Chapter III

Research Methodology
RESEARCH METHODOLOGY

INTRODUCTION

This chapter gives information about the methodology adopted to achieve the goals of this study. It includes the statement of the problem, significance of the study, scope of the study, aim, objectives, hypothesis, conceptual and operational definitions research design, universe and sampling techniques, tools for data collection, data collection procedure and statistical tests.

Research methodology is a way of systematically solving the research problem. In it we study the various steps that are generally adopted by a researcher in studying the research problem along with the logic behind them (Kothari, 1985).

The researches conducted related to the present study have been reviewed and presented in the previous chapter as a conceptual base for this comparative study. In accordance with the aim of this investigation, the insights gained from the researches have been utilized to explore the “Marital Correlates among Wives of Alcoholics and Wives of Non-alcoholics”.

The present investigation focuses on a better understanding of the marital life of wives of alcoholics and wives of non-alcoholics. The results of the present study would have implications for understanding the marital life of the wives of alcoholics from the social work perspective and to strengthen the practice base of the professional social work in general and psychiatric social work in particular with reference to alcohol dependents and their wives.

STATEMENT OF THE PROBLEM

Alcoholism has been described as a family illness. This implies that other family members particularly the spouse is caught up in the pathological processes of the alcoholic’s illness in such a way as to develop parallel emotional and / or behavioural problems.

According to Patti son and Kaufman, alcoholism is an economic drain on family resources, threatens job security, causes conflict, and demands adjustive and adaptive responses from family members. There is much evidence in the literature implicating alcoholism as an important factor in vitiating the domestic environment and adversely
Research Methodology

impacting the marital relationship between the spouses. Aruna (1988) reports that families of alcoholics are more disturbed in all areas of their family environment and family burden when compared to non-alcoholic families. Poor marital functioning has been reported by both the alcoholics as well as the spouses (Perodeau and Kohn, 1989). Better marital quality has been reported in families where neither spouse was an alcoholic than in those where one spouse was an alcoholic (McLeod, 1993).

Studies on alcoholic families have also revealed marital disruption, disrupted family rituals, poor cohesion, difficulties in communication etc. To sum up then, this investigation is based on the premise that marital system deficits are more likely to be seen in wives of alcoholics. The central thrust of this study is to ascertain whether the manifestation of certain marital dimensions vary in wives of alcoholics and those of non-alcoholics.

As there are few studies on the families of alcoholics in the Indian context, this study is carried out to provide an understanding of Indian alcoholics families as well as the marital life of both the alcoholics and their wives. Five marital dimensions namely Conflict Tactics, Proactive Coping, Family Interaction Pattern, Marital Quality and Perceived Quality of Life have been selected for this investigation.

SIGNIFICANCE OF THE STUDY

Alcoholism is a universal problem found in all classes of the society irrespective of age, sex, education, religion and occupation. It is a highly complex and progressive illness. In India about 20-25 percent of people take alcohol. According to a study by the All India Medical Institute of Medical Sciences – Delhi, over the past 20 years the number of drinkers in India has increased from 1 in 300 to 1 in 20 (Hindustan Times, April 15, 1997)

Researchers have found that the wives of alcoholics are nervous, hostile, dependant people and were unable to cope with the drinking by their husbands. In addition the wife becomes an insecure person with many personality deficits. It is also noted that alcoholism is a major factor of premature widowhood.

The review of literature has portrayed the wife of an alcoholic to be a victim of circumstantial distress, which affects her in more ways than one. It has revealed the presence of violence, emotional problems, and a stressful domestic environment in
most marriages to an alcoholic. This comparative study was planned against this background and the study seeks to compare wives of alcoholics with those of non-alcoholics with regard to their marital life.

Though there are several studies regarding family environment, family burden, marital adjustment, marital functioning etc. pertaining to alcoholics and their wives, this study is intended to highlight the marital life of the wives of alcoholics that includes the measurement of Conflict Tactics, Proactive Coping Behaviour, Family Interaction Pattern, Marital Quality and Perceived Quality of Life.

The alcoholics and their family members are looked down by the society, which requires the stigma attached to alcoholism that needs to be removed and the individual can be brought in for de-addiction treatment for betterment. The study would help the professional social workers and counselors to get better understanding regarding the marital life of alcoholics and their wives. It also helps to differentiate between wives of alcoholics and non-alcoholics in terms of the studied marital dimensions. The study can be used for future guidance in dealing with wives of alcoholics during Family therapy sessions.

Professional Social Workers/Counselors/Psychiatrists can focus more attention towards the problem by applying various methods of Social work, as it is associated with the well being of the individual, family as well as the society. It also helps the Professionals in Family Counseling and De-addiction Counseling to adopt universal screening procedure in the Counseling Practice for effective solutions during the individual counseling sessions both with the alcoholic as well as the spouse.

From this study, Social work practitioners/Counselors/other professionals will get few indications regarding areas of intervention with alcoholics. It helps them to focus on issues confronted by the wives of alcoholics and enable them to overcome problems focused by them. The study will also help the counselors to recognize psychological needs of the wives of alcoholics that will enable them to organize intervention programs, which in turn will help the wives to enhance their marital life. The study also benefits the wives to manage their husband’s differently.

This study may also find use as background material by future researchers interested in studying aspects related to marital life and also enables them to identify
related areas for further investigation. The findings of this research would benefit therapists, clinical social workers and counselors dealing with marital counseling.

This study would underscore the importance of involving the spouse of the alcoholic not only as a supplementary adjunct for her husband’s prognosis as is the case with most de-addiction programmes in India, but also to point out her need for therapy as a victim of living in a situation of turmoil and to enable her to resolve various issues in her marital life.

SCOPE OF THE STUDY

The study is conducted with the wives of alcoholics whose husbands are diagnosed by the psychiatrists as alcohol dependents according to ICD 10 at the De-addiction cum Rehabilitation Centre in Khajamalai Ladies Association (KLA), Tiruchirappalli from May 2007.

A comparative group (Wives of Non-alcoholics) was identified to see if the two groups differ in terms of the studied marital factors. The two groups of respondents were comparable and matched on various socio-demographic variables. The information of socio-economic variables on these dimensions of those groups and the influence of husband’s drinking habit on the studied subject variables will also be studied. The large size of the samples would provide adequate scope for generalization of findings.

The researcher has dealt with the relationship between subject variables and socio-demographic variables. The related concepts that influence the study are Conflict Tactics, Proactive Coping, Family Interaction Pattern, Marital Quality and Perceived Quality of Life.

AIM OF THE STUDY

This study seeks to understand the correlates in the alcohol complicated marital relationships and to look for similarities and differential aspects when compared to alcohol free marital systems, with the focus on their Conflict Tactics, Proactive coping behaviour, Family Interaction pattern, Marital quality and Perceived Quality of Life and to offer suggestions for intervention in couples involving an alcoholic husband.
OBJECTIVES
1. To study the socio-demographic background of the wives of alcoholics and non-alcoholics.
2. To collect background information pertaining to the husband's alcoholism.
3. To perceive whether the wives of alcoholics and wives of non-alcoholics differ in terms of conflict management tactics.
4. To compare both group of respondents with regard to proactive coping with difficult circumstances.
5. To understand and compare the nature of interaction pattern prevalent in families of alcoholics and those of non-alcoholics.
6. To determine and compare the marital quality, of the wives of alcoholics and that of non-alcoholics.
7. To compare both groups of respondents with regard to their perceived quality of life.
8. To compare and contrast the manifestation of these variables with a matched group of non-alcoholics respondents.
9. To study the association if any between socio-demographic variables and major subject dimensions studied.
10. To offer suggestions from the perspective of intervention.

INDEPENDENT VARIABLES

Quantitative variables
- Age
- Respondent's Monthly Income
- Husband's Income
- Family Income
- Duration of Marriage
- No of Children

Qualitative variables
- Respondent's Occupation
- Husband's Occupation
- Respondent's Education
- Type of Marriage
- Type of Family
DEPENDENT VARIABLES

- Conflict Tactics
- Proactive Coping
- Family Interaction pattern
- Marital Quality
- Perceived Quality of Life

HYPOTHESIS
1. There is a significant difference between the Wives of Alcoholics and Wives of Non-alcoholics with regard to overall Conflict Tactics.
2. There is a significant difference between the Wives of Alcoholics and Wives of Non-alcoholics with regard to overall Proactive Coping behaviour.
3. There is a significant difference between the Wives of Alcoholics and Wives of Non-alcoholics with regard to overall Family Interaction pattern.
4. There is a significant difference between the Wives of Alcoholics and Wives of Non-alcoholics with regard to overall Marital Quality.
5. There is a significant difference between the Wives of Alcoholics and Wives of Non-alcoholics with regard to overall Perceived Quality of Life.

DEFINITION OF CONCEPTS:

Conceptual Definitions

- ALCOHOLISM: or alcohol dependence syndrome is defined as a state psychic and usually also physically resulting from taking alcohol, characterized by behavioural and other responses that always include a compulsion to take alcohol on a continuous or periodic basis in order to experience its psychic effects, and sometimes to avoid the discomfort of its abstinence (World Health Organization, 1965).

- CONFLICT TACTICS: refers to overt actions used by persons in response to a conflict of interest in the marital relationship. This includes the use of reasoning, verbal aggression and violence (Straus, 1979).

By using median test the respondents were classified as those having less conflict tactics and high conflict tactics.

1. **Low Conflict Tactics:** The individual who scores up to 122 in the Conflict Tactics Scale 2 Short Form (CTS2S) of Murray A. Straus, Emily M. Douglas (2004) is termed as having less conflict tactics in the study.
2. **High Conflict Tactics:** The individual who scores above 123 in the Conflict Tactics Scale 2 Short Form (CTS2S) of Murray A. Straus, Emily M. Douglas (2004) is termed as having high conflict tactics in the study.

- **PROACTIVE COPING:** the 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 (Lazarus and Folkman, 1984a)

By using median test the respondents were classified as those having less proactive coping and high proactive coping.

1. **Less Proactive Coping:** The individual who scores up to 162 in the proactive coping inventory of Esther Green Glass, Ralf and Steffen (1999) is termed as having less proactive coping in the study.

2. **High Proactive Coping:** The individual who scores above 163 in the proactive coping inventory of Esther Green Glass, Ralf and Steffen (1999) is termed as having high proactive coping in the study.

- **FAMILY INTERACTION:** refers to the various social, psychological transactions occurring in the family as a system to evolve processes for decision making, emotional expression and personal views, assigning tasks and social status, enabling the family members to contribute to the growth of the family by generating morphogenesis at emotional, intellectual and social levels through the manipulation of internal and external social milieu of the family as a whole.

For the purpose of classifying the overall family interaction pattern into low and high, the researcher used the median test for the present study.

1. **Less Family Interaction:** The individual who scores up to 262 in the Family Interaction Pattern Scale of Dr. Bhatti et al., (1986) is considered to be having less family interaction in the study.

2. **High Family Interaction:** The individual who scores above 263 in the Family Interaction Pattern Scale of Dr. Bhatti et al., (1986) is considered to be having high family interaction in the study.

- **MARITAL QUALITY:** is defined as the global evaluation of marriage, i.e. the evaluation placed on the relationship as a whole by the marital partners (Fincham and Bradbury, 1987).
By using median test the respondents were classified as those having low marital quality and high marital quality. The scale indicates that higher the score lesser is the marital quality.

1. **Low Marital Quality**: The individual who scores above 118 in the Marital Quality Scale of Anisha Shah (1995) is termed as having low marital quality in the study.

2. **High Marital Quality**: The individual who scores up to 117 in the Marital Quality Scale of Anisha Shah (1995) is termed as having high marital quality in the study.

- **QUALITY OF LIFE**: is defined as the ‘individuals’ perceptions of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns (World Health Organization Quality of Life -WHOQOL, 1995)

For the purpose of classifying the perceived quality of life of the respondents into low and high, the researcher used the median test for the present study.

1. **Low Perceived Quality of Life**: The individual who scores up to 85 in the Perceived Quality of Life Scale by Dr. Donald Patrick and Dr. Marion Danis (1988) is termed as having Low Perceived Quality of Life in the study.

2. **High Perceived Quality of Life**: The individual who scores above 86 in the Perceived Quality of Life Scale of Dr. Donald Patrick and Dr. Marion Danis (1988) is termed as having High Perceived Quality of Life in the study.

**Operational Definitions**

- **ALCOHOLIC**: In this study, the term refers to an excessive drinker whose dependence on alcohol has attained such a degree that it shows a noticeable mental disturbance or an interference in which their body and mental health are affected. (World Health Organization, 1952).

- **NON-ALCOHOLIC**: In this study the non-alcoholic is one who abstains from the use of alcohol, has been identified as one according to a close associate (neighbour, friend or relative) and has a score below eight on the alcohol use disorders identification test (Babor et al, 1989).
• **WIVES OF ALCOHOLICS**: The term refers to the women in the age group of 19 - 55 yrs whose husbands are alcoholics and are registered for treatment in the de-addiction cum rehabilitation centre of Khajamalai Ladies Association from May 2007 to March 2008.

• **WIVES OF NON-ALCOHOLICS**: The term refers to the women in the age group of 19 - 55 yrs whose husbands did not consume alcohol.

• **MARITAL CORRELATES**: also referred to as marital aspects, factors or dimensions. In this study, it refers to Conflict Tactics, Proactive Coping, Family Interaction Pattern, Marital Quality, and Perceived Quality of Life.

**RESEARCH DESIGN**

This study attempts to compare two groups namely, wives of alcoholics and those of non-alcoholics with regard to certain dimensions of their marital life. The wives of alcoholics (Sample I) constitute the study group and the wives of non-alcoholics (Sample II) are being used as the control group to facilitate comparison. This study is of comparative nature.

The groups are being matched on key socio-demographic variables but differentiated on one major factor- ‘the husband’s alcoholism’, and they are being compared with the intention of obtaining an indication of whether the relative manifestation of certain marital dimensions in both the groups could be attributed to the presence or absence of an alcoholic spouse.

It is therefore presumed that the effect if any, of living with an alcoholic (study group) or a non-alcoholic (control group) would have already manifested itself on the marital life of both the groups and the researcher having matched them on important variables. This study is an attempt to determine and compare the manifestation of conflict tactics, proactive coping, family interaction pattern, marital quality and perceived quality of life dimensions of these wives as reported by them at the point of data collection. Studies of this nature are categorized as Ex-Post Facto research.

Kerlinger (1965) defines Ex-Post facto research as ‘systematic empirical enquiry in which the scientist does not have direct control of important independent variables because their manifestations have already occurred or because they are inherently not manipulable’. Shavelson (1988) holds that such designs are termed as Ex-Post Facto because when the researcher comes on the scene, nature has already
manifested certain consequences either through differences in environments in which subjects find themselves or through differences in inheritance or a combination of both factors.

The Ex-Post Facto research is aimed at the discovery of possible causes for a behaviour by comparing study participants in whom the behaviour is present with similar participants in whom it is absent, after the independent variables have occurred. This method is often used to test hypothesis about cause and effect because in many instances it would be unethical to manipulate the independent variables. Thus, keeping in mind the nature of this study, the type of variables involved and the kind of inferences being drawn, the researcher feels justified in basing this study on the Ex-Post Facto research design.

UNIVERSE AND SAMPLING

SAMPLE I - Wives of Alcoholics (Study Group)

Universe of this study consists of 150 wives of patients diagnosed, as alcohol dependents' by the Psychiatrists of the De-addiction centre in Khajamalai Ladies Welfare Association who were registered for treatment from May 2007. Since the universe is definite, the whole universe is taken for the study. No Sampling procedure was used and hence Census method was adopted with individuals' complete enumeration of all the items in the Universe.

Inclusion Criteria

- The husband should be registered for in-patient treatment after being diagnosed by the psychiatrist as per DSM –IV criteria
- Respondents must be living with the husbands at the time of study
- Married at least for 3 years
- Should not be with the wife of a relapsed or recovering alcoholic visiting the centre for follow-up services.

Exclusion Criteria

- The study excludes patients who come for counseling
- Respondents having major physical problems
- Respondents having a history of psychiatric illness
193 new patients were registered at the centre for de-addiction during the data collection period. Of these 164 spouses fulfilled the framed criteria and were enlisted for data collection. Of these, fourteen data sets could not be completed and the final number of respondents included in the study group stood at 150.

SAMPLE II - Wives of Non-alcoholics (Control Group)

The researcher adopted Purposive Sampling Method to select the control group respondents’. 179 wives of non-alcoholics were identified through the study group respondents, each of whom were asked to provide two addresses of friends, neighbours or relatives where the husband was not an alcoholic and who had a more or less similar socio economic background as theirs. Home visits were made and the family, which resembled the referrer study group respondent’s profile more closely, was short listed for data collection. The wife was included as a control group respondent only if her husband scored less than eight (indicating non-alcoholic status) on the AUDIT (Alcohol Use Disorders Identification Test - Babor et al, 1989). Out of 179 wives, 161 spouses fulfilled the framed criteria and were enlisted for data collection. Of these eleven data sets could not be completed and the final number of respondents included in the control group stood at 150.

In addition the following criteria were framed to include as control group respondents:

Inclusion criteria

- Husbands must be within the same income group as those of alcoholics
- Respondents should stay in the same locality as the study group respondents.
- Married and living for 3 years with the husband.

Exclusion criteria

- Respondents having major physical illness
- Respondents having a history of psychiatric illness

Earlier studies which were methodologically similar to the present one, involving comparison of the spouses of alcoholics and non-alcoholics were reviewed, prior to formulating the selection modality of the control group respondents for this investigation. In particular, the procedure followed by Rao and Kuruvilla (1992) helped to identify the mode of contacting perspective control group respondents.
TOOLS FOR DATA COLLECTION

Tamil translated version of all the questionnaires were used to collect data

1. Self-prepared Interview Schedule was used for both the groups to assess the socio demographic status of the respondents. This consists of 11 structured items.

   Another schedule was framed for the study group respondents’ (Wives of Alcoholics) to collect information pertaining to their husbands’ drinking habit, problems due to drinking, husbands’ drunken behaviour and treatment details.

2. DATA COLLECTION was done by using various tools as

CONFLICT TACTICS SCALE 2 SHORT FORM – CTS2S (Murray A. Straus, Emily M. Douglas, 2004)

The Conflict Tactics Scale 2 Short Form (CTS2S) by Murray A. Straus, Emily M. Douglas, 2004 is the most widely used instrument for measuring intimate partner violence. The instrument includes dimensions to measure three tactics used when there is conflict in relationships of marital couples: Negotiation, Physical Assault and Psychological aggression. In addition, there are two supplemental dimensions: Injury from assault and Sexual coercion. In the present study CTS2S is used to find the level of conflict tactics used by the wives to manage their conflict situations.

   The Conflict Tactics Scale 2 Short Form (CTS2S) is a 20-item scale scored from one to eight according to the frequency with which various acts of partner related violence occurred in the previous year. The reliability and validity of the scale were already established by the author.

   Dimensions and Item Numbers:
   1. Negotiation: 1-4
   2. Psychological aggression: 5-8
   3. Physical assault: 9 – 12
   4. Sexual coercion: 13-16

   The scoring for Physical assault, Injury, and Sexual Coercion dimensions is done by creating a dummy variable for ‘prevalence’ by assigning a score of 1 if one or more instances of the items were reported to have occurred and 0 if no instances were
reported. For Negotiation, the scoring method is to sum the number of times each behaviour was reported. For this, the answer categories are converted from 0 to 7 to the midpoint of the range of scores in each category (Straus et al., 1996).

Using the median test the researcher arrived at the cut-off scores for the present sample. Higher score indicates higher conflict tactics. If the total score is less than 122, the conflict tactics is classified as low conflict tactics and if the total score is 123 and above the conflict tactics is classified as high conflict tactics.

Table 5  
Cut-off Scores for Conflict Tactics

<table>
<thead>
<tr>
<th>S. No</th>
<th>Dimensions of Conflict Tactics</th>
<th>Cut-off Score</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Negotiation</td>
<td>Less than or equal to 21</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22 and above</td>
<td>High</td>
</tr>
<tr>
<td>2.</td>
<td>Psychological Aggression</td>
<td>Less than or equal to 25</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>26 and above</td>
<td>High</td>
</tr>
<tr>
<td>3.</td>
<td>Physical Assault</td>
<td>Less than or equal to 30</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31 and above</td>
<td>High</td>
</tr>
<tr>
<td>4.</td>
<td>Sexual Coercion</td>
<td>Less than or equal to 26</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>27 and above</td>
<td>High</td>
</tr>
<tr>
<td>5.</td>
<td>Injury</td>
<td>Less than or equal to 28</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>29 and above</td>
<td>High</td>
</tr>
<tr>
<td>6.</td>
<td>Overall Conflict Tactics</td>
<td>Less than or equal to 122</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>123 and above</td>
<td>High</td>
</tr>
</tbody>
</table>

PROACTIVE COPING INVENTORY - PCI (Esther Green Glass, Ralf and Steffen, 1999)

The Proactive Coping inventory is an inventory to assess skills in coping with distress, as well as those that promote greater well-being and greater satisfaction with life. The scale was developed by Esther Green Glass, Ralf and Steffen in the year 1999. The Proactive Coping Inventory consists of seven sub-scales and a total of 55 items, which implement, on a cognitive and behavioural level, a way of coping based on resourcefulness, responsibility, and vision. The seven sub-scales of the PCI are: The
Research Methodology

Proactive Coping Scale, the Reflective Coping Scale, Strategic Planning, Preventive Coping, Instrumental Support Seeking, Emotional Support Seeking, and Avoidance Coping. The reliability and validity of the scale were already established by the author.

**Sub-scales and Item numbers:**

1. Proactive coping: 1-14
2. Reflective coping: 15-25
3. Strategic coping: 26-29
4. Preventive coping: 30-39
5. Instrumental support seeking: 40-47
6. Emotional support seeking: 48-52
7. Avoidance coping: 53-55

Scoring procedure for Proactive Coping Inventory is, 1 is assigned to "not at all true", 2 to "barely true", 3 to "somewhat true" and 4 to "completely true". In addition 3 items of the proactive coping subscale are reverse scored: “I try to let things work out on their own”, “I often see myself failing so I don't get my hopes up too high”, and “When I have a problem, I usually see myself in a no-win situation”. That is, a score of 1 should be recoded to a score of 4, a score of 2 should be recoded to a score of 3, a score of 3 should be recoded to a score of 2, and a score of 4 should be recoded to a score of 1. Responses should be added to obtain a summed score for each of the 7 subscales.

Using the median test the researcher arrived at the cut-off scores for the present sample. Higher score indicates higher Proactive Coping. If the total score is less than 162, the coping is classified as low proactive coping and if the total score is 163 and above the coping is classified as high proactive coping.
### Table 6

**Cut-off Scores for Proactive Coping**

<table>
<thead>
<tr>
<th>S. No</th>
<th>Sub - Scales of Proactive Coping</th>
<th>Cut-off Score</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Proactive Coping SS</td>
<td>Less than or equal to 38</td>
<td>Low</td>
</tr>
<tr>
<td>2</td>
<td>Reflective Coping SS</td>
<td>39 and above</td>
<td>High</td>
</tr>
<tr>
<td>3</td>
<td>Strategic Coping SS</td>
<td>Less than or equal to 13</td>
<td>Low</td>
</tr>
<tr>
<td>4</td>
<td>Strategic Coping SS</td>
<td>Above 14 and above</td>
<td>High</td>
</tr>
<tr>
<td>5</td>
<td>Preventive Coping SS</td>
<td>Less than or equal to 32</td>
<td>Low</td>
</tr>
<tr>
<td>6</td>
<td>Preventive Coping SS</td>
<td>Above 33 and above</td>
<td>High</td>
</tr>
<tr>
<td>7</td>
<td>Instrumental Support Seeking SS</td>
<td>Less than or equal to 32</td>
<td>Low</td>
</tr>
<tr>
<td>8</td>
<td>Instrumental Support Seeking SS</td>
<td>Above 33 and above</td>
<td>High</td>
</tr>
<tr>
<td>9</td>
<td>Emotional Support Seeking SS</td>
<td>Less than or equal to 10</td>
<td>Low</td>
</tr>
<tr>
<td>10</td>
<td>Emotional Support Seeking SS</td>
<td>Above 11 and above</td>
<td>High</td>
</tr>
<tr>
<td>11</td>
<td>Avoidance Coping SS</td>
<td>Less than or equal to 8</td>
<td>Low</td>
</tr>
<tr>
<td>12</td>
<td>Avoidance Coping SS</td>
<td>Above 9 and above</td>
<td>High</td>
</tr>
<tr>
<td>13</td>
<td>Overall Proactive Coping Score</td>
<td>Less than or equal to 162</td>
<td>Low</td>
</tr>
<tr>
<td>14</td>
<td>Overall Proactive Coping Score</td>
<td>163 and above</td>
<td>High</td>
</tr>
</tbody>
</table>

**FAMILY INTERACTION PATTERN SCALE- FIPS (Bhatti, Krishna and Ageira, 1986)**

The Family Interaction Pattern scale was developed by Bhatti, Krishna and Ageira (1986). The FIPS has 106 items in a statement form with a four point rating scale with responses being always, sometimes, rarely and never. The score ranges from 4 to 1 for positive items and 1 to 4 for negative items. The FIPS consists of 6 areas of family interactions namely reinforcement, social support, role, communication, cohesiveness and leadership. The reliability and validity of the scale were already established by the author.
Scale dimensions and Item numbers:

1. Reinforcement: 1-10
2. Social support: 11-21
3. Role: 22-47
4. Communication: 48-73
5. Cohesiveness: 74-89
6. Leadership: 90-106

Scoring for Family Interaction Pattern scale is, 1 is assigned to ‘Always’, 2 to ‘Sometimes’, 3 to ‘Rare’, 4 to ‘Never’ for negatively worded items and it is the reverse for positively worded items. Responses should be added to obtain a summed score for each of the dimensions.

Using the median test the researcher arrived at the cut-off scores for the present sample. Higher score indicates higher Family Interaction Pattern. If the total score is less than 262, the family interaction pattern is classified as low family interaction pattern and if the total score is 263 and above the interaction pattern is classified as high family interaction pattern.

<table>
<thead>
<tr>
<th>S. No</th>
<th>Dimensions of Family Interaction Pattern</th>
<th>Cut-off Score</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Reinforcement</td>
<td>Less than or equal to 23</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>24 and above</td>
<td>High</td>
</tr>
<tr>
<td>2</td>
<td>Social Support System</td>
<td>Less than or equal to 28</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>29 and above</td>
<td>High</td>
</tr>
<tr>
<td>3</td>
<td>Role</td>
<td>Less than or equal to 62</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>63 and above</td>
<td>High</td>
</tr>
<tr>
<td>4</td>
<td>Communication</td>
<td>Less than or equal to 65</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>66 and above</td>
<td>High</td>
</tr>
<tr>
<td>5</td>
<td>Cohesiveness</td>
<td>Less than or equal to 38</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>39 and above</td>
<td>High</td>
</tr>
<tr>
<td>6</td>
<td>Leadership</td>
<td>Less than or equal to 46</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>47 and above</td>
<td>High</td>
</tr>
<tr>
<td>7</td>
<td>Overall FIP</td>
<td>Less than or equal to 262</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>263 and above</td>
<td>High</td>
</tr>
</tbody>
</table>
The scale has been administered to people with neurotic depression, hysterical neurosis, schizophrenia and alcoholism (Bhatti, et al., 1986). The same scale has been used for normal population too. The ability of the scale items to discriminate between the different sub-scales established its validity. The inter-rater reliability was tested and found to be statistically significant. The scale has been used in many studies like that of Varalakshmi and Ranganathan (1988), Sophie (1988), Parvath (1989), Reddy (1992), Jose (1992) and Kumar (1996) and found to be efficacious.

MARITAL QUALITY SCALE (Anisha Shah, 1995)

The marital quality scale is a multidimensional scale developed by Anisha Shah (1995). The initial item pool for the scale was obtained through content analysis of interviews with 58 married persons. The first version of the scale had 135 items, which were selected based on consensus among five mental health professionals. Data of 400 married persons from general population was subjected to principal component factor analysis for further item reduction. Fifty items obtained as a result of factor analysis were retained on the Marital Quality Scale. Factor structure identified through principal component factor analysis shows 12 factors in the Marital Quality scale namely understanding, rejection, satisfaction, affection, despair, decision making, discontent, dissolution potential, dominance, self-disclosure, trust and role functioning with the number of items ranging from 1-9.

The Marital Quality Scale has 50 items in statement form; with a four point rating scale with responses as usually, sometimes, rarely and never. The scale has 28 positively worded items and 22 negatively worded items. The following 5 factors have only positively worded items. They are understanding, satisfaction, decision-making, trust and role functioning. Factors of rejection, despair, discontent, dissolution-potential and dominance have only negatively worded items. Factors of affection and self-disclosure consist of both positively and negatively worded items. The reliability and validity of the scale were already established by the author.

Scale Dimensions and Item numbers
1. Understanding: 21,30,31,37,38,47,48
2. Rejection: 2,3,5,11,15,18,34,10,44
3. Satisfaction: 4,9,10,12,27
4. Affection: 13,28,32,33,35,45
5. Despair: 14,41
Research Methodology

6. Decision-making: 1,8,16,17,46,50
7. Discontent: 19,20
8. Dissolution potential: 22
9. Dominance: 7,23
10. Self-disclosure: 25,26,6
11. Trust: 39
12. Role-functioning: 29,36,43,49.

The scoring for the Marital Quality Scale is as follows: For positively worded items i.e., 1, 4, 8, 9, 10, 12, 13, 16, 17, 21, 25, 26, 27, 28, 29, 30, 31, 36, 37, 38, 39, 42, 43, 46, 47, 48, 49 and 50, ‘Usually’ got a score of 1, ‘Sometimes’ a score of 2, ‘Rarely’ a score of 3 and ‘Never’ a score of 4. The reverse scoring was followed for the negatively worded items, i.e., 2, 3, 5, 6, 7, 11, 14, 15, 18, 19, 20, 22, 23, 24, 32, 33, 34, 35, 40, 41, 44 and 45. The total score is summation of score obtained on individual items.

Using the median test the researcher arrived at the cut-off scores for the present sample. A higher score indicates poor quality of marital life. If the total score is less than 117, the marital quality is classified as high marital quality and if the total score is 118 and above the marital quality is classified as low marital quality.

Table 8
Cut-off Scores for Marital Quality

<table>
<thead>
<tr>
<th>S. No</th>
<th>Dimensions of Marital Quality</th>
<th>Cut-off Score</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Understanding</td>
<td>Less than or equal to 13</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>14 and above</td>
<td>Low</td>
</tr>
<tr>
<td>2</td>
<td>Rejection</td>
<td>Less than or equal to 28</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>29 and above</td>
<td>Low</td>
</tr>
<tr>
<td>3</td>
<td>Satisfaction</td>
<td>Less than or equal to 8</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9 and above</td>
<td>Low</td>
</tr>
<tr>
<td>4</td>
<td>Affection</td>
<td>Less than or equal to 15</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>16 and above</td>
<td>Low</td>
</tr>
<tr>
<td>5</td>
<td>Despair</td>
<td>Less than or equal to 6</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>7 and above</td>
<td>Low</td>
</tr>
<tr>
<td>6</td>
<td>Decision Making</td>
<td>Less than or equal to 12</td>
<td>High</td>
</tr>
<tr>
<td></td>
<td></td>
<td>13 and above</td>
<td>Low</td>
</tr>
</tbody>
</table>
### Dimensions and Item numbers

1. Physical health satisfaction: 1, 2, 4, 5, 19
2. Social health satisfaction: 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 20.
3. Cognitive health satisfaction: 3, 6

---

In Indian setting the scale has been used in many studies like Aruna (1988), Philip (1991) and Hamza (1992) and found to be useful. The scale has been used in the present study to assess the family environment of the subjects.
With regard to the scoring of PQoL, Nineteen item scores and an overall score based on the mean or median of the 19 item scores are constructed. A population mean/median of 7.5 has been observed (n=3359). Interpretation of the measure in cross-sectional use is [< 7.5 score is Dissatisfied] and [>7.5 score is Satisfied]. Subscale scores of physical, social, and cognitive health satisfaction (denoted by P, S, and C accordingly) can be used in further analysis as well as the overall score.

Using the median test the researcher arrived at the cut-off scores for the present sample. A higher score indicates higher perceived quality of life. If the total score is less than 85, the perceived quality of life is classified as low perceived quality of life and if the total score is 86 and above the perceived quality of life is classified as high perceived quality of life.

**Table 9**

<table>
<thead>
<tr>
<th>S. No</th>
<th>Dimensions of Perceived Quality of Life</th>
<th>Cut-off Score</th>
<th>Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Physical Health Satisfaction</td>
<td>Less than or equal to 20</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>21 and above</td>
<td>High</td>
</tr>
<tr>
<td>2</td>
<td>Social Health Satisfaction</td>
<td>Less than or equal to 51</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>52 and above</td>
<td>High</td>
</tr>
<tr>
<td>3</td>
<td>Cognitive Health Dimension</td>
<td>Less than or equal to 8</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>9 and above</td>
<td>High</td>
</tr>
<tr>
<td>4</td>
<td>Overall PQoL</td>
<td>Less than or equal to 85</td>
<td>Low</td>
</tr>
<tr>
<td></td>
<td></td>
<td>86 and above</td>
<td>High</td>
</tr>
</tbody>
</table>

**RELIABILITY ANALYSIS**

The researcher applied the Cronbach’s alpha reliability test to establish the reliability of the scales with regard to the samples selected for the study. The reliability co-efficient of the scales was found to be reliable for both categories of respondents namely Wives of Alcoholics and Wives of Non-alcoholics to justify the choice of tools of data collection for the present study.
Table 10
Reliability Co-efficient of the Tools

<table>
<thead>
<tr>
<th>Tools Used</th>
<th>Wives of Alcoholics reliability (r)</th>
<th>Wives of Non-alcoholics reliability (r)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conflict tactics Scale 2 Short form (CTS2S)</td>
<td>0.870</td>
<td>0.731</td>
</tr>
<tr>
<td>Proactive Coping Inventory (PCI)</td>
<td>0.919</td>
<td>0.898</td>
</tr>
<tr>
<td>Family Interaction Pattern Scale (FIPS)</td>
<td>0.898</td>
<td>0.719</td>
</tr>
<tr>
<td>Marital Quality Scale (MQS)</td>
<td>0.937</td>
<td>0.916</td>
</tr>
<tr>
<td>Perceived Quality of life Scale (PQoL)</td>
<td>0.853</td>
<td>0.924</td>
</tr>
</tbody>
</table>

PILOT STUDY

This was carried out to assess the feasibility of the study, the availability of respondents and the prospects of collecting data. The selected de-addiction centres is funded by the State Social Welfare Board run by the leading NGO in Tiruchirappalli that is known as Khajamalai Ladies Association (KLA), was approached for the purpose and the study proposal was discussed with local authorities. It was found that, the centre received large number of patients on a regular basis, caters to the lower income classes and offers subsidized services to their clientele. The psychiatrists and counselors responsible for the services of this centre assured all co-operation in facilitating data collection from among their patients’. The areas of data collection were discussed and the instruments were scrutinized by them. Time was also spent at this centre to get acquainted with the staff there and to observe the daily schedule to get an idea of various de-addiction services being offered.

It was decided that on registration of a new patient and following his screening and diagnosis by the psychiatrist, his spouse would be evaluated for eligibility based on the inclusion criteria framed. The data collection set would then be administered to the spouse as part of the routine intake procedure of the agency. Moreover, since Saturdays are exclusively ear marked for family therapy and it is mandatory for the spouses of all in-patients to turn up at the centre on these days, it was decided that a lot of respondents could be contacted on these days.
PRE-TEST

Pre-test was done to check if the items in the instruments were adequately comprehended by the respondents. Suitable modifications were made to the socio-demographic schedule and all the instruments were administered to 30 Wives of Alcoholics and to an equal number of Wives of Non-alcoholics.

DATA COLLECTION PROCEDURE

SAMPLE I

Data collection with the study group was carried out at the de-addiction centre in Khajamalai Ladies Association (KLA), Tiruchirappalli. As soon as a patient was diagnosed by the Psychiatrist and registered as an in-patient, a preliminary screening was done to check if his spouse met the inclusion criteria of the study. Following this, the questionnaire was incorporated as part of the regular intake procedure of the agency.

Data was collected from the wife in the absence of the husband after assuring her that all information disclosed would be treated with confidentiality. Personal interviews were conducted with each respondent and the researcher clarified doubts regarding scale items and explained the modality of answering each scale. The exhaustive interview sessions took about an hour to one and half an hour for some respondents, while mostly data was collected in a single session, for some it was collected over two or three sessions, depending on their comfort and convenience.

SAMPLE II

Each Sample-I respondents provided two addresses of people known to them who had an approximately similar background as themselves. They were asked to identify people preferably from their own locality and it was emphasized that the husband should not be an alcohol user. Their concurrence was obtained for contacting these families for inclusion in the study and their assistance was sought to enable the initial contact.

Home visits were made to the addresses provided by each study group respondent. The initial contact in most cases was made with the husband. The couple was told that the study was about marital life in general and their co-operation was sought after assuring them of absolute confidentiality. The comparative nature of the study was not disclosed. During the first contact, the socio-economic and marital
particulars were collected along with information pertaining to the matching variables. The Alcohol Use Disorders Identification Test (AUDIT) was also administered to the husband of both families, the one which was more closely matched with the referrer Sample-I respondent on the matching variable was visited subsequently for data collection. Information pertaining to the scales used was collected from the wife in the absence of the husband. The entire data collection procedure for the control group was a cumbersome and time-consuming ordeal. The process that began in May 2007 could be completed only by the end of March 2008.

ANALYSIS OF DATA

Analysis of the collected data after coding was subjected to both basic and advanced statistical procedures. This was due to the data’s nature of involving both qualitative and quantitative variables. The SPSS (Statistical Package for Social Sciences) was used to analyze the data collected. Simple tables were prepared for the socio-demographic data. Statistical analysis was done to analyze the hypothesis and objectives of the study. Statistical techniques such as Mean, Standard deviation, Median, Chi-square, ‘z’ test, One-way analysis of variance and Karl Pearson’s Co-efficient of Correlation were applied to interpret the data to draw meaningful inferences.

The mean and standard deviation were used for the quantitative data such as age, respondents’ monthly income, family income, husbands’ income, duration of marriage and number of children. The ‘z’ test was used to find any statistical difference between the wives of alcoholics and the wives of non-alcoholics as well as with regard to their occupation and type of family. The Chi-square test was used to find out the association between variables namely the type of marriage, wives of alcoholics’ perception of husbands’ alcoholism with regard to the major study variables. The one-way analysis of variance was used to test the significance of difference between the respondents’ education as well as the respondents’ husbands’ occupation and major subject variables.

The Karl Pearson’s co-efficient of correlation was computed to find out the nature and intensity of relationship between the major study variables as well as to find out the relationship between the personal data (age, respondents’ monthly income, family income, duration of marriage and number of children) and the major variables. To present the data; tables, graphs and interpretations have been used.
DIFFICULTIES FACED BY THE RESEARCHER

The researcher encountered the following problems while undertaking the investigation, which are enumerated below:

1. Some respondents who agreed to participate in the study dropped out of the study due to various reasons as lack of time, unwilling to disclose as they found the items too personal etc.
2. Questionnaire given to the respondents were not completed on time.
3. Many clarifications were required and explanations of the items were done for those unable to understand certain items.

LIMITATIONS OF THE STUDY

The picture which may emerge from this effort is neither a comprehensive nor a complete profile of the wife of an alcoholic vis-à-vis her marital system. Moreover, the selection of these dimensions for investigation is not intended to emphasize their greater importance in relation to other dimensions of marital life. Further, it is not the endeavor of the researcher to establish whether the manifestation of these dimensions antedate the husband’s alcoholism and were pre-disposing factors.

Information related to the husband’s drinking and the marital life of the couples has been exclusively obtained from a monadic perspective-that of the wife. The absence of corroborative information gathered from the husband, therefore only reflects the wife’s perception on these issues.

The Locale of the study is restricted to one particular De-addiction centre, in Tiruchirappalli. Hence generalizations of the finding at the district level cannot be made.

The experimental sample is clinical in nature representing alcoholics and their spouses who having experienced the deleterious consequences of alcohol consumption were motivated to seek treatment. As such it may not be appropriate to generalize the findings to other non-clinical samples particularly to certain sections of the community and occupational groups where indulgence in alcohol is accepted as a routine part of daily life. Majority of the respondents interviewed were working wives and it would be more apt to take the findings of this study to be representative of this category of women.
Other than these few limitations, which emerge from the nature of the study sample, the large size of the study and control groups provide ample scope for drawing reliable inferences and for their generalization.

CHAPTERISATION
The thesis consists of five chapters. The format of the thesis is as follows:

Chapter I is the introduction, that has been written carefully to cover the theoretical background, conceptual understanding and all adequate information that needs to be conveyed so as to introduce the present topic of research work.

Chapter II highlights the review of the background literature and the abstracts of previous research findings, which has provided the baseline to proceed with this research work.

Chapter III describes the methodology, which is the backbone of the thesis, which depicts the method of study, description of the samples and sampling procedure, the tools used, the data collection procedures adopted and the statistical techniques used for data analysis.

Chapter IV discusses the analysis and interpretation of results, which stands as the brain for the research work that has been carried out.

Chapter V provides salient findings of the present study. The implications, social work intervention and suggestions for future study are also discussed in this chapter.