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A COMPARATIVE STUDY OF COPING STRATEGIES IN SPOUSES OF NORMAL SUBJECTS AND PATIENTS DIAGNOSED WITH ALCOHOL DEPENDENCE SYNDROME

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ABSTRACT **Introduction:** Alcohol dependence syndrome is a very common condition affecting the general population. Alcohol abuse can result in novelty seeking and risk taking behaviour resulting in violence and road traffic accidents. Long duration abuse can cause several psychiatric disorders like anxiety, depression, and family disharmony. These problems are much more common in countries like India. **Methodology and Results:** In this single stage cross-sectional case control study, the degree of psychological well-being was grossly affected in spouses of patients with alcohol dependence in comparison to spouses of normal subjects. The overall mean (SD) of desirable coping strategies was 33.08 (7.7) in the study group and 68.0 (2.0) in the control group. The overall mean (SD) of undesirable coping strategies was 28.8 (4.2) in the study group and 5.2 (1.6) in the control group. In the study group, higher means were obtained by greater use of undesirable coping strategies in comparison to that in control group. Further analysis into the domains showed significant difference (P-value 0.001) between the study and control groups in all domains except substance use. **Conclusion:** The spouses of the study group showed higher usage of maladaptive coping strategies to handle their stress.

KEYWORDS : Alcohol, dependence, spouses, psychological well-being

INTRODUCTION:

Alcohol has a significant negative impact on the individual as well as family. Most affected people were the spouse and children of alcohol dependent[1]. But this problem in spouses who are females often goes unrecognised. The affected spouses go through various negative emotional states and try to cope up with the stress using multiple strategies[2]. The effects on the spouse are directly related to degree of violence linked to high risk behaviour of self injury, dysregulated sexual behaviour, or a fatal accident[3]. There are limited studies in India focussing on the current clinical context in question. If the psychiatric morbidity in the spouse of patients with alcohol dependence syndrome is identified early, effective treatment strategies can be planned accordingly which can have significant positive outcomes not only for the spouse, but for the whole family as well.

Aim:

To study the coping strategies in spouses of patients with alcohol dependence syndrome.

Objective:

To study and compare the coping strategies among spouses of patients with alcohol dependence syndrome with spouses of individuals who reportedly don't consume alcohol.

Hypothesis:

There is no difference in coping strategies between study and control groups (Assuming N_0 hypothesis).

Methodology:

A single stage cross-sectional study was carried out on subjects attending Government Hospital for Mental Care (GHMC), a tertiary care hospital in Visakhapatnam for a period of 1 year (September 2017-August 2018). The spouses of patients diagnosed as per ICD 10-DCR as F10-MENTAL AND BEHAVIOURAL DISORDERS DUE TO USE OF ALCOHOL and in category F10.2 DEPENDENCE SYNDROME and subcategories (F10.20 to F10.26) were enrolled for the study group. Control group was recruited from the spouses of the visitors to the hospital who reportedly did not consume alcohol. Informed consent was obtained from spouses of both groups before enrolling them for the study. Prior permission was taken from the Institutional Ethics committee, Andhra Medical College for this study.

Inclusion criteria-Subjects:

1. Willing to give an informed consent for study participation. 2. Age Group of Spouses between 20 to 45 years. 3. Duration of marriage being 6 months or above. 4. Living together for at least 1 month. 5. Spouses of patients who were diagnosed as per ICD 10 DCR as F10.2 Dependence syndrome falling in any of one the subcategories from F10.20-F10.26 [F10.20-Currently abstinent (in either early or partial or total remission), F10.21-Currently abstinent but in a protected environment, F10.22-Currently on a clinically supervised or replacement regime (controlled dependence), F10.23-Currently abstinent, but receiving treatment with aversive or blocking drugs, F10.24- Currently using the substance (active dependence with or without physical features), F10.25-Continuous use, F10.26-Episodic use] were enrolled for the study group. 6. Spouses of visitors who reportedly don't consume alcohol were enrolled for the control group.

Exclusion criteria-Subjects:

1. Unwilling to give an informed consent for study participation. 2. Presence of Psychiatric disorders like Schizophrenia, Mood disorders, etc. 3. Presence of comorbid medical, surgical, or substance use disorders. 4. Spouses of control group who were either close relatives of the patient with alcohol dependence syndrome or those who were living in the same family environment as that of the patient. 5. Spouses of study group of those patients falling in other diagnostic categories of F10 ie., F10.0, F10.1 and F10.3 to F10.7 as F10.0 (Acute Intoxication), F10.1 (Harmful use), F10.3 (Withdrawal state), F10.4 (Withdrawal state with delirium), F10.5 (Psychotic disorder), F10.6 (Amnesic syndrome) and F10.7 (Residual disorders and late-onset psychotic disorder).

Sample size estimation:

Sample size was estimated using the formula $4pq/d^2$ (p=prevalence from previous studies and d=allowable error, which is 5-20% of p). The prevalence of alcohol dependence in southern India ranging from 25 to 50%. Initially a sample of 162 comprising 81 each from study group and control group spouses was considered by the way of purposive random sampling. Out of these 21 from each group were excluded from the study due to several factors. In study group: 4 spouses failed to give the consent, 4 exceeded the inclusion age criteria, 4 had spouses with comorbid polysubstance use/dependence, 3 left the interview midway, 3 had spouses with comorbid liver disease, 2 have fallen short of the criteria for minimum duration of marriage, 1 had depressive disorder. In control group: 6 failed to give consent, 4 have fallen short of the criteria for minimum duration of marriage, 4 left the interview midway, 2 spouses had chronic severe medical disorders in the form of peptic ulcer disease and bronchial asthma, 2 currently not living together with spouse for more than 1 year, 3 were voluntarily dropped from the interview. A final sample size of 120 with (60 each in study and control group) were recruited for the study.

Procedure of study:

After appropriate screening, the eligible participants of both study and control groups were administered the BRIEF COPE SCALE. The responses were noted down and appropriate statistical analysis was carried out using IBM SPSS version 23. **BRIEF COPE SCALE[4]:** It was designed by Dr. C. Carver in 1997 to assess different coping behaviours, an individual can have in response to a stressful situation. The scale has 28 items with 14 sub-scales and an item score ranging from 1 to 4 on a likert scale. The sub-scales are self-distraction, active

coping, denial, substance abuse, use of emotional support, use of instrumental support, behavioural disengagement, venting, positive reframing, planning, humour, acceptance, religion, and self-blame. Out of 14 sub-scales, 4 sub-scales namely denial, behaviour disengagement, self-blame and substance abuse are considered as undesirable or maladaptive coping strategies. Higher the score on desirable coping sub-scales, greater is the use of desirable coping strategies. No coping strategy is specific for an individual or a group. Each coping strategy can be assessed distinctly, as well as in the form of composite scores. Internal consistency (cronbach's alpha) of the scale varies from 0.57-0.90.

RESULTS AND OBSERVATIONS:

Table 1: Comparison of BCS domains scores between study and control groups

BRIEF COPE SCALE	Study Group (N=60)		Control Group (N=60)		Statistical inference	
	Mean	S.D	Mean	S.D	Mann-Whitney U	P-value
Active coping	3.1	1.2	6.9	1.0	66	0.001
Use of emotional support (ES)	3.6	1.1	7.1	1.0	77	0.001
Use of instrumental support (IS)	3.5	1.2	6.7	0.9	111	0.001
Positive reframing	3.3	1.2	6.8	0.9	72	0.001
Planning	3.2	1.2	6.7	0.9	87	0.001
Humour	3.2	1.2	7.3	0.9	52	0.001
Acceptance	3.4	1.2	6.7	0.9	117	0.001
Venting	3.5	1.2	6.4	0.8	135	0.001
Self distraction	2.8	1.0	6.4	0.9	50	0.001
Religion	3.3	1.3	6.9	1.0	112	0.001
Denial	6.9	1.3	3.7	0.7	130	0.001
Self blame	6.8	1.1	3.2	2.0	68	0.001
Behavioural disengagement	6.5	1.2	3.3	1.0	135	0.001
Substance use	2.0	0.0	2.0	0.0	No statistics were computed as substance use was same in both groups	

DISCUSSION:

Alcohol dependence in a patient has a significant negative impact on family members. The majority of the stress was borne by their spouses which ultimately disrupts the family dynamics owning to unhealthy coping strategies in them. To test the Null hypothesis Brief Cope Scale was administered to both study and control groups. The overall mean (SD) of desirable coping strategies was 33.08 (7.7) in the study group and 68.0 (2.0) in the control group. The overall mean (SD) of undesirable coping strategies was 28.8 (4.2) in the study group and 5.2 (1.6) in the control group. In the study group, higher means were obtained by greater use of undesirable coping strategies in comparison to that in control group. Further analysis into the domains showed significant difference (P-value 0.001) between the study and control groups in all domains except substance use, with greater means (SD) obtained in denial [6.9 (1.3)], self blame [6.8 (1.1)] and behavioural disengagement [6.5 (1.2)] and lesser means (SD) obtained in self distraction [2.8 (0.9)], active coping [3.1(1.2)], planning [3.1(1.2)] and humour [3.2 (1.2)] in comparison to that in control group. In the control group, mean (SD) obtained are as follows; humour [7.3 (0.9)], use of ES [7.1 (1.0)], religion [6.9 (1.0)], active coping [6.9 (1.0)] and behavioral disengagement [3.3 (1.0)] being least commonly used undesirable coping strategy. Both types of coping strategies were used by the spouses of study group. Self- distraction was the least common desirable coping strategy used. Emotional support [3.6 (1.1)] was the most common desirable coping strategy used in study group, followed by venting [3.5 (0.8)]. Denial was the most common undesirable coping strategy used in the study group. Substance use was not used as a coping strategy in either of the groups. There was significant difference in usage of humor in both groups with greater mean scores obtained in control group [7.3 (0.9)] than in study group [3.2 (1.2)]. This study matches with results of the study conducted by **James and Goldman (1971)**[5] reported that spouses of patients with alcohol dependence used all the coping strategies in response to their partner's alcohol abusing behaviour. The results were different from the findings of **Jackson A. Jones (1954)**[6] who reported that spouses of patients with alcohol dependence showed poor coping mechanisms which are mainly neurotic in origin similar to obsessive control of partner's alcohol drinking behaviour. **TSS Rao et al. (1992)**[7] study on coping behaviours of 30 spouses of dependent males, using "Coping with drinking questionnaire" revealed that discord, fearful withdrawal, avoidance were the commonly reported coping behaviors. **Limitations of study:** This is a cross sectional study conducted in a tertiary care setting. Therefore it's results cannot be generalized to the community. Premorbid Personality structure of spouses was not considered.

CONCLUSION:

This study showed high degree of usage of maladaptive coping strategies in spouses of patients with alcohol dependence.

Future recommendations:

Larger sample size drawn from the community with a prospective study design should be considered. A prospective study design with pre-training assessment of spouses, then imparting adequate training to the spouses in coping strategies as a means of psychological intervention and post-training reassessment to understand the influence of psychological training. This could be included as a routine part of assessment of the spouses at the level of primary care, based on the existing robust evidence of handling stress by psychological interventions.

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