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# COMPARATIVE STUDY OF COPING BETWEEN SPOUSES OF PERSONS WITH ALCOHOL DEPENDENCE SYNDROME AND SPOUSES OF PERSONS WHO DO NOT ABUSE ALCOHOL

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## ABSTRACT

**Background:** Alcohol dependence problem is spread worldwide, it also includes India. During earlier times alcohol was used as the part of rituals and medicaments, but now it has become a worldwide problem and has posed a great challenge for mental health professionals. Alcoholism is a common illness (Haglud & Schuckit, 1992).

If we talk about the impact of alcohol on spouses of individual with alcohol dependence syndrome, we must confess that they are affected on many different levels. Several studies in this regard have been conducted about the spouses of individual with alcohol dependence syndrome and their results often present significant rates of problems in areas of mental and physical , communication, low social activity and poor marital satisfaction domains (Moos et al., 1990; Halford et al., 2001).

**Aim of the study:** The aim of the study is to assess and compare coping between the spouses of person with and without Alcohol Dependence (normal control).

**Methods and Material:** Informed consent was taken from spouses of both the groups and brief cope scale was administered along with socio demographic data sheet. The study was cross- sectional hospital based and single contact study. The present study will include 80 spouses, among which 40 spouses will be of person with alcohol dependence and 40 spouses will be normal control. Sample will be chosen purposely in OPD of RINPAS, Kanke, Ranchi.

**Results:** Result is discussed below.

**KEYWORDS :** Spouses of person with alcohol dependence syndrome, coping.

## INTRODUCTION:

The word "alcohol" came from the Arabic "Alkuhl" meaning essence. A proposed definition of alcohol use is a "primary chronic disease with genetic, psychological and environmental factors influencing its development and its manifestation. The disease is often progressive and fatal. It is characterized by impaired control over drinking, preoccupation with drug alcohol, use of alcohol and distortion in thinking" (National Council of Alcoholism, 1972).

The Vedic scriptures have documented the use 'soma sura' (intoxicating beverages) as early as 2000-800 BC in India. Even the ancient Indian texts of Charaka and Shusruta (around 300AD) made distinction between normal and excessive drinking. However, the process of distillation was discovered around 800AD in Arabia (Issac, 1998)

Alcohol, which is classified as a depressant, is probably the most frequently abused psychoactive substance. Alcohol abuse and dependence affects over 20 million Americans i.e., about 13% of the adult population. An alcoholic has been defined as a person whose drinking impair his or her life adjustment, affecting health, personal relationship, and / or work.

Alcohol dependence is considered to be a severe form of the disease. In simple words if an individual drinking is affecting his health, occupation or social functioning and in spite of that he continues to drink, we say he is dependent on alcohol. The Alcohol Dependence in some form or other has been universal phenomenon and has eventually become a human tragedy resulting in enormous toll in deaths, more crime and accident, marital disharmony, interpersonal disturbances and maladjustment at home and work place. Alcoholism is like a disease which does not only affect the individual but the whole family. Man has always been known to get entangled in the hazy web of chemical substances among which alcohol is the most common one. Alcohol has more social sanction than any other substance and has come to serve certain functions in the society. It is a relaxant for a few, a bad for a few others, while it symbolized the pride and the status of manhood for the youth. Thus alcohol has come to mean certain things for certain groups in the society.

In 1950s the WHO defined alcohol dependence as: "Those excessive drinkers whose dependence upon alcohol has attained such a degree that it shows a noticeable mental disturbance or an interface with their bodily and mental health, their interpersonal relations, and their smooth social and economic functioning, or who show the prodromal sign of such development" (WHO, 1952). In 1955, committee of experts on alcohol and alcoholism highlighted the importance of physical criteria describing alcoholism as: "A chronic disease characterized by a fundamental disturbance of the nervous system that is manifested on a behavioral level by a state of physical dependence. The forms of the dependence are either inability to stop drinking before drunkenness is achieved or inability to abstain from drinking because of the appearance of withdrawal symptoms" (WHO, 1955). Later in 1974 the WHO defined alcohol dependence as: "A state of physical and emotional dependence on regular or periodic, heavy and controlled consumption, during which the person experiences a compulsion to drink" (WHO, 1974). The use of alcohol for purposes of relaxation or socializing by mankind has been reported throughout history in most civilizations. The social approval to alcohol use has varied from strong disapproval to being actively encouraged. In the 20th Century Western World, the use of alcohol as well as the related disorders, has been increasing rapidly. The recognition of alcoholism as a disease occurred during the early 1950s by the World health Organization (WHO) Jellinek's description of "disease concept of alcoholism" and the subtypes of alcoholism generated a lot

of interest. It proved to be stimulus for systematic descriptions of alcohol related problems. The first description of "Alcohol Dependence Syndrome" in 1976 by Edwards and Gross emphasized inability to control consumption, salience of drink seeking behaviour, and narrowing of drinking repertoire as the characteristics besides the phenomena of tolerance and withdrawal. The concept of alcoholism can be well understood by the etymological origin of the term. Like all other "isms", alcohol becomes a way of life in persons with alcoholism. As in All other" isms", in this one too, alcohol becomes the "raison d' et re" or the reason for existence. In India, although alcohol use in ancient times and cannabis and affirm (raw opium) in more recent times have been known and reported for some time, substance use problems have been recognized to have a significant importance as a public health problems and in various other facets of life only very recently.

A large number of persons are involved in treating alcohol dependent individuals. They include, General Physicians, Psychiatrists, Psychologist, Social Worker, lay volunteer, spiritual leader and even recovered patient as a result, there is considerable difference of opinion on treatment issues. This is mainly due to their different conceptual models of treatment. Thus there is a need for a common and uniform treatment guideline which can help in comprehensive management of these patients.

**Alcohol Dependence as Psychiatric Condition and Current Nosology:**

The tenth revision of international classification of diseases-ICD-10, DCR (WHO, 1993) criteria for substance dependence states that a diagnosis for dependence should be made if three or more of the following have occurred together for at least 1 month or, if persisting for periods of less than 1 month, should have occurred together repeatedly within a 12 month period :

(a) A strong desire or sense of compulsion to take the substance.
(b) Impaired capacity to control substance taking behavior in terms of its onset, termination, or levels of use, as evidenced by: the substance being often taken in larger amounts or over a longer period than intended; or by a persistent desire or unsuccessful efforts to reduce or control substance use;
(c) A physiological withdrawal state when substance use is reduced or ceased, as evidenced by the characteristic withdrawal syndrome for the substance, or by use of the same substance with the intention of relieving or avoiding withdrawal symptoms;
(d) Evidence of tolerance to the effects of the substance, such that there is a need for significantly increased amounts of the substance to achieve intoxication or the desired effect, or a markedly diminished effect with continued use of the same amount of the substance;
(e) Preoccupation with substance use, as manifested by important alternative pleasures or interests being given up or reduced because of substance use; or a great deal of time being spent in activities necessary to obtain, take, or recover from the effects of the substance;
(f) Persistent substance use despite clear evidence of harmful consequences as evidenced by continued use when the individual is actually aware, or may be expected to be aware, of the nature and extent of harm.

**Coping**

**Definition and Concept:**

Coping as defined by Lazarus and Folkman (1984), consists of "constantly changing cognitive and behavioural efforts to manage specific external and or internal demands that are appraised as taxing or exceeding the resources of the person". Various authors have tried to understand coping reactions. According to Lazarus and Folkman (1984), there are two categories of coping styles – emotion-focused and problem-focused. Emotion-focused coping entails efforts to regulate emotional distress, including avoidance, while problem-focused forms of coping direct attention towards the problem and look for ways of solving it. Vollrath et al (1994) grouped the 15 dispositional coping styles given by Carver et al (1989) into three broad areas-problem focused coping, adaptive emotion focused coping, maladaptive emotion focused coping. *Moos and Billings (1982) have classified coping into 3 domains:*

***Appraisal focused coping:*** attempts to define meaning of a situation and includes strategies like logical analysis etc.
***Problem focused coping:*** seeks to modify or eliminate source of stress to deal with tangible aspects of a problem, or actively change the self to develop a more satisfying situation.
***Emotion focused coping:*** responses whose primary function is to manage the emotions aroused by the stressors and maintain effective equilibrium.

**Coping Strategies:**

The term stress is a "rubric" for a complex series of subjective phenomena, including cognitive appraisals (threat, harm, and challenge), stress emotions, coping responses and reappraisals. Stress is experienced when the demands of a situation tax or exceed a person's resources and some type of harm or loss is anticipated (Lazarus, 1966; Lazarus & Folkman, 1984).

Cohen and Lazarus (1979) defined the term coping as 'the action-oriented and intrapsychic efforts to manage environments and internal demands and conflicts among them, which tax or exceed a person's resources.' Lazarus and Folkman in1984 again revised the definition and said "constantly changing cognitive and behavioural effort to manage specific external and/or internal demands that are appraisal as taxing or exceeding the resources of the person." Various authors classified the coping strategies in various ways. Moos and Billings (1982) have classified it into three domains these are appraisal focused coping, problem focused coping and emotion focused coping. Appraisal focused coping attempts to define the meaning of a situation and includes such strategies as logical analysis and cognitive redefinition. Problem focused coping seeks to modify or eliminate the source or stress to deal with the tangible consequences of a problem or actively change the self and develop a more satisfying situation. Emotion focused coping includes responses whose primary function is to manage emotions aroused by stressors and there by maintain effective equilibrium.

***Maddi and Kobasa divided coping strategies as-***

i. Transformational coping which involves altering the events so that they are less stressful.
ii. Regressive coping which includes a strategy where in one thinks about the events pessimistically and acts evasively to avoid contact with them.

***Cohen and Lazarus (1979) classified coping strategies in five major types –***

i. Seeking information:
ii. Taking direct action:
iii. Inhabiting action:
iv. Engaging intrapsychic efforts:
v. Calling on others:

*Vollarath and Alnaes (1994) divided coping into three types these are*

i. Problem focused coping (active coping, planning, suppressing or competing activities, restraint, seeking social support for instrumental reasons)
ii. Adaptive emotion focused coping (seeking social support for emotional reason, positive reinterpretation acceptance, religion, humor)

iii. Mal adaptive emotion focused coping (denial, mental disengagement, behavioural disengagement, focus on and venting of emotions, use of substance).

**Review of literature:**

Spouses of individual with alcohol dependence syndrome are affected on many different levels. Several studies have shown that spouses of individual with alcohol dependence syndrome often present significant rates of mental and physical problems, communication problems, low social activity and poor marital satisfaction (Moos et al., 1990; Halford et al., 2001). Sathyanarayana Rao & Kuruvilla (1992) studied on the coping behaviors of wives of alcoholics on sample of 30 wives of person with alcoholics. They found most common coping behaviors restored to by the subjects were discord, avoidance, indulgence and fearful withdrawal. Occurring least frequently were marital breakdown, taking special action, assertion and sexual withdrawal. In order to assess the frequency of coping behaviors used individuals, the scoresonOrford-Guthire'sscaleweregon-vertedintopercentagefrequency. It was clear that 60 percent of the subjects restored to 'discord' more than70 percent of the time. While 'avoidance' was used by 50 percent of the group to similar extent, 'marital breakdown', 'taking special action 'and' competition' occurred rarely. Chandrashekaran R. & Chitraleka V. (1998) studied the patterns and determinants of coping behavior of wives of alcoholics on sample 100 wives of alcoholics. They found that positive correlation among the various coping components and alcohol related problem questionnaire were observed. The severity of alcohol dependence correlated with taking special action as coping measure. Kishor M., Lakshmi V. Pandit & Raguram R. (2013) studied on psychiatric morbidity and marital satisfaction among spouses of men with alcohol dependence on sample of 60 spouses of alcoholics. They found that more than half of the spouses (65%) had a psychiatric disorder. Primarily mood and anxiety disorder were present. Major depressive disorder was present in 43%. Psychiatric morbidity, marital dissatisfaction in spouses and higher adverse consequences alcohol dependence in their husbands, were found to be significantly correlated with each other and their association was robust particularly when problems in the physical, interpersonal and intrapersonal domains were high.

***Methodology: Aim of the study:***

The aim of the study is to assess and compare coping between the spouses of person with and without Alcohol Dependence Syndrome (normal control).

***Objective:*** objective of the study is to compare the coping of spouse of person with alcohol dependence syndrome and without alcohol dependence syndrome (normal control).

***Research design:*** This is hospital base cross-sectional comparative study designed to assess and compare the coping between the spouses of person with and without alcohol dependence syndrome (normal control).

***Sampling:*** Samples were selected by using the purposive sampling method, from RINPAS OPD. Total 80 spouses were recruited which were further divided in two groups, 40 spouses of the person with alcohol dependence syndrome and 40 spouses of person without alcohol dependence syndrome (normal control).

***Inclusion and exclusion criteria:***

1. Spouse of the person with Alcohol Dependence syndrome.
2. Person married for at least 5 years and living together.
3. History of person's alcohol dependent for at least 2 years to 10 years.
4. Patient's spouse in the age range of 20 to 45 years.

***Procedure:***

Spouses of the people with and without alcohol dependence (normal control) were selected from the outpatient department as well as ward on the basis of inclusion and exclusion criteria. Informed consent was obtained from them after explaining the details of study. The objectives of the study were explained to the participants. After establishing rapport and explaining the purpose of the study the details of the socio-demographic data, clinical variables were gathered from the informants, case record files and the patients themselves.

Brief cope (Carver, 1997) was administered one by one on the spouses. Finally study group was compare with the normal controls being matched by the parameters like 'age', 'sex' & 'educational status' of the study group. Normal controls were selected after completing the data collection of the study group. The collected data was tabulated, analyzed and assessed properly with appropriate use of statistics.

***Statistical analysis:***

The data were subjected to computerized statistical analysis using statistical package for social sciences (SPSS) version16.0 was used. In this study **T** test were used for statistical analysis.

***Tools used in the study:***

1. Socio-demographic & clinical data sheet
2. Brief cope (Carver, 1997)

***I. Socio-demographic & Clinical Data Sheet:***

The socio-demographic data sheet consist of information of the patient and his spouse, it included, age, gender, education, occupation, monthly income, religion, domicile, family type, marital status, duration of marriage, duration of illness, duration of alcohol intake.

***II. Brief Cope (Carver, 1997):***

The Brief COPE scale was designed to assess a broad range of coping responses among adults for all diseases; it contains 28 items and is rated by the four-point likert scale. Test-retest evaluation was undertaken at two/three weeks and ten weeks following surgery. Internal consistencies ranged from 0.25 to 1.00. Meanwhile, the Intraclass Correlation Coefficient (ICC) ranged from 0.05 to 1.00. Sensitivity of the scale was indicated by the mean differences as observed in most of the domains with Effect Size Index (ESI) ranged from 0 to 0.53. Significant differences between mastectomy and lumpectomy were observed for Active coping, Planning and Acceptance. Brief COPE Scale showed fairly good reliability and validity of the scale indicated a high Cronbach's alpha values for some domains such as Religion ($\alpha$=0.82) and Substance use ($\alpha$=0.90)[7]Other domains indicated acceptable values of Cronbach's alpha.

***RESULTS:***

**Table: 1 Socio-demographic details of Spouses of Individual with and without Alcohol Dependence Syndrome.**

| Variable | | Group | | df | $X^2$ |
|---|---|---|---|---|---|
| | | Spouses of ADS | Spouses of Control | | |
| Spouses Education | Primary | 18(45.0%) | 15(37.5%) | 3 | .611NS |
| | Middle | 9(22.5%) | 10(25.0%) | | |
| | Secondary | 7(17.5%) | 7(17.5%) | | |
| | Other | 6(15.0%) | 8(20.0%) | | |
| Spouses Occupation | House wife | 29(72.5%) | 32(80.0%) | 1 | .621NS |
| | Private job | 11(27.5%) | 8(20.0%) | | |
| Place of residence | Rural | 19(47.5%) | 36(90.0%) | 2 | 21.36NS |
| | Urban | 16(40.0%) | 0(0%) | | |
| | Semi-urban | 5(12.5%) | 4(10.0%) | | |
| Type of family | Nuclear | 19(47.5%) | 22(55.0%) | 1 | .450NS |
| | Joint | 21(52.5%) | 18(45.0%) | | |

| | | | | | |
|---|---|---|---|---|---|
| **Patient's education** | Primary | 5(12.5%) | 7(17.5%) | 3 | 4.117NS |
| | Middle | 8(20.0%) | 5(7.5%) | | |
| | Secondary | 8(20.0%) | 3(7.5%) | | |
| | Inter | 19(47.5%) | 25(62.5%) | | |
| **Patient's Occupation** | Farmer | 10(25.0%) | 7(17.5%) | 4 | 7.249NS |
| | Business | 6(15.0%) | 7(17.5%) | | |
| | Private Job | 9(22.5%) | 19(47.5%) | | |
| | Govt. Job | 5(12.5%) | 3(7.5%) | | |
| | Unemployed | 10(25.0%) | 4(10.0%) | | |

Table 1 shows socio-demographic variable between spouses of person with and without alcohol dependence syndrome. In education of spouses majority of respondents in both groups were educated up to primary level 18(45.0%) with alcohol dependence and without alcohol dependence syndrome 15(37.5%). In domicile majority of rural respondents from the sample of both groups 19(47.5%) spouses of person with alcohol dependence and 36(90.0%) spouses of person without alcohol dependence. In occupation of spouses majority respondents were housewives in both groups of person with 29(72.5%) and without alcohol dependence syndrome 32(80.0%). In type of family majority of them belonging to joint family in the spouses of ADS group 21(52.5%) and 18(45.0%) spouses of control, and majority spouses of control group belonging to nuclear family 22(55.0%).

**Table 2: Comparison of Coping among the Spouses of Individual with and without Alcohol Dependence Syndrome.**

| Variable | Group | | t |
|---|---|---|---|
| | ADS(N=40) Mean ± SD | Normal (N=40) Mean ± SD | |
| Total Coping | 47.22±14.93 | 64.35±19.87 | 4.356** |

** = Significant at 0.01 level

Table 2 shows comparison of coping among the spouses of person with and without alcohol dependence syndrome. The mean score of total coping of spouses of person with alcohol dependence symptoms were 47.22±14.93 and mean score of spouses of person without ADS mean score were 64.35±19.87 which indicates significant difference between two groups ($p<0.01$).

### *Discussion:*

No significant difference was found in social demographical variables between two groups. However in case of coping the mean and standard deviation of spouses whose partner is taking is alcohol is 47.22±14.93 and mean and standard deviation of spouses whose partner is not taking alcohol is 64.35±19.87, indicating that spouses whose partner is not taking alcohol show better coping as compared to that of spouses whose partner is taking alcohol. This finding is also inconformity with the research conducted by to Rao and Kuruvilla. According to Rao and Kuruvilla (1992) most often results of the studies conduct in this area shows the poor coping and neurotics among wives of alcoholics found that discord, avoidance, intelligence and fearful withdrawal where the common coping behavior and marital breakdown, less assertion and sexual withdrawal of some other reasons for poor coping and overall marital adjustment of spouses of the person with alcohol dependence syndrome.

Coping rifest to both cognitive and behavioral strategies that can be used to deal with a stressful event the coping behavior involves intrinsic and extrinsic factors.

The present study shows the poor coping of the spouses of person with alcohol dependence syndrome is suggestive of that wives of alcoholics are always in turn able phases feeling excess economic burden, social pressure and also remains insecure as most often person with alcohol dependence syndrome are unpredictable and engaged frequently in domestic violence. A poor social support of the family may also be one reason for poor coping of the spouses of person with alcohol dependence syndrome.

### *Conclusion:*

There is a significant difference in coping between spouses of individuals who are having ADS and spouses of individuals who do not abuse alcohol.

Spouses of individuals whose other spouse is not taking alcohol are having good coping. Spouses whose other spouses are having ADS are having poor coping.

### *Limitations:*

**The limitations of present study are as follows:**

1. Sample size was not large enough on the basis of which generalization of the results are somehow questionable.
2. Spouses assessment of psychopathology could not be done.
3. Duration of marriage was 5 years and above which could have been lowered.

1. Babor T.F, Kanzledr HR, and Lauerman RL (1987a). Social drinking as a health and psychosocial risk factor: Ansite's limit revisited. In Recent Developments in Alcoholism. Galanter M(ed),5,373-402.
2. Bamford, Z., Barrowclough, C., & Booth, P. (2007). Dissimilar representations of alcohol problems, patient–significant other relationship quality, distress and treatment attendance. Addiction Research and Theory, 15, 47–62.
3. Baxter, L.A. (1988). A dialectical perspective on communication strategies in relationships development. In S.W. Duck (Ed). A Hand Book of Personal Relationships, 257-273.
4. Sangeeta Arya Tanwar & K. Ranga Swamy (2010). Alcohol Dependence and Its Influences on Marital Satisfaction, Family Environment and Quality of Life of the Spouses. Indian Journal of Clinical Psychology .
5. Satyanarayan Rao, Kuruvilla K. (1992). A study on the Coping Behaviours of wives of Alcoholics. Indian Journal of Psychiatry, 34(4), 359-365.
6. Steinglass, P. (1976). Experimenting with treatment approached to alcoholism. Family Process, 15, 97-123.
7. Thomas, E.J. & Ager, R.D. (1993). Unilateral Family Therapy with Spouses of Uncooperative Alcohol Drinkers. O'Farrell, T.J. (Ed.) Treating Alcohol Problems: marital and family interventions, 3–33.
8. Van-Hasselt, V.B., Morrison, R.L., & Bellack, A.S. (1985). Alcohol use in wife abusers and their spouses, Addictive Behaviours, 10,127–135.
9. WHO, Alcohol Consumption & Alcohol- Related Problems in Germany, Buhringer, Mental and social problems as well as effects on others, 6.
10. Wiseman, J. (1991). The other half: Wives of alcoholic and their social-psychological situation. New York: Aldine de Gruyter.
11. World Health Organization (1992). The ICD-10 Classification of Mental and Behavioral Disorders.