Comparison of Behavioral Disorders between Children with Addicted and Normal Parents

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Abstract

Objective: The present study aimed at comparing behavioral disorders between children with addicted fathers and children with non-addicted fathers. **Method:** In a causal-comparative study, 80 students (40 students with addicted fathers and 40 students with non-addicted fathers) were selected through random cluster sampling method. The two groups were evaluated using Child Behavior Checklist (CBCL) (teachers, parents, and self-assessment questionnaires). **Results:** The results of this study showed that the level of behavioral disorders in children with addicted fathers is higher than that in children with non-addicted fathers. In addition, behavioral disorders in boys were more than those in girls. **Conclusion:** It seems that fathers' addiction along with family disruption can be involved in the incidence of early behavioral disorders in children.

Keywords: behavioral disorders, addicted father, children

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Introduction

The strategic position of the country and its placement in the neighborhood of countries of the world's drug production centers have resulted in a high prevalence of drug use and addiction (Heidari et al., 2012, as cited in Vazirian, 2010). Narcotics are among the health problems in the country that lead to the prevalence of some infectious diseases (Zafarghandi, 2014). Addiction is a chronic and relapsive type of disorder that threatens human health and well-being (Fallahzadeh, & Hoseini, 2013; Xiberras, 2011).

In addition to threatening the health, addiction imposes highly serious complications on the family life, economy, security, and cultural development of the community. Restriction of development, breaking of political stability, and threatening of the process of democracy in societies are among the problems attributed to the issue of addiction (Faramarzai, Meisami, & Holakoonayini, 2014). Unfortunately, addiction, along with malnutrition and environmental pollution, has afflicted all industrial and non-industrial societies and has confronted our society, as well. In fact, addiction has been growing in recent years in Iran (Heidari et al., 2012, as cited in Sadeghieh Abhari et al., 2010).

Family is the foundation of social construction in such a way that the health of the society always depends on the family health. Indeed, many social deviations and abnormalities are rooted in this small social system. The presence of children at home leads to their construction or degeneration; indeed, childrens' thoughts and behaviors in that environment are shaped in such a way that these thoughts will have a lifelong effect on them. Several psychoanalytic studies have concluded that childhood experiences are the human constructor, and the family's behavior, attributes, and circumstances affect their adulthood. If we delve into the positions, sources, knowledge, and roots of children's behavior, we will come to the conclusion that family is the most important source. From the scientific point of view, family is the most important source of construction and development or destruction since it is responsible for the development of the behavior, formation and organization of the biological, mental, psychological, emotional, and moral aspects; furthermore, family is the greatest factor in the development of their personality. The kind of childrearing, inducements, discipline, and organization of the family is effective in the growth or lack of growth, and the dignity or decadence of the children. Family's effectiveness should be sought in its atmosphere and the environment. Parents, on the one hand, are affectionate, and are, on the other hand, the source of exerting justice and discipline. When love and discipline come together, a miracle of training and influence will come true. Most importantly, family is an inevitable environment for children and their long-term life will be a prerequisite for reconciliation and adaptation. Researchers and scholars have various opinions about the complications of family disorder on the growth and education of children where the common point among all of them is the proportion of the type of disorder with specific behavioral problems. Scientific research has also shown

that an unorganized family leads to the generation of criminal offenders. The majority of research findings have introduced the family as the most important factor in the growth and development of crimes among children and adolescents (Aghabakhshi, 2014).

Today, addiction is one of the most fundamental social issues in our society, which can eliminate efficient and young forces and may also pave the way for other diversions. This destructive societal phenomenon, which has now penetrated into many Iranian families due to the society's potential to develop addiction, has reduced the age of addiction. On the other hand, it has been spread and, thereby, has practically created a serious impediment to the functioning of families (Aghabakhshi, 2012).

According to recent reports on addiction, the number of addicts in Iran has been estimated between 800,000 and 1,700,000 people. Thus, the number of addicts is an average of 1,250,000 people. Iran has a population of 70,000,000 people; therefore, 7.1% of this population is addicted where 95% of the addicts are male. According to this report, 47.3% of these addicts are married, and the average number of family members being addicted is 5.74 people per family (Xiberras, 2011). Taking a look at these figures, one intones that many of them have the function of father in the family; therefore, addiction also affects the children's modeling. If we consider the total number of Iranian addicts to be two million, out of whom 70% are married, and only 85% have only one or two children; 2,500,000 children with addicted fathers experience difficult and confusing socialization conditions. Observations indicate that the family members with an addicted father are constantly worried and anxious and are always under the stress and threat of their father's arrest and imprisonment. Children see their father usually go out of home with hands full of properties to change them into money and spend it on drugs instead of seeing their father coming home with full hands. Father are usually monitored instead of monitoring their home affairs. Family members are somehow forced to support the father instead of being supported by him. Therefore, the descendants of an addicted father are in a very confusing situation, which plays a decisive role in their socialization (Kazemian, 2012).

The Corrective Convention on the Rights of the Child, adopted by the UN General Assembly in 2010 states that "the family, as the main component and natural environment for the development and well-being of all its members, especially children, must enjoy the necessary support and assistance in order to accomplish their responsibilities in the community." In our current society, the attention of researchers interested in family issues is mostly focused on the broken-down families with single-parent or orphan children. While the situation of these children has been clearly defined with regard to all the issues and difficulties and their responsibility is clear, the situation of children with addicted parents is, in fact, more critical and incomparable. The children of these families feel the physical presence of the father next to them, but the father who

is no longer a real father and has a destructive and annoying role. The main point in the families with an addicted father, which prevents the attention of the authorities and policy-makers, is that, unlike homeless and orphan children without a father, they are still living in the family, go to school like other children, and apparently have parents. The process of their socialization within the family is so complex and impalpable that it cannot be assessed until the revelation of the issue of the father's addiction. The difficulty of the problem and inattention to children of such families originates from the fact that they are still not offenders, but with a deeper perspective, there is a fear that if the creation of such destructive family centers is not prevented, the catastrophe will spread to the whole society. In the future, the health of our society depends on the salvation of the families that are called families with addicted fathers in this research. It is noteworthy that attention must be paid to the living conditions of the spouse and children of such families as the priority of anti-addiction programs. Observations indicate the bitter fact that some children in the family's infected environment are forced to go out to take delivery of their fathers' drugs from distributors; indeed, these children unwittingly enter social destructive processes solely for the sake of their emotional dependence on the father (Aghabakhashi, 2012). In principle, the father's addiction on drugs can cause the child to get addicted to drugs, as well. Addiction is a physical and mental illness that threatens all aspects of life, health, family, and society due to its progressive nature; and family system is the first institution that is affected in this regard (Wolman, 2011). Adolescents with a family history of addiction are more likely to suffer the consequences of addiction and other psychological problems. On the other hand, children learn adaptive behaviors and skills in the family environment; as a result, children of addicted parents may learn to deal with the difficulties and problems of their parents' lives as their parents do it (Esfandabad, Sadr-al-Sadat, & Emamipor, 2013).

In families whose father addiction does not allow the father to meet the expectations of his roles, improper behavior patterns are passed on to the offspring. The present research seeks to answer the following question: Can the degree of behavioral disorders in children with an addict father be more than that in children with a non-addicted father?

Method

Population, sample, and sampling method

A causal-comparative research method was employed for the conduct of this study. The statistical population of this study included the primary school children with addicted fathers in the city of Sorkheh during the academic year 2016-17. Another population of the study included the children of fathers who had no history of addiction and were studying in the primary schools of Sorkheh city. From the first population, 40 students were randomly selected; and 40 students were also selected through purposive sampling from the second

population. The second sample was homogenized with the first group in terms of demographic variables, such as age, gender, education, and location of study.

Instruments

1. Achenbach's Child Behavior Checklist: This questionnaire is known as Achenbach System of Empirically Based Assessment, which is a multidimensional model and provides a framework for the organization and integration of empirical data from various information sources. In the Achenbach system, three sources of parenting, teacher, and child are used to obtain information from the behavioral grading scales. These scales are Child Behavior Checklist, Youth Self Report Form (YSR), and Teacher Report Form (TRF). These scales have been converted into two general factors, namely internalization and externalization by factor analysis. Achenbach System of Empirically Based Assessment consists of a set of forms for easy and cost-effective measurement of competencies (capabilities), adaptive action, function, and affective-behavioral problems. By using these forms, it is possible to easily obtain some standardized data and information on a range of competencies, adaptive function, and emotional-behavioral problems. Contrary to many standard tests, Achenbach's forms obtain some information on the best features and the most important weaknesses in children using 113 open-ended questions. These forms are typically completed in 20 to 25 minutes. To get a complete picture of the child's performance, all pages of each of the 3 Achenbach forms must be completed by the child's parents or custodian, the teacher, and the child him/herslef where the children are within the age range of 11 to 18 years old.

2. Child Behavior Checklist (CBCL): This checklist is completed by parents, or the person who cares for the child and or anyone who is fully associated with the child in pseudo-family settings and who knows him/her fully. On the pages of this questionnaire, the emotional, behavioral, and social problems of the child are included. Respondents rates each question as 0 = incorrect, 1 = somewhat or sometimes true, and 2 = totally or often correct based on the child's situation in the past six months. For those respondents who are poorly able to read, or those who are not able to complete the forms for other reasons, we recommend this method: The interviewer will take a copy of the form and gives another copy of it to the respondent. The interviewer will then say: I will read the questions of this form to you one by one, and I will record the answers you give them. The respondents who have the ability to read the items without the help of the interviewer will answer the items to the end. However, for respondents who cannot read well, this method prevents cramping and the respondents who have the ability to read the items without the help of the interviewer will answer the items to the end. However, for respondents who cannot read well, this method prevents carelessness and clumsiness.

3. Youth Self Report Form (YSR): This form, which has been standardized for respondents within the age range of 11 to 18 years, is completed by the

teenager him/herself. If s/he is not able to complete the form independently, as in the case of the child's behavioral checklist, another person can read the form for him/her. In the first page of the form, in addition to demographic information, raw scores, T scores, and percentage rankings of competency and adaptive function scales; empirically based syndrome scales, and DSM-based syndrome scales are also recorded. The 105 questions related to emotional-behavioral problems are matched with the items in CBC. Also, 93 questions of this form, which pertain to emotional, behavioral, and social problems, are identical with the questions of the teacher report form.

4. Teacher Report Form (TRF): This form, which has been standardized for the respondents within the age range of 6 to 18 year, is filled out by the teacher or other school staff, such as the advisor, manager or vice-president, teacher's assistant, and a specialist tutor who is familiar with the child's performance at school. It provides an efficient and economical way to obtain an immediate picture of the child's performance at school from the perspective of the teacher or other staff. The TRF can be used to compare reports from different teachers and other people who view the child at school; in addition it is compared with the reports obtained from CBSL and YSR. The first page of the TRF relates to demographic information about the student. On this page, also the raw scores, T scores, competency scale scores, empirically-based syndrome scales, and DSM-based syndrome scales are recorded. The second page of this form has been designed to provide information about the respondent and the context in which the student is being observed. Respondents are asked to determine their role in the school, theirs familiarity duration with the student and their degree of recognition, and the length of time they spend on the student, and the type of service they offer to the student.

Results

The descriptive statistics of behavioral disorders from parents' point of view are presented in the table below for each group.

Table 1: Descriptive Statistics of Behavioral Disorders from Parents' Perspective for Each Group

Variables	*Group*	*Mean*	*SD*	*N*
Anxious/Depressed	With an addicted family	6.97	4.06	40
	Normal	4.85	2.33	40
Withdrawn/Depressed	With an addicted family	3.82	2.54	40
	Normal	2.75	1.55	40
Somatic Complaints	With an addicted family	3.57	2.52	40
	Normal	2.42	1.98	40
Social Problems	With an addicted family	4.60	3.42	40
	Normal	3.52	1.97	40
Thought Problems	With an addicted family	4.10	2.20	40
	Normal	3.70	2.33	40
Attention Problems	With an addicted family	10.57	4.07	40
	Normal	9.85	3.09	40
Rule-Breaking Behavior	With an addicted family	3.02	2.07	40
	Normal	4.01	1.82	40
Aggressive Behavior	With an addicted family	8.17	3.92	40
	Normal	7.74	2.87	40

The descriptive statistics of behavioral disorders from teachers' perspective are presented in the following table for each group.

Table 2: Descriptive Statistics of Behavioral Disorders in Teachers' View for Each Group

Variables	*Group*	*Mean*	*SD*	*N*
Anxious/Depressed	With an addicted family	3.55	2.07	40
	Normal	4.29	2.22	40
Withdrawn/Depressed	With an addicted family	2.52	1.35	40
	Normal	3.24	1.75	40
Somatic Complaints	With an addicted family	1.87	0.72	40
	Normal	2.65	1.18	40
Social Problems	With an addicted family	2.25	1.10	40
	Normal	3.40	1.64	40
Thought Problems	With an addicted family	3.00	1.10	40
	Normal	4.60	1.74	40
Attention Problems	With an addicted family	10.82	2.60	40
	Normal	12.51	2.76	40
Rule-Breaking Behavior	With an addicted family	5.02	1.85	40
	Normal	6.50	2.28	40
Aggressive Behavior	With an addicted family	5.87	1.90	40
	Normal	9.84	2.37	40

The descriptive statistics of behavioral disorders from students' perspective are presented in the following table for each group.

Table 3: Descriptive Statistics of Behavioral Disorders in Students' View for Each Group

Variables	*Group*	*Mean*	*SD*	*N*
Anxious/Depressed	With an addicted family	8.77	4.85	40
	Normal	5.46	3.08	40
Withdrawn/Depressed	With an addicted family	4.40	3.92	40
	Normal	3.09	2.37	40
Somatic Complaints	With an addicted family	3.75	3.15	40
	Normal	3.14	2.30	40
Social Problems	With an addicted family	5.15	3.64	40
	Normal	3.51	2.64	40
Thought Problems	With an addicted family	8.47	6.92	40
	Normal	4.46	3.19	40
Attention Problems	With an addicted family	16.07	9.46	40
	Normal	5.88	6.32	40
Rule-Breaking Behavior	With an addicted family	7.95	3.09	40
	Normal	7.15	4.30	40
Aggressive Behavior	With an addicted family	9.78	6.15	40
	Normal	5.86	3.25	40

In order to investigate the difference between students with addicted and normal families in terms of behavioral disorders, multivariate analysis of variance should be used. One of the assumptions of using this analysis is the equality of covariance matrices. The results of Box's test showed that this assumption has not been satisfied (M Box = 113.37, F = 2.805, P <0.001). Another assumption is the equality of error variances. The results of Levene's test are presented in the following table.

Table 4: Results of Levene's Test on the Analysis of the Equality of Error Variances for Each Group

Variables	*F*	*Between-group df*	*Within-group df*	*Sig.*
Anxious/Depressed	6.159	1	78	0.015
Withdrawn/Depressed	2.147	1	78	0.147
Somatic Complaints	1.074	1	78	0.303
Social Problems	3.488	1	78	0.066
Thought Problems	6.898	1	78	0.01
Attention Problems	30.429	1	78	0.0005
Rule-Breaking Behavior	4.563	1	78	0.036
Aggressive Behavior	22.09	1	78	0.0005

As it is observed in the table above, there is a significant difference between the error variances in anxious/depressed, thought problems, attention problems, delinquent behavior, and aggressive behavior. Considering the fact that none of the assumptions were satisfied, Pillai's trace was considered as the multivariate index. The results of multivariate analysis of variance indicated that the groups were not equal in behavioral disorders ($P< 0.05$, $F = 2.262$, Pillai's trace = 0.203). To examine the patterns of difference, univariate analysis of variance was used as follows.

Table 5: Univariate Analysis of Variance Results on Examining Patterns of Difference for Each Group

Variables	*Mean Squares*	*F*	*Sig.*	*Effect size*	*Statistical power*
Anxious/Depressed	90.31	8.248	0.005	0.096	0.81
Withdrawn/Depressed	23.11	5.221	0.025	0.063	0.62
Somatic Complaints	26.45	5.138	0.026	0.062	0.61
Social Problems	23.11	2.967	0.089	-	0.40
Thought Problems	72.20	5.244	0.025	0.063	0.62
Attention Problems	845.00	15.857	0.0005	0.0169	0.98
Rule-Breaking Behavior	18.05	1.836	0.176	-	0.27
Aggressive Behavior	261.25	10.599	0.002	0.12	0.89

As it can be observed in the table above, there is a significant difference in the components of anxious/depressed, withdrawn/depressed, somatic complaints, thought problems, attention problems, and aggressive behavior between the two groups. It is noteworthy that all components were higher in the group with addicted families than the other group according to descriptive statistics. In order to investigate the difference in behavioral disorders between students with addicted and normal families from teachers' point of view, multivariate analysis of variance should be used. One of the assumptions of using this analysis is the equality of covariance matrices. The results of Box's test showed that this assumption has not been satisfied (M Box = 189.232, $F = 4.682$, $P <0.001$). Another assumption is the equality of error variances. The results of Levene's test are presented in the following table.

Table 6: Results of Levene's Test on the Analysis of the Equality of Error Variances for Each Group

Variables	*F*	*Between-group df*	*Within-group df*	*Sig.*
Anxious/Depressed	7.619	1	78	0.007
Withdrawn/Depressed	9.564	1	78	0.003
Somatic Complaints	11.158	1	78	0.001
Social Problems	09.99	1	78	0.003
Thought Problems	14.849	1	78	0.0005
Attention Problems	13.091	1	78	0.0005
Rule-Breaking Behavior	12.718	1	78	0.0005
Aggressive Behavior	9.879	1	78	0.0005

As it is observed in the table above, there is a significant difference between the error variances in anxious/depressed, withdrawn/depressed, somatic complaints, thought problems, attention problems, delinquent behavior, and aggressive behavior. Considering the fact that none of the assumptions were satisfied, Pillai's trace was considered as the multivariate index. The results of multivariate analysis of variance indicated that the groups were not equal in behavioral disorders ($P< 0.05$, $F = 2.684$, Pillai's trace = 0.232). To examine the patterns of difference, univariate analysis of variance was used as follows.

Table 7: Univariate Analysis of Variance Results on Examining Patterns of Difference for Each Group

Variables	*Mean Squares*	*F*	*Sig.*	*Effect size*	*Statistical power*
Anxious/Depressed	43.51	3.727	0.057	-	0.749
Withdrawn/Depressed	27.61	3.880	0.052	-	0.494
Somatic Complaints	24.45	6.283	0.014	0.075	0.697
Social Problems	26.45	3.703	0.058	-	0.476
Thought Problems	72.20	5.968	0.017	0.071	0.675
Attention Problems	135.01	16.497	0.0005	0.0175	0.980
Rule-Breaking Behavior	201.61	8.500	0.098	-	0.821
Aggressive Behavior	316.25	6.172	0.073	-	0.689

As it can be observed in the table above, there is a significant difference in the components of somatic complaints, thought problems, and attention problems between the two groups. It is noteworthy that all components were higher in the group with addicted families than the other group according to descriptive statistics. In order to investigate the difference in behavioral disorders between students with addicted and normal families from students' point of view, multivariate analysis of variance should be used. One of the assumptions of using this analysis is the equality of covariance matrices. The results of Box's test showed that this assumption has not been satisfied ($M Box = 87.028$, $F = 2.150$, $P <0.001$). Another assumption is the equality of error variances. The results of Levene's test are presented in the following table.

Table 8: Results of Levene's Test on the Analysis of the Equality of Error Variances for Each Group

Variables	*F*	*Between-group df*	*Within-group df*	*Sig.*
Anxious/Depressed	3.710	1	78	0.058
Withdrawn/Depressed	3.842	1	78	0.054
Somatic Complaints	1.137	1	78	0.292
Social Problems	5.262	1	78	0.025
Thought Problems	3.676	1	78	0.059
Attention Problems	1.842	1	78	0.179
Rule-Breaking Behavior	0.534	1	78	0.223
Aggressive Behavior	5.490	1	78	0.022

As it is observed in the table above, there is a significant difference between the error variances in social problems and aggressive behavior. Considering the fact that none of the assumptions were satisfied, Pillai's trace was considered as the multivariate index. The results of multivariate analysis of variance indicated that the groups were not equal in behavioral disorders ($P< 0.001$, $F = 5.036$, Pillai's trace = 0.365). To examine the patterns of difference, univariate analysis of variance was used as follows.

Table 9: Univariate Analysis of Variance Results on Examining Patterns of Difference for Each Group

Variables	*Mean Squares*	*F*	*Sig.*	*Effect size*	*Statistical power*
Anxious/Depressed	304.81	15.420	0.0005	0.167	0.972
Withdrawn/Depressed	4.49	0.590	0.445	-	0.118
Somatic Complaints	7.02	0.924	0.339	-	0.158
Social Problems	44.96	4.862	0.030	0.059	0.586
Thought Problems	47.56	3.150	0.080	-	0.418
Attention Problems	863.68	23.217	0.0005	0.232	0.997
Rule-Breaking Behavior	12.52	0.897	0.347	-	0.155
Aggressive Behavior	258.93	11.458	0.001	0.130	0.917

As it can be observed in the table above, there is a significant difference in the components of anxious-depressed, thought problems, attention problems, and aggressive behavior between the two groups. It is noteworthy that all components were higher in the group with addicted families than the other group according to descriptive statistics.

Discussion and Conclusion

In the assessment of behavioral disorders differences, the results showed that anxious-depressed, thought problems, attention problems, delinquent behavior, and aggression behavior are available in higher degrees in the group with addicted fathers than that in the group with normal families from parents' viewpoints. In addition, the results showed that the group with addicted fathers obtained higher scores in the components of anxious/depressed, withdrawn/depressed, somatic complaints, thought problems, attention problems, delinquent behavior, and aggressive behavior than that in the group with normal families from teachers' perspective. According to the students

themselves, the results showed that families with addicted fathers obtained higher scores in the components of somatic complaints, thought problems, and attention problems between the two groups. The family environment is the first environment in which a person grows up and learns norms. Family is the first place where personality, beliefs, and behavioral patterns of an individual develop; in addition, it can be a source of disorder. The family environment has a direct relationship with addiction on narcotic drugs and psychotropic drugs. In many cases, addiction is caused by disorders in the family structure. The addiction of one of the parents or both, conflicts that arise after drug addiction, and the tragic situation of addicts in the family have serious effects on children's spirits and cause emotional and mental disorder. This leads children to model their behavior and consider substance abuse as a norm, behave in the same way, and begin to use narcotic drugs or psychotropic drugs without knowing their immediate consequences (Shakeri, 2014). In the comparison made by Richard Bloom between the addicted and non-addicted families in Algeria, it was found that if the family has free ideas about drug use, then adolescents of the same family are likely to go through the same path, tend to drug use easily, and choose the friends who are willing to consume drugs. The probability of a tendency toward substances in children with addicted parents is much higher than that in others (Kim, Kwak, & Yun, 2011). In a study conducted in 2012, Haker concluded that children tended to follow their parents in alcohol drinking. This also holds true in children's imitation in the use of cigarettes and other addictive substances (Saedi, 2013). The results of Haker's research are consistent with those of the studies conducted by Durkhem et al. (2011), Aghabakhshi (2012), and Shayegan (2014).

Children within the family environment sometimes show the modeling process by imitating the elders and taking their roles. With such an imitation of elders' behavior, they are prepared for a more complete social life as an adult. It has been observed repeatedly that children play the same role that they like their parents to behave toward them by means of their toys. Pre-revolutionary scholars have observed children in addicts' families who use their pencil and pen to mimic heroin use and then have seen in the kindergarten after the revolution that some under-age children played the role of addicts, smugglers, and comets in multiplayer games. During the game, children become aware of the roles and, thus, achieve the nature of the roles in this way. Children play their roles not only in group games but also recognize the roles of others about themselves. Studies have also shown that children in lower-income families are more likely to get oriented to drugs (Heidari et al., as cited in Arafa, 2013). Parental guidance and monitoring is also a component of drug prevention. Studies have shown that the prevalence of drug use among the adolescents and young people who are managed and monitored by their parents less is much easier. The results of this study are consistent with those of the study conducted by Dalvandi in 2012 and Sabzi and Nazer in 2015. In this area, Sabzi & Nazer (2015) conducted a study

on social control, social support, and resilience in children with addicted fathers where a group of addicted persons with addicted fathers (non-resilient or control group) and another addicted group with non-addicted fathers (resilient group or the homogenized group) filled out social control and social support questionnaires. Independent chi square and logistic regression tests were used to analyze the data. Social control and social support in the resilient group were significantly higher than those in the non-resilient group (P <0.001). Dalvandi, & Sadr-al-sadat (2012) conducted a research on psycho-social problem of adolescents with addicted fathers. The aim of this study was to identify psycho-social problems (academic failure, disturbance in social relations, and anxiety) among adolescents with addcited fathers as a case-control study. The results of this study indicated a significant difference in academic status, disturbance in social relations, and anxiety levels among adolescents with addicted fathers and adolescents with non-addicted fathers. In other words, in the case group, academic failure, anxiety and disturbance in interpersonal relationships were more significant; and there was a significant relationship between father's addiction and psychosocial problems of their children ($p<0.05$).

Each research encounters some limitations during its process. The present research has also been confronted with some limitations as follows:

1. Non-provision of an accurate response by the addicted families to Child Behavioral Checklist
2. The lack of a suitable condition for doing the research with a larger sample size
3. Non-cooperation of some teachers of students with addicted fathers
4. Non-cooperation of children to complete the questionnaire
5. Reluctance of parents and sometimes their misbehavior ts when providing information
6. Restricted access to research resources
7. The lack of desirable reliability and validity of research in questionnaires

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