	n- Ach Scale	Self-Efficacy Scale	GHQ 12
n- Ach Scale		.40**	-.191**
GSES			.04
GHQ 12			
** Correlation is significant at the 0.01 level (2- tailed) List wise N= 200			

The inter scales correlation is employed to elucidate correlation between each of the scales and the result indicated that Achievement Motivation Scale(n-Ach) and Generalized Self-efficacy Scale (GSES) has a significant correlation at 0.01 level (2 tailed).Again, Achievement Motivation Scale (n-Ach) and General Health Questionnaire(GHQ 12) has a significant correlation at 0.01 level. However, no significant correlation has been found between Self-efficacy and GHQ 12.

Table- 3: Descriptive statistics on psychological measures for the whole samples.

Descriptive statistics	N	Mean	SD	Skewness		Kurtosis	
				Statistics	Std.Error	Statistics	Std.Error

n-Ach Scale	200	10.71	1.02	-.588	.172	.496	.342
GSES	200	5.17	0.59	4.394	.172	43.859	.342
GHQ 12	200	16.18	3.94	.045	.172	.526	.343

Normality and Homogeneity of Data

After ascertaining the reliability of the test scales, the normality and homogeneity of the collected data was tested. Table 3 shows the Mean, Standard Deviation, Skewness and Kurtosis of all the variables under study. The Mean n- Ach score is found to be 10.7 and 1.02 SD. For GSES, the mean score is 5.17 and SD 0.5 and for GHQ 12, the mean score is 16.18 and SD 3.94. The analysis of the skewness and kurtosis of the variables showed that all the variables were skewed except GHQ 12. The Hartley test (Hartley Critical values df=200-1) was employed to ensure homogeneity and the Hartley test scores for the variables which were skewed were analyzed by the Hartley test scores for all the variables and have been found to be normal.

Table-4: Hartley's table of Fmax.

Variables	SD diff. value	Sig.	Df.
n- Ach Scale	0.265	1.00	199
Self-Efficacy Scale	0.6	1.00	199

Descriptive statistics on the behavioral measures used in the study have also been analyzed for both male and female children of alcoholics and non-alcoholics. The results of this analysis are shown in tables 5(a) to 5(d).

Table-5(a): Descriptive statistics on behavioral measures for male children of alcoholics.

Descriptive statistics	N	Mean	SD
n-Ach Scale	50	10.11	.829
GSES	50	5.00	.426
GHQ 12	50	16.72	3.73

Table 5(a) shows the Mean and Standard Deviation of all the variables under study for male children of alcoholics. The Mean n- Ach score is found to be 10.11and .829 SD. In Self-efficacy scale, the mean score is 5.00 and SD 0.426. In GHQ 12, the mean score is 16.72 and SD 3.73.

Table-5(b): Descriptive statistics on behavioral measures for female children of alcoholics.

Descriptive statistics	N	Mean	SD
n-Ach Scale	50	10.43	1.06
GSES	50	5.04	.954
GHQ 12	50	16.02	3.80

Table 5(b) shows the Mean and Standard Deviation of all the variables under study for female children of alcoholics. The Mean n- Ach score is found to be 10.43 and 1.06 SD. In GSES, the mean score is 5.04 and SD 0.96. In GHQ 12, the mean score is 16.02 and SD 3.80.

From tables 5(a) & (b), it is seen that male COAs scores are M= 10.11 and S.D= 0.83 while female COAs scores are M= 10.43 and S.D= 1.06 in n-Ach scale which indicated that female COAs were higher in achievement motivation than male COAs. For GSES Male COAs scored M= 5.00 and S.D= 0.43 while female scored M= 5.04 and S.D=0.96 in which indicated that female COAs were higher in self-efficacy than male COAs. And the scores of Male COAs for GHQ were M= 16.72 and SD= 3.73 and female COAs scored M= 16.02 and S.D=3.80, which indicated that male COAs were higher in psychological distress than female COAs.

Table-5(c): Descriptive statistics on behavioral measures for male children of non-alcoholics.

Descriptive statistics	N	MEAN	SD
n-Ach Scale	50	11.02	.967
GSES	50	5.28	.356
GHQ 12	50	16.60	4.24

Table 5(c) shows the Mean and Standard Deviation of all the variables under study for male children of non-alcoholics. The Mean n- Ach score is found to be 11.02 and 0.97 SD. In Self-efficacy scale, the mean score is 5.28 and SD 0.36. In GHQ 12, the mean score is 16.60 and SD 4.24.

Table-5(d): Descriptive statistics on behavioral measures for the female children of non-alcoholics.

Descriptive statistics	N	MEAN	SD
n-Ach Scale	50	11.28	.779
GSES	50	5.36	.352
GHQ 12	50	15.35	3.95

Table 5(d) shows the Mean and Standard Deviation of all the variables under study for female children of non-alcoholics. The Mean n- Ach score is found to be 11.28 and 0.78 SD. In Self-efficacy scale, the mean score is 5.36 and SD 0.36. In GHQ 12, the mean score is 15.35 and SD 3.95.

From table 5(c) & (d), it can be seen that the scores for male nCOA was (M=11.02 and S.D=0.97) and for female nCOA (M= 11.28, S.D= 0.78). Indicating that female nCOA were higher in achievement motivation than male nCOA, this finding is consistent with the study conducted by Salili in 1996 among the British students. Male nCOA scored 5.28 mean and .356 SD while female nCOA scored 5.36 and .352 SD which indicated that female nCOA were higher in self-efficacy than male snCOA. This finding is consistent with the finding of McKenzie (1999). Male nCOA scored 16.60 mean and 4.24 SD while female nCOA scored 15.35 mean and 3.95 SD which indicated that male nCOA were higher in psychological distress than female nCOA. This finding is consistent with the study conducted by Mustafa & Suman (2009).

Table-6: Gender differences/comparison of Male and Female children of alcoholics and children of non-alcoholics (whole sample) on achievement motivation scale, self-efficacy and GHQ 12.

Gender		n-Ach	Self-efficacy	GHQ 12
Male	N	100	100	100
	Mean	10.57	5.14	3.98
	SD	1.00	.42	.57
Female	N	100	100	100
	Mean	10.85	5.20	3.75
	SD	1.03	.734	.646

The mean score of male participants in Achievement Motivation scale is 10.57 with a standard deviation of 1.00 while the mean score of female participants is 10.85 with a standard deviation of 1.03. This shows that female scored higher than male in n- Ach scale which indicated that female were higher in achievement motivation than male.

The mean score of male participants in Generalized Self-efficacy Scale is 5.14 with a standard deviation of .42 while the mean score of female participants in Generalized Self-efficacy Scale is 5.20 with a standard deviation of .734.This show that female scored higher that male in generalized Self-efficacy scale which indicated that female were higher in self-efficacy than male.

The mean score of male participants in GHQ 12 scale is 3.98 with a standard deviation of .97 while the mean score of female participants in GHQ 12 scale is 3.75 with a standard deviation of .646. This shows that male scored higher than female which indicated that male have higher psychological distress than female. The analysis of the gender difference (

male/female) of children of alcoholic and non-alcoholic revealed that female were higher than male in achievement motivation and self-efficacy but male were higher than female in psychological distress. This finding is consistent with the findings such as Salili (1996), McKenzie (1999) and Mustafa & Suman (2009).

Table-7: Comparison between children of alcoholics and those of non-alcoholics on n-Ach, GSES and GHQ 12.

Parental condition		n-Ach	GSES	GHQ 12
Alcoholics	N	100	100	100
	Mean	10.27	5.33	16.37
	SD	.961	.74	3.76
Non- Alcoholics	N	100	100	100
	Mean	10.71	5.01	15.98
	SD	1.02	.35	4.13

COA mean score in n-Ach scale is 10.27 with a standard deviation of .961 while nCOA mean score is 10.71 with a standard deviation of 1.02.This shows that children of non-alcoholics (nCOA) scored higher than children of alcoholics COA in achievement motivation . This finding is consistent with a study on 'Academic Achievement in Adolescent' which confirmed that COAs, particularly those whose parents are alcohol dependent as opposed to having a diagnosis of alcohol abuse, achieve relatively lower academic outcomes in comparison to non-COA peers. Adolescent task orientation partially mediated the relations between parent alcohol dependence

and academic achievement, indicating that academic difficulties in COAs may be partly due to impaired motivation and organization.(Mc Grath CE, Watson AC, & Chassin L, 1999 Jan)

The COA mean score for GSES is 5.01 with a standard deviation of .74 while nCOA mean score in GSES is 5.33 with a standard deviation of .35. This shows that the nCOA scored higher than COA in self-efficacy. This finding is consistent with Cole et al. (1980) which observed that emotional maturity manifests in high self-esteem and enhances one's interpersonal ability. Thus the low self-esteem seen in COAs is indicative of poor emotional maturity and may diminish their interpersonal competence. This perhaps is reflected in the poor adjustment scores obtained by the COAs across several domains seen in the study. The finding is in contrast with Churchill et al. (1990), who found no significant relationship between parental alcoholism and self-esteem of their children. But the results are congruent with that of Morey (1999), who reports that self-esteem ratings for COAs were significantly lower in comparison to ratings for nCOAs.

The COA mean score in GHQ 12 scale is 16.37 with a standard deviation of 3.76 while the nCOA mean score in GHQ 12 is 15.98 with a standard deviation of 4.13. This shows that COA scored higher than nCOA in GHQ 12 which indicated that children of alcoholics have higher psychological distress than children of non-alcoholics. This finding is consistent with Bird and Canino (1991) finding which found that children of alcoholics when compared to those of non-alcoholics manifested higher levels of behavioural under control, more neuroticism and greater psychiatric distress. It is well established that children of problem drinkers have an increased risk of developing mental health problems, not only during childhood but also when they grow up into adolescents and adults observe Cuijpers et al (2006). Children of alcoholic

fathers are at high risk for psychopathology and gender-related differences also seem to exist contend Furtado et al. (2006). Depression and anxiety are recurring themes in the literature on COAs (e.g. Callan and Jackson, 1986; Williams and Corrigan, 1992; Steinhausen, 1995; Kelley, 1996; Deborah,1997)

Table-8(a): Levene's test of equality of error variance for Achievement Motivation (n-Ach).

	F	Df1	Df2	Sig.
n-Ach Scale	1.14	3	196	.333

To indicate there is a difference between the variances as assumed by the 2X2 ANOVA Levene's test was applied. Levene's test shows non-significant test result on the variables under study that indicated that there are equal variances. Table 8(a) shows Levene's test of equality of error variance for Achievement Motivation (n-Ach) scale which is 1.14 F with a significant level of .333.

Table-8(b): 2X2 ANOVA for children of alcoholic parents and non-alcoholic parents X gender for achievement motivation (n-Ach Scale).

Source	Sums of Squares	Df.	Means	F	Sig.	Partial Eta Squared
Alcohol condition	38.65	1	38.65	45.52	.000	.19

Gender	4.0	1	4.0	4.71	.031	.023
Interaction	.03	1	.03	.04	.85	.000

The difference between children of alcoholic parents (COA) and children of non-alcoholic (nCOA) on achievement motivation was analyzed using 2x2 ANOVA and the results shown in Table 8(b). Results show significant differences between COA and nCOA on achievement motivation ($p<.01$). This finding is consistent with a study on academic performance which indicated that COAs repeatedly score lower on verbal scales, reading and writing tasks, and standardized college test scores while also having lower GPAs and class rank than control nCOA. (Murphy, O'Farrell, Floyd, & Connors, 1991; Sher, Walitzer, Wood, & Brent, 1991; von Knorring, 1991).

The gender difference of adolescents on achievement motivation was also analyzed using 2x2 ANOVA and the results shown in Table 8 (b). Results show that there are no significant gender differences on achievement motivation. . This finding is consistent with the finding of the study conducted on British and Chinese students by Salili (1996) which indicated that female subjects of both cultures had higher scores than males, although this difference was significant for British female subjects only. Liu & Zhu (2009) findings also supported the result which indicated that there is significant difference between male and female children but the result was the reverse of the above result which indicated that male subjects were higher in achievement motivation than female. But the finding is contrast with the finding of Nagarathanamma & Rao (2007) which indicated that there is no significant difference between boys and girls with regard

to achievement motivation level. Similar findings were reported by Kaushik & Rani (2005) and Adsul et al. (2008).

Table-8(c): Post Hoc test on Achievement Motivation (n-Ach Scale)

Variable 1	Variable 2	Mean Diff.	SE	Sig.
Male COA	Female COA	-.308	.184	.428
	Male nCOA	-.904**	.184	.000
	Female nCOA	-1.16**	.184	.000
Female COA	Male COA	.308	.184	.428
	Male nCOA	-.596*	.184	.017
	Female nCOA	-.854**	.184	.000
Male nCOA	Male COA	.904**	.184	.000
	Female COA	.596*	.184	.017
	Female nCOA	-.258	.184	.582
Female nCOA	Male COA	1.16**	.184	.000
	Female COA	.854**	.184	.000
	Male nCOA	.258	.184	.582
**p<.01, *p<.05				

Post Hoc analysis was further conducted to examine the differences between male COA and female COA on achievement motivation and the results shown in Table 8(c). Results show that there is no significant difference in achievement motivation between male COA and female

COA. However, male COA have been found to score significantly lower than male nCOA on achievement motivation ($p<.01$). Results also show that male COA scores significantly lower than female nCOA on achievement motivation ($p<.01$). Further, female COA have been found to score significantly lower than male nCOA ($p<.05$) on achievement motivation . Significant difference has also been found between female COA and female nCOA on achievement motivation, with female COA scoring higher than female nCOA ($p<.01$).

From the results obtained in table 8(c), it can be seen that in achievement motivation, male COA and female COA have no significant difference. Male COA scored lower than male nCOA which indicated that male nCOA are higher in achievement motivation than male COA. Male COA scored lower than female nCOA which indicated that female nCOA are higher in achievement motivation than male COA. Female COA scored lower than male nCOA which indicated that male nCOA are higher in achievement motivation than female COA. Female COA scored lower than female nCOA which indicated that female nCOA are higher in achievement motivation than female COA.

Table 9(a): Levene's test of equality of error variance for Self-efficacy (Generalized Self-efficacy Scale).

	F	Df1	Df2	Sig.
GSES	1.61	3	196	.187

Table 9(a) shows Levene's test of equality of error variance for Generalized Self-efficacy scale which is1.61 F with a significant level of .187.

Table-9(b): 2X2 ANOVA for children of alcoholic(COA) and non-alcoholic (nCOA) X gender for self-efficacy (Generalized Self-Efficacy Scale).

Source	Sums of Squares	Df.	Means	F	Sig.	Partial Eta Squared
Alcohol condition	4.67	1	4.67	13.90	.000	.066
Gender	.161	1	.161	.481	.489	.002
Interaction	.025	1	.025	.075	.785	.000

The difference between children of alcoholic (COA) and children of non-alcoholic (nCOA) on self-efficacy was analyzed using 2x2 ANOVA and the results shown in Table 7(b). Results show significant differences between COA and nCOA on self-efficacy ($p<.01$). This finding is consistent with the research on behavioral problems which demonstrated that children of alcoholics has revealed some of the following traits: lack of empathy for other persons; decreased social adequacy and interpersonal adaptability; low self-efficacy; and lack of control over the environment (Jones, M.C., 1968).

The gender difference of adolescents on self-efficacy was also analyzed using 2x2 ANOVA and the results shown in Table 9(b). Results show that there are no significant gender differences on self-efficacy. This finding is consistent with the study done by Shikullaku (2013) on st "The Relationship between Self-efficacy and Academic Performance in the Context of Gender among Albanian Students" sample for analysis The study consisted of 180 students, 78 men (43%) and 102 women (57%) with the participants age ranged from 19 to 31 years. In this study he found that there is no significant difference level of self-efficacy between male and

female. In additions, abd-Elmotaleb and Saha (2013) revealed in their study that self-efficacy have negative significant correlation ship with sexes. This finding is contrast with the study conducted by Abdullah et al. (2006) which found that girls have higher self efficacy rather than boys.

Table-9(c): Post Hoc test on self-efficacy (Generalized Self- Efficacy Scale).

Variable 1	Variable 2	Mean Diff.	SE	Sig.
Male COA	Female COA	-.034	.115	.993
	Male nCOA	-.283	.115	.117
	Female nCOA	-.362*	.115	.023
Female COA	Male COA	.034	.115	.993
	Male nCOA	-.249	.115	.206
	Female nCOA	-.328*	.115	.049
Male nCOA	Male COA	.283	.115	.117
	Female COA	.249	.115	.206
	Female nCOA	-.079	.115	.926
Female nCOA	Male COA	.362*	.115	.023
	Female COA	.327*	.115	.049
	Male nCOA	.079	.115	.926
*= p<.05 **= p<.01				

Post Hoc analysis was further conducted to examine the differences between male COA and female COA on self-efficacy and the results shown in Table 9(c). Results show that there is no significant difference in self-efficacy between male COA and female COA, male COA and

male nCOA, female COA and male nCOA. Results also show that male COA scores significantly lower than female nCOA on self-efficacy ($p<.01$). Significant difference has also been found between female COA and female nCOA on self-efficacy, with female nCOA scoring higher than female COA ($p<.01$).

From the results obtained in table 9(c), it can be seen that there is no significant difference between male COA and female COA which indicated that there is no gender difference between male and female COA in self-efficacy. And there is no difference between male COA and male nCOA which indicated that male COA and male nCOA have no significant difference in self-efficacy. Again, there is no difference between female COA and male nCOA which indicated female COA and male nCOA have no significant difference in self-efficacy. However, male COA scored lower than female nCOA which indicated that female nCOA have higher self-efficacy than male COA. Female COA also scored lower than female nCOA which indicated that female nCOA have higher self-efficacy than female COA.

Table 10(a): Levene's test of equality of error variance for General Health Questionnaire (GHQ 12).

	F	Df1	Df2	Sig.
n-Ach Scale	.194	3	195	0.90

Table 10(a) shows Levene's test of equality of error variance for General Health questionnaire scale which is .194 F with a significant level of 0.90.

Table-10(b): 2X2 ANOVA for children of alcoholic and non-alcoholic X gender for psychological well-being (GHQ 12).

Source	Sums of Squares	Df.	Means	F	Sig.	Partial Eta Squared
Alcohol condition	7.82	1	7.82	.505	.478	.003
Gender	47.44	1	47.44	3.06	.082	.015
Interaction	3.80	1	3.80	.246	.621	.001

The difference between children of alcoholics (COA) and children of non-alcoholics (nCOA) on psychological well-being was analyzed using 2x2 ANOVA and the results shown in Table 10 (b). Results show that there are no significant differences between COA and nCOA on psychological well-being. This finding is contrast with Bird and Canino (1991),finding which showed that children of alcoholics when compared to those of non-alcoholics manifested higher levels of behavioural under control, more neuroticism and greater psychiatric distress. (Bird, S. &Canino, G. (1991). Children of alcoholic parents in the community.Journal of Studies onAlcohol 52,78-88.)

The gender difference of adolescents on psychological well-being was also analyzed using 2x2 ANOVA and the results shown in Table 10(b). Results show that there is no significant gender differences on psychological well-being ($p<.01$). This finding is contrast with the study conducted by Mustafa N. Kirmani and L.N. Suman (2009) which revealed that boys had higher psychological distress along with a more favorable attitude towards alcohol than girls.

SOCIO- DEMOGRAPHIC PROFILE OF THE TWO GROUPS :

Figure- 1: Family Pattern of Children of Alcoholics (COA)

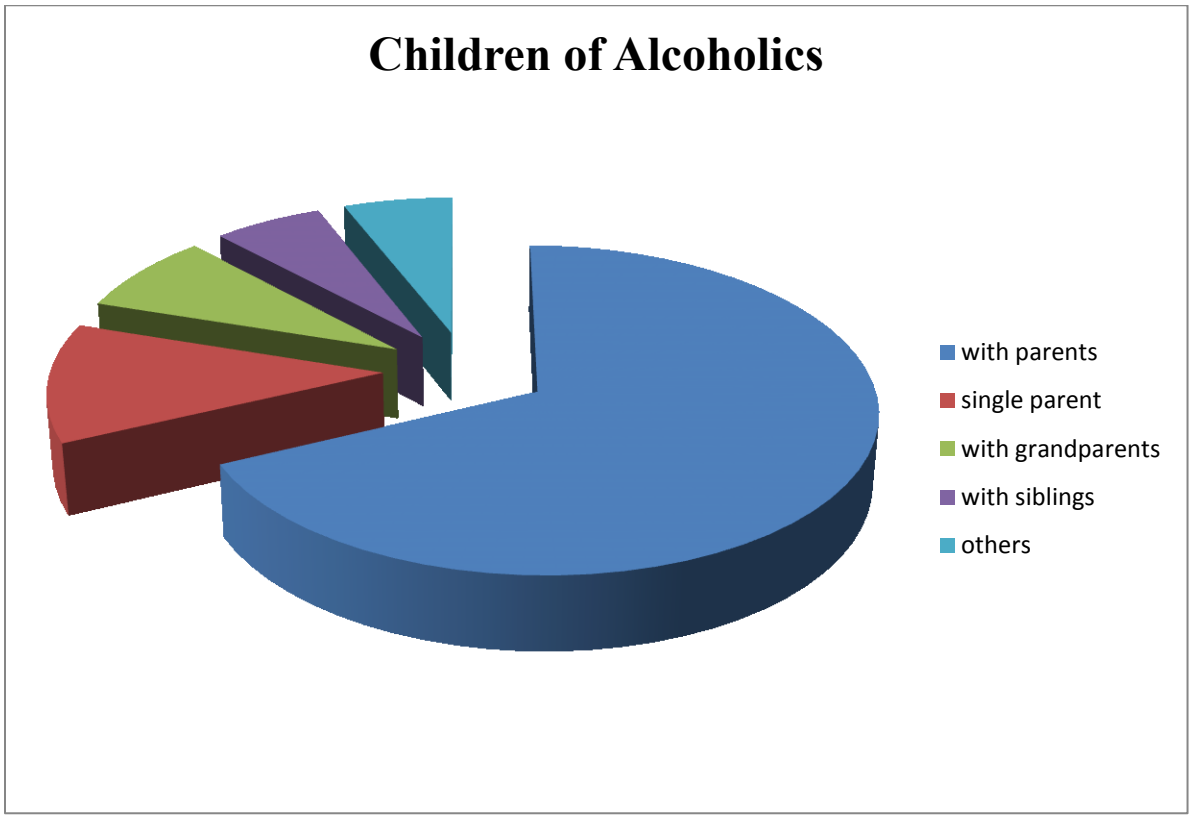


Fig. 1 shows the family profile of the children of alcoholics (COA) which represented that 68% of the participants were living with their parents, 12% were living with a single parent 8% were living with their grandparents and 6% were living with their siblings, because of different reasons like parents separation, parents stayed at home/rehabilitation centers, etc., and 6% were living with others that is with other caregivers.

Figure- 2: Family Pattern of Children of non- Alcoholics (nCOA)

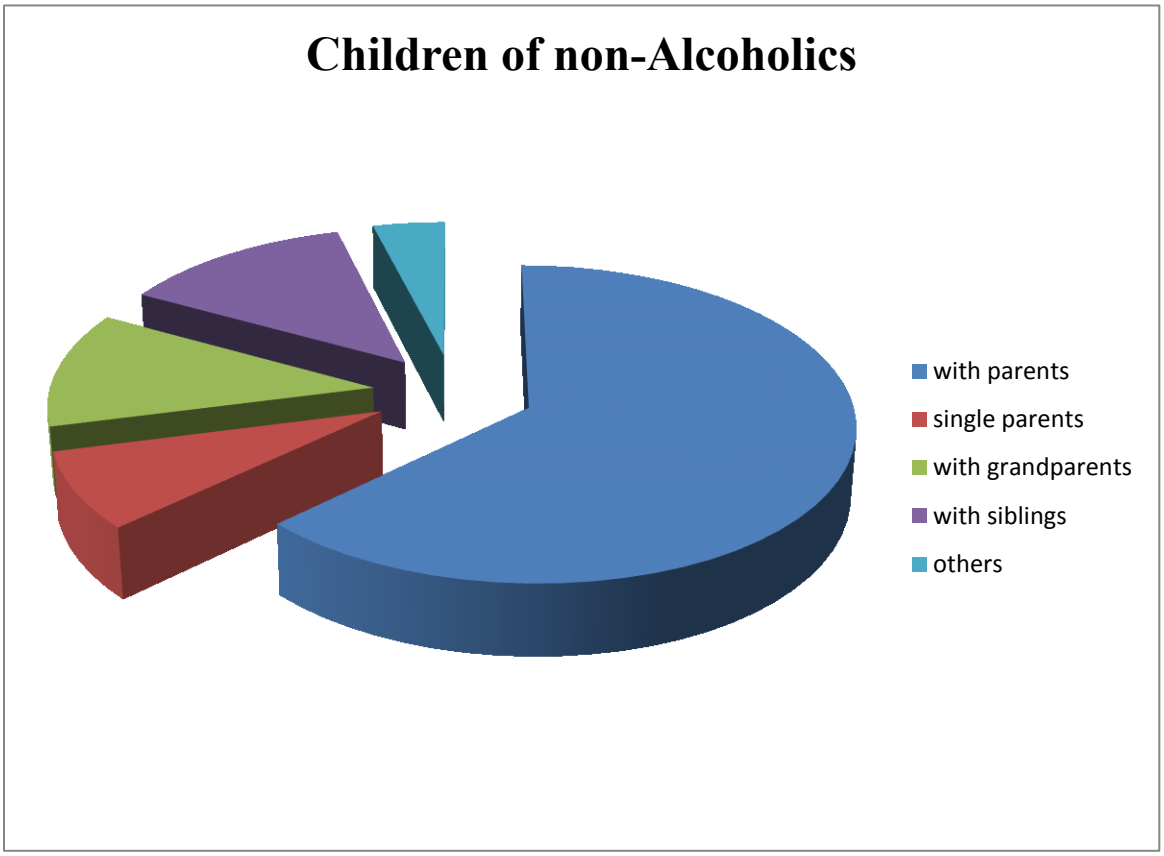


Fig. 2 shows the family patterns of the children of non-alcoholics (nCOA) which represented that 63% of the participants were living with their parents, 8% were living under single parenting, 12% were living with their grandparents and 13% were living with their siblings because of different reasons like parents separation, parents stayed at home/rehabilitation centers, etc. and 4% were living with others that is with other caregivers.

Figure 1 and 2 represent the family pattern of the 2 groups in the present study that is alcoholic and non-alcoholic. The findings can be summarized as follows: Higher number of children in the alcoholic group were found to be living with their parents than children of non-alcoholics. The number of children living in single parent families were more for children of

alcoholics than children of non-alcoholics. That higher percentage of children from non alcoholic families were living with their grandparents than children of alcoholics. Also, more children from non-alcoholic families were living with their siblings then children from alcoholic families. Finally, higher number of children of alcoholics than children of non-alcoholics were living with other caregivers.

SUBSTANCE USE PROFILE OF THE CHILDREN IN THE TWO GROUPS

Figure- 3: Substance Use Profile of Children of Alcoholics (COA)

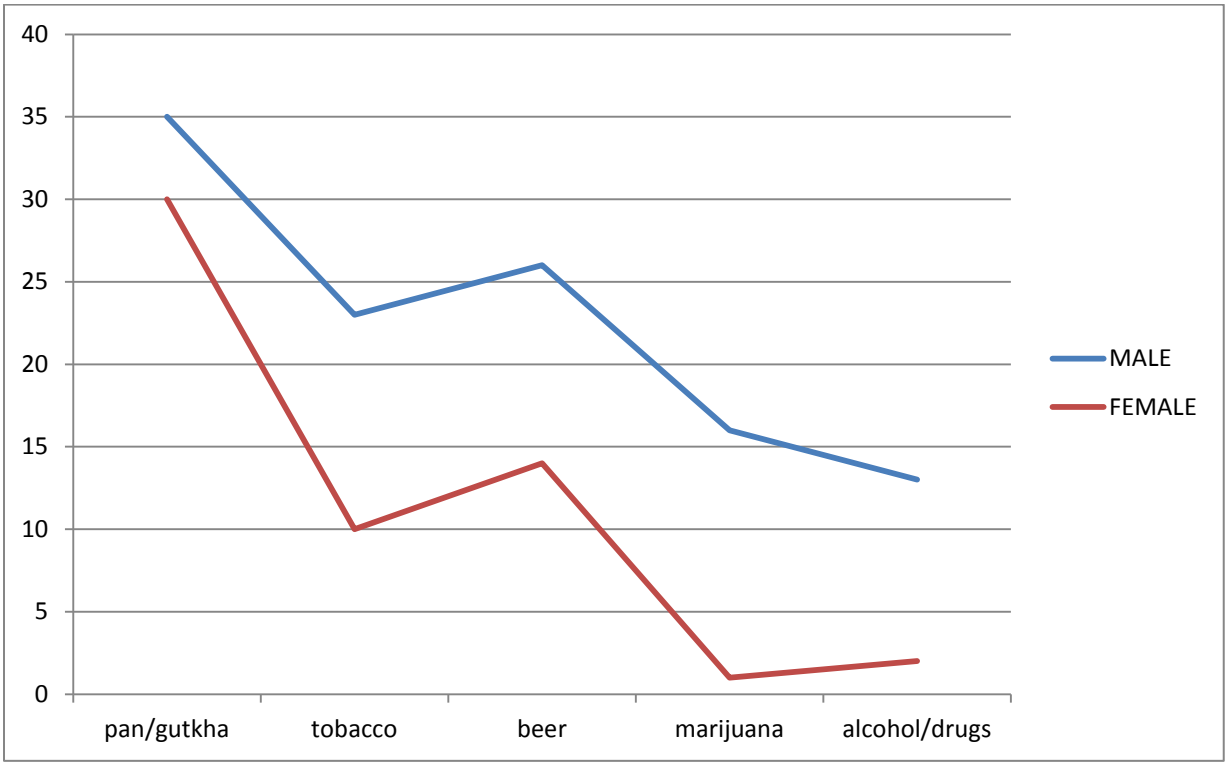


Fig. 3 shows profile of substance use by children of alcoholics represented that 35% male and 30% of female children of alcoholics had tasted, abused or addicted pan/gutkha. 23% of male and while 10% of female children of alcoholics had tasted, abused or addicted tobacco.

That 26% of male and 14% of female participants had tasted, abused or addicted beer/grape wine while. 13% of male and while 1% of female participants had tasted, abused or addicted marijuana. 14% of male while 2% of female had tasted, abused or addicted alcohol/drugs.

Figure- 4: Substance Use Profile of Children of non-Alcoholics.

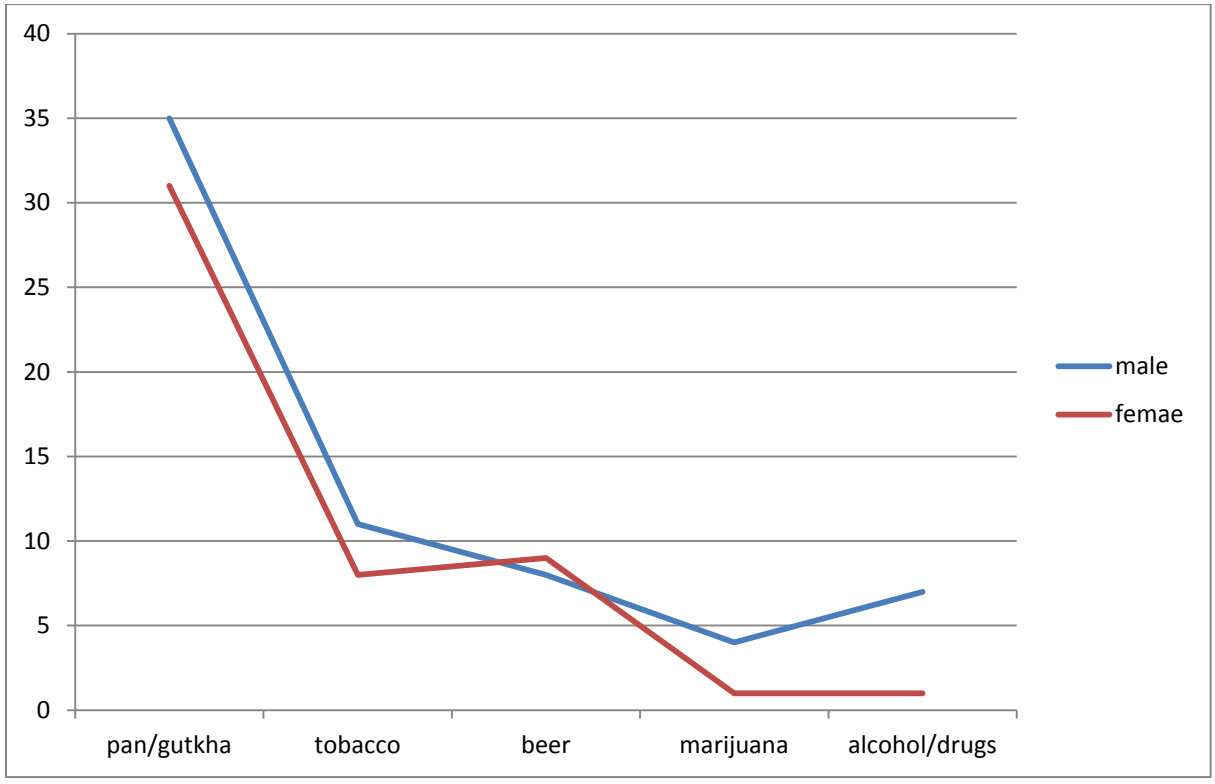


Fig. 4 shows profile of substance use by the male and female children of non-alcoholics represented that 35% male and 31% of female children of non alcoholics had tasted, abused or addicted pan/gutkha. 11% of male while 10% of female children of non alcoholics had tasted, abused or addicted tobacco. That 8% of male and 9% of female participants had tasted, abused or addicted beer/grape wine while 4% of male and while 1% of female participants had tasted, abused or addicted marijuana. 7% of male while 1% of female had tasted, abused or addicted alcohol/drugs.

Regarding types of substances used by children of alcoholics and non alcoholics the study revealed use of pan and gutka to be highest in both groups followed by tobacco, beer/wine, marijuana, alcohol or other drugs. The use of tobacco, beer/ grapewine, marijuana , alcohol and other drugs use is significantly higher for male COA as compared to male nCOAs. Gender difference between COAs and nCOAs in regards to substance use also appears to be to be significant. Forty per cent of the COAs reported daily drinking by their father while forty two per cent said it was on alternate days, the remaining were not sure of the frequency of drinking. Regarding the duration of drinking, forty per cent said it was up to three years with the remaining respondents mentioning that it was between three and ten years. With regard to the behaviour of the father when intoxicated, fifty four per cent said that he became more silent than usual, twenty six per cent said that he became boisterous and shouted at others while the remaining twenty per cent expressed that he scolds and beats up the family members. Because of the high likelihood of a dysfunctional family environment for alcoholic families, the adolescent COAs are at risk of having more depressive symptoms (Lease, 2002).COAs experience barriers to achievement of adolescent developmental tasks, such as establishing positive self-identity (Gemelli, 1996; Hollinger-Smith, 2004; Lerner & Steinberg, 2004; Nurmi, 2004). Experiencing significant conflict within the family can drive adolescents to take risks with their health, for example, by starting to use alcohol, tobacco, and other drugs (Mylant et al., 2002). In addition, a lack of autonomy may lead COAs to suffer from depression or depressive symptoms, especially in relation to repeated failure in coping with familial stressors (Harter, 2000; Lease, 2002). By identifying characteristics that distinguish COA's from children of non-alcoholics (non-COA's), researchers hope to identify variables that might be important in the etiology of alcoholism. Most of these descriptions are based on data obtained relatively systematically from nonclinical and

clinical populations. Despite a common interest in COA's, the literature based on clinicians' experiences and the literature from the community of researchers have not overlapped to any great extent and have provided two distinct bodies of knowledge.

FATHERS EMPLOYMENT STATUS OF ALCOHOLICS AND NON-ALCOHOLICS

Figure- 5: Employment Status of Children of Alcoholics (COA) and Children of non-Alcoholics (nCOA)

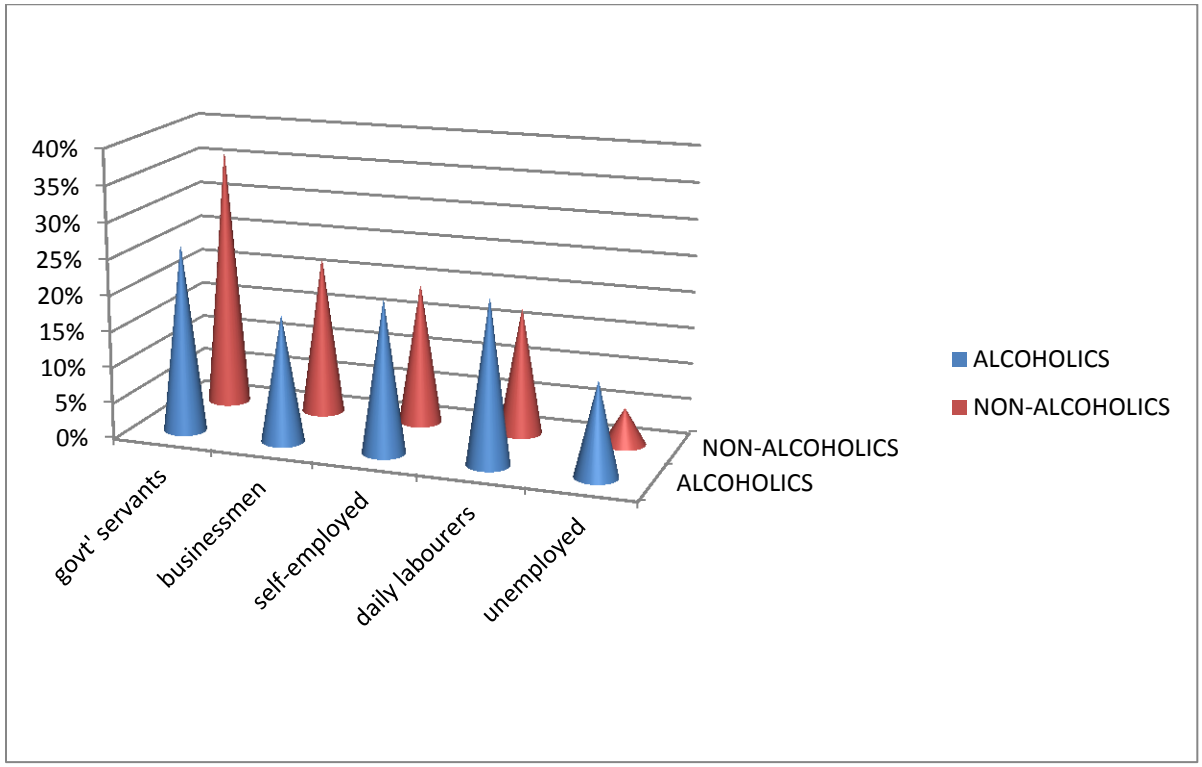


Fig. 5 shows the employment status of fathers of alcoholic and non-alcoholic. The blue cones indicated the alcoholics while the red cones indicated the non-alcoholics. The chart shows

that 26% of alcoholic fathers were government servants while 36% of non-alcoholic fathers were government servants, 17.5 % of alcoholic fathers were businessmen while 22% of non-alcoholic fathers were businessmen, 21% of alcoholic fathers were self-employed while 19.5% of non-alcoholics were self-employed, daily laborers of alcoholic fathers were 22.5% while 17.5% of non-alcoholic fathers were daily laborers and 13% of alcoholic fathers were unemployed while 5% of non-alcoholic fathers were unemployed. From the employment status obtained, the non-alcoholic fathers were having more prosperous job than the alcoholic fathers which might affect the economic status of the families showing that alcoholic families might be poorer than non-alcoholic families.

SUMMARY AND CONCLUSION

The present study was designed to investigate 'The Impact of Paternal Alcoholism on Achievement Motivation, Self-efficacy and Psychological Well-being of adolescents' to provide empirical and methodological foundations and also to provide an insight into the sub cultural variations that may or may not exist, for further/future studies on Mizo Adolescents in particular and Mizos in general. This is a comparative study based on the presumption that the effect if any, of living with an alcoholic (study group) or non-alcoholic (reference group) father would have already manifested itself on both groups of respondents. The groups being matched on key socio-demographic variables, the study is an attempt to determine and compare the impact of paternal alcoholism on psychosocial functioning of the adolescent children of alcoholic and non alcoholics.

This study attempts a brief summary of the whole study and some conclusions drawn based on the results and the findings. The findings, conclusions and recommendations may help to provide data on the impact of alcoholism and perhaps provide data/information for development of intervention strategies for the pose (d) problems.

The present study has been designed with four-fold objectives: 1) To explore the impact of paternal alcoholism on psychosocial (Achievement Motivation, Self-efficacy and Psychological Well-being) functioning of adolescents. 2)To study the achievement motivation, self-efficacy and wellbeing in adolescent children of alcoholics and those of non-alcoholics. 3) To explore the relationship between the measures in the study i.e. self-efficacy, achievement

motivation and wellbeing and 4) to highlight the relationship of socio-demographic characteristics and the variables under study.

The study incorporated purposive sampling procedure. Keeping in view the objectives of the study, 200 (M= 100; F= 100), Mizo adolescents with age ranging between 14 to 20 years from Aizawl city served as subjects for the present study. Paternal alcoholic status was determined by AUDIT (Alcohol Use Disorders Identification Test) and the two groups –i) children of alcoholics (50M and 50 F= 100) and ii) children of non- alcoholics (50M and 50 F= 100) were thus categorized for the conduct of the study. The socio-demographic background information of the subjects like age, gender, education, occupation, permanent residence, family structure etc. were recorded with the help of a socio-demographic information schedule to match the subjects in order to maintain the homogeneity of the sample.

To meet the objectives of the present study on "The Impact of Paternal Alcoholism on Achievement Motivation, Self-efficacy and Psychological Well-being in Adolescents the following Psychological measures were incorporated: 1), Deo-Mohan Achievement Motivation Scale (Deo, P & Mohan, S.,2002); 2) Generalized Self-Efficacy Scale (R. Schwarzer and M. Jerusalem,1995) and 3) General Health Questionnaire -12 (GHQ-12;Goldberg, D.,1992).

Since this is the first endeavor in Mizoram to study the impact of paternal alcoholism on achievement motivation, self-efficacy and psychological well-being of adolescents, the researcher felt it necessary to include the Socio-demographic profile to give the reader a perspective of the Mizo culture and background and also to provide a backdrop/reference for further studies in the population. Of late there has been an increasing focus on children of alcoholics seeking to understand the adverse impact of parental

alcoholism on their growth and psychosocial functioning. Indian literature from this perspective is scanty and there is a need for more comprehensive investigation to explore the consequences of parental alcoholism particularly on adolescent Children of alcoholics (COA's).

Today, research has advanced on several fronts and has helped to clarify the nature and extent of problems facing COA's based on the working definition of COA which is any child whose parent (or parental caregiver) uses alcohol or other drugs in such a way that it causes problems in the child's life. The child may no longer be living with the substance abusing parent because of separation, divorce, abandonment, incarceration or death. And the parent does not have to be still actively drinking or using for the child to continue to feel the impact of the abuse.(Sher J, Kenneth,1997) ,as well as the numerous variables that must be considered when attempting to make generalizations about this group (Sher 1991; Windle and Searles 1990). Review of literature for the present study has highlighted the findings of numerous studies conducted on the topic of the study. The findings of these studies identifies a host of issues and challenges some of which include fetal alcohol syndrome, which is first manifested in infancy; emotional problems and hyperactivity in childhood; emotional problems and conduct problems in adolescence; and the development of alcoholism in adulthood. They have also reported on the psychosocial aspects that indicate that COA status is related to higher levels of negative and lower levels of positive events, (Roosa et al., 1990) that COAs reported more alcohol and drug problems, had stronger alcohol expectancies, higher levels of behavioural under-control and neuroticism, and more psychiatric distress in relation to nCOAs (Sher et al. 1991), that children of alcoholics when compared to those of non-alcoholics manifested higher levels of behavioural under control, more neuroticism and greater psychiatric distress (Bird and

Canino, 1991; Hall et al., 1994). Additionally, dysfunctional family environment created due to the presence of parental alcoholism has also been the focus of several investigations.

According to Williams and Corrigan (1992), Johnson and Leff, (1999), growing up in a household with alcoholic parents is more likely to produce emotional disorders, increases the child's risk of health problems, physical abuse and neglect and that the single most potent risk factor is their parent's substance-abusing behaviour and that this can place children of substance abusers at biologic, psychological, and environmental risk. Also Mylant et al. (2002) found that adolescent COAs scored significantly lower on all psychosocial factors of family/personal strengths and school bonding and significantly higher on all factors of at-risk temperament, feelings, thoughts, and behaviours than non-COAs and that they were at risk for depression, suicide, eating disorders, chemical dependency, and teen pregnancy. Findings from a longitudinal study by Andreas & O'Farrell (2007) show that fathers' heavy drinking patterns and children's psychosocial problems appear to be closely related to one another over time, waxing and waning in meaningful patterns, such that children's adjustment was improved during times of parental alleviated drinking and was worsened during times of parental exacerbated drinking. Thus most of the studies on COAs and adolescent COAs in particular typically report that they display high levels of anxiety and depression, and they receive twice as much psychiatric treatment for anxiety and depressive symptoms and conduct disorders than their non-COA peers (Workman & Beer, 1992). That Adolescent COAs are also at high risk for drug and alcohol abuse and Parental alcoholism is correlated with increased adolescent drug and alcohol abuse (Chassin, Pillow, Curran, Molina, & Barrera, 1993; Chassin, Rogosch, & Barrera, 1991).

Various studies have put forward different perspectives on the impact and challenges brought about by parental alcoholism and two such perspectives in line with the present study are

the Developmental Perspective according to which Parental alcoholism has been reported to have a significant impact on both young children and adolescents in the family. If alcoholic parents have other emotional problems, the children may be more likely to have difficulties in achieving normal "role regulation" (Nardi, 1981). The opportunities for role development for children of alcoholics (COA) can be severely limited, so COAs may have problems accomplishing the necessary stages for healthy development (Lee, 2003).For instance, if the father is an alcoholic, the son may have no have any positive male role model in the family, and the daughter might have long-term problems making and maintaining intimate relationships as a result of negative experiences with the alcoholic father (Hussong &Chassin, 2004; Scharff, Broida, Conway, &Yue, 2004). And the Cross-Cultural Perspective which opines that according to family systems theory, individuals who belong to subsystems within a family learn and perform specific skills, and all these members become interrelated as a whole (Jacobs, 1992). However, the family itself is by external factors, including cultural norms or values (Hendershot, MacPherson, Myers, Carr, & Wall, 2005).This view lends support to the general environmental mechanism hypothesis (Velleman, 1992) and suggests that the distress within alcoholic families creates a state of chronic stress for COA's, thereby hindering their development.

Following the review of literature pertaining to psychosocial correlates in adolescent children of alcoholics and non alcoholics and the research objectives put forward, the findings of the present study can be briefly summarized as follows :-

Hypothesis 1 predicted that adolescent children of alcoholics (COAs) will have lower achievement motivation, self-efficacy and psychological well being as in comparison to adolescent children of non-alcoholics (nCOAs). The findings of the present study revealed that children of non-alcoholics (nCOA) scored higher than children of alcoholics (COA) in

Achievement Motivation scale(n-Ach) indicating that COA have lower achievement motivation than nCOA. This finding is more or less in line with that of a study on Academic Achievement in Adolescent which reported that **COAs,** particularly those whose parents are alcohol dependent as opposed to having a diagnosis of alcohol abuse achieve relatively lower academic outcomes in comparison to non-COA peers. Other studies also lend support to the findings of the present study according to Casas-Gil and Navarro-Guzman (2002) more COAs than comparison offspring were experiencing serious problems in the areas of educational and social functioning, COAs also evidenced lower academic achievement and less verbal ability than nCOAs (Sher et al.1991) and that adolescent task orientation partially mediated the relations between parent alcohol dependence and academic achievement, indicating that academic difficulties in COAs may be partly due to impaired motivation and organization.(Mc Grath CE, Watson AC, & Chassin L, 1999 Jan).

In regards to the Generalized Self-efficacy dimension the findings show that children of non-alcoholics (nCOA) scored higher than children of alcoholics (COA). This finding is supported by a study which observed that emotional maturity manifests in high self-esteem and enhances one's interpersonal ability and thus the low self-esteem seen in COAs is indicative of poor emotional maturity and may diminish their interpersonal competence (Cole et al. 1980). The findings are also congruent with that of Morey (1999), who reported that self-efficacy ratings for COAs were significantly lower in comparison to ratings for nCOAs. However, a study by Churchill et al. (1990), found no significant relationship between parental alcoholism and self-esteem of their children.

The GHQ 12 findings reveal that children of alcoholics (COA) scored more or less the same with children of non-alcoholics which indicated that children of alcoholics have equal psychological distress with children of non-alcoholics. This finding is contrast with a study by Bird and Canino, (1991) who reported that children of alcoholics when compared to those of non-alcoholics manifested higher levels of behavioral under control, more neuroticism and greater psychiatric distress. Several other studies have also well established that children of problem drinkers have an increased risk of developing mental health problems, not only during childhood but also when they grow up into adolescents and adults and that Depression and anxiety are recurring themes in the literature on COAs (Cuijpers et al 2006 ; Callan and Jackson, 1986; Williams and Corrigan, 1992; Steinhausen, 1995; Kelley, 1996; Deborah,1997).

Hypothesis 2 predicted that there will be significant differences between adolescent children of alcoholics (COAs) and adolescent children of non-alcoholics (nCOAs) on the overall psychosocial functioning.

The findings indicated that there is a significant differences between COAs and nCOAs on the overall psychosocial functioning. This finding is corroborated by a host of studies. Obot and Anthony (2004), found evidence that adolescent children living with an alcohol dependent parent have more delinquency problems than other adolescents. Mylant et al.(2002) found that adolescent COAs scored significantly lower on all psychosocial factors of family/personal strengths and school bonding and significantly higher on all factors of at-risk temperament, feelings, thoughts, and behaviors than non-COAs and that they were at risk for depression, suicide, eating disorders, chemical dependency, and teen pregnancy. Findings from a longitudinal study by Andreas & O'Farrell (2007) also show that fathers' heavy drinking patterns and children's psychosocial problems appear to be closely related to one another over time,

waxing and waning in meaningful patterns, such that children's adjustment was improved during times of parental alleviated drinking and was worsened during times of parental exacerbated drinking. Their results thus add additional support to the hypotheses of causal linkages between problematic parental and problematic child functioning.

Hypothesis 3 predicted that there will be significant gender differences on the dimensions under study.

In regards to gender differences for the n-Ach scale, female COA scores were higher in achievement motivation than male COA. This finding is consistent with the finding of the study conducted on British and Chinese students by Salili (1996) which indicated that female subjects of both cultures had higher scores than males, although this difference was significant for British female subjects only. While a study by Liu & Zhu (2009) reported significant difference between male and female children wherein male subjects were higher in achievement motivation than female however, this finding is reversed to finding of the present study. Also a study by Nagarathanamma & Rao (2007) Adsul et al. (2008) reported that there is no significant difference between boys and girls with regard to achievement motivation and academic level.

Gender difference was not found on the GSES where female COAs scored more or less the same in self-efficacy with male COA. This study is contrast with Britner and Pajares (2001) reported that girls hadhigher self-efficacy.

There is no significant gender differences on psychological well-being.This finding is contrast with the study conducted by Abdullah et al. (2006) who reported d that male scored higher than female which indicates that males have higher psychological distress than females.

Results from the analysis of the overall scores obtained by male and female participants, indicate that there is a significant gender differences between male and female participants. Females scored higher in n-Ach and self-efficacy scale than male; while male scored more or less the same with female in psychological distress. The finding is contrast in regards to gender indicated that male COA were higher in psychological distress than female COA. This finding is contrast with the study conducted by Mustafa N. Kirmani and L.N. Suman (2009) which revealed that boys had higher psychological distress along with a more favorable attitude towards alcohol than girls. This finding is further corroborated by Furtado et al. (2006) who contended that children of alcoholic fathers are at high risk for psychopathology and gender-related differences also seem to exist.

Hypothesis 4 predicted that there will be significant relationship between achievement motivation and self-efficacy in adolescent children of alcoholics.

The findings shows that there is a significant relationship between achievement motivation and self-efficacy in adolescent children of alcoholics. This finding is more or less consistent with the findings of Bandura (1997) & Schunk (1995).

Hypothesis 5 predicted that there will be significant relationship between achievement motivation and psychological well being in adolescent children of alcoholics. Findings shows that there is significant relationship between achievement motivation and psychological well-being.

Hypothesis 6 predicted that there will be significant relationship between self-efficacy and psychological well being in adolescent children of alcoholics. The results indicated that there is no significant relationship between self-efficacy and psychological well-being.

Hypothesis 7 predicted that there will be significant relationship between achievement motivation, self-efficacy and well being in adolescent children of non- alcoholics. The findings indicated that there is a significant relationship between achievement motivation, self-efficacy and well-being in adolescent children of non-alcoholics which shows that high in achievement motivation is followed by high in self-efficacy and low in psychological distress.

The analysis of the socio-demographic schedule to provide additional information to bring more clarity to the issue under study and perhaps give the reader a perspective of the Mizo culture and background and also to provide a backdrop/reference for further studies in the population revealed an interesting picture and congruence with the family systems theory which states that the family unit is the source of dysfunction because alcoholism becomes so intertwined with family operation that it cannot be separated from the rest of family functioning (Wolin, Bennett & Noonan, 1979). The dysfunctional family environment created due to the presence of parental alcoholism has been the focus of several investigations. Furtado et al.(2002) for further in depth study based on this theory in the population under study. By identifying characteristics that distinguish COA's from children of non-alcoholics (non-COA's), researchers hope to identify variables that might be important in the etiology of alcoholism. Most of these descriptions are based on data obtained relatively systematically from nonclinical and clinical populations. Despite a common interest in COA's, the literature based on clinicians' experiences and the literature from the community of researchers have not overlapped to any great extent and have provided two distinct bodies of knowledge.

The study found that higher numbers of children in the alcoholic group were living with their parents than children of non-alcoholics. The numbers of children living in single parent families were more for children of alcoholics than children of non-alcoholics. Higher percentage of children from non alcoholic families was living with their grandparents than children of alcoholics. Also, more children from non-alcoholic families were living with their siblings than children from alcoholic families. Finally, higher numbers of children of alcoholics were living with other caregivers than children of non-alcoholics.

Regarding types of substances used by children of alcoholics and non alcoholics the study revealed use of pan and gutka to be highest in both groups followed by tobacco, beer/wine, marijuana, alcohol or other drugs. The use of tobacco, beer/ grapewine, marijuana , alcohol and other drugs use is significantly higher for male COA as compared to male nCOAs. Gender difference between COAs and nCOAs in regards to substance use also appears to be to be significant. Studies based on the hypotheses that have focused mainly on genetics and the general environmental mechanism according to Velleman (1992), an explosion of recent genetic research has established that heredity does play a significant role in the transmission of alcoholism (Schuckit, 1993; Cook &Winokur, 1993), and may even contribute to other deficits exhibited by COAs. The Frequency of Alcohol consumption/use by father reports indicated that 40% of the COAs reported daily drinking by their father while forty two per cent reported drinking on alternate days, and the rest were not sure of the frequency of drinking. Regarding the duration of drinking, forty per cent said it was up to three years with the remaining respondents mentioning that it was between three and ten years. With regard to the behaviour of the father when intoxicated, 54% reported that their father was more silent than usual, 26% said that he became

boisterous and shouted at others while the remaining 20% reported verbal and physical violence.

Because of the high likelihood of a dysfunctional family environment for alcoholic families, the adolescent COAs are at risk of having more depressive symptoms and experience barriers to achievement of adolescent developmental tasks, such as establishing positive self-identity (Gemelli, 1996; Hollinger-Smith, 2004; Lerner & Steinberg, 2004; Nurmi, 2004). Experiencing significant conflict within the family can drive adolescents to take risks with their health, for example, by starting to use alcohol, tobacco, and other drugs (Mylant et al., 2002). In addition, a lack of autonomy may lead COAs to suffer from depression or depressive symptoms, especially in relation to repeated failure in coping with familial stressors (Harter, 2000; Lease, 2002).

The employment status of fathers of alcoholic and non-alcoholic to explore the socioeconomic impact revealed that the non-alcoholic fathers had more prosperous job than the alcoholic fathers which might affect the economic status of the families indicate that alcoholic families might be poorer than non-alcoholic families. Both general environmental risk factors (psychological problems in the fathers, family climate, family health and conflicts) and environmental factors related to the parental alcohol abuse (severity of the alcohol abuse, the child's level of exposure to the alcohol abuse, changes in routines and rituals due to drinking) were related to child adjustment Kelly et al. (2006).

The multitude of research on this topic clearly demonstrates that COAs are at a greater risk for exhibiting a variety of negative outcomes throughout span their life. Also, during adolescence which has been globally accepted to be a period of turbulence and a significant developmental

milestone. Parental alcoholism could further compound and create a not so conducive domestic environment significantly impacting the adjustment and personality of the adolescent as he tries to come to grips with this tumultuous phase in his developmental career. Adolescence is also a time of growth in independence, which can result in decision making that leads to involvement in risky behaviors (Bandura 1997). Adolescents create a belief in efficacy in relation with their personal outcomes from familial, peer, educational, and socioeconomic influences (Bandura et al.1996, 2001). The academic achievement/ motivation of the children of alcoholics being lower could be that COAs experience a greater number of life stressors than do non-COAs. Alcoholic parents may be less encouraging of academic success in their children because their own educational attainment may be lower. Parents with lower educational attainment and/or parents who are coping with their own impairment may not value education and may not provide an intellectually stimulating environment that encourages academic success. With regards to the role of self-efficacy and opportunities to use alcohol during adolescence research has consistently shown that adults, students, and adolescents with low self-efficacy confidence have higher consumption rates than those with high self-efficacy expectations (Aas et al.,1995). Bandura (1986) found that people with low self-efficacy are less likely to resist alcoholic drinks, whereas people with high self-efficacy are more likely to resist the pressures. Also according Rosenberg, (1985). It has been found that self-esteem is strongly negatively correlated with distress and depression, while individuals with high perceptions of self-worth and self-esteem are thought to cope better with stress and conflicts in relationships (Pearlin et al., 1981). Additionally the availability of an adequate social network is a significant factor impacting the development of both high self-esteem as well as adaptive coping (Sarason&Sarason, 1986; Williams & Corrigan, 1992, Stanley S &Vanitha C.,2008). Furthermore, a father's problem

drinking can be a chronic stressor. Apart from episodes of disruptive behavior, simply having a father with a reputation for being a problem drinker may be stressful to adolescents, who often are sensitive to aspects of their family that are unusual. Even when fathers no longer live with the adolescent, episodes of heavy drinking may directly affect the children during visits or may affect them indirectly through accounts of the father's drinking episodes. In support of this reasoning, a heavy-drinking parent has been associated with depression and other symptoms including poor academic success and lower involvement in school activities. Additionally the availability of an adequate social network is a significant factor impacting the development of both high self-esteem as well as adaptive coping (Sarason&Sarason, 1986; Williams & Corrigan, 1992, Stanley S &Vanitha C.,2008). Furthermore, a heavy-drinking parent has been associated with depression and other symptoms including poor academic success and lower involvement in school activities.

To date, existing research indicates that care should be taken when making generalizations about the psychological characteristics of COA's. Clearly, evidence indicates that as a group, COA's are at higher risk than nonCOA's for a number of psychological disorders in both childhood and adulthood and that they seem to be more impulsive and possibly more neurotic than people without alcoholic parents. With the exception of the risk for substance use disorders, however, the proportion of COA's affected by these other psychological disorders does not appear to be large. Furthermore, it is potentially harmful (Burk and Sher 1988) to infer much about a specific person based solely on his or her family history of alcoholism. Thus, many of the popular portrayals of COA's are clearly overgeneralizations and have the potential to be harmful. The more that is known about other elements of a person's family history (e.g., the number of family members who are alcoholic or who have disorders frequently comorbid with

alcoholism) and, more important, about the details of the person's behavior, the more valid the statements will be about his or her personality and psychological adjustment. From this perspective, simply knowing that someone is a COA represents no more than a starting point for obtaining more in depth information.

The present study examines the impact and relationship between parents' alcoholism and adolescent psychosocial development. The finding of the present study across all domains studied in COAs is consistent with the literature on the issue under study. The findings of the present study is corroborated by research evidence that paternal alcoholism has an impact on the psychosocial functioning of adolescents and that gender difference exist within group and between group (COA and nCOA). The current study confirmed that COAs, have relatively lower achievement motivation and academic achievement in comparison to nCOA peers. Adolescent self efficacy/ self esteem and mental health are impacted by parental alcohol dependence. Thus, one can conclude drinking does negatively influence the children's psychosocial functioning that children of alcoholic parents are at a greater disadvantage than are children who come from families of non-alcoholic parents. Conclusively, the evidence in the literature review as well as the aims of this research project effectively illustrate that the hypothesis that paternal alcoholism impacts psychosocial functioning of adolescent children and the family systems theory offers a possible explanation for these results which states that the family unit is the source of dysfunction because alcoholism becomes so intertwined with family operation that it cannot be separated from the rest of family functioning (Wolin, Bennett & Noonan, 1979).

However, there is a contention within the alcoholism literature pertaining to children of alcoholics that holds that they manifest no significant differences in terms of psychopathology or other behavioural and personality deficits when compared to children of non-alcoholics. Segrin

and Menees (1996), opine that children may exhibit undisturbed psychosocial functioning despite having an alcoholic parent and found no differences between adult children of alcoholic's and controls. Baker and Stephenson (1995), suggest that parental alcoholism does not necessarily result in personality differences in adult children. Morey (1999), found that COAs and nCOAs demonstrate no significant differences on measures of social support and shame while Reich et al. (1993), report few differences between children of alcoholics and controls with respect to self-esteem and achievement tests. Harter (2000) observes that there is little empirical support for "adult COA syndromes" described in the clinical literature since the reported outcomes in them are neither uniformly observed nor are specific to them. He contends that co-morbid parental pathology, childhood abuse, family dysfunction, and other childhood stressors may contribute to or produce similar outcomes (Stanley S &Vanitha C,2008). Additionally, many methodological complexities exist, including the way in which alcoholism is measured in the parent(s), how extensively alcoholism is assessed in other family members, whether parental alcoholism is "active" or in recovery, the way in which subjects are sampled.(Sher J, Kenneth,1997)

CONCLUSION

The findings of present study indicated that COAs, particularly those whose parents are alcoholics have lower achievement motivation in comparison to nCOA peers. Also, COAs, particularly those whose parents are alcoholics have lower self-efficacy in comparison to nCOA peers. While COAs, particularly those whose parents are alcoholics have equal psychological well-being with nCOA peers. Thus, having an alcoholic parent may affect the achievement motivation, self-efficacy but not on psychological well-being of adolescents in Aizawl. The

finding of the present study across all domains studied in COAs is consistent with the literature on the issue under study. The findings of the present study is corroborated by research evidence that suggests that paternal alcoholism has an impact on the psychosocial functioning of adolescents and that gender difference exist within group and between group (COA and nCOA). In summary, the findings of the current study are that COAs, have relatively lower achievement motivation and academic achievement in comparison to non-COA peers. Adolescent self efficacy/ self esteem is impacted by parental alcohol dependence. That while significant differences was not seen between children of alcoholics and children of non-alcoholics on psychological well-being but was found between male and female.

Thus, one can conclude drinking may negatively influence the children's psychosocial functioning that children of alcoholic parents are at a greater disadvantage than are children who come from families of non-alcoholic parents. Conclusively, the evidence in the literature review as well as the aims of this research project effectively illustrate that the hypothesis that paternal alcoholism impacts psychosocial functioning of adolescent children and the Family systems theory offers a possible explanation for these results which states that the family unit is the source of dysfunction because alcoholism becomes so intertwined with family operation that it cannot be separated from the rest of family functioning (Wolin, Bennett & Noonan, 1979).

Limitations of the Study

Research on COAs is still in its adolescence. Many studies suggest that a variety of differences exist between children of alcoholics and children of non-alcoholics and these differences occur at all ages. However, because of the limitations of the methodology and the inadequate number of comprehensive studies, research findings cannot be generalized to all children who grow up with alcoholic parents. (National Institute on Alcohol Abuse and

Alcoholism,1990) Although much has been learned over t he last two decades, a number of controversial research areas remain. The present study being the first in the population under study has methodological and technical challenges which may imply a further studies to address the challenges to present a more comprehensive research finding.

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Appendix- I

PARTICIPANT INFORMATION (MIZO AND ENGLISH)

Research description:

You are invited to participate and share your opinion about impact of alcoholism. This research is being undertaken as part of M.Phil research and request you kind participation to answer several study questions. (Research sawifiahna : He project atan hian I hun hlu tak seng a zawhna te min chhan sak tur in ka ngen a che. Zu ngawlveina in Nghawng a neih dan zir chianna a ni a. M.Phil zirna a tan a tih a ni a, min tel sak tur in ka ngen a che).

Participation:

Your participation in this research is voluntary. If you do agree to participate, you can withdraw from participation at any time during the research. Try to answer the questions in order. Information provided by you will be kept confidential. (Hriattirna: He project atan hian mahni duh thu ngei a tel i ni a. I tel hnu ah paw hi inhnukdawk leh duh a nih pawn i inhnukdawk their eng a ni. Zawhna hi a indawt in chhan hram hram tum ang che. Chhanna te hi puanzar a nilo ang)

Expected outcome:

This study will help participant and researcher in finding the impact of alcoholism in our families which has been currently an issue in our society.(Hmuhchhuah beisei: He zirna hian zirna a tel leh zirchhiangtu ten zu ngawlveina in kan chhungkuaah nghawng a neih mek dan zir chianna a ni)

Appendix- II

PARTICIPANT CONSENT FORM (MIZO AND ENGLISH)

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions.
   (A chung a zawhna pawimawhte khi ngun takin ka chhiar a, a tul a nih chuan zawhna pawh ka zawt thei a ni.)
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, and without any medical care or legal rights.
   (Keima duhthu ngei in he zirna ah hian ka tel a,ka duh thu in ka inhnukdawk leh thei bawk tih ka hria)
3. I understand that there are no risks involved in the participation of this study and that I will not directly benefit from participation.
   (He zirna a ka tel vang hian harsatna leh hlawkna a awm dawnlo tih ka hria)
4. I agree to take part in the above study.
5. (He zirna ah hian tel ka remti e)

Date Signature

Research Scholar Date Signature

Appendix- III

Code.....

DEMOGRAPHIC PROFILE(Father)

1. ☐ Male ☐ Female
2. Age: _____
3. Occupation: Retired (Position/name of job hold_____)
   Currently working (position hold_____)

4. Education:
   - ☐ M.Phil/Ph.D etc
   - ☐ Postgraduate (M.A/M.Sc/B.Com etc.)
   - ☐ Graduate (B.A/B.Sc/B.Com etc)
   - ☐ Intermediate/Higher Secondary (HSSLC)
   - ☐ Matric/High School (HSLC)
   - ☐ Middle School
   - ☐ Primary School
   - ☐ Illiterate

5. ☐ Unmarried ☐ Married ☐ Divorced ☐ Widower
6. Type of Family: ☐ Nuclear ☐ Joint ☐ Others
7. Number of Family members:_____
8. Name of Substance Used:
   - ☐ Pan/Gutkha
   - ☐ Smoking/chewing of tobacco
   - ☐ Beer/Grape Wine
   - ☐ Tip/Marijuana
   - ☐ Alcohol/Drugs

Appendix- IV

Code.....

DEMOGRAPHIC PROFILE(Children)

1. ☐ Male ☐ Female
2. Age: _____
3. Occupation : ☐ Student ☐ employed ☐ unemployed
4. Education:

☐ M.Phil/Ph.D etc
☐ Postgraduate (M.A/M.Sc/B.Com etc.)
☐ Graduate (B.A/B.Sc/B.Com etc)
☐ Intermediate/Higher Secondary (HSSLC)
☐ Matric/High School (HSLC)
☐ Middle School
☐ Primary School
☐ Illiterate

5. ☐ Unmarried ☐ Married ☐ Divorced ☐ Widower
6. Type of Family: ☐ With parents
   ☐ Single parent
   ☐ With grandparents
   ☐ With siblings
   ☐ Others
9. Number of Family members:_____
10. Name of Substance Used(If used):

☐ Pan/Gutkha
☐ Smoking/chewing of tobacco
☐ Beer/Grape Wine
☐ Tip/Marijuana
☐ Alcohol/Drugs

Appendix- V

Alcohol Use Disorders Identification Test (AUDIT): Interview Version

1. How often do you have a drink containing alcohol?	Never ☐ Go to Q 9 & 10	Monthly or less ☐	2- 4 times a month ☐	2- 3 times a week ☐	4 or more times a week ☐
2. How many standard drinks do you have on a typical day when you are drinking?	1 or 2 ☐	3 or 4 ☐	5 or 6 ☐	7 to 9 ☐	10 or more ☐
3. How often do you have six or more standard drinks on one occasion ?	Never ☐	Less than monthly ☐	monthly ☐	weekly ☐	Daily or almost daily ☐
4 How often during the last year have you found that you were not able to stop drinking once you had started ?	☐	☐	☐	☐	☐
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	☐	☐	☐	☐	☐
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	☐	☐	☐	☐	☐
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	☐	☐	☐	☐	☐

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?	☐	☐	☐	☐	☐
	No	Yes but not in the year	Yes, during the last year		
9. Have you or someone else been injured because of your drinking?	☐	☐	☐		
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	☐	☐	☐		

Appendix-VI

Deo-Mohan Achievement Motivation (n-Ach) Scale

1. I shall be most pleased if I have to miss the classes for some days.
2. I pay full attention to the work in the class.
3. I mind much if I reach late in the class.
4. I love to read more and more to find unknown reasons of knowledge,.
5. I love to have a personal library, not counting text books.
6. I set standard for myself and then strive to achieve them.
7. I wish to specialized and become top most in the field of my liking.
8. I like to experiment and create new things and surprise people.
9. I work hard for hours together to be successful in whatever I undertake.
10. I have a tendency to find solutions of problems and puzzles other people fail at.
11. I aspire to get excellent results in all academic competitions.
12. I am ready to leave the job half done and try a new one.
13. I get nervous in the examination if one or two questions are not from the syllabus.
14. I prefer to go to a party rather than prepare for an examination next week.
15. On getting low marks, I feel disappointed and determined to work hard to do better next time.
16. I think I find my lessons meaningful and interesting.
17. While studying, my mind wanders off the lessons and I get lost in imagination.
18. I think it is better to gossip in the canteen than to attend the class.
19. When the teacher is teaching , I like to read stories/novels/comics or make cartoons in the class.
20. The school/collage haunts me and I want to leave it at the very first opportunity.
21. It irritates me a lot, if I have to stay late in the school/collage for some lectures.
22. I want to go to collage/universities because there is plenty of opportunity to enjoy life.
23. I think studies, sports and other activities can go together.
24. I agree that the present course of my study will help making my future life a success.
25. I feel very much frustrated if I do not get a chance to complete in the field of my choice.
26. I regularly take down notes in the class and complete my assignment.
27. I plan to study carefully all the year around in an effort to get good marks in all the subjects in all the tests.
28. I believe in work first and play later.
29. I do a lot of preparation at home for the next day's work in the class.

30. I like to ask questions regarding every information given in the tables and charts in the books rather than leav e the as such and read further.
31. I think my teachers are competent in their work.
32. I like to create nuisance in the class and annoy the teacher.
33. I try my utmost to please m teacher through work and not through flattery.
34. My friends consider me dull an d shirker.
35. It is true that my teachers think of me as a sincere and hard working student.
36. I feel hurt if others (parents, teachers and friends) criticise me and U try to improve my weakness.
37. My parents advise me to take life easy and never bother too much for studies or for future.
38. I wish to carry my mission forward in spite of facing a lot of criticism.
39. I think of life to be an intellectual challenge.
40. I am interested in organizing the activities of a group/team/class/committee.
41. I try to get associated with top most person in the field of my choice.
42. I love to have some adventure in my leisure hour.
43. I would like to watch surgical operation being performed.
44. I like to complete in dramatics.
45. I think of dancing and music to be good hobbies for students.
46. I have a strong desire to be a champion in games/sports/athletes.
47. I have tried to get in the sports team of my school/collage to represent my team in other states or countries.
48. I believe sports develop initiative, leadership and discipline.
49. Hill climbing and mountaineering are a welcome challenge I would like to take.
50. On a holiday, I prefer going for cycling, swimming or boating to sitting at hme without much work.

Appendix- VII

General Self- efficacy Scale (English version by Schwarzer & Matthias Jerusalem,1995)

	Not at all true	Hardly true	Moderately true	Exactly true
1. I can always manage to solve difficult problems if I try.	☐	☐	☐	☐
2. If someone opposes me, I can find the means and ways to get what I want.	☐	☐	☐	☐
3. It is easy for me to stick to my aims and accomplish my events.	☐	☐	☐	☐
4. I am confident that I couldv deal efficiently with unexpected events.	☐	☐	☐	☐
5. Thanks to my resourcefulness , I know how to handle unforeseen situations.	☐	☐	☐	☐
6. I can solve most problems if I invest the necessary efforts.	☐	☐	☐	☐
7. I can remain calm when facing difficulties because I can rely on my coping abilities.	☐	☐	☐	☐
8. When I am confronted with a problem, I can usually find several solutions.	☐	☐	☐	☐
9. If I am in trouble, I can usually think				

of a solution.	☐	☐	☐	☐
10. I can usually handle whatever comes my way.	☐	☐	☐	☐

Appendix- VIII

General Health Questionnaire -12 (GHQ 12)

		Often	Sometimes	Seldom	Never
1	Able to concentrate				
2	Loss of sleep over worry				
3	Playing a useful part				
4	Capable of making decisions				
5	Felt constantly under strain				
6	Could not overcome difficulties				
7	Able to enjoy day to day activities				
8	Able to face problems				
9	Feeling unhappy or depressed				
10	Losing self-confidence				
11	Feeling worthless				
12	Feeling reasonably happy				

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Extension (If any)	:	Nil

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