Resilience in Wives of persons with Alcoholism: An Indian exploration

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ABSTRACT

Context: Mental health has currently shifted focus from “deficit” to strength-based approaches such as Resilience. Coping styles and personality factors have been well studied in Wives of persons with Alcoholism (WopA) but not Resilience. Alcohol dependence in spouse is seen as an adversity.

Aims: To evaluate Resilience in the WopA and explore its relationship with marital quality and clinical variables of Alcohol Dependence in their husbands.

Settings and Design: A cross-sectional study in a tertiary care hospital in Bangalore, Karnataka.

Subjects and Methods: WopA (n=34) between 25–55 years, were assessed for Resilience using Resilience Scale for Adults (RSA), while marital quality was assessed using Marital Quality Scale (MQS). The Severity of Alcohol Dependence, Age of onset of Initiation, Age of onset of Problem Drinking, and Age of onset of Dependence were evaluated in their husbands.

Statistical Analysis: Independent sample t-test, Chi-square test, and Pearson’s correlation were used.

Results: Majority of the WopA (82%) scored low on the RSA. Low Resilience (LR) WopA scored significantly lower on all factors of RSA except the perception of future; in comparison to High Resilience (HR) WopA. Additionally, the LR WopA reported significantly poorer marital quality.

Conclusions: Most WopA had low Resilience. LR WopA also had significantly poor marital quality. These findings need to be studied further in a larger population with culturally appropriate scales. The low scoring Resilience factors amongst WopA may be utilized in strength-based psychotherapeutic approaches. There is a need to improve the understanding of Resilience and its assessment in this population.

Key words: Humor, Marital Quality, Rebounding, Resilience, Self-determination, Self-efficacy, Severity of Alcohol Dependence, Wives of Alcoholics

INTRODUCTION

Alcoholism affects not only the consumer but also all their family members. In India, it has been estimated that there are 10.6 million dependent alcohol users among 62.5 million alcohol users.[1] While some help for them is getting initiated at least in urban areas of the country, their spouses and children continue to be the “forgotten victims.”[2] The wives of persons with alcoholism (WopA) are known to have significant problems such as marital dissatisfaction, poor social interaction, communication problems, physical problems, and mental health disorders.[3]

Various models of coping, personality, stress response, and family interaction in WopA have been described from the

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“disturbed personality” model of Futterman\(^{[6]}\) to the “stress model” of Jackson\(^{[5]}\) and later the “Psychosocial model” of Orford and Guthne.\(^{[4]}\) All have stressed the “deficits” in WopA in coping with their husband’s alcoholism. Most of the literature concludes that the predominant coping behaviors used by WopA around the world include avoidance, withdrawal or termination from marital relationship, co-dependency of alcohol, and feelings of helplessness and distress.\(^{[7-9]}\)

In India, marriages are usually endogamous in nature, arranged by the family, carried out based on the caste and religious considerations compared to western marriages. Alcohol use is widely and variedly viewed as a symbol of economic status, caste, gender privilege, and a person’s Karma. It is used during a period of turmoil or as an obligation during family and social occasions such as marriage and death.\(^{[10]}\) There have been a series of studies\(^{[11-14]}\) on coping behavior in WopA in India too. They have reiterated that women used avoidance predominantly as their coping behavior while using assertion, sexual withdrawal, discord, or taking special course of action in moderation. Co-dependency of alcohol was found in WopA who were young (<30 years), with poor social support and lesser coping resources. A study from Eastern India in a sample of 1718 women found that age, occupation, longer marital duration, and husband’s alcoholism were significant predictors of physical, psychological, and sexual violence.\(^{[15]}\) In a series of studies in India, Stanley found that WopA had higher levels of neuroticism, pessimism, conflict, and perceived more danger than the control group. A cross-sectional study of 150 WopA by the same author found that WopA had lower levels of marital adjustment and a poorer family interaction pattern in domains such as cohesion, consensus, general, and marital satisfaction compared to controls. He concluded that the de-addiction programs should also focus on WopA to overcome and deal with various interactional deficits in the marital system.\(^{[16-18]}\)

In a comparative study, assessing the quality of life between WopA and healthy participants, the authors found that the former had scored poorly on all dimensions of quality of life. Furthermore, the dimensions of social relation and environment were affected more significantly by the severity of alcoholism than the physical and psychological dimensions.\(^{[19]}\) In a recent study, addressing the problems faced by and the coping strategies of WopA, it was found that they used three types of coping. The engaged coping was the one that was commonly used and some of the commonly used styles in them were sitting together and talking about drinking (93.4%), reporting that their partner’s drinking was upsetting them often (93.4%), pleading their partners for not drinking (93%), and arguing (70%). Tolerant coping styles were less commonly used. The third commonly used strategy was withdrawal coping, and the styles commonly used were avoidance (25%) and reporting that they tried getting on their own as their coping mechanism (23%).\(^{[20]}\)

The “deficit model” in psychiatry and allied subjects have now been getting superseded by strength-based approaches such as Resilience.\(^{[21]}\) A qualitative study in 16 Indian WopA who self-identified as resilient in the face of intimate partner violence identified six themes such as the support of women, men, and family; personal attributes; dignity and work; being strong for the children; and faith in God. Among these themes, supportive social networks, personal attributes, and aspirations were found to be major clusters contributing to Resilience.\(^{[22]}\) It has gained popularity in view of its potential influence on quality of life, health, and well-being.\(^{[23]}\) The current definition of Resilience is that “it is the process of negotiating, managing, and adapting to significant sources of stress or trauma. Assets and resources within the individual, their life and environment facilitate this capacity for adaptation and “bouncing back” in the face of adversity. Across the life course, the experience of Resilience will vary.”\(^{[24]}\) The concept of Resilience has been extensively used following major catastrophes like Tsunami.\(^{[25]}\) Later, studies have been focusing on chronic adversities of human health such as cancer and children of alcoholics. A recent case–control study by Sreekumar \(\text{et al.}\) attempted to study Resilience and factors associated with it in a sample of 80 WopA. They concluded that Resilience was associated with a shorter duration and lower severity of alcohol dependence, an absence of domestic violence, and the involvement in external support groups whereas poor Resilience was associated with higher depression scores.\(^{[26]}\)

We intend exploring the concept of Resilience in WopA. Here, chronic alcohol use or alcohol dependence syndrome in husband is viewed as an adversity or stress from which the WopA adapt or “bounce back” with their existing assets or resources. The primary objective of this study is to attempt evaluating Resilience in the WopA. We have tried to study how a measure of Resilience compares with marital quality in the index couples. We have also explored the association of the Resilience measure with clinical variables of alcohol dependence in the husbands.

**SUBJECTS AND METHODS**

The study was conducted in the Department of Psychiatry, St. John’s Medical College Hospital, Bengaluru. The WopA between 25 and 55 years, married for more than 5 years and who screened negative on the MINI-Screen\(^{[27]}\) were invited to participate in this study. The study was approved by the Institutional Ethical Review Board. Informed consent was taken from the participants and their husbands. As this was a pilot study, we aimed to have at least the same number of subjects as there were items in the Resilience measure.

Initially, a semi-structured proforma was used to collect sociodemographic data and clinical information about the couples. Later, Resilience Scale for Adults (RSA)\(^{[28]}\) was used to assess Resilience in the WopA. It is a 33-item self-report scale with 5-point Likert type of rating. The scale provides six factors...
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Out of the 34 participants, 28 were found to have LR and six had HR. There were significantly lower scores in the total Resilience score as well as the subfactors of Perception of self, Structured style, Social competence, Family cohesion, and Social resources in LR WopA compared to HR WopA. There was no significant difference in the subfactor of "Perception of future" between the groups [Table 1]. There were no significant differences in the age of husband or WopA, standard of living index, duration of the marriage, family size, number of children, Age of onset of Initiation, Age of onset of Problem Drinking, Age of onset of Dependence and Severity of Alcohol Dependence between the two groups.

While the total scores of MQS of the couples did not significantly differ between the two groups, the LR WopA had significantly poor marital quality in the areas of Understanding, Satisfaction, Affection, Decision-making, Self-disclosure, and Role functioning compared to HR WopA on the MQS (female form) [Table 2].

The categorical variables such as financial freedom, support from the family of origin, support from in-laws, current stressors and family history of mental illness; obtained from the initial semi-structured interview did not significantly differ between the two groups. There were no significant meaningful correlations noted between the studied variables.

**DISCUSSION**

In our study, we found that the mean Resilience score in WopA was 123.85 (±12.89). Significantly higher total scores of this sample on the MQS reflected poor quality of marital relationship as compared to the Indian norms. [30] This is consistent with the literature worldwide that alcohol problem drinking or heavy drinking leads to poor marital satisfaction. [34]

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**Table 1: Resilience scores and subscores between two groups of wives of persons with alcoholism**

| Resilience scores | Mean±SD | Group | n | Mean±SD | P |
|-------------------|---------|-------|---|---------|---|
| Total score       | 123.85±12.89 | Low Resilience | 28 | 119.64±9.65 | 0.001 |
| | | High Resilience | 6 | 143.50±5.65 | |
| Perception of self | 21.21±3.47 | Low Resilience | 28 | 20.50±3.32 | 0.008 |
| | | High Resilience | 6 | 24.50±2.17 | |
| Perception of future | 15.18±2.88 | Low Resilience | 28 | 14.79±2.85 | 0.088 |
| | | High Resilience | 6 | 17.00±2.53 | |
| Structured style  | 14.58±2.48 | Low Resilience | 28 | 14.18±2.37 | 0.036 |
| | | High Resilience | 6 | 16.50±2.26 | |
| Social competence | 22.94±3.04 | Low Resilience | 28 | 22.21±2.73 | 0.001 |
| | | High Resilience | 6 | 26.33±2.07 | |
| Family cohesion   | 22.03±2.94 | Low Resilience | 28 | 21.29±2.51 | 0.001 |
| | | High Resilience | 6 | 25.50±2.43 | |
| Social resources  | 28±4.88 | Low Resilience | 28 | 26.75±4.43 | 0.001 |
| | | High Resilience | 6 | 33.83±1.33 | |

WopA – Wives of persons with alcoholism; SD – Standard deviation; Independent sample t-test
There are only a few studies in this area to compare Resilience in WopA. In the study of Resilience by Narayanan,[29] which was done in healthy postgraduate students, where the mean Resilience was 134.63 (±18.28). Based on the above study, it appears that the mean Resilience in WopA was lower. While the normative data on Resilience in later ages are not available, these findings suggest that most of the WopA were having low Resilience. That this is seen in persons with higher socioeconomic status who are likely to have more resources available for help, is a matter of concern, given that most WopA in India would be expected to have far less resources. However, in the study by Narayanan,[29] the details about the socioeconomic status is not available; hence, we may not be able to compare our findings and comment on the relationship with Resilience and socioeconomic status. On the other hand, it raises some important questions in this area.

Do WopA in India despite staying together with their husbands for many years, tolerating various kinds of stress during husband’s alcohol use, often working to make ends meet, seeking help for their husband’s alcoholism, and taking care of their family amidst various stressors using all their resources, have poor Resilience? Or is it that the Resilience measure used is not able to evaluate the phenomenon of Resilience in our culture. Or if one accepts the measure, could it be plausible that WopA from poorer backgrounds, schooled in adversities for much longer, demonstrate better Resilience. This needs to be explored.

A key issue with normative studies such as the one by Narayanan[29] is the absence of key necessary assumptions. To reiterate, the construct of Resilience rests on two important assumptions (1) an individual should be exposed to an adversity and (2) the individuals use their assets and resources to adapt and “bounce back” in the face of adversity; but when one studies the Resilience in normal healthy individuals, the primary assumption may not be met. Hence, in future, it is important to consider studying subjects exposed to adversity and have clearer protocols for comparative studies.

The concept of Resilience has been criticized, challenged, and reclarified. At the foremost, it is very clear that we are discussing about the phenomenon of Resilience and not ego-resiliency. Ego-resiliency is a personality characteristic of an individual and includes asset of traits reflecting general resourcefulness, sturdiness of character, and flexibility of functioning in response to varying environmental circumstances and does not presuppose exposure to substantial adversity. On the other hand, the phenomenon of Resilience is a dynamic developmental process which has two conditions that include (1) an individual should be exposed to an adversity and (2) the individuals use their assets and resources to adapt and “bounce back” in the face of adversity.[21] Even though some researchers view psychological Resilience as a fixed and stable personality trait,[35] others argue that Resilience cannot be an observed trait.[36,37]

There is some consensus that Resilience needs certain protective factors (“assets,” “resources,” or “strengths”) for its optimal development.[38,39] The protective factors function at three levels; they include individual, social (family level), and community.[40] Individual level protective factors, are internal to the individual such as assets (includes competence and efficacy); while resources that are external to the individual include contextual or environmental influences, such as family support and community services. Some of the important defining attributes of Resilience are Self-esteem/ Self-efficacy, Self-determination, Rebounding, Flexibility, Social support, and Sense of Humor. Self-esteem/self-efficacy is described as the belief in one’s own ability to achieve a goal or overcome an event. This attribute enables the person to remain strong in the event of adversity or a life-changing event. It is seen both in adults and children, in different forms and levels.[41,42] Furthermore, studies have reported that they are found innately and mastered from their previous experiences.[38] The concept of self-esteem/self-efficacy is captured by the factor “perception of self” in the Resilience scale for adults. We found that the HR WopA had significantly higher scores in the “Perception of self” than the LR-WopA; this reinforces the concept that persons with better Resilience have improved self-esteem or efficacy. Self-determination is described as a feeling that regardless of what circumstances
or barriers occur in life, the individual will overcome these barriers and excel. It incorporates the concept of self-worth which is not being overwhelmed by feelings of hopelessness or extreme challenge based on a strong internal belief that whatever life brings, the individual will persevere. The concept of Self-determination is captured by the factor “Perception of future” in the RSA; however, in our study, there were no significant differences on this aspect between the two groups. This needs to be explored in further studies. Rebounding or “bouncing back” is described as the ability to bounce back after facing a life-altering event. It involves understanding or accepting the adverse event, negotiating, and moving toward normal functional life. Flexibility which keeps reemerging in the literature of Resilience basically looks at the construct of adaptability or being able to roll with changes, being cooperative, amiable, tolerant, and having an easy temperament. This has been captured by few items in the factors “Perception of self and future.” HR WopA had significantly more scores in the “Perception of self” than LR WopA, a positive relationship with at least one significant person has been found to be an important attribute in resilient outcomes. Social support has been found to be an important attribute in children and adults. In our study too, we found that HR WopA had better Social competence and Social resources. Sense of humor about life and self has the ability to make the adversity light and has been found to enhance coping mechanisms and moderate intensity of emotional reactions. It has been found in all age groups. This has been captured by few items in the factor social competence, and we found that HR WopA had significantly more scores in Social competence. Some of the important consequences of Resilience such as integration, personal control, psychological adjustment, personal growth, and effective coping have emerged in the literature.

We have thus far raised questions about the cultural sensitivity of the Resilience measure, but also pointed out certain strengths of the Resilience scale as seen from our limited data.

The study by Sreekumar et al. was a case–control study and their subjects had depressive symptoms, this raises some of the key issues of the research design and psychiatric symptoms in the subjects necessary for studying Resilience in WopA. First, is a case–control methodology acceptable? Assessing Resilience in people who have not been exposed to adversity may not capture Resilience and comparing them may not be a correct methodology. Then what about a cross-sectional design such as our study? In the context of an ongoing persistent issue such as alcoholism would such a measure demonstrate an individual’s level of Resilience. If the scale for Resilience is applied as a fixed measure separating cases from controls, there is a real risk that it may just be a proxy for a measure of brief coping capacity following an adversity. As mentioned earlier, it may also be erroneous to think of a fixed concept of Resilience within a given person. As pointed out, Resilience is not just recovery from adversity but a dynamic process, growing and strengthening from the adversity. Hence, it has to be studied at different time points to see whether Resilience is constantly changing to “bounce back” to normalcy with adversity. This would differentiate Resilience from coping. Future research needs to consider prospective long-term designs to study Resilience in WopA. The next question is; can Resilience be assessed in people with psychiatric symptomatology? As suggested by Bonanno; in his definition of Resilience as “the ability of adults in otherwise normal circumstances, who were exposed to an isolated and potentially highly disruptive event, to maintain relatively stable and healthy levels of psychological and physical functioning and the capacity for generative experiences and positive emotions.” It would be better to assess the subjects without any psychiatric symptoms. This definition also raises a key challenge for work related to Resilience in WopA. That is: Can an ongoing difficulty meet the definition of a “isolated highly disruptive event” that can help evaluate Resilience?

There were significantly more difficulties in the factors of MQS in WopA with low Resilience scores compared to the HR group even though there were no differences in the total marital quality score. The Resilience scores did not have any relationship with the clinical variables of alcoholism. It appears that Resilience is an independent phenomenon seen in WopA and not associated with the clinical variables of alcoholism of alcoholic subjects. This could arguably provide some support for the measure. However, this is too early to conclude this aspect since our study had a small sample size and the severity of alcohol dependence in our alcoholic subjects was in the mild category. A larger sample size drawn from across the socioeconomic strata and a broader spread of severity scores may help arrive at reliable conclusions.

Sample size apart the limitations of this study include the hospital-based sample, which was further biased toward the higher socioeconomic strata.

CONCLUSIONS

Large number of WopA had low Resilience. LR WopA were found to have significantly poorer marital quality. The low scoring Resilience factors amongst WopA may be utilized in strength-based psychotherapeutic approaches. The concept of Resilience in ongoing adversity such as alcoholism in spouse needs more clarity. There is a need to study Resilience in community settings with culturally and phenomenologically appropriate Resilience measures using conceptually appropriate research designs in larger samples with a broader spread of severity of alcoholism.

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