ALCOHOLISM : PERSONALITY, MARITAL ADJUSTMENT AND GENERAL WELLBEING OF SPOUSES

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DECLARATION

I, Malini K., do hereby declare that this thesis entitled **Alcoholism: Personality, Marital Adjustment and General Wellbeing of Spouses** has not been submitted by me for any award of degree or diploma in this or in any other University.

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CERTIFICATE

This is to certify that this thesis entitled **Alcoholism: Personality, Marital Adjustment and General Wellbeing of Spouses** is a record of bonafide study and research carried out by **Malini K.** under my supervision and guidance.

This research work has not been submitted by her for any award of degree or diploma in this or in any other university before. The thesis embodies the results of the investigation conducted during the period of her work as a Ph.D. scholar.

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ABBREVIATIONS

ALCH	-	Spouses of Alcoholics
NALCH	-	Spouses of Non alcoholics

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Alcoholism is one of the oldest universal problems of man. Alcohol has been part of Western Civilization for thousands of years. The use of alcohol in the form of beer and wine was prominent in early Egyptian and Mesopotamian civilizations more than 6,000 years ago. Alcohol remained as the most common psychoactive substance in the form of ale, beer or wine not just a social and recreational intoxicant but also a valued source of uncontaminated fluids and much needed calories (Jothaaker, 2003). Alcohol has been used for recreational, medicinal and ceremonial purposes for atleast ten thousand years (Sarason & Sarason, 2002).

In 1941 Bowman and Jellineck published an elaborate classification scheme for the disease. As cited by Sarasan & Sarasan (1996) Jellineck, often referred to as the father of the modern study of alcoholism, published the disease concept of alcoholism in which he stated that alcoholism is a permanent and inevitable condition and that alcoholics are essentially different from non alcoholics. In 1852 the term 'alcoholic' was coined by Magnus Huss in Sweden to describe people who suffered negative consequences of alcohol use (c.f. Kahn & Fawcett, 2004).

Today, Alcoholism is seen as the word's highly prevalent public health problem and therefore alcoholism is a matter of serious concern, not confined to any group, culture or country.

Drinking in India flourished during British rule and it rose to the status of legally recognised and respectable occupation enjoying official patronage. Our countrymen freed themselves from the anti-drink habit in the pre-colonial era and divulged into active drinking. Liquor became a menace and it posed serious threat to public health. In 1884 Bengal Commission, appointed to review excise policy, noticed increase in consumption and felt that primary cause might be the effect of social moral and religious changes relaxing the restrictions (Salim, 2006). Government of India have funded 483 de-toxification and 90 drug de-addiction programme to treat people with substance abuse disorders. Forty five percent people seeking treatment in de-addiction centres are for alcohol dependence.

Inspite of the numerous studies in India on this topic, factual information on the incidence and magnitude of the problem of alcoholism is not readily available. Due to the differences in sampling techniques, data collection and definition of the terms, results of these studies are not strictly comparable. Yet they are of great value in understanding the prevalence among the general population.

Recent review of epidemiological studies, 'Pattern and Problems of Alcoholism in India' by Isaac (1994) highlights the increasing prevalence of alcoholism, especially in the last decades. This is evident in the increase in the number of addicts seeking help from de-addiction centres. For instance the record of admission for the past 7 years in such a centre in Calicut is as shown in Table 1.1.

TABLE 1.1

Record of admission at Suraksha De addiction centre during 2000-2007

Sl. No.	Period	No. of cases registered
1	2000 – 01	524
2	2002 – 03	1251
3	2004 – 05	1264
4	2006 – 07 (March)	1582

According to the records of the Kerala State Excise Department the sales figures for the past 20 years is as shown in table 1.2.

TABLE 1.2

Kerala State Excise Department
Details of Arrack and IMFL (Indian made Foreign Liquor) Sales

Arrack and IMFL (Indian made Foreign Liquor) sales from 1986-87 to 2005-06 and revenue contribution

Year	Sales (Cases in lakhs)		Revenue contribution (Rupees in Crores)	
	Arrack	IMFL	Arrack	IMFL
1986 – 1987	24.23	12.09	70.93	40.07
1987 – 1988	26.50	12.56	82.86	40.11
1988 – 1989	24.10	9.99	101.70	57.25
1989 – 1990	26.56	14.66	111.48	78.33
1990 – 1991	16.80	15.43	110.84	92.07
1991 – 1992	15.35	16.78	133.44	112.59
1992 – 1993	17.63	18.30	130.50	133.45
1993 – 1994	20.75	23.77	187.91	179.73
1994 – 1995	26.14	24.61	172.04	224.03
1995 – 1996	75.14	32.62	250.37	302.00
1996 – 1997	--	32.42	--	611.19
1997 – 1998	--	57.25	--	753.48
1998 – 1999	--	52.95	--	847.56
1999 – 2000	--	64.52	--	898.89
2000 – 2001	--	72.09	--	1022.79
2001 – 2002	--	92.02	--	1310.17
2002 – 2003	--	97.08	--	1468.05
2003 – 2004	--	105.98	--	1621.51
2004 – 2005	--	108.92	--	1824.04
2005 – 2006	--	109.47	--	2055.71

(Courtesy, Jayaraj, CI Excise, Kozhikode)

In addition to this, data regarding the sales in Kozhikode district is as shown in table 1.3.

TABLE 1.3

Sale of IMFL (Indian made Foreign Liquor) in the District during 2006 (in crores)

		IMFL other than Beer	Beer
1	KSBC FL-1 Shops	88.86	7.43
2.	FL-III Bar	24.97	5.09
3.	Consumer Fed FL-1 Shops	29.80	2.03
4	KTDC	--	1.03
	Total	143.63	15.61

(Courtesy, Jayaraj, CI Excise, Kozhikode)

Moreover these records are excluding the sales of country made liquor and other types sold without proper records.

The information in Table 1.2 and 1.3 clearly indicates the seriousness of the problems in Kerala.

Definition of Alcoholism

The terms alcoholic and alcoholism have been subjected to some controversy and have been used differently by various groups in the past. From the time of its inception in 1948, WHO played a major role in formulating public health definitions of alcoholism, addiction and dependence through a series of expert committees.

The 1995 committee of experts on alcohol and alcoholism highlighted the importance of physical criteria describing 'alcoholism' as a chronic disease characterised by a fundamental disturbance of the nervous system which is manifested on a behavioural level by a state of physical dependence. The major forms of this dependence are either inability to stop drinking before drunkenness is achieved, or inability to abstain from drinking because of the appearance of withdrawal symptoms (Gelder, Lopez & Andereasen, 2000).

The American Medical Association (AMA) in 1956 passed a resolution officially recognizing alcoholism as a disease which defines it as an illness characterized by significant physiological, psychological or social dysfunction that is directly associated with persistent and excessive use of alcohol (Kahn and Fawcett, 2004).

The World Health Organization no longer recommends the term alcoholism but prefers the term alcohol dependence syndrome – "a state, psychic and usually also physical, 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 absence; tolerance may or may not be present" (Carson, Butcher and Mineka, 2004, p.4).

The DSM-IV, currently in general use, represents another approach to the definition of alcoholism, one more closely based on specifics than the

1992 committee definition. It defines alcohol dependence as, "maladaptive alcohol use with clinically significant impairment as manifested by at least three of the following within any one-year period; tolerance, withdrawal; taken in greater amounts or over longer time course than intended; desire or unsuccessful attempts to cut down or control use; great deal of time spent obtaining, using, or recovering from use; social, occupational, or recreational activities given up or reduced; continued use despite knowledge of physical or psychological sequence" (http:/www.Answers.com).

Current classifications of alcohol use disorders follow the USA based DSM IV and the European ICD 10. DSM IV defines substance dependence as a maladaptive pattern of substance use that leads to clinically significant impairment or distress (Epstein, 2001; Sarason & Sarason, 2002).

Stages of Alcoholism

Alcoholism is a chronic, progressive disease that manifests itself with symptoms that affect one physically, mentally, emotionally, spiritually and socially.

The process of becoming an addict was the focus of study for many researchers. The reports suggest two dimensions that develop simultaneously - Behavioural and Physiological. According to Leskinen (1999). There are four stages of alcoholism:

Pre-alcoholic stage: Most people in this stage are usually amazed how much they can drink. Symptoms of this first phase include drinking to provide relief from stress and mental fatigue or to relax; seeking more opportunities when drinking will occur; and a gradual development of increase in tolerance (use of more and more alcohol to get the same desired effects).

Early stage: In this second stage of the illness, the person may have alcohol induced blackouts. These are amnesia like periods that occur while drinking, when the person seems to be functionally normal but will later have no recall of some or all of what he or she said or did. Other symptoms include sneaking extra drinks before or during events; gulfing the first drink or two; and feeling of guilt.

Middle stage: This is a crucial phase for loss of control sets in. This is the inability to drink according to intention. Once the first drink is taken, the individual can no longer predict what will happen, even though the intention may have been to only have a few drinks. Other symptoms include drinking bolstered with excuses; grandiose and aggressive behaviour; persistent remorse, increasing in amount and frequency of drinking; failure of repeated attempts to control drinking, failed promises and resolutions to self and others, loss of interests, avoidance of family and friends, trouble with money and work, unreasonable resentments, problems with law; neglect of food and loss of will power; tremors and early morning drinks; decrease in alcohol

tolerance; needing less alcohol to feel the effect; and the beginning of physical deterioration.

Final stage: The fourth, final and late state of alcoholism is chronic. Until this point, the individual may have been successful in maintaining a job, but now drinking occurs earlier in the day and can go on all day. Symptoms in this stage include onset of lengthy intoxications, moral deterioration; impaired thinking; indefinable fears; obsession with drinking; and vague spiritual desires. A person may not develop all these symptoms or in this particular order, but there is continual loss of control. (http:/www.alaskawellness.com)

Effects of Alcoholism

Negative effects from the overuse of alcohol have been considered a serious problem for many years. Alcohol consumption and problems related to its excessive use vary from country to country, and in a particular country often from region to region (Sarason & Sarason, 2002).

Most of the studies on alcoholism in terms of its effects are in line with the definition in DSM IV which highlights the negative effects. Nevertheless, quite a few have referred to the health and psychosocial benefits (Heather, Peters & Stockwell, 2001; Walter, Dammann & Klapp, 2005). The focus of present study being the former the latter is not elaborated. Although some what artificial, it is helpful to classify alcohol-related problems of individuals

into physical, psychological and social categories. There is often considerable overlap between these three areas. The more severe the dependence, the greater the likelihood of problems of all three kinds.

The most common indication of intoxication are disturbance of perception, wakefulness, attention, thinking, judgement, motor behaviour, and interpersonal behaviour (Sarason & Sarason, 2002). Although individual characteristics have a major influence on person's response to a mood-or behaviour modifying substance, such substances do have certain general effects that are experienced by most people who use them.

Most of the researchers have classified the effects of alcoholism into two categories, short term and long term effects (Sarafino, 1998; Barlow & Durand, 1999; Sarason & Sarason, 2002).

Heather, Peters and Stockwell (2001) pointed out that the pains of alcohol include harm to physical health, psychological well-being, interpersonal relationships and wider social functioning, together with criminal, legal, occupational financial economic & spiritual varieties of harm.

Physical Effects of Alcoholism

Alcohol has been shown to adversely effect the Liver, the Pancreas, the Cardiovascular system to increase the risk of coronary artery disease and other cardiovascular diseases such as hypertension, cardiomyopathy, and

stroke. The immune system concerns of the upper airways, mouth, liver, endocrine system and also to cause neurologic disorders in both the alcoholic and in the fetus of female alcoholics (Laheg, 1995; Ottmanns & Emery, 1995; Peterson, 1996; Bootzin, Acocella & Alloy, 1998; Chunkapura, 1998; Schuckit, 2000; Epstein, 2001; Sarason & Sarason, 2002). Risk for breast cancer in women is reported by Schuckit (2000); Izevbigie (2005).

Kaplan and Sadock (1988); Carson, Butcher and Mimeka (2004) found significant structural changes in the left hemisphere of the brains of chronic alcoholics. Similar observations have been reported by a few others also (Laheg, 1995; Peterson, 1996; Bootzin, Acocella & Alloy, 1998; Rosenzweig, Breedlove & Leiman, 2002).

Sustained use of alcohol can damage nerve cells. Disruption in brain function and a release of inhibitions on emotions and impulses normally held in check is reported by a few others (Bootzin, Acocella & Alloy, 1998; Peterson, 1996; Sadock & Sadock, 2003).

Memory problems are common in heavy drinkers, and the occurrence of memory blackouts is associated with brain impairment from alcohol (Carson, Butcher and Mineka, 2004; Epstein, 2001; Helgeson, 2005).

The direct effects of alcohol include menstrual irregularities, feelings of sexuality, and possible effects on a developing fetus (Chambers, 2005). Men can develop decreased sperm production and mobility through the direct

effects of ethanol on the testes with decreased ejaculate volume, sperm count, and sperm motility and impotence (Sarafino, 1998; Schuckit, 2000).

Through direct effects as well as interference with immune functioning, heavy doses of alcohol appear to increase the risk for psychosomatic disorders affecting various organ systems (Ottmanns & Emery, 1995; Schuckit, 2000).

Bootzin, Acocella & Alloy (1993); Ottmanns and Emery (1995); Laheg (1995) reported that sensory and motor performance are noticeably impaired. They also stated that alcohol has direct harmful effects on the liver, brain and circulatory system and as a result the life span of the addicted alcoholics is 12 years shorter than average.

In the gastrointestinal tract the major diseases like Oesophagitis, Gastritis, Gastric Ulcer, Pancreatitis are caused (Chunkapura, 1988; Bajaj, 2006). Anaemia is caused by destruction of RBC and also due to iron deficiency. Mild jaundice is caused due to liver damage and RBC damage. Alcohol interferes with the absorption, storage, or distribution of a number of essential vitamins (Schuckit, 2000). Alcohol abuse also appears to inhibit the intestine's capacity to absorb various nutrients, such as vitamins and amino acids. Along with poor dietary habits of those with alcohol-related disorders can cause serious vitamin deficiencies, particularly of the B vitamins (Sadock & Sadock, 2003) and malnutrition (Estruch, Sacanella, Sola & Nicolas, 2005).

Fewer than 1% of people with alcoholism develop permanent incoordination, and other more dramatic but even rarer neurological disorders that can result in rapid death (Schuckit, 2000).

All these evidences strongly reveal the devastating effects of alcohol on the bodily functions. In addition to what alcohol does to the body, its role in behavioural maladaptation is also powerful. Among people with alcohol disorders, other mental diseases like psychosis, depression and anxiety and antisocial personality disorders are more prevalent (Sarason and Sarason, 1996; Benegal, Murthy, Shantala & Janakiramaih, 2001). Specific problems such as alcohol withdrawal delerium and Korsakoff's psychosis as caused by excessive drinking were also reported (Bootzin, Acocella & Alloy, 1993; Ottmanns & Emery, 1995; Peterson, 1996; Schuckit, 2000; Carson, Butcher & Mineka, 2004; Sarason & Sarason, 2002; Kalat, 2004).

Psycho Social Effects of Alcoholism

Alcohol intake has a number of important emotional consequences. Most people experience sadness, anxiety, irritability and a whole host of resulting interpersonal problems. At persistent higher doses, alcohol can cause almost any psychiatric symptom, including temporary pictures of intense sadness, auditory hallucinations, insomnia and paranoia in the presence of clear thought processes and intense anxiety.

Behavioural disorders most commonly associated with alcohol use problems and dependence include depression, anxiety and antisocial personality in community (Epstein, 2001; Palaksha, 2003; Kazdin, 2000; Roesch 2004; Bajaj, 2006).

Vanshree and Haridas (2003) reveal in their study that 75% of Patients had psychiatric comorbidity, and are more likely to be associated with schizophrenia. Even low levels of alcohol in the blood stream can significantly impair driving ability (Bootzin, Acocella & Alloy, 1993; Laheg, 1995; Baron, 2001).

In addition to adverse effects on physical health and appearance, chronic alcohol misuse involves a series of negative psychosocial effects which include legal problems, social consequences, damage to relationships, financial problems and emotional loneliness and social isolation on the part of the alcoholic (Walter, Dammann & Klapp, 2005).

Many report that alcoholic individuals are at high risk for suicide (Porteinsson *et al.,* 1997; Sadock and Sadock, 2003; Deshpande, Chauhan & Kar, 2003; Roesch, 2004; Lunetta & Smith, 2005; Sher, 2006). Chunkapura (1988) stated that the dangerous symptoms of alcoholic hallucinosis may cause suicide or homicide.

An excessive use of alcohol becomes counterproductive, however resulting in lowered feelings of adequacy and worth, impaired reasoning and

judgement and general personality deterioration. Behaviour typically becomes coarse and inappropriate, and the drinker assumes increasingly less responsibility, loses pride in personal appearance, neglects spouse and family and becomes generally touchy, irritable and unwilling to discuss the problem. As judgement becomes impaired, an excessive drinker may be unable to hold a job and generally becomes unqualified to cope with new demands that arise. General personality disorganization and deterioration may be reflected in loss of employment and marital break up. Chronic alcohol consumption may result in psychotic disorder most commonly with hallucinatory features (Carson, Butcher & Mineka, 2004).

Alcohol dependent individuals have scored significantly higher on the neuroticism and psychoticism dimensions. They are significantly more emotional, frequently anxious and/or depressed, moody, tense, with irrational ideas and guilt feelings. They are also characterized by low self esteem and shyness. In addition, they are significantly more aggressive, impulsive and antisocial with a tendency to be egocentric and tough minded. Further they are frequently cold, unempathic and impersonal in interpersonal relationships as compared to normal husbands (Pande, 1987; Suman & Nagalakshmi, 1993).

Ottmanns and Emery (1995), Laheg (1995) in their studies found that there is strong association between crime and alcohol use. Alcohol

consumption intensifies violence and aggression in predisposing situations, such as provocation (Sadock & Sadock, 2003; Fillmore & Sprott, 2006). Job loss, imprisonment, marital and family break up have been reported due to severe alcoholic use. Drunk driving has profound effects on the wellbeing of the drinker, their family and society (Nutt & Law, 2003).

It is impossible to measure the extend of damage done to society at large as a result of alcohol dependence and abuse. Most of the economic loss is concentrated in three areas: decreased work productivity, health problems and motor vehicle accidents (Fabbri, Marchesini & Vandelli, 2005; Bajaj, 2006). Workers with drinking problems are slower and less efficient, lose time on the job, make hasty decisions, cause accidents, and lower the morale of their co-workers. Furthermore, they are more likely to become prematurely disabled and to die young. Alcohol contributes to the incidence of physical assault and sexual offenses (Bootzin, Acocella & Alloy, 1993; Peterson, 1996).

Alcohol can worsen negative moods, particularly deepening depression and making it more likely that anger will result in verbal or physiological aggression. Heavy drinking can affect job performance, disrupt marriages, Alcohol abuse frequently leads to highly stressful consequences such as divorce and loss of employment (Laheg, 1995). According to Trethowan (1979) in cases of assault such as wife or baby-battering, drunkenness more

often, than not, plays an important part (Sreedevi, Gangadharaiah and Benegal, 2003). Murphy, Winters and O'Farell et al. (2005) also found that alcoholism and substance abuse are closely related to domestic violence.

Throwe (1986) discusses alcoholism as a multifaceted affliction that directly affects the family as a total unit and each member as an interacting individual of that system. Four prevalent problems shared by alcoholic families include altered communication patterns, role difficulties, poor sexual interaction and aggressive behaviours.

Thus alcoholism/alcohol dependence is a multifaceted problem that affects not only the individual but the entire community or nation. Therefore it is imperative to understand and tackle the consequences at various levels for helping the alcoholic and for minimising the damages.

Alcohol and Family

Alcohol consumption is increasing in the world and there is some evidence that the increase is soon accelerating most sharply in developing countries (WHO, 2002).

Although alcoholism is primarily a problem of the individual, studies have explored the dynamics of family interaction and alcoholism. There has been much speculation about the effects of the family on alcoholism. The personality structure of the spouses of alcoholics has been the focus of many

early studies. Based on psychoanalytic concepts the disturbed personality hypothesis was introduced in the 1980s to explain alcoholism in the male on the basis of neurotic conflicts of the spouse. Those studies attempt to study dependency, dominance, inter-personal perception and several measures of psychopathology which produced conflicting results (Drewery & Rae, 1969; Kogan, Fordyce & Jackson, 1973; Lanyon, 1973; Paulino & McCrady, 1977). A variant of the disturbed personality hypothesis is the decompensation hypothesis which states that the spouse of an alcoholic will decompensate and successfully becomes sober.

Three decades ago, Jackson proposed a sociological stress theory, which changed the focus from individual psychopathology to family interaction and role functioning in the family unit (Jackson, 1962). In this model alcoholism in a family member was seen as stressful experience, resulting in redefinition of family roles with the spouse taking over responsibility and control as a way to cope with the unpredictable behaviour of the alcoholic family member. The process of the family members coping with stress put on them by the alcoholic was described in five stages of family disorganization (i) denial of the drinking problem by all family members (ii) disorganisation of family relationships (iii) attempts at reorganisation of family roles including the alcoholic (iv) separation from the alcoholic and (v) reorganisation of the partial family systems or in the case of successful

rehabilitation of the alcoholic-reorganisation of the complete family unit as a dry system.

With special reference to marriage partners Leskinen had described six stages that they pass through in dealing with the chaos and disruption caused by the alcoholic which appear in the order as follows: Denial, attempts to eliminate the problem, disorganization and chaos; Reorganization inspite of the problem, efforts to escape and family reorganization. It is pointed out that during the second and third stage the non alcoholic spouse and children are likely to experience intense stress that may trigger and make the problems perceptible (http:/www.alaskawellness.com).

According to Carson, Butcher and Mineka (2004) excessive drinking often begins during crisis periods in marital or other intimate personal relationships, particularly crises that lead to hurt and self-devaluation Suman and Nagalakshmi (1977) pointed out that as the pressure increases the chances of the family disintegrating become very real. This accounts for the increased incidence of dissolution of the marital relationship in alcoholic family in forms of separation or divorce. Alcoholics having unhealthy marital relationship was reported in many studies (Drewery & Rae, 1969).

As it is evident, life seems very challenging for the spouses of alcoholics. They are forced to adjust in order to cope with the stress and handling a person who is physically affected, difficulty in maintaining

interpersonal relation creates challenges to spouses. As spouses interaction is inevitable, the person who is facing the problems of the alcoholics next to the person himself is the spouse. There are mainly two tasks for the spouse. First is to help the alcoholic in maintaining day to day relationship and secondly to assist the alcoholic to gain confidence and to be more independent by extending more social support. To interact and to maintain harmony with the alcoholic in the family and outside is highly stressful which demands more effective coping.

When a family member becomes addicted to alcohol, the entire family system is affected. Sheikh and Flanagan (2001) reported that among other negative consequences, spousal or parental alcoholism is associated with other family member's depression. This finding emphasises the need to look into and ensure the mental health of the family members of alcoholics. The alcoholic having serious physical problems, is psychologically dependent, less confident, irritable having adjustment problems in almost all areas of life, and thus the characteristics of the situation to which the spouse has to cope is highly challenging.

Woman in Marriage and Family

'Gender' is an area of interest to researchers for the past several decades. The general assumption of subordination of women to men has been the primary focus that is challenged by the feminist tradition. At the same

time, there are quite a number of theories and reports suggesting gender differences without fixing either any one gender as the model or criteria. The differences could be put under these categories: Physical, psychological and the sociological.

The very status of womanhood, across cultures, is inextricably related to marriage and family. For understanding woman in the context of marriage and family the psychological and sociological dimensions have a greater share. Usually the sociological dimension presupposes the other two which challenges or pressurises even the psychological existence.

Ancient Hindu scriptures describe woman as a wife who enjoyed a status almost equally to that of her husband performing social as well as biological functions and had been provided with religiously sanctioned high status. 'She was the half of man, the best of his friends, the source of his well being, wealth and happiness, the root of the family and of its' perpetuity" (Jain, 1988, p.74).

The author also opined that since late Vedic period, with the introduction of Manusmriti and Brahminical dominance position of woman got deteriorated which got further eroded under Mughal and English rulers.

Historically, the Indian system depicts marriage as a holy sacrament in which man and woman get into a life long relationship of oneness that include the physical, psychological and spiritual dimensions.

Universally marriage is one of the most intimate and socially recognised interpersonal domains. In marriage two people share their present life, their future, and their past. This element of commitment to a permanent union of lives distinguish marriage from other relationships that may temporarily meet the needs of two people. The resulting personal confidence, even security, contributes to an ability and a willingness to work to create a successful marriage. By marrying, individuals change status permanently, even if the marriage should later be broken. The couple become a new family unit. They now have legal, emotional, financial and other responsibilities toward each other.

Marriage provides a person an opportunity for a secure and protected satisfaction of his needs for companionship, affection and sexual expression. It involves the most intimate type of emotional relationship between two individuals (Coleman, Morris & Glaros, 1987). Many marriages suffer because the two partners fail to develop a relationship which is characterized by mutual acceptance, trust, care, concern, love, admiration and sharing of role responsibilities. The success in marriage is said to depend partly on finding the right person (Ruch, 1970). But the mere fact that two persons are suited to each other does not guarantee that they will make a successful marriage. Ruch rightly says that being the right person is more a matter of becoming the right person. This implies considerable change in their personalities they bring with them at the time of marriage. In short, a good

marriage does not simply happen, it has to be worked out (Stone and Stone, 1967).

Many things affect the quality of the relationship within a marriage. The personality traits of the husband and wife and their family backgrounds are major factors. A successful marriage will provide a healthy emotional climate for any child who is born to the couple. Through children, martial happiness is extended and perpetuated.

Marriage provides one with a sense of identity, a source of self esteem, and a companion to share activities, all of which should promote a positive psychological state. Marriage also may promote good health behaviour, decrease risk behaviour and promote early detection of disease. These effects of marriage on health are referred to as direct effects or main effects (Helgeson, 2005). In each case, marriage is directly linked to a psychological state or behaviour that influences health.

Certain developmental tasks confront all married couples, which differ at each of the four or five stages of the married life cycle.

(1) In early marriage (2) after children come (3) in middle life after the children leave home (4) after retirement time comes (5) when crisis occur, such as death, serious illness or financial disaster.

The specific areas which necessitates adjustability and co-operation are: sexual relations, money matters, religion, social activities and recreation, in-law relationships; associating with friends individually or as a couple; and after children come; their training and discipline (Dallos & McLaughlin, 1997).

According to Parsons and Bales (1956) since the nineteenth century, the burden of sorting out the family problems has fallen increasingly on the women in families. Women came to be seen as not only responsible for nurturance of the children but for the management of all relationships and feelings. This responsibility is predicted on the assumption or discourse of natural differences between men and women with women being regarded as naturally more nurturing, caring and sensitive (c.f. Dallos & Mc Laughlin, 1993).

On the other hand, women were largely responsible for providing a decent home and ensuring that their husbands were satisfied and happy. This could be interpreted to mean that women were expected to 'service' their husbands domestically and sexually (Jeffreys, 1990). It could also be interpreted to mean that because of their greater sensitivity, women were better at working out ways of conflicts than men.

It was often assumed that a drunken, violent husband was a result of the wife's sluttish immorality. She therefore deserved the beatings she

received which only symbolized her failure as a woman and virtuous wife. The image of the ideal women constructed largely by the middle classes, was a woman who kept the house clean and comfortable for her man to come home to. She was seen as non sexual, non-aggressive in contrast to the view of men who were seen as essentially driven by and unable to control these impulses. Within this discourse women in the nineteenth century were regarded as being morally superior to man and therefore generally better able to sort out "family matters" (Dallos & Mc Laughlin, 1993).

In most situations involving human relationships, elements of conflict are present. Marriage is no different from other relationships in this respect. Whenever two or more people attempt to live harmoniously together adjustments must be made. One person who is selfish and demanding or thoughtless and inconsiderate of the rights of others can create constant friction and unpleasantness. In marriage people are inclined to take their differences more seriously and to project themselves into controversial issues because they feel they belong to each other. They cannot go their separate ways and avoid differences so easily as can room-mates. In addition, the marriage relationship involves sex, which plays an important part in determining levels and types of interactions. The sexual part of their interaction may serve as a strong bond that holds husband and wife together and aids them in working out points of difference, or points of friction so that

they react more emotionally in all other areas requiring adjustability (Landis & Landis, 1977).

An alternative hypothesis is that marriage indirectly affects health by providing resources to cope with stress. These effects are referred to as buffering effects; marriage is buffering one against the negative effects of stressors (Cohen & Wills, 1985). During times of stress, marriage may help us perceive a stressful event as less troublesome and may provide resources to cope with stress.

According to Walter, Style and Hughes (1990) the housewife role is inherently frustrating, lacks status, structure, and recognition because "accomplishments" often go unnoticed. They argue that the lack of structure in the housewife role left women with time to ruminate about their problems.

It is not only the women's perception of her marriage that influences her health, but her husbands perception of the marriage also affects her well being (Whiffen and Gotlab, 1989) examined couples in which the husband, the wife, both or neither was dissatisfied with the marriage the results of which suggest that husband's marital satisfaction influences wives well-being more than wives marital satisfaction influence husband's well-being. Another study by Quiroculted and Gold found that husband's marital satisfaction, psychological well-being, and physical health all were associated with wive's psychological well-being, but characteristics of wives were not associated with husbands well-being (c.f. Helgeson, 2005).

Mc Cubbin and Mc Cubbin found that a family crisis is a turning point in the course of family living that requires members to change how they have been thinking and acting (c.f. Lamanna & Riedmann, 2003). They also cited another study which, reported that families whose members choose to be flexible in roles and leadership meet crisis creatively. A family can be stressed not just by one serious, chronic problem but also by a series of large or small, related or unrelated stressors that build on one another too rapidly for the family members to cope effectively.

Although there exist certain cultural differences in the roles, perceptions and attitudes toward marriage and family, it is imperative that the oriental health and coping skills of each member of the family, especially of the spouses, have a significant bearing on the maintenance and progress of the unit as a whole to the extent that the quality is to influence the future generations also.

Marital Adjustment

Adjustment refers to the psychological process through which people manage or cope with the demands and challenges of every day life (Weiten & Lloyd, 2003).

There are predictable patterns of development for families, just as there are life cycle, and orderly sequence of developmental stages that families tend to progress through. The institution of marriage and family are inevitably

intertwined. With the advent of marriage, two persons add a new member to their existing families, create an entirely new family. Typically, this new family forms the core of one's life as an adult.

Marriage is a socially recognized and approved union between individuals who commit to one another with the expectation of a lasting and stable intimate relationship. The initiation, development and maintenance of the relationship vary for each individual and couple. It involves the interpersonal processes that include cognition, affect, physiology, behavioural patterns, social support and violence (Fincham & Bradbury, 1993).

Quality of marital life is determined, to a large extent, by the satisfaction available in the marital relationship, specific aspects of marital relationship which contribute to marital satisfaction include companionship, love, emotional well-being, understanding, problem solving and supportiveness (Fincham & Bradbury, 1993).

One of the clearest findings in sociological studies of stress and social support is the beneficial impact of marriage on health and wellbeing. Studies uniformly show that compared to the unmarried, married people have less morbidity, mortality, mental illness, substance abuse and distress (Umberson, 1987). Marriage directly contributes to mental and physical health, serves as a buffer when stressful life events emerge and is a source of long term support for people undergoing chronic strain (Stanley, 1976). Earlier, it was believed

that probably healthier people get married, and people with poor mental health do not get married, and thus the gap in the status of mental health between married and unmarried people. However, longitudinal studies indicate that the selection of healthier people into marriage does not account for the health and mental health advantages of married people as compared to unmarried people (Horowitz, Mc Laughlin & White, 1997). The benefits of marriage persumably stem from the enhanced feelings of social support, belonging and attachment that are related to higher states of well-being among the married. Married people also have more satisfying intimate relationships which are associated with well-being.

To optimize the positive effects of marriage, marital adjustment is a key determinant. Marital adjustment requires adjustment in specific areas.

1. *Adjustment of the spouse*: Every man or woman builds up an image of an ideal spouse during adolescence or later, and he or she has to adjust with the real partner keeping the expectations related to that ideal in mind: if the expectations are fulfilled adjustment becomes easier; similarity of background ensures adjustment to the spouse, and in India, while negotiating a marriage, much importance is given to this factor; a realistic concept about the roles of husband and wife may lead to better adjustment.

2. *Sexual adjustment*: It has been found that sexual adjustment tends to be more difficult for women to make, and the end result is less satisfactory for men. The reason has been attributed to the process of socialization by inhibition or repression of sexuality in women from childhood. Some other factors influencing sexual adjustment are attitudes towards sex, premarital sex experiences, degree of sexual desire.

3. *Financial adjustment*: Today the incompatibility between financial resources of a family and the aspirational level of the spouses regarding their economic status is a source of financial maladjustment. Both the partners have either to reshape their life style according to the financial means or indulge in resentment, dispute, conflict etc. Financial adjustment is also a dynamic adjustment pattern, as new needs may arise at any stage and financial aspirations may change.

4. *In-law adjustment*: In Indian culture, this seems to be highly important because the number of extended families is appreciably large. Some important factors that influence the adjustment to in-laws are (i) stereotypes of typical mother-in-law or daughter in law (ii) desire of independence (iii) family cohesiveness (iv) care of aging persons and (v) financial support of in-laws.

5. *Adjustment to parenthood*: This is an important transition to maturity and responsibility. According to the sociological model, parenthood needs special adjustment when individuals transit from ego-centered to family centered adjustment.

Marital adjustment contributes to marital satisfaction which is another determining factor for continuance of marriage. Dissatisfaction with any domain of life experience is produced by the difference between an individual's perceived reality of the current situation and his/her aspirations connecting the domain. Berger and Kellner (1970) in "Marriage and the construction of reality", define the process in which individuals aspirations and perceptions of reality are constituted, as 'conservation'. It is in this way that marital satisfaction may be viewed as a socially constructed reality, created by the partners to the marriage. That reality is sustained by being embodied in routines, by being reaffirmed in interactions with significant others, by 'conservation' that modifies, and by a set of plausibility structures (Rhyne, 1981).

Another important factor leading to stability and continuance of marriage is commitment. Marital commitment is distinct from global commitment and concerns the partners perceptions of the likelihood that they will form and maintain marriage to a particular partner.

According to the investment model of commitment, proposed by Rusbult (1983), three categories of variables are said to enhance commitment.

a. Individuals become more strongly committed in so far as satisfaction level is high. Satisfaction is greater to the extent that the outcomes resulting from involvement are good and comparison level is low.

b. Commitment is argued to be influenced by comparison level of alternatives, defined as the perceived desirability and availability of alternatives. Outcomes obtained in the current relationship are compared to anticipated outcomes in the best alternative option (Canary & Stafford, 1994).

c. The third class of variable is said to be the investment size, which is said to shape commitment. Invested resources presumably enhance commitment because the acts of investment serves as a powerful psychological inducement to persist and as the cost of ending a relationship.

Lund (1985) measured commitment in terms of the likely permanence of the relationship. In the most general sense, commitment concerns partner's beliefs about whether the relationship is likely to continue over a long run. Johnson (1991), differentiated between personal commitment, defined as "an individual's dedication to the maintenance of a line of action" and structural commitment as "external restraints that make it difficult to disengage oneself

should one's sense of personal commitment decline". Johnson also conceptualized of moral commitment, the sense that one is morally obliged to continue a relationship.

Johnson, Caughlin and Huston (1999) included another type of commitment to Johnson's original conception of moral commitment. It is a function of three components.

(i) A relationship-type obligation refers to values concerning the morality of the dissolution of particular types of relationships.

(ii) One might feel a personal moral obligation to another person.

(iii) One might feel obligated to continue a particular relationship because one believes in being generally consistent.

Canary and Stafford (1994), studied the behavioural characteristics of the committed partners and reported that commitment appears to exert general effects on behaviour, in that committed individuals also enact diverse relationship maintenance behaviours. For example, highly committed individuals exhibit greater (i) willingness to accommodate rather than retaliate when a partner behaves poorly (ii) tendencies to derogate tempting alternative partners (iii) willingness to sacrifice immediate self-interest for the good of the relationship and (iv) inclinations to perceive their relationship as superior.

Rusbult, Verette, Whitney, Slovik and Lipkus (1991) examined accommodative process in commitment, based on research on Rusbult's 'exit-voice-loyalty neglect' typology of responses to dissatisfaction in close relationships. 'Exit' refers to actively destroying the relationship, moving out of the residence, abusing the spouse etc. 'Voice' refers to actively and constructively attempting to improve conditions, example - discussing problems, changing oneself. 'Loyalty' refers to passively but optimistically waiting for conditions to improve, example - praying for improvement. 'Neglect' refers to passively allowing one's relationship to deteriorate, example - avoiding discussing problems, ignoring the spouse etc. The responses differ along two dimensions: constructiveness versus destructiveness and activity versus passivity. Voice and loyalty are constructive responses; exit and neglect are relatively more destructive. Previous research has demonstrated that the four response are influenced by numerous qualities of relationships and of individuals. It has also examined the adaptive value of the responses, exploring their link with distress and non-distress in couple relationships and found that variations in destructive responses are substantially correlated with couple distress/no-distress, whereas variations in constructive responses are only weakly related to couple functioning (Rusbult, Johnson & Morrow, 1986).

Wieselquist, Rusbult, Foster and Agnew (1999) linked interpersonal trust with commitment. Trust is said to include three components, i.e., of (a)

predictability, or, belief that the partner's behaviour is consistent; (b) dependability, or belief that he partner can be counted on to be honest, reliable, and benevolent and (c) faith, or conviction that the partner is intrinsically motivated to be responsive and caring-belief that the partner's motives go beyond instrumental bases for benevolence. Commitment and trust go hand-in-hand, and they constantly get influenced by each other.

Commitment has been implicated as an important factor in the stability or dissolution of a marriage. Heaton and Albrecht (1991) found that marital duration and commitment to the relationship were important factors in the stability of unhappy marriages. The interaction of many years in a relationship contribute somewhat to its stability, even if not to its satisfaction. Belief and attitudinal patterns also seem to be quite important. The belief that marriage is a life time commitment contributes to its stability.

Even in the most extreme cases of battered women; Strube and Barbour (1983) found that both economic dependence and commitment to the relationship were independently and significantly related to decisions to leave/ stay in an abusive relationship. This shows another important face of marriage, i.e., the relationship between negative impact of a distressing marriage on the well-being of individuals and vice versa. All social relationships involve both wanted and unwanted demands, conflicts and gratification, irritation and pleasure. The intensity and importance of intimate

relationships exacerbate the negative and demanding, as well as the positive and rewarding side of human interaction. The conflictual critical and controlling aspects of relationship with spouses should have an especially powerful impact on mental health because they stem from important and valued social ties. Moreover, spouses cannot easily terminate their relationships, their negative behaviours are likely to be reciprocated or escalate. These types of relationships may have negative aspects and these negative aspects may have strong detrimental effects on mental health of concerned partners.

Poor mental health can be a cause as well as consequence of a distressing marriage. The link between depression and interpersonal relationship has received considerable theoretical and empirical attention. Some causal structures have been proposed. First, interpersonal discord could precipitate or maintain a depressive episode. Second, an episode of depression could lead to marital discord. Few studies support the second model i.e., that depression has a negative impact on intimate relationships. Nelson and Beach (1990) report that the depressed individual's self critical comments can be frustrating to a spouse or family member, who may consequently treat the depressed individual in a negative or rejecting manner. The depressed person, perceiving this hostility, may in turn, become more depressed, potentiating a vicious circle. Mathews, Wickrama and Conger (1996) on examining the relationship between quality of marital interaction

and marital instability, found that, couples who were observed to exhibit high level of hostile, angry, critical, stubborn, inconsiderate, defiant or rejecting behaviour, which has not counter balanced by considerate, co-operative or affectionate behaviour, were more likely to perceive high levels of hostility in their marital interactions.

Gender differences has also been pointed out through studies. Heim and Snyder (1991) in their study to examine the interaction between marital distress and Spouse's attributions, found that 55% of the variance in wive's depression was accounted for by relationship variables, in contrast to only 32% for husbands. Fujita, Diener and Sandvik (1991) in their study on gender differences in negative affect and wellbeing, also found that depression findings of more negative affect in women do not conflict with well-being findings of equal happiness across gender. Generally, women's more intense positive emotions balance their higher negative affect.

Chandwick, Albrecht and Kunz (1976), conceptualized material satisfaction as both a global measure of marital happiness and as a specific measure of satisfaction from participation in specific family role activities. Adequacy of role performance of both self and spouse and spouse's conformity to expectations emerged as the strongest predictors of satisfaction derived from playing family roles.

Thus, marital adjustment is probably the most complex component that contributes to mental health and well-being for an adult of either sex.

Coping Mechanisms in Marital Adjustment

'Coping' has been a focus of research in the social sciences for more than three decades. Many investigators undertook this research with the hope that the concept of coping might help explain why some individuals fare better than others do when encountering stress in their lives.

Coping is defined as constantly changing cognitive and behavioural efforts to manage specific external for internal demands that are appraised as taxing or exceeding the resources of the person (Lazarus & Folkman, 1984).

Individuals, however, do not passively experience hardships and difficulties. They may actively try to avoid being harmed by life-strains (Pearlin & Schooler, 1978). The existence of stress, as measured through stressful life events, may therefore be less important than how an individual appraises and copes with it (Antonovosky, 1979; Lazarus, 1981). The last two decades has been a shift in focus from the area of stress to the concept of coping.

Weber (1997) proposed two main reasons for the steady and ever increasing interest in coping. Firstly, the need to understand and analyse how people manage their lives despite adversity and secondly, the flexibility and

adaptability of the concept of coping which provides a very broad and useful frame for analysing behaviour. Lazarus & Folkman opined that theoretically contextual cognitive model of coping explains the phenomenon comprehensively. According to this, coping is a process that unfolds in the context of a situation or condition that is appraised as personally significant and as taxing or exceeding the individual's resources for coping (Lazarus and Folkman, 1984). The coping is initiated in response to the individual's appraisal that important goals have been harmed, lost or threatened. These appraisals are characterized by negative emotions that are often intense. Coping responses are thus initiated in an emotional environment, and often one of the first coping tasks is to down – regulate negative emotions that are stressful in and of themselves and may be interfering with instrumental forms of coping. Emotions continue to be integral to the coping process throughout a stressful encounter, as an outcome of coping, as a response to new information, and as a result of reappraisals of the status of the encounter. If the encounter has a successful resolution positive emotions will pre dominate. If the resolution is unclear or unfavourable, negative emotions will pre dominate (Folkman & Moskowitz, 2004).

People cope with stress in many ways. A number of researchers have attempted to identify and classify the various coping techniques or strategies that people use in dealing with stress. Their work reveals quite a variety of coping strategies. For instance, in a study McCrae (1986) identified 28

coping techniques. Carver, Scheier & Weintraub (1989) grouped coping tactics into 14 categories. Thus in grapping with stress, people select their coping tactics from a large and varied menu of options.

Folkman and Lazarus (1980) refers to two broad categories of coping with stress: problem focused and emotion focused strategies. A cited by Weiten, Lloyd (2003) in problem focused coping individuals attempt to lower their levels of stress by altering or confronting the situation head on. In emotion focused coping individuals attempt to lower their levels of stress by changing the way they view the stressor. Endler and Parker (1990) commended "if there is a consensus in the coping literature use, it is the important distinction between emotion focused and problem focused coping" (p.845). "Several researchers used this distinction, and others have expanded on it, adding appraisal focused coping" or hypothesizing that coping can regulate behaviour, emotion, or attention (c.f. Skinner, Edge, Altman & Sherwood, 2003). Folkman & Lazarus (1980) observed that in most situations, a combination of both these types of coping are used, rather than any one of them to the exclusion of the other.

Another conceptual approach to the coping literature has been to divide coping into approach Vs avoidant activities (Suls & Fletcher, 1985; Roth & Cohen, 1986). Approach and avoidance coping are types of cognitive and emotional activity that are oriented either towards or away from threat.

Approach strategies allow for appropriate action and for ventilation of affect. Avoidant strategies, on the other hand, seem useful in reducing stress.

Further distinctions of coping behaviours hence proposed a typology consisting of active behavioural, avoidance and active cognitive coping. More specific variants of this distinction have been captured by other terms, such as sensitisation Vs repression; monitoring Vs blunting; vigilance versus avoidance and engagement Vs disengagement coping (Roth and Cohen, 1986).

The most important set of higher order distinctions are ones that contribute to the identification of action types. In this context, action doesn't refer to its common language usage as a synonym for behaviour. Instead, it refers to the notion of "action schema" from the long European theoretical tradition of action theories. Compared with behaviour, action is a more complex construct. It incorporates not only behaviour but also requires simultaneous consideration of individual's emotions, attention and goals (Skinner, Edge, Altman & Sherwood (2003).

Within the field of coping, the most common distinction between action types is primary Vs secondary control or assimilation and accommodation.

Primary Vs Secondary Control Coping

Skinner, Edge, Altman and Sherwood (2003) have discussed elaborately on the mechanism of coping as follows: The primary secondary model of control distinguishes between

primary control: defined as coping designed to influence objective events or conditions;

secondary control: defined as coping aimed at maximizing one's fitness to current conditions;

relinquished control: defined as the absence of any coping attempt".

A related distinction, which arose from action theoretical perspectives on successful aging, contracts assimilative processes, which refer to "transforming developing circumstances in accordance with personal preferences", and accommodative processes, which refer to "adjusting personal preferences to situational constraints" (p.230). These refer to two qualitatively different and independent action categories. The opposite of assimilation is helplessness; where as the opposite of accommodation is rigid perseverance, such as the continued fixation on unattainable goals or viability to disengage from ineffective paths of action. This structure (two separate bipolar dimensions) has been confirmed in analyses of self-report measures, designed to tap both processes.

Although coping is often characterized as a highly individual affair, more and more researchers are emphasizing the social embeddedness of coping processes. Some researchers have suggested that an important distinction in categorizing coping is the social orientation of the strategy, specifically, whether a way of coping is social versus solitary. Or is pro-social (engages or solicits others), antisocial (manipulates or coerces others or views others as obstacles), or a social (prefers to approach a stressor with out the assistance of others).

Such distinctions raise the larger issue of the heterogeneity and multiple functions that can be served by seeking social support and highlight the general finding that the use of this strategy does not seem to have consistent positive or negative effects. It seems possible that all individual ways of coping might have social equivalents. For example, seeking instrumental support seems conceptually similar to active problem solving, seeking emotional support is likely to have many of the same functions as emotion regulation; seeking advice or consultation with professionals might be considered social forms of information seeking; getting together with friends might be considered a social form of distinction; blaming others may be a social form of opposition; and incessant complaints to others may be a social form of rumination.

A relatively new distinction has been used to formally introduce the issue of volition to coping. Skinner cited Compas and colleagues who pointed out that responses to stress include not only effortful, intentional, controlled, and volitional responses but also responses that are automatic, over learned or involuntary. Compas *et al.,* argued that the term coping be restricted to effortful responses only.

Skinner, Edge, Altman & Sherwood (2003) thus summarises that five categories of coping are important; problem solving, support seeking, avoidance distraction and positive cognitive restructuring. They also added that four more categories could be considered strong candidates-rumination, helplessness, social withdrawal and emotional regulation while three more families appeared, less frequently, but likely to deserve further consideration as information seeking, negotiation, and opposition.

Stability of coping styles has been a matter of debate among researchers. Although some researchers have postulated the existence of coping styles that are consistent across situations and are stable (Moos, 1976) Folkman and Lazarus (1985) have disputed this assertion. They argue that different strategies of coping are called into play in different situations. Personal factors have been studied as determinants of coping styles where as situational variables have been investigated as contributing to the choice of coping strategies in different situations.

Hann (1969) and Valliant (1994) viewed coping as a stable predisposition to handle stress in a particular manner. Evidence arguing for the existence of stable dispositional coping styles was also provided by Amirkhan (1990) and Carver and Scheier (1994).

Thus it can be assumed that the quality of marital adjustment is related to the coping styles used by the partners. This assumption is also supported by the findings of a study on marital problems by Shanty and Anita (2006).

Personality

'Personality' is one of the major concepts referred in the study of behaviour. It has been defined by different schools and scholars in their own ways. However, some of them have been widely agreed upon. The following definitions reveal that the basic idea has remained almost the same over years.

Monte (1980) defined the concept of personality "as a hypothetical construct designed to bring order and consistency to the explanation of an individual's behaviour" (p.30).

According to Allport, personality is "the dynamic organisation within the individual of those psychophysical systems that determine his characteristic behaviour and thought" (Mischel, 1984. p.2)

For Magill (1996), "A broad definition of personality typically includes the dimension of stability, determinism and uniqueness. That is, personality

changes little over time, is determined by internal process and external factors and reflects an individuals' distinctive qualities. Personality also can be thought of as unique, relatively stable patterns of behaviour, multiply determined over the course of an individual's life" (p.1223).

Nicholson (1998) defined personality as that set of non-physical and non-intellectual psychological qualities, which make a person distinct from other people. According to Pervin and John (2001), personality represents those characteristics of the person that account for consistent patterns of feeling, thinking and behaving. Weiten and Lloyd (2003) further defined personality as an individual's unique constellation of consistent behavioural traits.

There are many theories for understanding the patterns of behaviour and their development. Although there are dozens of different theories of personality, most of them can be grouped into four basic types. Here, the development of theories is reviewed chronologically. Although Hippocrates and Galen had first introduced their ideas in the study of temperaments, the first personality theory is psychoanalytic theory.

There are five basic approaches to the study of personality. They are:

1) Psychoanalytic perspective which emphasises the role of the unconscious.

2) Behaviouristic perspective explains personality as a group of learned behaviour patterns and thus emphasise learning.

3) Humanistic perspective stresses the individual's unique potentials and self-actualisation.

4) Existential perspective focus on subjective experiences and the human potential for modifying one's experiences.

5) Biological perspective deals with some major physical and physiological determinants of behaviour and certain predispositions within the individual. Mainly there are two groups of theories – type theories and trait theories.

Type theories are based on the assumption that people can be grouped based on certain shared characteristics while Trait theories propose that individuals differ with respect to certain inherent dispositions called trait.

In the present investigation Cattell's trait concept of personality is followed.

Lerner, Brooks and Mistry (2003) also commended that the most well-known perspective on personality is the trait view. A trait is commonly described as an enduring personality characteristic that remains stable overtime and is consistent across situations. Purportedly, roots of traits can be traced to genetic components, and their expression is manifested in early

temperament. Raymond Cattel's research propagated a two tiered personality structure with sixteen "primary factors" (16 personality factors) and five "secondary factors".

According to the Diagnostic and statistical manual of the American Psychiatric Association (APA), personality traits are "enduring pattern of perceiving, relating to, and thinking about the environment and oneself that are exhibited in a wide range of social and personal contexts (http.encyclopedia.compersonality).

Described by Hall, Lindzey and Campbell (1998) Cattell views personality as a complex and differentiated structure of traits, with its motivation largely dependent upon a subset of these, the so-called dynamic traits. For him a trait is a "mental structure"; and inference that is made from observed behaviour to account for regularity or consistency in behaviour. Central to Cattells' point of view is the distinction between surface traits, which represent clusters of manifest or overt variables that seem to go together; and source traits which represent underlying variables that enter into the determination of multiple surface manifestations. Source traits are identified only by means of factor analysis. Cattell considers source traits more important than surface traits, this is became "source traits promise to be the real structural influences underlying personality, which is necessary for us to deal with developmental problems, psychosomatics, and problems of

dynamic integration – as research is showing, these source traits correspond to real unitary influences – physiological, temperamental factors; degrees of dynamic integration; exposure to social institutions – about which more can be found out once they are defined" (p.318).

Surface traits are produced by interaction of source traits and generally can be expected to be less stable than factors. Surface traits are likely to appear to be more valid and meaningful than source traits because they correspond to the kinds of generalizations that can be made on the basis of simple observation. In the long run, it is the source traits that prove to have the most utility in accounting for behaviour.

Any single trait may represent the outcome of the operation of environmental factors, hereditary factors, or some mixture of the two. The traits that result from the operation of environmental conditions are called environmentally mold traits; those that reflect hereditary factors are the constitutional traits. Traits are further classified based on their function such as dynamic traits, ability traits and temperament traits.

The important dynamic traits in Cattell's system are of three kinds, attitudes, erges and sentiments.

Erg is a constitutional dynamic source trait. Cattell defines an erg as 'an innate psycho physical disposition which permits its possessor to acquire reactivity (attention, recognition) to certain classes of objects more readily

than others; to experience a specific emotion in regard to them, and to start on a course of action which ceases more completely at a certain specific goal activity than at any other" (p.327).

Sentiment is an environmentally molded dynamic source trait. Thus it is parallel to the erg, except that it is the result of experimental or socio cultural factors, not constitutional determinants.

Attitude, for Cattell is the manifest dynamic variable, the observed expression of underlying dynamic structure from which ergs and sentiments and their interrelationships must be inferred.

Sentiments, in Cattell's view tend to be organized around important cultural objects, such as social institutions or persons, toward which elaborate constellations of attitudes accure during an individuals' life experience.

The self is one of the sentiments, but an especially important one, since nearly all attitudes tend to reflect the self-sentiment in greater or lesser degree. It in turn is linked to the expression of most or all of the ergs or other sentiments.

Thus Cattell's conception of trait appears to be significant in determining the quality of behaviour of a person.

Wellbeing

Wellbeing is a relative term. For some people it may mean a sense of achievement at work or a feeling of closeness to family, friends and community. For others it means material wealth and the goods it can purchase. And for many others, wellbeing might be a simple but nourishing meal or a day free of pain. But from scientific point of view many philosophers and social scientists have been concerned themselves with defining wellbeing.

Sehgal and Sharma (1998) reported that for more than 20 years, the study of psychological wellbeing has been guided by two primary conceptions of positive functioning: one formulation, traceable to Bradburn's seminal work, distinguished between positive and negative affects and defined happiness as the balance between the two. The second, primary conception which has gained prominence among sociologists was by Campbells, Converse and Rodgers, which emphasizes life satisfaction as the key indicator of wellbeing. Viewed as cognitive component life satisfaction seem to complement happiness, and more effective dimensions of positive functioning. They have also cited Andrew's view that other studies passed wellbeing according to global questions about works, income, social relationship and neighbourhood. Feldman (1998) defined wellbeing as 'the sense of psychological and physical robustness" p (153).

In his article on wellbeing Diener (1984) explained that the area of subjective wellbeing has three hallmarks:

(1) It is subjective. According to Campbell, it resides within the experience of the individual and pointed out that concepts notably absent from definition of subjective wellbeing are the necessary objective conditions such as health, comfort, virtue or wealth. Although such conditions are seen as potential influences on subjective wellbeing, they are not seen as an inherent and necessary part of it.

(2) The subjective wellbeing includes positive measures. It is not just the absence of negative factors; as is true of most measures of mental health. However, the relationship between positive and negative is not completely understood.

(3) The subjective wellbeing measures typically include a global assessment of all aspects of a person's life. Although affect or satisfaction within a certain domain may be assessed, the emphasis is usually placed on an integrated judgement of the person's life.

Bryant and Veroff (1982), reviewing studies on the perceived quality of life, cited Campbell's classification of three types of wellbeing – affect, strain and satisfaction. Campbell recognises that when people speak of satisfaction they cognitively focus on experience, but when people speak of affects or strains they focus more spontaneously on the flow of every day life.

Major indicators of Wellbeing

Penrod (1986) explained the major indicators of wellbeing as health, marriage, family life, confidence and job satisfaction. Among these, the most important indicators were health and marriage, the least important were financial circumstances and an involvement in community or professional organisation. Malhotra, Nair & Jyoti (2007) found that personality type and social roles have an interactive effect on wellbeing in women. Employment is reported to have a linear relation with wellbeing in women (Nair & Malhotra, 2006).

Health and Wellbeing

Some people seem quicker than others to see the positive aspects of the worst experiences. They reassert their sense of control when they are buffeted by fate. They know when to deny and when to hope. Their coping skills seem to come in personality packages, one that resists stress and promotes wellbeing. The factors that lead to this condition can be classified into two sections. The first section is the individual side of health and wellbeing which discusses what health and wellbeing are to an individual. The second section refers to the social side of health and well being which discusses how health and wellbeing depend on the people around an individual (Wade and Tavris, 1978).

(1) Individual side of Health and Wellbeing

According to wade and Tavris (1987) stress-resistant people have a sense of coherence, psychological hardiness, a sense of control and social interests .

(i) Sense of Coherence

People who have a sense of coherence believe that their lives are comprehensible that is the world is meaningful, orderly and consistent instead of chaotic, random and unpredictable.

ii) Hardiness

Hardiness consists of three psychological components which are very similar to those in the sense of coherence.

a) *Commitment* is the feeling of attachment to one's activities and relationships and the belief that they are important.

b) *Challenge* is the willingness to accept and to enjoy the new and unpredictable experiences, to see opportunities in change rather than only losses, to feel curiosity and interest.

c) *Control* reflects the belief that one is not helpless, but can influence many events and other people.

iii) Locus of Control

One of the most important personality factors that affect stress is the feeling of control of one's life. People who feel that they are in-charge of their lives often deal more effectively with problems and decisions than the people who lack this sense of mastery. People who feel powerless tend to respond to stress with anger, depression, drug use or physical symptoms. It is also important to note that everything cannot be controlled by an individual. So a critical step in promoting health and wellbeing is to learn the difference between what can be controlled and what cannot be controlled.

There are mainly two kinds of control:

Primary control in which people try to influence existing reality by changing other people, circumstances or events.

Secondary control in which people try to accommodate to external reality by changing their own attitudes, perceptions, goals, or desires. Health and wellbeing seem to depend on the right combination of primary and secondary controls.

(iv) Social Interest

The factor to consider among those leading to emotional and physical wellbeing is the trait which Adler called social interest. Social interest reflects the ability to be unselfish, to be sympathetic, to be co-operative and to

feel connected to other people and to the world. People who are high in social interest when compared to others, have fewer stressful experiences and are better able to cope with the stressful episodes they have. Among people low in social interest, stress is more likely to be associated with anxiety, depression and hostility. Social interest seems to soften the effects of stress on psychological wellbeing.

2) The social side of health and wellbeing

According to Wade and Tavris (1987) health and wellbeing do not entirely depend on the individual. They also depend on the people around one, i.e., family, friends, neighbours, lovers and enemies. The importance of social relationships to health has been studied by many psychologists and they found that social networks may influence health positively or negatively. Positive social networks such as friendships, family, acquaintances maintain physical health and emotional wellbeing. They help to cope with life's problems when one is too drained to budge. Wade and Tavris cited Benjamin Gottileb while discussing in what way friends help one to cope with life's problems discussed three categories of help.

(1) *Emotional support*: Friends communicate concern and affection, they boost one's self confidence and thus emotional support is provided to cope with the problem.

(2) *Cognitive guidance*: Friends help one to evaluate problems and plan to a course of action.

(3) *Tangible support*: Friends often come through with resources and services.

Wade and Tavris (1987) also cited Weiss' view that people need two kinds of relationships : an 'attachment figure' such as lover or spouse and a social network of friends or group members. An attachment figure provides emotional closeness and the group provides a sense of community and one cannot be replaced with the other. In short, wellbeing depends on relationships that provide intimacy and good feelings.

Social networks can also have negative effect on wellbeing by having problems with them. Wade and Tavris say that friends can also be stressful as a source of hassles, conflicts, burdens and betrayals. They sometimes provide the wrong kind of support or too much support or they support at the wrong time. The psychology of wellbeing and health poses a paradox, for the sources of our greatest strengths are also the sources of our greatest struggle. "The healthy person faces problems, copes with them and gets beyond them, but problems are necessary if the person is to acquire coping skills that endure" (Wade and Tavris, 1987, p. 569).

Malhotra, Nair & Jyothi (2007) opined that social support particularly within the marital relationship has been considered to be a necessary ingredient for wellbeing.

Theoretical Approaches

We have seen that Penrod (1986) has pointed out health as the most important indicator of wellbeing. There are certain others who believe health is not an inherent and necessary part of wellbeing. But even they agree that health is a potential influence on wellbeing and many theoretical views have been put forward by many theorists.

Various models have been developed to understand health and wellness. Edlen, Golanty and Brown (1998) discussed the medical model, the environmental model and the holistic or wellness model.

(1) The Medical Model

Medical model is mainly a statistical account of diseases. It is excellent for gathering numerical data on the prevalence and incidence of disease which is interpreted to measures health.

(2) The Environmental Model

The environmental model of health emerged with modern analysis of ecosystem and environmental risks to human health.

In this model, health in defined in terms of the quality of a person's adaptation to the environment as conditions change. This includes the effects of socio-economic status, education and multiple environmental factors on personal health. Unlike the medical model which focusses on diseased organs and biological abnormalities, the environmental model focuses on conditions outside the individual that affect his or her health. These conditions include quality of air and water, living conditions, exposure to harmful substances, socio-economic conditions, social relationships and the health care system.

(3) The Holistic Model

The Holistic model defines health in terms of the whole person, not in terms of the diseased part of the body. The holistic model encompasses the physiological, mental, emotional, social, spiritual and environmental aspects of individuals and communities. It proposes that health is a state of optimum or positive wellness. Wellness is much more than physical health and it addresses mental, emotional and spiritual aspects of a person, as well as the relationships among these dimensions.

Wellbeing: Related Concepts

Many social scientists explain that our overall sense of wellbeing is influenced as much by our everyday state of mind as it is by physiological factors. Social psychologists have examined the social and psychological components that determine the sense of wellbeing and they include views on

how self influences our perception of wellbeing, how a sense of helplessness many lead to depression and how attributional patterns affect psychological health. They also discuss how certain kinds of illusions we mistakenly hold may ultimately produce a sense of wellbeing.

(a) Self-Complexity and Wellbeing

Feldman (1998) cited social psychologist Linville's description of self-complexity which says that it is the phenomenon of viewing oneself as having many distinct facts. Self complexity is important because it seems to function as a barrier against illness and depression. Feldman also refers to reports by Kalthoff and Neimeyer, Smith and Cohen and Evans which say people with higher self-complexity show greater resistance to depression brought about by stress and that their rate of physical stress-related illness is lower.

When a person with high self complexity has difficulties on the job, she can turn for psychological compensation to success that she is experiencing in other domains of her life. In contrast, when a women with self-complexity, who defines herself primarily by her career performance has problem on the job, the story is very different because she does not have as many alternative selves to turn to, the consequences of her job problems are more profound.

(b) Self-Discrepancy Theory

Despite our desire to be brilliant, likeable, and terrific, the truth is that many of us see ourselves as quite different from our ideals. Many scientists have worked in this area and have put forward many views on the concept of self. Carl Roger's extensive research on self-concept in 1950's is considered a major attempt in this area.

While discussing about Roger's theory of personality, Feist (1985) explained that a wide gap between the ideal self and the perceived self indicates an incongruent and unhealthy personality. Incongruence can be defined as a discrepancy between the self-concept and the ideal self. Psychologically healthy individuals perceive little discrepancy between what they truly perceive themselves to be and what they ideally would like to be.

In 1989, Higgins also discussed the same view in his article 'self discrepancy theory'. What patterns of self-beliefs cause people to suffer? Feldman (1998) has cited Higgin's self discrepancy theory which argues that the discrepancy between self-concept and self-guides leads to negative emotions and ultimately to lower psychological wellbeing. Self guides are the standards that people strive to attain.

There are actually several types of self-guides, including the ideal self and the ought self. The ideal self is made of the hopes and aspirations that either the person or others feel as important. The ought self is composed of

what people feel they ought to do for the obligation they place on themselves and on others. In short, the ideal self is what people want to be and the ought self is what people feel they should be. According to this theory both the degree and kind of discrepancy between the actual self and self guides affect an individuals' psychological wellbeing.

At the same time, minor inconsistencies between the actual self and self-guides can be helpful in sparking efforts to reduce the discrepancy. In such cases, incongruities between actual self and self-guides can be expected to promote wellbeing as people feel a sense of accomplishment at their progress in reducing the gap between their various selves.

(c) Self-Disclosure and Wellbeing

Self-Disclosure is defined by Coleman, Morris Glaros (1987) as any information we communicate about ourselves to another person. They have also pointed out that this is a healthy way of resolving identity crisis during adolescence. According to Weiten and Lloyd (2003) self disclosure is the act of sharing information about yourself with another person.

In certain ways, according to some social psychologists, the more you disclose about yourself the better. Jourard (1973) reports that towards the end of the 19th century, Brewer, discovered that when his hysterical patients talked about themselves, their hysterical symptoms disappeared. Jourard also

reported that Freud too discovered that when people struggle to avoid being and knowing themselves they got sick.

Self disclosure is both a symptom of personality, health and at the same time a means of ultimately achieving healthy personality. Just as thermometer, sphygmomanometers etc disclose information about the real state of the body, self-disclosure reveals the real nature of the soul or self. Withholding self-disclosure seems to impose a certain stress on people. Self-disclosure to a significant other is the means by which an alienated person can rediscover his real self. Real self being is a necessary condition for healthy personality, making continued growth possible. Full disclosure of the self to atleast one other significant human being appears to be one means by which a person discovers not only the breadth and depth of his needs and feelings but also the nature of his self-affirmed values (Jourard, 1973).

Rathus and Nevid (1983) reported that in a review of the literature on self disclosure, Cozby has noted some sex difference in self disclosure. Women tend to disclose more intimate information than men do, especially to other women and that individuals who are labelled mentally healthy or well adjusted disclose a good deal of information that might be self damaging or prematurely revealing.

Feldman (1998) also refers to certain studies related with self-disclosure and its influence on wellbeing. He refers to the studies by

Jourandi, Derlega and Metls; Pekroma and Margulis; Monsour, Waring, Schaefer and Fry; Rogers and Halloway which report that one important consequence of self-disclosure is an increase in the level of intimacy in social interactions. Another group of studies by Emron and Colby; Demakis and Mcadams; Gupta and Korli, Johnson Hobfoll, Zolebug Linetzy, Coher, Mansfield and Marx; also reported by Feldman reveal that the increased intimacy in social interactions may inturn provide social support that can also help reduce stress.

Self-disclosure may also promote more honest responses from others, who may then become more useful sounding boards. In these situations, others ultimately may provide worthwhile feed back that can reduce stress. According to the research of a social psychologist, Pannebaker, self disclosure may be good not only for the soul but also for the mind and the body. Pannebaker and colleagues have found that giving the opportunity to air their most personal and disturbing experiences, which they typically have kept-hidden, produces clear health benefits (c.f. Feldman, 1998).

d) Self-Regulation Failure

If people could only control themselves better, many self-destroying issues might well disappear. While discussing about Bandura's social learning theory, Monte (1980) stated that people have some degree of control over their behaviour.

According to Bandura, the most central of all mechanisms of self regulation is self-efficacy which is referred as "the belief that one has the ability, with one's actions, to bring about a certain outcome. Self efficacy beliefs function as determinants of behaviour by influencing motivation, thought process and emotions in ways that may be self-aiding or self-hindering" (Magill 1996, p. 1579).

Bandura distinguishes between a person's outcome expectation and his efficacy expectation. An outcome expectation is the individual's estimate of a given event that will occur. In contrast efficacy expectation is the individual's belief that he can produce, originate or create the necessary course of action to bring about the anticipated outcome. To put it simply, people may believe that something can happen, but whether they embark on a course of action depend on their perceived ability to make it happen (Monte, 1980).

In Feist's (1985) view though people have no dependent self with the capacity to manipulate the environment at will, they are capable of some degree of self-regulation. By using reflective thought, they can manipulate their environments and produce consequences of their actions. These consequences feedback into the reciprocal determinism paradigm that enable people to regulate their own behaviour.

Three component processes are involved in self regulatory behaviour : The first class of self regulatory processes is person's self-observation of their

own performance quality including evaluations. According to Singh & Shyam (2007) evaluation of one's life is an essential component of wellbeing.

When self-regulation failure is present there are inadequacies in the control of one's behaviour and often result in crime, teen pregnancy drug abuse, gambling, etc. (Feldman, 1998). According to social psychologists – Roy Bacemister and Tdd heatherston; self – regulation failures actually take two forms : under – regulation and misregulation. In under regulation, people are unable to exert self – control. In contrast, misregulation is the attempt to exert control over onself, but in ways that were either misguided or counter – productive, the result is another kind of self regulation failure (c.f. Feldman, 1998).

e) Attributional style and wellbeing

Attributional style refers to the tendency to use similar causal explanations for a wide variety of events in one's life. According to Seligman, people tend to exhibit, to varying degrees, one or two attributional styles: an optimistic explanatory style or a pessimistic explanatory style. Pessimistic explanatory style can foster passive behaviour and make people more vulnerable to learned helplessness and depression (c.f. Weiten and Lloyd, 2003).

As cited by Feldman (1998) Seligman says that learned helplessness is the belief that one can exert no control over one's environment. When people

hold such a belief, they feel unable to escape their environment and may simply give up-leading, in some cases, to profound feelings of depression.

Feldman (1998) also refers to a report by McKean which says that learned helplessness has proved to be a durable concept, relevant to both physical health and general psychological wellbeing.

Brown and Harris (1984) agreeing with Melges and Bowlby stated that hopelessness is the key factor in the genesis of clinical depression and loss is probably the most likely course of profound hopelessness. Feelings of hopelessness will not always be restricted to the provoking incident – large or small. It may lead to thoughts about the hopelessness of one's life in general.

Mear and Gatchel (1979) cited Seligman that this phenomenon of learned helplessness can actually cause death in some individuals who, after learning that their lives and behaviours are futile, today give up hope and the will to live. The psychological state of helplessness increases the risk of death.

(f) The Benefit of Illusions

The peril of having an accurate view of the world and of oneself seems to be pronounced. But as cited by Feldman (1998) Tylor and Brown argue that certain types of inaccuracies about oneself and others may actually promote mental health. Specifically they suggest these basic illusions that are

associated with better psychological functioning : holding unrealistically positive evaluation of oneself, having an exaggerated sense of control over occurrences in one's life and being unrealistically optimistic.

Positive illusions are related to happiness and contentment, productivity and creativity and ability to care about others. But there are limits to how far people can twist reality and sometimes it is clearly maladaptive to ignore objective threats and to assume that one can always exert control over any situation (c.f. Feldman, 1998).

With or without basis of these theories philosophers, writers and scientist have hypothesized numerous causes of wellbeing. Thus in brief, wellbeing may be defined as the subjective feeling of contentment, happiness, satisfaction with life's experiences and of one's role in the world of work, sense of achievement, utility, belongingness and no distress, dissatisfaction or worry.

With regard to gender differences in wellbeing, women have shown comparable more positive profiles on wellbeing than men. For the interpersonal dimension of wellbeing – positive relations with others - women always score significantly higher than men. Interpersonal wellbeing is the lowest rated dimension.

Considering the various approaches for understanding the state of wellbeing and the studies conducted in relation to different samples and conditions it appears meaningful to assume that chronic alcoholism of husbands might effect the general wellbeing of their wives.

CHAPTER II

REVIEW OF LITERATURE

- Biological Effects of Alcoholism
- Effects of Alcoholism on Children
- Psycho social effects of Alcoholism
- Effects of Alcoholism on Marriage and Family

The existing literature about alcohol and alcoholism is so vast and varied. But a review of the available ones reveal that studies related to the spouses of alcoholics are very few.

For designing the present study the significant findings and observations of earlier studies are critically looked into. Though the major theoretical approaches and landmark studies were cited in the first chapter itself, the present chapter gives a review of empirical studies conducted on various aspects related to alcoholism and observations by a few researchers in this area. However, the review primarily includes studies reported during the past five years apart from the very significant older ones. Studies are classified and presented under four major sections:

(1) Biological effects of alcoholism

(2) Effects of Alcoholism on children

(3) Psycho social effects of Alcoholism.

(4) Effects of alcoholism on marriage and family

Biological effects of alcoholism

Sabhesan and Natarajan (1988) found posttraumatic amnesia (PTA) to be prolonged in subjects who were alcohol dependents prior to head injury. A comparison with controls indicated that the PTA in the alcoholics was significantly longer.

Shankar, Ray and Desai (1986) analyzed liver tissue from 41 male alcoholics and blood samples from the alcoholics and from 52 male nonalcoholic controls. Mean consumption of alcohol among alcoholic subjects was 183.1 g of ethanol for an average of 9.7 years. Only 5 subjects had normal livers. Six subjects had fatty livers, 23 had alcoholic hepatitis, and 4 had precirrhosis and cirrhosis. Biochemical analysis showed that alcoholics had elevated values of SGOT, SGPT and GGT compared to controls.

Ravindran (1995) explores the psychodiagnostic ability of the Bender Visual Motor Gestalt Test (BVMGT) in detecting perceptuomotor dysfunction due to chronic alcoholism. 30 chronic alcoholic males and 30 male controls were individually administered the BVMGT. Both groups had been matched on age and education. The scoring proposed by Pascal and Suttell (1951) was used to analyze the data. Results reveal that alcoholic subjects performed poorly on 5 of the 8 designs. Frequencies of deviations were consistently higher for alcoholic subjects.

Kurup and Kurup (2003) assessed the pathway in patients with alcoholic addiction, alcoholic cirrhosis, and acquired hepatocerebral degeneration. The role of hemispheric dominance in their pathogenesis also was studied. In the patient group there was elevated digoxin synthesis, increased dolichol and glycoconjugate levels, and low ubiquinone and

elevated free radical levels. There was an increase in tryptophan catabolites and a reduction in tyrosine catabolites, as well as reduced endogenous morphine synthesis from tyrosine. There was an increase in cholesterol; phospholipid ratio and a reduction in glycoconjugate level of RBC membrane in these groups of patients. Alcoholic cirrhosis, alcoholic addiction, and acquired hepatocerebral degeneration were associated with an upregulated isolprenoid pathway and elevated digoxin secretion from the hypothalamus. This can contribute to NMDA excitotoxicity and altered connective tissue/lipid metabolism important in its pathogenesis. Alcoholic addiction, alcoholic cirrhosis, and acquired hepatocerebral degeneration occurred in right hemispheric, chemically dominant individuals.

Moore, Endo and Carter (2003) investigated the relationship between (1) two thresholds of excessive alcohol drinking, (2) binge drinking, and (3) impairment in functional status in older drinkers. In this cross sectional study, ten internal medicine practices affiliated with an academic medical centre. One hundred sixty-one persons aged 60 and older who reported drinking one or more drinks in the previous 3 months. Two commonly used thresholds of excessive drinking: (1) eight to 14 drinks per week for women and men (lower threshold) and (2) more than 14 drinks per week for women and men (higher threshold); a measure of binge drinking (> or = 3 drinks per occasion for women or > or = 4 drinks per occasion for men); and self-reported instrumental activities of daily living (IADLs) and advanced activities of daily

living (AADLs). Results showed that older persons consuming seven or fewer drinks per week, those exceeding the higher threshold of excessive drinking were more likely to have impairments in IADLs (adjusted odds ratio (AOR) = 8.4) and, to a lesser extent, AADLs (AOR = 3.7); those exceeding the lower threshold were more likely to have impairments in IADLs (AOR 56.0) but not in AADLs (AOR = 1.7). Binge drinkers were also more likely to have impairments in IADLs (AOR = 3.0) but not in AADLs (AOR = 1.5). In this group of older men and women, drinking more than seven drinks per week was associated with impairments in IADLs and, to a lesser extent, AADLs. Drinking more than three drinks per occasion was associated with impairments in IADLs.

Schweinsburg, Omar and Michael et al. (2003) used proton magnetic resonance spectroscopy to evaluate gender influences on alcohol-associated changes in brain metabolism. Concentrations of *N*-acetylaspartate, choline-containing compounds, *myo*-inositol, and creatine plus phosphocreatine in frontal lobe gray matter and white matter were estimated in eight women and 17 men who were recently detoxified from long-term alcoholism. Twelve women and 13 men with no history of alcoholism were used as a comparison group. Results showed that lower concentrations of white matter *N*-acetylaspartate, which may indicate neuronal loss or dysfunction, is equally severe in men and women with comparable alcohol abuse histories. However, female alcoholics exhibited significantly less *N*-acetylaspartate in

frontal gray matter relative to female nonalcoholic comparison subjects, which could mean that female alcoholics are more susceptible to gray matter injury than their male counterparts.

Effects of Alcoholism on Children

Brown and Sunshine (1982) in their study suggests that children of alcoholics, like their parents are isolated and typically bear shame, confusion, and quite alone. Groups can provide children with a feeling that their experiences are not unique.

Ambrozik (1983) diagnosed the social situation of 91 children from 34 alcoholic families. Generally, Ss lacked parental care and control, lived in difficult financial and housing conditions, and were involved in disturbed and often pathological family relations. They witnessed incest, seductions, suicides, fights, and their mothers prostituting themselves, resulting in developmental disturbances. They showed poor health; unsatisfactory progress at school; lack of educational aspirations; disturbed relations with their parents, teachers, and other children; and socially unaccepted or even criminal behaviour.

Callan and Jackson (1986) compared 21 adolescent children (mean age 13.6 yrs) of recovered alcoholic fathers and 14 children (mean age 13,6 yrs) of alcoholic fathers with 35 socio demographically matched controls (mean age 13.5 yrs) on aspects of family and personal adjustment (Rosenberg Self-

Esteem Scale and Rotter's Internal-External Locus of Control Scale), the parent-child relationship, and perceptions of alcoholism. Children of recovered alcoholics and controls rated their families as happier and more trusting, cohesive, secure, and affectionate than did children of families in which fathers still drank. Adolescents scored similarly on measures of self-esteem and locus of control, but children of alcoholics were less happy with their lives. The 3 groups did not differ in their relationships with either parent. Children of alcoholic or recovered alcoholic fathers were less likely to attribute alcoholism to internal causes than controls, however, and were more positive about alcoholics and their recovery.

Throwe (1986) discusses alcoholism as a multifaceted affliction that directly affects the family as a total unit and each member as an interacting individual of that system. Four prevalent problems shared by alcoholic families include altered communication patterns, role difficulties, poor sexual interaction, and aggressive behaviours. In process that families use to deal with an alcohol problem involves 5 stages: (1) denial behaviour, (2) control attempts, (3) disorganization of the family, (4) disassociation, and (5) making choices on whether to stay with or separate from the family unit. Anger and guilt are the 2 most common family reactions to the crisis of hospitalisation of an alcoholic family member. Assessment and intervention strategies that must be offered by health care providers to deal with these 2 reactions are described.

Kondandaram (1995) studied the adjustment problems of 30 adolescent children of alcohol dependent fathers and 30 adolescent children of non-alcohol dependent fathers. Results indicate that the children of alcoholics have more adjustment problems than their counterparts in the areas of home, health, social and emotional. Children of alcoholic fathers had problems of parental rejection, persistent tension at home, and inability to identify with or relate to one or both parents.

Jacob and Windle (2000) conducted a study on 128 adult children of alcoholic fathers and found out serious problem in the areas of drinking, personality, psychopathology, educational and social functioning. 128 adult offspring of alcoholic fathers (COAs), 138 adult offspring of normal control fathers and 127 adult offspring of depressed fathers shows that significantly more COAs than comparison offspring were experiencing serious problems in these areas. According to the authors, these findings indicate that the risks for COAs might relate specifically to parental alcoholism and its impact on offspring development and not to the combiner effects of various parent psychopathologies and/or extreme form of family instability.

Skibbee (2001) studied the relationship between parental mental health, family rituals, family environment, and the resiliency of adolescents of alcoholic parents. A significant correlation was found among adolescent offspring regarding family disruption and low family rituals/closeness. The

study data suggested that adolescents boys, not girls, may be experiencing more stress due to being raised by an alcoholic parent, regardless of the gender of the alcoholic parent, as reflected by lower self-esteem scores, higher depression, greater perceived family disruption, and lower levels of family rituals.

El-Sheikh (2001) investigated parent drinking problems and children's adjustment in a sample of 6 to 12 years old, found that children are vulnerable to increased anger and fear.

Orford, Krishnan and Velleman (2003) explored through the use of simple family diagrams constructed during personal interviews, the childhood families of young adult 'offspring' of parents with drinking problems and to compare them with those of nonproblem-drinking parents ('comparisons') using Cross-sectional interview. Fifty 'offspring' and 50 'comparisons', aged between 16 and 35 years were matched by sex and number of siblings. Quantitative data obtained through assigning value to bonds drawn on family diagrams, during semistructured interviews. Results revealed that families of offspring of parents with drinking problems may be comparatively deficient in positive aspects of family cohesion, although relationship with the nonproblem-drinking parent are mostly well preserved. One new finding that requires replication is that relationships between siblings, rather than

receiving compensatory strengthening, are often adversely affected by having a parent with a drinking problem.

Walsh, MacMillan and Jamieson (2003) examined the relationship between reported exposure to child abuse and a history of parental substance abuse (alcohol and drugs) in a community sample in Ontario, Canada. The sample consisted of 8,472 respondents to the Ontario Mental Health Supplement (OHSUP), a comprehensive population survey of mental health. The association of self-reported retrospective childhood physical and sexual abuse and parental histories of drug or alcohol abuse was examined. Results showed that the rates of physical and sexual abuse were significantly higher, with a more than two fold increased risk among those reporting parental substance abuse histories. In conclusion, parental substance abuse is associated with a more than two fold increase in the risk of exposure to both childhood physical and sexual abuse.

Haugland (2003) examined possible risk factors associated with child adjustment in a sample of children with alcohol abusing fathers in Norway (N=37) which showed strong effects of childhood aggression (men only) and poor family functioning on enhanced levels of problem drinking in young adulthood. Further, the combination of high levels of aggression and low levels of family functioning were related to problem drinking in men, whereas

the combination of low parental control and low levels of affection expression were related to problem drinking in women.

Kelley and Fals-Stewart (2004) examined lifetime psychiatric disorders and current emotional and behavoural problems of 8- to 12-year-old children living with drug-abusing (DA) fathers compared to children living in demographically matched homes with alcohol-abusing (AA) or non-substance-abusing fathers. Children's lifetime psychiatric diagnoses were determined using the Schedule for Affective Disorders and Schizophrenia for School-Age Children, Present and Lifetime Version. In addition, both parents completed the Pediatric Symptom Checklist. Substance-abusing fathers were recruited from an outpatient treatment program. Compared to children in the other groups, children in DA homes were more than twice as likely to exhibit clinical levels of behavoural symptoms. Children living with DA fathers were more likely to experience a lifetime psychiatric disorder and more negative behaviours compared to children living with an AA father or non-substance-abusing parents.

Ohannessian, Hesselbrock and Kramer (2004) studied the relationship between parental alcohol dependence (with and without comorbid psychopathology) and adolescent psychopathology examined in a sample of 665 13-7 year old adolescents and their parents. Results indicated that adolescents who had parents diagnosed with alcohol dependence only did not

significantly differ from adolescents who had parents with no psychopathology in regard to any of the measures of psychological symptomatology (substance use, conduct disorder, and depression) or clinical diagnoses (alcohol dependence, marijuana dependence, conduct disorder, or depression) assessed. In contrast, adolescents who had parents diagnosed with alcohol dependence and either comorbid drug dependence or depression were more likely to exhibit higher levels of psychological symptomatology. In addition, adolescents who had parents diagnosed with alcohol dependence, depression, and drug dependence were most likely to exhibit psychological problems. These findings underscore the importance of considering parental comorbid psychopathology when examining the relationship between parental alcoholism and offspring adjustment.

Grekin, Brennan and Hammen (2005) in their study examined the relationship between parental alcohol use disorders (AUDs) and child violent and nonviolent delinquency. It also explored the mediating effects of executive functioning and chronic family stress on the parental AUD/child delinquency relationship. Participants were 816 families with children (414 boys and 402 girls) born between 1981 and 1984. Parents and children completed semistructured interviews, questionnaires and neuropsychological tests that assessed parental alcohol use, family psychiatric history, chronic family stress, child delinquency and child executive functioning. Results support a biosocial conceptualization of the paternal AUD/delinquency

relationship. They suggest that paternal AUDs may be associated with child executive functioning and family stress, which may in turn lead to child delinquency.

Kuendig and Kuntsche (2006) studied the relationship between excessive drinking parents to adolescent alcohol use and family bonding. They used equation models for multiple group comparisons estimated based on a national representative sample of 3,448 eight and ninth graders in Switzerland (mean age 14.77; SD 0.89). Results reveal excessive parental drinking to be positively related to adolescent alcohol used and family bonding negatively related.

Keller, Cummings and Davies (2005) in their research studied the problems of children exposed to parental drinking problems. Model tests indicate that problem drinking was associated with greater marital conflict, and that marital conflict was related to ineffective parenting which was in turn related to poorer child adjustment. Even in a community sample, parental problem drinking behaviours are associated with reduced family functioning that relates to child otucomes.

Peiponen, Laukkanen and Korhonen (2006) in their study aimed to determine whether parental psychiatric problems are associated with problems and problem behaviour in adolescents in a clinical sample of 70 outpatient adolescents (age 13-18 years, boys 30%) and their parents. The adolescents

were assessed using the structural clinical interview for DSM-III-R (SCID) and a semi-structured questionnaire, and the parents were interviewed using a semi-structured questionnaire. The findings indicate that parental psychiatric problems and alcohol abuse are correlated with adolescent psychological problems and should be considered and assessed when studying adolescents.

Psycho social effects of Alcoholism

Bakshi, Mehra and Sigh (1984) compared the level of aspiration in 50 male alcoholics and 50 male non alcoholics, as measured by the Self Anchoring Striving Scale. Alcoholic subjects were defined as consuming at least a half bottle of liquor at a time and at least once or twice a week over the course of a year. Results reveal higher levels of aspiration among non alcoholics. Growth motivation in alcoholics was reduced over a 5-year period, suggesting stagnation.

Trivedi and Raghavan (1980) in their study, 30 chronic alcoholics (aged 25-55 years) were subjected to psychological tests to explore the influence of regular alcohol intake on their cognitive functioning and its relationship with prognosis. The functions chosen were arousal and maintenance of attention, verbal intelligence, and performance intelligence. Level of education was positively correlated with attention span and verbal intelligence but not with performance intelligence. Poor performance quotient scorers sought medial consultation before their mid-thirties and had earlier

onset of alcoholism. Older alcohol abusers (aged 35+ years) showed a greater deficiency in abstraction.

Suman and Nagalakshmi (1987) in their study of self concept, anxiety and adjustment among anxiety neurotics, alcoholics and normals. Twenty male Indian subjects (aged 18-45 years) were divided into 3 groups: anxiety neurotics, alcoholics, and normals. Data show that normals had higher self-concept, lower anxiety, and better adjustment. Both alcoholics and anxiety neurotics had low self-concept, high anxiety, and personal and social maladjustment.

Pande (1987) administered the Eysenck Personality Questionnaire to 50 alcoholic and 50 non alcoholic adult males matched for age, education, and socio-economic status (SES). Alcoholics had significantly higher scores on the Neuroticism and Psychoticism scales.

Kannappan and Cherian (1989) investigated whether 79 male alcoholics (aged 20-50+ years) would differ from the norm on the extraversion and neuroticism dimensions of the Eysenck Personality Inventory (EPI) and whether a relationship would exist between EPI scores and age, religion, and duration of drinking. Scores on both dimensions were high, indicating that subjects were more extraverted and neurotic. Age, religion and duration of drinking and excessive drinking did not differ significantly on the personality dimensions.

Trivedi and Raghavan (1991) determined the personality of 30 alcoholic inpatients (aged 25-55 years), using the Multi-Phasic Questionnaire (MPQ), and the role of age of onset of drinking, age of problem drinking before mid-30s and after crossing mid-30s, chronicity, and performance quotient (P) in relation to the MPQ profile. Results show highest loading on depression (85%) and lowest on anxiety (3%). A significant correlation was found between scales of psychopathic deviance and hysteria. Age of problem drinking under 35 years and poor PQ level were associated with depression and psychopathic deviance. Clinical diagnosis was corroborated by the findings of the MPQ.

Shylaja and SanandaRaj (1994) examined the basic hypothesis that there will be significant differences between alcohol as well as drug addicts and nonaddicts in Mental Health Status and Value Orientation on the Mental Health Status Scale and Study of Values Scale; a general data sheet was also used. Subjects were 30 alcohol addicts and 15 drug addicts selected from a de-addiction centre where they were undergoing treatment; all were male and aged 15-20 yrs. For comparative purpose, a sample of 30 non addict matched controls was selected. Results indicated that alcohol addicts differ from normal controls in the theoretical value and attitudes towards the self, environmental mastery, and total mental health status variables. Drug addicts differ significantly from controls on integration, autonomy, environmental mastery, and total mental health status.

Singh, Mehta and Ahmad (1997) assessed the quantitative changes in the degree of depression and anxiety among alcohol dependent cases during and after detoxification. 112, 30-60 year old alcohol-dependent inpatients of the Drug De-addiction unit of a hospital in New Delhi, India were rated based on the Hamilton Anxiety and Depression Scales, and the Beck Depression Inventory 1 week after admission to avoid the impact of withdrawal symptoms on assessment. Reassessment was conducted on patients who completed the treatment after 3months. Results showed that the scores on the anxiety and depression scales were considerably lower during postdetoxification period assessment than during admission. Findings suggest that alcohol dependents who manifest depressive and anxiety features during admission for detoxification benefitted from the treatment targeted at their alcohol abuse rather than at their depression and anxiety.

Langeland, Draijer and VandenBrink (2004) in their study among treatment-seeking alcoholics examined the relationship between childhood abuse (sexual abuse only [CSA], physical abuse only [CPA], or dual abuse [CDA] and the presence of comorbid affective disorders, anxiety disorders, and suicide attempts, controlling for the potential confounding effects of other childhood adversities (early parental loss, witnessing domestic violence, parental alcoholism, and/or dysfunction) and adult assault histories. They assessed 155 (33 females,122 males) treatment-seeking alcoholics using the European Addiction Severity Index, the Structural Trauma Interview, and the

Composite International Diagnostic Interview. Results revealed that the severity of childhood abuse was associated with posttraumatic stress disorder (PTSD) and suicide attempts in females and with PTSD, social phobia, agoraphobia, and dysthymia in males. Among men, multiple logistic regression models showed that CPA and CDA were not independently associated with any of the examined comorbid disorders or with suicide attempts. However, CSA independently predicted comorbid social phobia, agoraphobia, and PTSD. For the presence of comorbid affective disorders (mainly major depression) and suicide attempts, maternal dysfunctioning was particularly important. CSA also independently contributed to the number of comorbid diagnoses. For females, small sample size precluded the use of multivariate analyses.

Maharajh and Ali (2005) studied the aggressive sexual behavour of alcohol-dependent men and its implications in clinical practice. A total of thirty women of male alcohol-dependent partners were taken from a psychiatric clinic and matched with a control group of spouses of healthy non-drinking men for the variables of age, gender, ethnicity and social class. These groups were tested for sexually induced marks over a one month period, areas of the body that were marked, duration of body marks and lovemaking experiences. Our findings indicate that the spouses of alcohol-dependent men are subjected to more aggressive and painful sexual experiences, more body marks in more regions that lasted an average of 7

days and more biting of body surfaces than wives of non-alcohol-dependent men. These behaviours are interpreted as subtle signs of domestic violence.

Ostermann, Sloan and Taylor (2005) using the fist five waves of the US Health and Retirement Study, a nationally representative survey of middle-aged persons in the USA conducted between 1992 and 2000, assessed the association between alcohol consumption and separation and divorce (combined as divorced in the analysis) for 4589 married couples during upto four repeated 2 year follow-up periods. They found that drinking status was positively correlated between spouses. The correlations did not increase over the follow-up p3eriod. Discrepancies in alcohol consumption between spouses were more closely related to the probability of subsequent divorce than consumption levels per se. Couples with two abstainers and couples with two heavy drinkers had the lowest rates of divorce. Couples with one heavy drinker were most likely to divorce. Controlling for current consumption levels, a history of problem drinking by either spouse was not significantly associated with an increased probability of divorce. Our findings on alcohol use and marital dissolution were highly robust in alternative specifications.

Plant, Miller and Plant (2005) investigated the possible association between alcohol consumption and eight types of problem behaviour in the lives of a sample of 2027 British adults. It also examines gender differences

in the prevalence of these problems. The problems considered were related to working, eating, shopping, use of the internet, sexual activity, exercise, gambling and dieting. Last occasion's alcohol consumption was significantly associated with having experienced problems related to work, gambling, dieting and sexual activity. Total previous week's drinking was only associated with two of these problems – gambling and sexual activity. There were a number of distinct gender differences in the levels of specific problems reported. Females were significantly more likely than males to report having experienced problems related to eating and dieting. Conversely, males were more likely than females to report having had problems related to work, use of the Internet, sexual activity and gambling. These findings do indicate that adult drinking was associated with several forms of "problem behaviour". Even so, they do not support the conclusion that all such behaviours are necessarily interconnected. The gender differences that emerged were not unexpected in view of prevailing social norms and stereotypes concerning the behaviour of the sexes.

Akvardar, Arkar, Akdede and Bagimlik (2005) determined the discriminating personality characteristics of patients with alcohol use disorders compared to healthy control subjects. Cloninger's Temperament and Character Inventory (TCI) was employed to the patients with a diagnosis of alcohol use disorder meeting the DSM-IV criteria (n=31) and their personality profiles were compared with age and gender matched non-

psychiatric healthy control subjects (n=31). Results showed that patients with alcohol use disorder were characterized by higher rates of novelty-seeking and harm avoidance. Higher novelty-seeking is related to impulsivity, and is considered to be important at the onset of drug taking behaviour. High harm avoidance is related to shyness, social inhibition, fear of uncertainity, and pessimistic worry in anticipation of problems. These negative feelings may be comforted by alcohol, whereas heavy alcohol use may lead to dependence. Individuals with low persistence tend to give up easily when faced with frustration. Lower self-directedness was reported as indicating a higher probability of personality disorder.

Alcoholism is a major risk factor for suicide (Murphy & Wetzel, 1990). Hufford (2001) suggested 4 possible mechanisms for alcohol's ability to increase the proximal risk for suicidal behaviour (1) increase psychological distress (2) increase aggressiveness (3) propel suicidal ideation into action through suicide specific alcohol expectancies, and (4) constrict cognition, which impairs the generation and implementation of alternative coping strategies.

Pirkola, Marttunen, Henriksson et al. (1999) reported more precipitating life-events in adolescent suicide attempters with comorbid alcohol use disorder/diagnostically subthreshold alcohol misuse than other adolescent suicides.

Other possible causal links between alcoholism and suicidal ideation/ behaviour include depression and hopelessness, which are likely to have been induced by toxic effects of alcohol (Miller, Mahler & Gold, 1991). There is a strong suggestion from literature that recent adverse life events (divorce, separation, family arguments) are important factors in alcoholic suicide. Modestin (1986) reported adverse life events to be more common among nine alcoholic suicide victims than among 24 alcoholic inpatients.

Some interview studies have compared interpersonal life events between alcoholic suicides and non-abusing depressive suicides (Murphy & Robins, 1967), between alcoholic/other substance abuser suicides and non-abusing depressive suicides (Rich, Fowler, Fogarty & Young, 1988a), and among victims with alcohol/substance dependence relative to those with mood/anxiety disorders (Duberstein, Conwell & Caine, 1993). These studies have demonstrated that disruption of interpersonal relationship has been more common among alcohol and substance abusers before suicide typically clustering within the last 6 weeks. The types of interpersonal stressors were conflits/arguments and attachment disruptions. The excess of recent interpersonal crisis in relation to the alcoholics has been demonstrated in other studies as well (Murphy, Armstrong, Hermele, et al., 1979; Beskov, 1979; Berglund, Krantz, Landqvist, 1987; Berglund & Moberg, 1990).

Effects of alcoholism on marriage and family

Chakravarthy and Ranganathan (1985) examined the coping behavior of the wives of alcoholic men who were admitted into a therapeutic program for giving up alcohol drinking. The study reveal that discord, fearful withdrawal, and avoidance were the styles used most by the wives of alcoholics men. The combination of styles used by wives at a particular time seemed dependent on the age, extraversion, and neuroticism in the wife and the duration of the husband's drinking.

Kutty and Sharma (1988) investigated the characteristics of 35 wives of alcoholics (WOAs) and wives of non-alcoholics using a Malayalam version of a temperament scale that measures maladjustment, gregariousness, and thoughtfulness. WOAs scored high in maladjustment and low in gregariousness and thoughtfulness compared with controls.

Weinberg and Vogler (1990) examined how 38 women, married to alcoholics, managed the stigma resulting from the behavior of their husbands and adjusted to this behavior. Questionnaire data reveal that Ss learned about their husbands' drinking early in the relationship and responded to this with anger, hostility, and resentment. Fears included concerns for the husband's health and effects on their children and his job. Over time, fears have decreased, but problems in the marriages remain. Most Ss had participated in their husband's drinking. Although one-third of the Ss rated their marriages

as happy, most Ss reported unsatisfactory sexual adjustments. Support group membership helped Ss cope with their situation and develop self-esteem. Self-esteem was related to attitudes toward husband's drinking. Feelings of control were related to coping ability.

Sommer, Barnes and Murray (1992) investigated the relationship between Alcohol consumption, alcohol abuse, personality and female perpetuated spouse abuse. This study examined the problem of female perpetuated spouse abuse and its relationship to alcohol consumption and personality. Data from the subsample of 452 female Ss who were married or cohabiting were drawn from a random sample of 1,257 Winnipeg residents of the Health and Drinking Survey (aged 18-65 yrs). Results show that more than 39% of female Ss participated in some form of spouse abuse with their male partners. Being young and having high scores on the Eysenck Personality Questionnaire (EPQ) psychoticism scale, the Neuroticism Index, and the MacAndrew Scale (a subscale of the MMPT) were significant risk factors in the occurrence of partner abuse among females. Also, the interaction between alcohol consumption and the Psychoticism scale was a weak but significant predictor for this form of violence.

Suman and Nagalakshmi (1993) examined the personality dimension of alcohol dependent individuals (ADI) and their spouses on the Eysenck Personality Questionnaire. Forty alcohol dependent individuals and their

spouses and 10 normal couples in India with an age range from 25 to 45 yrs were studied. Results reveal high Neuroticism and Psychoticism in ADIs and low Extraversion and high Neuroticism in spouses of ADIs. The spouses of ADIs were significantly less extraverted than normal wives, who were more sociable, carefree and relaxed in interpersonal relationships. The spouses of ADIs were more inhibited, more withdrawn, and less assertive in interpersonal relationships. Results are discussed in terms of implications for influences, such as higher level of parents' education, parental discord, family size, and paternal domination. Alcoholics showed greater tolerance of criticism and were more likely to be eldest children.

McLeod (1993) estimated levels of spouse concordance for life time and current alcohol dependence and heavy drinking, using data from a community sample of 586 married couples. In addition, marital quality ratings in concordant and discordant couples were compared. Spouse concordance was significant for lifetime alcohol dependence and for both lifetime and current heavy drinking. Marital quality varied as a function of current heavy drinking and alcohol dependence such that members of couples in which neither spouse drank heavily reported better marital quality than other couples. Further more, although marital quality does not differ significantly between concordant and discordant couples, couples concordant for current heavy drinking consistently reported poorer marital quality than other couples.

Casey, Criffin and Googins (1993) investigated the role of work for wives of alcoholics. They collected questionnaire and interview data from 60 employed wives aged 23 –62 yrs whose husbands received inpatient treatment for alcoholism. The majority of working wives reported minimal negative impact of their husbands' drinking on all areas of their work functioning, with a small subset indicating impairment attributable to the drinking. These Ss were very satisfied with their current positions and described work as a positive experience. However, there were several indirect signs that the family alcohol problem spilled over into the workplace. These included changing jobs, absenteeism, and discussing husbands' drinking at work. Further, these Ss scored closer to a sample of depressed women than did a community sample on measures of physical and mental health, depressed mood, and smoking symptoms.

Brennan, Moos and Kelly (1994) studied the functioning, coping responses, and family contexts of spouses of late-life problem drinkers. At initial assessment, 87 spouses of late-life problem drinkers reported poorer health-related and social functioning, more reliance on cognitive coping strategies, and more shared, cognitive avoidance coping than did 87 spouses of non problem drinkers; they also reported more stressful, less supportive family contexts. 22 spouses of individuals who would remit over a 1-yr interval did not appear to provide their partners with an impetus for recovery. However, spouses of remitted problem drinkers improved in several areas

over the 1-yr follow-up. By contrast, 65 spouses of non-remitted partners continued to function more poorly and reported less supportive relationships with partners and escalating conflicts with children.

Banister and Peavy (1994) conducted an ethnographic study of 5 women married to alcoholics to develop knowledge about how these women lived out, interpreted, and expressed the experience of living with an alcoholic husband. Ss were interviewed, and interviews were analysed according to the Developmental Research Sequence Method developed by Spradley (1979) to discover the cultural experiences of Ss. Three common themes were identified that represented Ss' lives: constantly being on guard, being in a pit (weakening of self), and push and pull (disillusionment with cultural norms). The experience of Ss married to alcoholics was a complex interaction of culture that involved the internalisation of cultural expectations, weakening of self, and embeddedness in an alcohol-dependent marriage that encouraged Ss to be passive, dependent, self-sacrificing, and self-blaming.

Jiloha and Soni (1994) studied influence of family and marital relationship in alcoholism. 60 lower middle class men, half of whom were alcoholic, and their wives completed the Marital Adjustment Scale and the Family Relationship Inventory. Alcoholic Ss experienced their parents as avoidant in their childhood, while non-alcoholic Ss perceived them to be more

accepting. Non-alcoholics were better adjusted in their marital life than were alcoholics.

Moskalenko and Gun'ko (1994) examined 215 wives of alcoholics or divorced women who had been previously married to alcoholics. None of the women abused alcohol. Only 12 of them were officially registered as psychiatrist's patients. Borderline psychopathological conditions were diagnosed in 174 women who had long been married to alcoholic husbands or lived with them in one apartment. Of them, psychopathy, neurotic personality, neurosis, reactive depressions were identified in 27%, 24.7%, 23%, 15%, respectively. 41 divorced women living apart from former alcoholic husbands had no psychopathology at the moment of the study.

Dumka and Roosa (1995) studied the role of stress and family relationships in mediating problem drinking and fathers' personal adjustment. Family stress included negative life events, and father's family system resources included marital adjustment and positive father-child relationships. Interview data were obtained from fathers and mothers in 93 two-parent families of 4^{th}-6^{th} graders. Fathers' problem drinking contributed marginally to family stress, and directly to fathers' diminished personal adjustment. Family stress was related to reduced marital and personal adjustment. Mothers' problem drinking contributed. Results show that too less positive father-child relationships and stress process models differ for fathers and

mothers; family relationships do not appear to play a significant mediational role for fathers' adjustment.

Schiavi, Stimmel, Mandeli and White (1995) assessed the effect of chronic alcoholism on sexual function, marital adjustment, sleep-related erections, sleep disorders, and hormone levels during abstinence from alcohol. 20 chronically alcoholic (ALC) men (aged 28-59 yrs)

Suman and Nagalakshmi (1995) examined the nature of family interaction patterns in alcoholic families in India in comparison with those of non-alcoholic families. Forty alcoholic families (AFs) and 10 non-alcoholic families (NAFs), comparable in age and duration of marriage, were assessed using the Indian modification of the Family Interaction Scale. Results reveal that alcoholic families were characterized by significantly poorer communication patterns, lack of mutual warmth and support, spouse abuse and poorer role functioning. Spouses of alcoholics expressed greater dissatisfaction in all the areas of family functioning than alcoholics. Non-alcoholic families were characterized by free and open communication, mutual warmth and satisfaction and sharing responsibilities.

Boyle (1996) compared alcoholic and non-alcoholic families of origin as related to marital choice and emotional expressiveness of women. The focus of this investigation was to examine empirically how women who marry alcoholics and how women who are daughters of alcoholic parents

differ from other women in terms of their families of origin and emotional style. 120 Caucasian women who were non-alcoholic, as measured by the Michigan Alcohol Screening Test, and who were either married or had been married at least once to a spouse who was determined to be alcoholic or non-alcoholic, as measured by the Michigan Alcohol Screening Test for Significant Others along with the Children of Alcoholics Screening Test. The Family Environment Scale (FES) was administered retrospectively and the Test of Emotional Style (TES) examined perceptions of the subjects, comfort with their emotions as an adult. Results on several scales of the FES indicated that daughters of alcoholics perceived themselves to have had significantly less satisfactory relationships in their families of origin, (i.e. experienced less support for their personal growth and more family chaos). As expected, wives of alcoholics revealed a pattern within their families of origin similar to that of adult daughters of alcoholics. Several of the FES scales, especially those on the Personal Growth Dimension, indicated that the families of origin of adult daughters of alcoholics who are also wives of alcoholics were the most dysfunctional, when compared to all other subject groups. On the TES, the finding of greatest magnitude was that adult daughters of alcoholics who had married alcoholics were least satisfied with their emotional life whereas their counterparts who married a non-alcoholic were most satisfied with their emotionality.

Kocmur and Rus (1996) investigated the characteristics of 2 groups of wives of alcoholics: (1) 30 Ss (mean age 38.5 yrs) whose husbands are under treatment for alcoholism and 2) 30 Ss who seek help for their depression (mean age 39, 1 yrs), while their alcoholic husbands are not being treated for their alcoholism. Ss seeking help for themselves were found to be much more externally oriented than Ss participating in their husband's treatment. Differences found in Ss' personality development suggest that the perception of the locus of control is a personality dimension, such as decisive behaviour and reactions in a burdening situation. For externally oriented Ss, the behavioural pattern in crisis situations was helplessness, passivity and depression while for the internally oriented Ss, the pattern included active confrontation and problem solving.

Kodandaram (1996) compared the personality profiles of 30 wives of alcohol dependent individuals and of 30 normal controls with mean ages 31.1 and 36 years respectively. Subjects completed the General Health Questionnaire, and the Sixteen Personality Factor Questionnaire (16 PF) Form C. Wives of alcoholics were found low in general ability; submissive, and suspicious. They were also found to be shy, withdrawn, and aloof with considerate and careful behaviours.

Suman and Nagalakshmi, (1996) examined the variables that influence the degree of family dysfunction in alcoholic families. 40 alcohol dependent

men with mean age – 39 & 40 yrs and their spouses with mean age 32 & 55 yrs) were administered a semi structured interview schedule, the interpersonal Checklist, the Eysenck Personality Questionnaire and Family Interaction Scales. Results indicate that 8 variables significantly influenced are family functioning; emotional problems in the children, discrepancy between spouse's perception of the alcoholic and spouse's perception of ideal spouse on the Dominance dimension, role functioning of the alcoholic, Psychoticism scores of the alcoholic, discrepancy between alcoholic's perception of self and spouse's perception of the alcoholic on the Love dimension, Neuroticism scores of the spouses, discrepancy between alcoholic's perception of self and spouse's perception of ideal spouse on the Dominance dimension, and spouse abuse by the alcoholic.

Leadley, Clark and Caetano (1999) studied couples drinking patterns, intimate partner violence, and alcohol-related partnership problems of both romantic partners of 1,615 married and cohabiting couples using the "drinking partnerships" construct developed by Ruberts and Leonard (1997). Results show that despite considerable concordance between couple members' drinking behaviours, discrepant drinking patterns were strongly predictive of relational distress and the incidence of physical violence. These findings suggest that the interaction between couple member's alcohol-related behaviors has crucial implication for the health and well-being of the entire family.

Kahler, McCrady and Epstein (2003) examined sources of psychological and relationship distress among 90 non-alcoholic women with alcoholic male partners seeking outpatient, conjoint alcohol treatment. Results indicated that greater psychological distress among these women was most strongly associated with lower satisfaction with the marital relationship, presence of domestic violence, lower frequency of male partner's drinking, lower perceived social support from family, and more frequent attempts to cope with the partner's drinking. Controlling for psychological distress, greater marital satisfaction was associated most strongly with greater attempts to reinforce positively the partner's abstinence and with less effort to detach from the partner's drinking. Severity of partner's alcohol problem was unexpectedly associated with greater marital satisfaction in multiple regression analyses, though not in bivariate analyses. Results highlight the close connection between psychological and relationship distress and potential relations between alcohol related coping behaviours and both psychological and relationship distress.

Marshal (2003) in his study proposed three questions: (1) Do alcoholic marriages differ from nonalcoholic marriages? (2) Is alcohol consumption related to marital functioning? (3) What theoretical and methodological factors moderate the relation between alcohol consumption and marital functioning? The primary goal of this review was to evaluate the nature of the relation between alcohol use and marital functioning (adaptive Vs.

maladaptive) using these techniques. The secondary goal was to evaluate and summarize the methodological strengths and weaknesses of this literature and the extent to which they inform us about the internal and external validity of the findings, and the ability to make causal inferences regarding the relationship between alcohol use and marital functioning. Sixty studies were reviewed that tested the relation between alcohol use and one of three marital functioning domains (satisfaction, interaction and violence). Results provide overwhelming support for the notion that alcohol use is maladaptive, and that it is associated with dissatisfaction, negative marital interaction patterns, and higher levels of marital violence. A small subset of studies found that light drinking patterns are associated with adaptive marital functioning.

Scharff, Broida, Conway and Yue (2004) investigated within-group differences in psychological symptomology as measured by the Millon Clinical Multiaxial Inventory (MCMI). ACOAs, were compared by roles (Hero, Mascot, Lost Child, and Scapegoat) to non-ACOAs as measured by familial dysfunction and roles. MANOVA indicated significant main effects of dysfunction, role, ACOA, and an interaction of role and ACOA. Failures to recognize the impact of parental alcoholism may be caused by multiple adaptation strategies.

Kearns-Bodkin and Leonard (2005) examined the impact of the partner's drinking and the quality of the marriage. They studied 592 couples

using separate self-administered questionnaires. The results clearly indicate an association between alcohol use and marital quality.

Tempier, Boyer and Lambert et al. (2006) studied the consequences of alcoholism on the mental health of spouses of alcoholics using questionnaires which measures symptoms of anxiety, depression, aggressivity and cognitive impairments. This study confirmed higher levels of psychological distress in female spouses of male alcoholics.

Floyd, Cranford and Daughterty (2006) examined problem-solving marital interactions of alcoholic and nonalcoholic couples (N=132). Four alcoholic groups (husband alcoholic with antisocial personality disorder or not, paired with alcoholic or nonalcoholic wives) were compared with each other and with a both-spouses-nonalcoholic group. Consistent with the alcoholic subtypes hypothesis, couples with an antisocial alcoholic husband had higher levels of hostile behaviour regardless of wives' alcoholism status. In contrast, rates of positive behaviours and the ratio of positive to negative behaviours were greatest among couples in which either both or neither of the spouses had alcoholic diagnoses and were lowest among alcoholic husbands with non alcoholic wives.

The Present Study

Alcoholism has emerged globally as a very serious personal as well as community problem. Studies and reports reveal that the rate of incidence is alarmingly increasing both in India and abroad. Chakravarthy (1990) reported that 26-50% of Indian rural men are alcohol drinkers. In Kerala, according to the records of the Excise Department the revenue contribution by the sales of Arrack and Indian made foreign liquor only have shown an increase of 10 and 51 times (approximately) respectively in the past 20 years (from 1986 to 2006). Simultaneously literature on alcoholism and its effects clearly indicate the devastative and multifaceted impact on personal adequacies, interpersonal relations and family. Family exist as the most significant social component, especially in the Indian milieau, that is affected by alcoholism of a member and the disturbed family becomes an additional stress on the alcoholic person and thus creating a vicious circle in itself. The two major effects repeatedly agreed upon by researchers in various disciplines are financial and health related.

Marriage is the 'axis' of a family. Penrod (1986) has identified marriage as one of the most important indicator of Wellbeing of a person. Universalisation of the concept of marriage and changes in the pattern of family with urbanisation, industrialization, education and individualism taking place simultaneously have revolutionized family life and child rearing

which have become much more challenging for women. According to Jain (1988) "..... her task therefore is to develop physical, mental and emotional processes of the children in a perfect balance" (p. 148).

This implies that the role of woman as a creator of the race is marginalised and that as a mentor of the future generation is emphasised which is demanding more psychological resources from woman in the process of family making. It can also be inferred that demands of personal gratification and pleasures are looked upon as aspects to be subordinated to make marriage and family life a success by compromise and adjustment.

In view of these factors it can be safely stated that for the spouse of an alcoholic meeting the personal, familial and social demands, maintaining a psychological Wellbeing is a Herculean task. Ironically, despite a considerable amount of researches done on the problems and sufferings of the alcoholic man and woman at the global level and also on the effects of alcoholism of parents, the nonalcoholic spouses of alcoholics and their problems have not received sufficient attention. Some attempts were initiated in the west, such as by Boyle (1996); Kocmur and Rus (1996); Cierpialkowsk (1998); Kahler, McCrady and Epstein (2003) and Tempier, Boyer and Lambert et al. (2006); Dawson et al. (2007). But the results are too inadequate for generalisation or confirmation mainly due to reasons that:

(1) The pattern and significance of relation between spouses in the western families differ from those in India.

(2) The interaction and significance of relation with other members of the family and extended family in India differ from that of other countries.

The relations between individuals in a family and the impact of a stressed relation between spouses is quite different and is likely to be relatively more significant in view of the pluralistic attitudes prevalent in Indian culture. In India each family member is more dependent on others and when it comes to spouses it is likely to be overwhelming, especially, because the attitude to separation or divorce is highly stigmatised and freedom of the partners is restricted. Moreover, in the case of a woman it is too impractical, more often, due to her additional economic dependence on the spouse or the family. Under these circumstances a chronic alcoholic husband imposes severe stress that is unavoidable for the spouse. A perusal of the few studies on the 'alcoholic-spouse' dimension reveals that the focus has been either to study the effect of personality or behaviour pattern of the spouse on the alcoholic or just as an exploration of the difference between wives of alcoholics and non alcoholics. Negligible attention has been paid to the sufferings of the spouses of alcoholics. This view is endorsed by Hansson *et al.* (2004) also.

Although creating awareness and providing medical care to the addicts have considerably improved in India, their spouses are not getting due attention. She has to be given timely help so that she can extend emotional support to her addicted husband and can also manage the family and children without allowing to develop vicious circles of unhealthy interactions that could be lethal for the integration of the family itself.

Therefore, the present study is intended to initiate a process of helping the female spouse of an alcoholic, as part of helping the entire family, to readjust and recover from the problem, for moving towards a healthier time.

Marriage being the most intimate relation in an adult's life, the quality of the relation or the partner's adjustment to each other and the relation is vital for their Wellbeing. This becomes more relevant in the present context of more nuclear families emerging in India against the tradition of joint family system.

Empirical and theoretical literature on Stress, Adjustment and Coping indicate that the quality and level of adjustment in any context is not a function of the situation per se but is a product of the interaction between the characteristics of the individual and situation (Coleman, Morris and Glaros, 1987; Frydenberg, 1997). Coping style used by the individual has emerged as one of the crucial individual factors that mediate the effect of the stressor and reactions to the stressors. Reduction of effectiveness of coping and quality of

life have been the two frequently reported outcomes of stress. Hansson *et al.* (2004) have reported that information and coping skill training can improve spouses psychiatric symptoms and hardship.

Personality or individual characteristics have been consistently pointed out as a significant factor in the degree of stress experienced, reactions to stress and adjustment or coping to the stressful situation. So also personality has been found to be a determinant of the state of wellbeing of a person where state of wellbeing is an outcome of coping and adjustment.

Wellbeing at the outset can be considered as the outcome of the person - situation interaction which serves as a buffer that adds to the efficacy of the person in handling the situations.

In the light of these the present study is proposed to explore the relevance of Personality and Marital Adjustment of spouses of alcoholics in their General Wellbeing and to initiate a spouse focused helping by psychological counselling.

In view of these, certain objectives of the present study were identified. They are:

Objectives

1. To study the Marital Adjustment of the female spouses of alcoholics.

2. To study the role of personality and Coping styles as mediator variables in the effect of spousal alcoholism.
3. To study the role of certain Sociodemographic factors as mediator variables in the effect of spousal alcoholism.
4. To study the effectiveness of psychological counselling to enhance the General Wellbeing of the female spouses of alcoholics.

Hypotheses

A few hypothesis were formulated for evaluation to meet the objectives which are as follows:

1) Personality pattern of spouses of alcoholics differ from that of spouses of non alcoholics.
2) Marital Adjustment of spouses of alcoholics and spouses of non alcoholics differ.
3) General Wellbeing of spouses of alcoholics and spouses of non alcoholics differ.
4) Marital Adjustment of spouses of alcoholics differ with certain socio demographic factors.
5) General Wellbeing of spouses of alcoholics differ with certain socio demographic factors.
6) Personality characteristics and Marital Adjustment are significantly related in spouses of alcoholics.

7) Personality characteristics and General Wellbeing are significantly related in spouses of alcoholics.

8) Marital Adjustment and General Wellbeing are significantly related in spouses of alcoholics.

9) Psychological counselling improves the Marital Adjustment of the spouses of alcoholics by modifying their coping styles.

10) Psychological counselling improves the General Wellbeing of the spouses of alcoholics.

CHAPTER III

METHODOLOGY

- Design
- Sample
- Tools
- Administration and Scoring
- Analysis of Data

As discussed in the second chapter the present study focuses on alcoholism with respect to Personality, Marital Adjustment and General Wellbeing of spouses of alcoholics. Present investigation aims to study the influence of alcoholism on Marital Adjustment and General Wellbeing of spouses of alcoholics and their personality as a mediator variable.

Research methods are often divided into two main types: quantitative and qualitative methods. According to Aliaga and Gunderson quantitative research is explaining the phenomena by collecting numerical data that are analysed using mathematically based methods (Muijs, 2004). In Breakwells (1995) opinion, research methods can be differentiated according to whether data are submitted to a qualitative or quantitative treatment.

According to Cook and Campell (Smith, 2000) research design is the systematic planning of research to permit valid conclusions. It involves the specification of the population to be studied, the treatments to be administered and the dependent variables to be measured, all guided by theoretical conceptions underlying the research. Kothari (1993) opines that generally the design which minimises bias and maximises the reliability of the data collected and analysed is considered a good design.

Research design most fundamentally affects the internal validity of research, that is the ability to draw sound conclusions about what actually

causes any observed differences in dependent measures. In fact the research design is the conceptual structure within which research is conducted, it constitutes the blue print for the collection, measurement and analysis of data.

Design of the present study

The first part of present study falls under Exploratory research with non experimental data. This type of research is recommended for researches in the areas of emotion and personality to identify the distinct psychological dimensions (Wegener & Fabrigar, 2000). The second part of the study follows the action research format. Accordingly the quasi experimental design is used with non randomised control and experimental groups (Creswell, 1994).

This chapter gives a description of the research design followed, the sample of the study, the instruments which were employed to obtain the empirical data and other relevant informations necessary for the study and lastly analysis of the gathered data to meet the objectives of the study.

SAMPLE

The present sample consists of two groups. Group 1 comprising of 118 spouses of alcoholics. Group 2 comprising of 68 spouses of non alcoholics. Only female spouses of alcoholics were selected for the investigation because only male alcoholics were available in the de addiction centers. The multistage sampling is used.

In order to select a representative sample all the addicted male subjects were selected from a de-addiction centre at Kozhikode recognised by the central board of Social-Welfare and where a psychiatrist confirms the diagnosis first. Then the investigator also examined and verified the diagnosis by the clinical interview method. It was also ensured that they were in the habit of drinking even prior to marriage. Moreover, all these subjects had a history of 10 or more years of alcoholism so that the entire group falls under the category of chronic alcoholics. As a second step their wives were included in group 1.

Besides this criteria it was also ensured that the selected spouses of alcoholics were free from any noticeable physical or psychological illness for which treatment is to be taken. The spouses of non alcoholics were also selected from the same families so that the socio-economic factors of the family environment other than having an alcoholic spouse do not contribute to variance between the groups. In this group also any history of physical and/or psychological illness was ruled out. Thus the two groups were matched with respect to certain characteristics. Initially 125 spouses of alcoholics and 75 spouses of non alcoholics were selected. Based on their tendency to distort the responses and lack of motivation in responding to the personality test, 14 were deleted and thus the final sample constitute 118 subjects.

A post-hoc analysis of the sample gives a detailed description of the sample with respect to certain socio-demographic factors. Table 3.1 gives the distribution regarding age and education.

TABLE 3.1

Distribution of the sample by age and education

Sl. No.	Groups	Age in years		Educational level		
		18-35	36-55	Upto High School	Upto Plus Two	Graduation and above
1	Wives of Alcoholics	64	54	60	40	18
2	Wives of Non Alcoholics	34	34	20	33	15

Table 3.2 gives the scatter regarding family type, employment and religion.

TABLE 3.2

Distribution of the sample by Religion, Employment and Family type

Sl. No.	Groups	Religion			Employment		Family type	
		Hindu	Christian	Muslim	Employed	Un-employed	Joint	Nuclear
1	Wives of Alcoholics	75	12	31	45	73	44	74
2	Wives of Non Alcoholics	36	14	18	42	26	29	39

With respect to the last two hypotheses of the study for testing the effectiveness of counselling in improving the General Wellbeing and Marital Adjustment of the wives of alcoholics 20 subjects were selected from the 118 on the basis of their duration of stay and availability for daily counselling continuously.

TOOLS

For the present investigation four standardised self report measures and a Personal Data Sheet prepared by the investigator were used.

1. To study the Personality patterns of subjects in the samples Malayalam adaptation of 16PF form C (Rema & Anita, 1994) was used.

2. To study the Marital Adjustment of the subjects, a Malayalam version of the Marital Adjustment Questionnaire (Kumar & Rohatgi, 1987) prepared by the investigator was used.

3. To study the Wellbeing of the entire sample a Malayalam version of the PGI General Wellbeing measure was used (Sareena & Anita, 2004).

4. A Malayalam version of the AECOM Styles Questionnaire (Shanty & Anita, 2006) was used to verify the change in Coping styles effected by counselling among selected subjects.

A brief description of tools is given in the following pages.

1. Personal Data Sheet

A list of items prepared by the researcher was used to collect the socio-demographic factors like age, education, etc. and some other relevant informations regarding the nature and history of alcoholism of their husbands. It consists of 15 points which was used as an aid for clinical interview.

2. 16 PF Form C

On the basis of their factorial research, Cattell and his co-workers have developed a number of personality inventories of which the best known is the Sixteen Personality Factor Questionnaire. Originally published in 1949, the 16 PF is virtually self administering, and can be used with groups and individuals. It is applicable to a wide range of educational levels and is available in some 15 languages.

There are six forms of the 16 PF, each meant for different populations and varying slightly in the number of items. Forms C and D are with a some what less demanding vocabulary and consisting of 105 items each with a three-choice response pattern including an "in between" option.

Whether longer or shorter forms of 16 PF are used all forms measure 16 dimensions of Personality. Each dimension is identified as a primary factor and each factor is designated by an alphabet. Four second order factor scores from a combination of the sixteen factors are also obtained. The

second order scores provide a convenient capsule description of personality. The primary and second order factors of 16 PF questionnaire are shown in Table 3.3 and Table 3.4 respectively.

TABLE 3.3

The Primary Source Traits on the 16 PF Test

1. Primary factors		
Factor	Low Sten Score Description	High sten score Description
A	Reserved-Sizothymia	Outgoing-Affectothymia
B	Dull-Low intelligence	Bright-High Intelligence
C	Affected by feelings - Lower ego strength	Emotionally Stable-Higher ego strength
E	Humble-submissiveness	Assertive-Dominance
F	Sober-Desurgency	Happy-Go-Lucky-Surgency
G	Expedient-weaker super ego strength	Conscientious - stronger super ego strength
H	Shy-Threctia	Venturesome - Parmia
I	Tough-Minded-Harria	Tender minded - Premsia
L	Trusting-Alaxia	Suspicious-Protension
M	Practical-Praxernia	Imaginative-Autia
N	Fourthright-artlessness	Astute-Shrewdness
O	Self-assured-Untroubled adequacy	Apprehensive-Guilt Proneness
Q_1	Conservative-Conservation temperament	Experimenting-Radicalism
Q_2	Group dependent-Group adherence	Self-sufficient-Self sufficiency
Q_3	Undisciplined self conflict Low self-sentiment integration	Controlled-High strength of Self-sentiment
Q_4	Relaxed-Low Ergic Tension	Tense-High ergic tension

TABLE 3.4

Second order factors on the 16 PF Test

Symbol	Technical Title	Popular label
Q_I	Exvia Vs Invia	Extraversion Vs Introversion
Q_{II}	Adjustment Vs Anxiety	Low Anxiety Vs High Anxiety
Q_{III}	Pathemia Vs Cortertia	Sensitivity, Emotionalism Vs Tough Poise
Q_{IV}	Subduedness Vs Independence	Dependence Vs Independence

Usha Seetharam (1974) modified form C of the 16 PF in English with the language made simpler than the original form to suit Indian population. Rema and Anita adapted this questionnaire into Malayalam in 1989.

Reliability

Sufficiently high parallel form reliability and item to factor correlations were reported by Seetharam.

Validity

Validity of the Malayalam adaptation of 16 PF form was found by computing factor wise correlations between scores on the English and Malayalam forms and this ranged from 0.74 to 0.98. Validity was also estimated by calculating the mean of the correlations of all the items with the respective factor scores and this ranged from 0.58 to 0.90. The validity of the

version is further supported by several studies (Sareena & Anita, 2004; Job & Asha, 1996).

3. Marital Adjustment Questionnaire

The Marital Adjustment Questionnaire (MAQ) by Kumar & Rohatgi (1987) has been developed to provide a handy tool to identify couples who are making poor marriage and need psychodiagnostic help. Further, the questionnaire is developed in a way to provide a more meaningful single composite marital adjustment score for the couple unlike other available scales which gives separate marital adjustment scores for both. Thus it reflects the relation more meaningfully.

Marital Adjustment Questionnaire (MAQ) in its final form consists of 25 highly discriminating 'Yes-No' types of items. Personality qualities, emotional factors, sexual satisfaction, marital role and responsibility factors, in-law relationship, attitudes towards family planning and children, interpersonal relationship and economic, religious and social factors are the areas included.

In the initial form of the questionnaire there were 57 positively worded and 7 negatively worded items. All these items were scored "1" or '0' depending on the direction of the Marital Adjustment score for the subject. The total Marital Adjustment score varied from 0 to 64, showing lowest to the highest Marital Adjustment.

Twenty five items with discrimination values of 0.19 or above were finally selected for the questionnaire. The reliability and validity reported by the authors are as follows:

Reliability

The split half reliability, correlating odd-even items applying the Spearman-Brown formula for doubling the test length was found to be 0.49 (N=60) with an index of reliability of 0.70. The test-retest reliability was found to be 0.71 (N=60) with an index of reliability of 0.84. The retest was given with a time interval of 3 weeks.

Validity

The face validity of the questionnaire appeared to be fairly high as the items were prepared following intensive interviews of 100 married couples regarding their concept of happy married life. The content validity was adequately ensured as only those items from the initial questionnaire for which there was 100 percent agreement among the judges were selected. Only items which showed a fairly high discriminating value following item-analysis were selected for the final questionnaire. The diagnostic meaningfulness of the items at the time of final selection was also taken into account. The questionnaire was also validated against Singh's Marital Adjustment Inventory (Singh, 1972). The coefficient of correlation between

the questionnaire and Singh's Marital Adjustment Inventory for a group of 20 wives was found to be 0.71 with index of reliability of 0.84.

Linguistic adaptation

For the present study the Marital Adjustment Questionnaire was linguistically adapted, as part of the pilot study, to suit the present sample. A summary of the procedure of adaptation from English to Malayalam is as follows:

Translation

As the first step, the items of the English version were translated into Malayalam to suit the local population. A word to word translation was not followed, but it was made in such a way that the meanings were conveyed in the local vernacular. The translation in Malayalam was made by the investigator with the help of academically competent persons and was checked by language experts before it was administered on a selected sample.

Sample of standardisation

The sample for standardisation was drawn from a population of school teachers in the different schools of Malappuram district. Systematic random sampling technique was used for selecting the subjects. It was made sure that all subjects had equal proficiency in Malayalam and English. The sample

consisted of 33 teachers of which 18 were men, 15 were women whose age ranged from 22 to 35 years with an average age of 26 years.

In order to establish efficiency of the Malayalam form, comparable to that of the English form and also for establishing reliability and validity, the English version and the translated Malayalam version were administered on this selected sample. For the first fifteen subjects of the group, questionnaire in English was given first. After a two week interval, the translated Malayalam version of the test was given to the same subjects. To minimise the influence of priority for one language, the remaining eighteen subjects were given the Malayalam version first and two weeks later the English version was administered. Product moment correlation computed between total score on the English version and total score on the Malayalam version was .92 which is sufficient to establish the comparability of the two linguistic forms.

4. PGI General Wellbeing Measure

Many attempts have been made in the past to measure the positive mental health, only one of which is the measure of subjective, general sense of psychological well-being. Verma and Verma (1989), developed one such tool which appears to be reliable and valid.

Verma and Verma (1989) reported that the development of a scale to measure the general wellbeing of an individual was made by Dr. H. Dupery in

1970 and this schedule was later used and modified by Edwards and Fazio and many others in several large scale studies. This scale was a 25 item, 6 point scale with 33 scores measuring several aspects of adjustment like freedom, health concern, worry, distress, energy level, satisfaction, cheerfulness, relaxation, emotional behaviour control etc.

This scale was tried out and modified, with certain items deleted from the format and was completely changed and simplified, to suit Indian conditions where majority of our clinic population is rural, illiterate and unsophisticated to use complex tests. A 20 point scale was thus constructed called PGI General Wellbeing scale. Hindi version of this scale is also made available by Moudgil *et al.* in 1986. As cited by Verma and Verma (1989) Moudgil stated that scale scores have been found to be independent of socio-economic status (-0.39) and education (0.12) when correlated with these variables but it showed correlation with age (0.52, $P<0.01$).

Reliability

Verma and Verma (1989) have cited that reliability estimated by Kuder and Richardson formula 20 was 0.98 ($P < 0.01$) and for test retest reliability the coefficient was 0.91 ($P < 0.01$) for the English version.

Validity

The test was correlated with a number of tests in different studies. The scale showed significant correlations of 0.56 with Bradburn wellbeing scale and of 0.54 with PGI Quality of Life Scale (Verma and Verma, 1989).

Sareena and Anita (2004) translated the English version into Malayalam to suit the local population. A word to word translation was not followed, but it was made in such a way that the meanings were conveyed in the local vernacular.

In order to establish efficiency of the Malayalam form, comparable to that of the English form and also for establishing reliability and validity, the English version and the translated Malayalam version were administered on a selected sample of 100 PG students including equal number of boys and girls. Table 3.5 gives the details of correlations between scores on the two versions.

TABLE 3.5

Correlation Co-efficients between Scores on the English and Malayalam Versions of PGI Well-being Scale

Sl. No.	Group	r	Level of Significance
1	Girls	0.9316	0.001
2.	Boys	0.9510	0.001
3	Total	0.95440	0.001

The value in the Table establishes the validity of the Malayalam version. This was therefore used with subjects of the present study.

5. AECOM Coping Scale

Albert Einstein College of Medicine Coping Styles Questionnaire developed by Plutchick and Conte (1989) is based on the psychoevolutionary theory of emotion described by Plutchink in 1980, which postulates systematic connection between 8 basic emotions and 8 coping styles. This consists of 87 items, each related by the subject on a 4point scale ranging from 'never' to 'often', weighed 0 to 3. It is based on the expressed opinion that the way each individual cope with stressful life events is relatively independent of his or her emotional or psychopathological state and is characteristic of him or her.

This model assumes that there are 8 basic Coping Styles that may be used by an individual in his or her attempt to reduce stress or cope with life problems. These Coping Styles are defined by the author as:

Minimization: Minimizing the importance of the problem or solution.

Suppression: Avoiding the problem or situation.

Help seeking: Asking others for help.

Replacement: Dealing with problems by finding alternative solutions.

Blame: Blaming others or the "system" for his or her problems.

Substitution: Engaging in tension reducing activities such as sports.

Mapping: Collecting information about the situation or problem.

Reversal: Acting the opposite of the way he or she feels.

Reliability and Validity

The internal reliability of AECOM-CSQ is reported to be quite high. Coefficient alphas ranged from +0.62 to +0.83 for the individual scales, with an average of +0.70 for the 8 scales.

Though the validity of this scale is not mentioned by the author, it was used successfully in a number of studies. In one, prisoners were found to be lower on the Coping Styles of Minimization and Replacement and higher on Suppression and Help seeking than control group (Plutchick and Conte, 1989). In a study of hospitalized alcoholics they had a strong tendency to use Suppression, Blame and Help seeking as Coping Styles in contrast to matched normal controls (Conte, Plutchick, Picard, Galaner and Jacob, 1989). Some of the coping styles have also been found to discriminate between violent and non-violent sex offenders (Langerin, Lang, Handy and Majpruz, 1989). Personality and social class differences have also been reported in relation to these coping styles. In a study of academic achievement in adolescent students three coping styles, minimization, suppression, seeking succorance

appeared to be different among High, Average and Low achievers. High achievers showed a tendency to use seeking succorance as a coping style. Low achievers tend to blame others and use suppression as coping styles (Neetha & Anita, 2002). All these studies prove sufficient validity of the scale.

For use with the native population a Malayalam adaptation of the AECOM-CSQ prepared by Shanty and Anita (2006) was used. This translated form and the original form were administered to 30 PG students (15 girls and 15 boys) of various departments of Calicut University with an interval of 48 hrs. The scores for the two forms were correlated using Product Moment method to estimate reliability. Details of the correlation are given in Table 3.6.

TABLE 3.6

Correlation coefficients between English and Malayalam version of AECOM

Sl. No.	Coping Styles	Correlation coefficient
1	Minimization	0.9480
2	Suppression	0.9203
3	Help seeking	0.9226
4	Replacement	0.9058
5	Blame	0.9427
6	Substitution	0.9581
7	Mapping	0.8299
8	Reversal	0.9617

The range of correlation coefficients in table 3.6 clearly establishes the reliability of the adapted form. This adaptation successfully differentiated coping styles of couples with healthy and unhealthy mental relationships and could also indicate improvement in the relation among couples who sought counselling for marital conflicts (Shanty and Anita, 2006).

Copy of all the tools used in the study are given as Appendices.

ADMINISTRATION AND SCORING

During the clinical interview personal data was collected using the Personal Data Sheet. Then the three tests measuring Personality, Marital Adjustment and General Wellbeing were administered on the entire sample individually. The test to assess coping pattern was administered only on selected subjects for testing efficacy of Psychological counselling. The tests were administered with short intervals because all the subjects may not be willing to spend many days for testing and their availability depended on their stay in the clinic. Three tests, MAQ, PGI General Wellbeing Scale and AECOM Scale were administered on the counselled subjects before and after counselling sessions.

The four tests used are scored following the directions given by the respective authors. Hand scoring method is followed in all cases. Description of administration and scoring used for each tool is as follows.

1. 16 PF

Administration

The 16 PF form C was administered on spouses of alcoholics and spouses of non-alcoholics individually. After seating the subject comfortably and establishing sufficient rapport, the question booklet along with answer sheet was given. Simple and clear instructions are printed on the booklet. Though the test was untimed, the investigator reminded the respondents that they should not dally and should give immediate answers and move along. Answers were always made on separate answer sheets.

Scoring

Hand scoring method was used. Two card-board stencil keys were used. One covered factors A, C, F, H, L, N, Q_1 and Q_3 and the other covered factors M, D, B, E, G, I, M, O, Q_2 and Q_4. Each answer scored 0, 1 or 2 points except for factor B answers, which scored 0 or 1. The score of each single item contributed to only one factor. The raw scores were converted to sten scores by referring the appropriate table. A sten score of 1 to 3 was considered low, score of 4 and 7 as slightly deviant, score of 5 and 6 as average and a score of 8 to 10 as high. As the author of the original test suggested, the subjects with a score of 12 and above on MD (Motivational Distortion) scale were deleted from the sample as they show poor motivation to respond to the test. Second order factors were analysed, which were

derived from the sten scores on the primaries following the method shown in the manual (Rema & Anita, 1994).

2. Marital Adjustment Questionnaire (MAQ)

Administration

It was emphasised that there is nothing 'right' or 'wrong' about these items and that no item be omitted. Since many items are related to very personal life of the subject they were assured that their replies would be kept confidential. They were requested to be free and fair in giving their replies as the very success of the project depended on it.

Scoring

A 'Yes' response is assigned a score of 1 except for items 4, 10 and 19 in which case the reverse is applicable. Sum of the values gives the marital adjustment score for the husband or wife. Since the responses contributing towards marital adjustment are given a score, the higher the total score, the higher would be the marital adjustment of the husband or wife.

3. PGI General Wellbeing Scale

Administration and Scoring

The PGI General Wellbeing Scale in Malayalam was administered on the entire sample individually. After making sure that they are ready and

relaxed, the simple instructions printed on the scale was read to them. Then the respondents were asked to tick the statements which were applicable to them. Number of ticks was counted and that constituted the wellbeing of that particular individual at that time. Subjects who got more than 10 points on this scale were considered healthy (Verma & Verma, 1989).

4. AECOM Coping Style Questionnaire

Administration

The test was administered only on 20 subjects who were given counselling. The subject was seated comfortably and after establishing a good rapport, oral instructions were given to the subject and the AECOM coping scale was given. The subject was asked to rate the statements on a 4-point scale ranging from 'never' to 'often'. Doubts if any were clarified. 45 minutes were taken to complete the test.

Scoring

For each item, 'never' is scored as '0', 'rarely' as 1, 'sometimes' as 2 and 'often' as 3. These numbers were transferred to the corresponding item boxes in the scoring sheets. All the scores in each column is added and the totals are recorded. Scores for the 8 types of coping are thus found out.

Analysis of Data

The present investigation, an attempt to understand the personality, Marital Adjustment and General Wellbeing of spouses of Alcoholics; had formulated certain hypotheses presented in the second chapter. After scoring and tabulating the responses on each tool, tenability of hypotheses was tested statistically as follows.

For testing hypotheses 1, 2 & 3 significance of mean difference between the scores of the female spouses of alcoholics and non alcoholics were tested by computing percentages of extreme scores on the personality variables and t-test for each variable in the study.

For testing hypotheses 4 & 5 Two way ANOVAs were computed to study the difference in Well-being and Marital Adjustment with respect to each demographic variable included in the study, viz., Age, Education, Religion, Employment and Family type and their interactions.

For these variables and interactions yielding significance F-values, t-tests were computed between pairs of means to verify the nature and extent of differences.

Hypothesis 6, 7 & 8 were tested by Multivariate Analysis. Simple and Stepwise Multiple Regression method was applied to study the nature and

extent of relationship between the variables and the extent of predictions of their interdependence.

With respect to the last two hypotheses mean differences between pre and post counselling test scores were tested for significance separately for each variable.

The results obtained in each analysis is discussed in relation to the theoretical and empirical literature and is presented in the next chapter.

CHAPTER IV

RESULTS AND DISCUSSION

Section A

- Hypothesis 1
- Hypothesis 2
- Hypothesis 3
- Hypothesis 4
- Hypothesis 5

Section B

- Hypothesis 6
- Hypothesis 7
- Hypothesis 8

Section C

- Hypothesis 9
- Hypothesis 10

In the present study an attempt has been made to understand the Personality, Marital Adjustment and General Wellbeing of the spouses of alcoholics. The results obtained in the study are divided into three sections. In the first section, results with regard to Personality, Marital adjustment and General Wellbeing of spouses of alcoholics (ALCH) in comparison with spouses of non alcoholics (NALCH) are presented. In the second section, results pertaining to the relationship between personality, Marital Adjustment and General Wellbeing are described. In the third section, the results obtained with regard to effects of psychological counselling on Coping, Marital Adjustment and General Wellbeing of the selected subjects are discussed.

SECTION A

This section verifies the first five hypotheses of the present investigation in two steps. In the first step differences between ALCH and NALCH groups (hypotheses 1, 2, 3, 4 & 5) are discussed. In the secondstep the differences on three variables with respect to certain demographic characteristics (hypotheses 4 and 5) are also verified.

Hypothesis 1

With respect to the first hypothesis that personality pattern of spouses of alcoholics differ from that of nonalcoholics, results are discussed in two subsections. Firstly, the personality of the entire sample is analysed and

secondly comparisons of the personality of the spouses of alcoholics (ALCH) with those of non alcoholics (NALCH) is attempted.

Personality pattern of alcoholic spouses and nonalcoholic spouses are analysed in terms of percentage of subjects scoring low (1-3), scoring high (8-10), and others on the 16PF variables. Factorwise details of the percentage is as shown in Table 4.1.

TABLE 4.1

Percentage of Low Scorers, High Scorers and Others in ALCH and NALCH group on the 16PF Factors

16 PF factors	Percentages					
	Low Scorers		High Scorers		Others	
	ALCH	NALCH	ALCH	NALCH	ALCH	NALCH
A	46.2	51.4	-	1.5	53.8	47.1
B	61.0	47.0	-	3.0	39	50
C	65.0	69.0	-	-	35	31
E	55.0	51.5	4.0	5.5	41	43
F	43.7	35.2	8.3	11.7	48	53.1
G	5.0	10.4	5.0	4.4	90	85.2
H	34.7	33.7	2.3	7.3	63	59
I	3.3	-	22.7	8.9	74	91.1
L	11.8	38.2	11.0	8.8	77.2	53
M	24.5	17.6	13.5	8.8	62	73.6
N	28.9	23.5	12.7	16.2	58.4	60.3
O	6.7	5.5	42.3	23.5	51	71
Q_1	18.6	32.2	10.2	8.8	71.2	59
Q_2	43.0	50.5	8.0	1.5	49	48
Q_3	30.5	26.0	1.0	-	68.5	74
Q_4	10.1	20.6	12.7	13.2	77.2	66.2

An examination of the percentages reveal that extreme and strongly dominant scores are not very frequent in both the groups. However on factors, I and O, the percentage of high scoring wives of alcoholic is higher as compared to those of non alcoholics. On factor I, 22.9% of the group scored high. This indicates that wives of alcoholics tend to be more tender minded, feminine, demanding attention and help, dependent and sensitive than the wives of non alcoholics.

On factor O, 42.3% of the ALCH group and 23.5% of the NALCH group scored high. This reveals that wives of alcoholics tend to be more worried, depressive and troubled than those of nonalconholics. On factor B the trend is reversed with some subjects in the NALCH score high and more in the ALCH group have scored low. However the percentage of high scorers in the NALCH is also very few indicating that they are not too different from the ALCH group.

Another feature that is noticeable in Table 4.1 is that fewer spouses of alcoholics (ALCH) have scored low on factors L, Q_1 and Q_4 and more people in the group have scored low on factor B as compared to the spouses of non alcoholics (NALCH).

According to the definition of factor L fewer spouses of alcoholics scoring low indicates that they are not having a trusting, easy to get on trait as a stable characteristic in their behaviour. The table also reveals that almost an

equal number of the same group have scored high on the factor L. This means that they are neither very trusting nor suspicious by nature. Kodandaram (1996) has also reported similar findings. More number of spouses of non alcoholics have scored lower on this factor with fewer members of them scoring high on the factor as compared to the ALCH group indicating that the spouses of non alcoholics are relatively more trusting and easy going. This finding is in the theoretically expected direction that interaction in life with the emotionally and behaviourally unstable alcoholic spouses might lead to reduction in the trusting nature of the partner which may even make them suspicious about their spouses at times.

Analysing the scores on factor Q_1, representing *conservative* and *experimenting* as the two extremes, the spouses of the alcoholics (ALCH) are mostly average scorers with relatively lower number of ladies scoring low, revealing lesser tolerance of traditional ideas, while wives of non alcoholics (NALCH) tend to be either conservative or average scorers. This finding can be attributed to the fact that wives of non alcoholics having a healthier family life can afford to the more tolerant and respecting of traditional ideas, where as the wives of alcoholics being exposed to many stress and strains in the family life may tend to lose their faith in the traditional roles, behaviour and beliefs.

The next factor showing some difference in percentage is Q_4. It is revealed that relatively more number of subjects have scored low, i.e., relaxed in the NALCH group than in the ALCH group, which is very well expected of. It is also interesting to note that in both groups more Ss tend to be neither very relaxed nor tensed, which is probably the mental state of women in this culture. Suman and Nagalakshmi (1993); Kahler, McCrady and Epstein (2003); Homish and Leonard (2007) and Tempier et al. (2006) have also reported reduced sociability and psychological distress among wives of alcoholics.

Secondly the percentage of low, high and others on the second order factors of 16PF was found out. Table 4.2 gives the details.

TABLE 4.2

Percentage of low, high and others on the secondary factors of Personality in ALCH and NALCH group

Sl. No.	Personality factors	Percentages					
		ALCH			NALCH		
		Low	High	Others	Low	High	Others
1.	Extraversion (QI)	44.5	4.0	51.5	39.7	1.5	58.8
2.	Anxiety (QII)	2.4	34.4	63.2	3.0	17.8	79.2
3.	Toughness (QIII)	38.8	.8	60.4	51.5	3.0	45.5
4.	Independence (QIV)	45.1	.8	54.1	35.4	0	64.6

An examination of the percentages reveal that on factor Q II (Anxiety) more number of (34.4) alcoholic spouses fall under high scorers category whereas in the non alcoholic group the percentage of high scorers is 17.8 only. Number of low scorers are less in both groups with more spouses of NALCH scoring average or deviant.

The table also reveals that an apparently lower percentage of spouses of alcoholics scored low on factor QIII (Emotionally vs Alert Poise). At the same time it is also noteworthy that a negligible percentage of them have scored high on this factor and majority falls under the average scoring group. This means that they are neither dependent on feelings nor they are objective or skilled in problem solving. They tend to the relatively more passive. On the other hand spouses of nonalcoholic in this study are also not emotionally alert as revealed by the values in Table 4.2. But a higher percentage of them have scored low indicating that they are more feeling oriented. This pattern fits into the traditional concept of femininity and probably most of the women in the geographical areas of sampling confines to it.

Therefore the results in Table 4.2 suggest that spouses of alcoholics are more anxious which could be situational and is an indication of dissatisfied with life as mentioned by Cattell, Eber and Tatasuoka (1976), but they are not much bothered by their feelings.

Finally, significance of difference between means of the spouses of alcoholics and those of nonalcoholics were tested using students 't' for the 20 personality variables on the 16PF. Table 4.3 gives the details of the computations.

TABLE 4.3

Means, SDs and 't's on Primary Personality factors for ALCH and NALCH groups

Personality factors	Mean of ALCH	SD	Mean of NALCH	SD	df	't'	Signi-ficance
A	3.9316	1.920	3.7206	2.198	183	0.66	0.511
B	2.7881	1.632	3.6324	2.094	184	3.06	0.003
C	2.9237	1.971	2.6324	1.647	184	1.03	0.305
E	3.5339	1.933	3.7647	2.152	184	-0.75	0.453
F	3.7458	2.043	4.1471	2.241	184	-1.24	0.215
G	6.0254	1.516	5.5735	1.568	184	1.93	0.055
H	4.5000	1.903	4.5735	2.010	184	-.25	0.804
I	6.4492	1.528	6.1618	1.154	170.89	1.45	0.149
L	5.4576	1.907	5.1765	1.969	184	0.96	0.340
M	5.2288	1.950	5.2353	1.754	184	-0.02	0.982
N	4.7797	2.238	5.0147	2.077	184	-0.71	0.480
O	6.8644	1.890	6.3382	1.890	184	1.83	0.069
Q1	5.0254	1.771	5.3235	1.688	184	-1.12	0.262
Q2	3.8729	1.795	3.6618	1.913	184	0.75	0.452
Q3	4.0085	1.593	4.0000	1.466	184	0.04	0.971
Q4	5.6525	1.914	5.2500	2.119	184	1.33	0.186

An examination of the 't' values in Table 4.3 indicate that there are only two 't's significant for primary factor - 'B' and 'G'. On factor B the mean value is high in spouses of nonalcoholics, which indicates that they are more intelligent when compared to spouses of alcoholics. It may suggest that alcoholic spouses are unable to handle abstract problems, and are less well organized and poorer in making judgments. Similar finding is reported by Kodandaram (1996). Although the difference is significant both the mean values fall below average on the variable indicating that the gross level of intelligence does not differ much between the groups. This also supports the homogeneity of samples of the study in terms of general intelligence.

The mean values for factor G show that ALCH group is scoring significantly higher which means that spouses of alcoholics are more duty bound and those of non alcoholics are more casual. The spouses of alcoholics tend to be more steady in purpose. These tendencies are probably the consequence of the family life. With an alcoholic relatively irresponsible husband wife has to be purpose oriented and responsible.

The significance of mean differences for the second order factors are shown in Table 4.4.

TABLE 4.4

Means, SDs and 't' on Second Order Personality factors for ALCH and NALCH groups

Second order factors	Mean ALCH	SD	Mean NALCH	SD	df	't'	Signi-ficance
Anxiety (QI)	7.1161	1.484	6.6941	1.286	184	1.96	0.052
Extraversion (QII)	4.2780	1.486	4.3706	1.541	184	0.40	0.687
Toughness (QIII)	4.1754	1.364	4.2750	1.433	184	0.47	0.638
Inde-pendence (QIV)	4.2822	1.449	4.5941	1.383	184	1.44	0.152

The results in Table 4.4 reveal that mean of spouses of alcoholics and non alcoholics do not differ much on second order factors except in QI, for low anxiety Vs. high anxiety. The mean of ALCH group is high when compared to that of NACCH group which indicates that the spouses of alcoholics experience higher anxiety. As suggested by Cattell they need not be neurotic, since anxiety could be situational, but it is probable that, they have some maladjustment, i.e., they are dissatisfied with the degree to which they are able to meet the demands of life and to achieve what they desire. Very high anxiety is generally disruptive of performance, and productive of physical disturbance. Although here the differences between the means and SDs of NALCH and ALCH are not too high, this situation may lead to a state of helplessness, and less productive in their day to day life. Higher anxiety of

spouses of alcoholics is also supported by the findings of Tempier *et al.* (2006).

On the other three factors the ALCH and NALCH groups are similar, tending towards the lower range. Thus comparison of the two groups on personality suggests that there is only very little difference and hence the first hypothesis cannot be accepted fully.

Hypothesis 2

For testing the second hypothesis that Marital Adjustment of spouses of alcoholics and spouses of non alcoholics differ, mean scores for Marital Adjustment of the two groups are compared. The results are shown in the Table 4.5.

TABLE 4.5

Mean, SD and 't' on Marital Adjustment of ALCH and NALCH group

Marital adjust-ment	Mean	SD	df	't'	Signi-ficance
ALCH	10.8983	6.371	145.79	15.64	0.000
NALCH	20.6618	1.767			

From the table 4.5, it is clear that the mean of NALCH is very high when compared to the mean of ALCH. The mean value of NALCH is 20.6618, but that of ALCH is 10.8983 only. This indicates that Marital

Adjustment of spouses of alcoholics is much inferior to that of spouses of non alcoholics. In addition to this, on comparing these means with the norms given by Kumar and Rohatgi (1987) means of theNALCH group reveal that they are just above average in marital adjustment and mean ofthe ALCH group falls even beyond the score of 13.22 which is rated as very poor. This clearly establishes that marital adjustment of the ALCH group is very much affected.

Hypothesis 3

For testing this hypothesis that General Wellbeing of spouses of alcoholics and spouses of non alcoholics differ, differences in mean scores for General Wellbeing of the two groups are tested for significance. The results are shown in Table 4.6.

TABLE 4.6

Mean, SD and 't' on General Wellbeing (PGI) of ALCH and NALCH group

PGI	Mean	SD	df	't'	Signi-ficance
ALCH	5.0085	3.971	160.64	31.59	0.000
NALCH	17.7647	1.415			

The results tabulated in Table 4.6, shows that the mean of spouses of alcoholic is very low when compared to spouses of non alcoholics and the

difference is statistically significant. From these results it is evident that General Wellbeing of spouses of alcoholics is very poor as compared to the spouses of non alcoholics. The score itself indicates that the ALCH group's mean is almost $1/3^{rd}$ of the mean of the NALCH group. A comparison of the mean of ALCH group with the mean reported by Verma & Verma (1989) also reveal that while the normals score around 10, the present group has scored 5 which is indicative of a very unhealthy state. Therefore the wellbeing of the spouses is very seriously affected. This result can be related to their poor Marital Adjustment also. The quality of marital relationship is probably the significant factor that has affected their General Wellbeing. Higher psychological distress and poor marital quality was also observed by Kahler, McCardy and Epstein (2003); Kearns-Bodkin & Leonard (2005) and Tempier *et al.* (2006).

Hypothesis 4

The fourth hypothesis of this study is that Marital Adjustment of spouses of alcoholics differ with certain socio-demographic factors. Inorder to test this, 2 way $ANOVA_s$ were computed for scores of Marital Adjustment with respect to different socio- demographic factors. The results are tabulated in Tables 4.7 and 4.8.

TABLE 4.7

Summary of 2 way ANOVAs of Marital Adjustment for the demographic variables of ALCH group showing main effects

Sl. No.	Main Effects							
	Family Type				Religion			
	SS	DF	MS	F	SS	DF	MS	F
1.	295.888	1	295.888	7.842**	83.409	2	41.704	1.105
	Family Type				Education			
2.	153.771	1	153.771	4.932*	834.566	2	417.283	13.385**
	Family Type				Employment			
3.	33.474	1	33.474	1.493	1833.158	1	1835.158	81.869**
	Family Type				Age			
4.	170.101	1	170.01	4.628*	198.683	1	198.683	5.406*

*P > 0.05; **P > 0.01.

TABLE 4.8

Summary of 2 way ANOVAs of Marital Adjustment for the demographic variables of ALCH group showing Interaction and Residual effects

Interaction				Residual		
Family x Religion						
SS	DF	MS	F	SS	DF	MS
95.127	2	47.564	1.261	4225	112	37.731
Family Type x Education				Residual		
78.215	2	39.108	1.254	4748.780	117	40.588
Family Type x Employment				Residual		
13.877	1	13.877	.619	255.411	114	22.416
Family Type x Age				Residual		
16.148	1	16.148	.439	4189.615	118	36.751

*P > 0.05; **P > 0.01.

The F values in Table 4.7 show that four out of the five demographic variables have emerged significant. Influence of family type, education, employment and age on Marital Adjustment is significant and that none of the interactions in Table 4.8 are significant. It is also indicated that religion does not play a significant role in Marital adjustment. This suggests that Marital Adjustment of the spouse of alcoholic is likely to change with the type of family to which she belongs, her age, educational level and employment. To understand the actual nature of influence inter group differences in mean scores were tested by computing 't' test for those variables with significant F-value Table 4.9 gives the detail.

TABLE 4.9

Means, SDs and 't' of Marital Adjustment on Demographic Variables

Category	Variable	Mean	SD	't'	Signi-ficance
1. Family Type	Joint Family	13.1136	6.735	2.90	0.005
	Nuclear Family	9.5811	5.798		
2. Education	Group 1 (up to 10th Std.)	13.7500	5.853	4.32 (Group I Vs II)	0.000
	Group II (upto 12th)	8.4500	6.106	1.03 (Group II Vs III)	0.306
	Group III (Degree and above)	6.8333	3.823	5.88 (Group I Vs III)	0.000
3. Employ-ment	Group I (Employed)	5.4667	1.236	12.22	0.000
	Group II (Unemployed)	14.2466	5.934		
4. Age	Group I (18-35)	2.6563	1.904	1.67	0.109
	Group II (36-55)	3.2407	2.018		

From the table 4.9 it is clear that for Marital Adjustment difference of means of Ss from the two family types is significant with three out of four F-values being significant. It also shows that spouses of alcoholics who are living in joint family set up with a higher mean are better with respect to their Marital Adjustment. This may be due to the close interaction, open communication and emotional support from other family members, which is absent in a nuclear family set up. Interaction with other family members also helps to shift her attention from the distressing marital relations and operates as a stress relieving situation.

For the second variable, education, the significant F- value indicates that Marital Adjustment differ with education levels. To understand this explicitly 't' test was applied to pairs of mean scores in Table 4.10 reveals that two of the three 't's are significant indicating that Marital Adjustment is influenced by differences in educational level of the spouses. The mean scores indicates that subjects with lowest education level is the most adjusted among the three groups, in marital life and subjects with highest level of education is the least adjusted.

However the 't' between the scores of Ss with education upto 12^{th} and degree and above is not significant. The reason may be in the nature of the scatter (difference in SDs) and there may be very little difference between the

2nd and 3rd group as both the groups have been exposed to same educational environment and interaction in the colleges.

This trend is interestingly against the commonsense notion about influence of education on the person. It can be assumed that for spouses of alcoholics education equips them with more information and understanding about quality of marital life and interpersonal relations which in turn is used for appraisal of their own family relations. This results in a negative evaluation of their spouses and interactions that makes them react with dissatisfaction. The interactive effect leads to poor Marital Adjustment. On the contrary poorly educated women expects very little from marriage due to her poor perception and understanding of the very productive and healthy relation possible. And she is easily able to conform to the passive and less productive interactions in the family.

Interestingly with respect to employment also the mean of unemployed is higher which shows that unemployed spouses of alcoholics are better adjusted in marriage than their employed counterparts.

That is the younger, less educated and unemployed spouse of the alcoholic is ignorant and indifferent to the pathetic condition of her family and the poor prospects of her children which imposes an additional source of deprivation to the family members that leaves the next generation also passive

and irresponsible. This finding strengthens the results with respect to education.

With respect to age although F is significant the mean differences is not significant as obtained in Table 4.9. This suggests that age is not contributing much to the spousal interaction and satisfaction among the subjects. Based on the results in Table 4.9 it can be inferred that spouses of alcoholics who are less educated, unemployed and belonging to joint families are more adjusted in marital life and those who are better educated and employed are less adjusted. Although this may also lead to the argument that women education and employment are detrimental to marital harmony, 'marriage' when understood in a wider perspective as the axis of the society and it's development the results of the present study has to be considered very significant and alarming.

On the contrary, if the spouse of the alcoholic is elderly, educated and employed she becomes more alert and may try to create better environment and facilities for her children, to reduce the negative impact of the alcoholic father. The lady of the house may thus take over the responsibilities of the man of the house, which is much better than a family with no one responsible and foresighted.

Thus the results of the study support the hypothesis 4 and the null hypothesis is rejected.

Hypothesis 5

The fifth hypothesis of this study is that General Wellbeing of spouses of alcoholics differ with certain socio-demographic factors. In order to test this, 2 way ANOVAs were computed for scores of General Wellbeing with respect to different socio-demographic factors. The results are tabulated in Table 4.10 and 4.11.

TABLE 4.10

Summary of 2 way ANOVAs of PGI (General Wellbeing) for the demographic variables of ALCH group showing main effects

Sl. No.	Main Effects							
	Family Type				Religion			
	SS	DF	MS	F	SS	DF	MS	F
1.	93.473	1	93.473	6.570**	54.619	2	27.310	1.920
	Family Type				Education			
2.	69.271	1	69.271	5.178*	168.190	2	84.0945	6.286**
	Family Type				Employment			
3.	35.342	1	35.342	2.732	245.925	1	245.925	19.011**
	Family Type				Age			
4.	78.269	1	78.269	5.300*	17.945	1	17.945	1.215

*P > 0.05; **P > 0.01.

TABLE 4.11

Summary of 2 way ANOVAs of PGI (General Wellbeing) for the demographic variables of ALCH group showing Interaction and Residual effects

Interaction				Residual		
Family Type x Religion						
SS	DF	MS	F	SS	DF	MS
80.709	2	40.355	2.836	1593.452	112	14.227
Family Type x Education				Residual		
62.150	2	31.075	2.323	1498.441	112	13.379
Family Type x Employment				Residual		
8.161	1	8.161	.631	1474.695	114	12.936
Family Type x Age				Residual		
27.307	1	27.307	1.849	1683.528	118	14.768

The F-values in Table 4.10 show that three out of the five demographic variables have emerged significant. Influence of family type, education and employment on General Wellbeing is significant, and none of the interactions shown in Table 4.11 are significant. This suggests that General Wellbeing of the spouses of alcoholic is likely to change with the type of family to which she belongs, her educational level and employment. Religion and age are not having a significant influence on the General Wellbeing of these women. To understand the actual nature of influence, inter group differences in mean scores were tested by computing 't'- test for those variables with significant F-value. Table 4.12 gives the details.

TABLE 4.12

Means, SDs and 't's of PGI (General Wellbeing) for Demographic Variables

Category	Variable	Mean	SD	't'	Signi-ficance
1. Family Type	Joint Family	6.2955	4.958	2.48	.006
	Nuclear Family	4.2432	3.033		
2. Education	Group 1 (up to 10th Std.)	6.2833	4.669	2.99 (Group I Vs II)	.004
	Group II (upto 12th)	4.0500	2.791	2.04 (Group II Vs III)	.047
	Group III (Degree and above)	2.8889	1.530	4.83 (Group I Vs III)	.000
3. Employ-ment	Group I (Employed)	2.8889	1.613	5.00	.000
	Group II (Unemployed)	6.3151	4.415		

From the table 4.12 t-value and the significant means indicate that in the joint family set up the General Wellbeing of the spouses of alcoholics is better than in the nuclear family set up. This is also a clear indication of mutual warmth and support which is provided by the joint family set up and that with people to share responsibilities and agonies the wife of an alcoholic is able to feel better psychologically. In the nuclear family, the lady of the house is lonely and left alone to solve her family problems and meet the needs of the family which makes her more distressed.

In the case of employment the higher mean value and significant 't' value reveals that unemployed spouses of alcoholics have better General Wellbeing compared to the employed. As the unemployed is confined to her family only the task of maintaining the respect of the family and keeping many of her and her family's problems due to her alcoholic spouse secret is less challenging, while for the employed it is more difficult. Employed wife also gets opportunities to become aware of better family environments and relations while interacting with others outside the house. This makes the appraisal of her family and relations more negative or unhealthy. This will further deteriorate her level of satisfaction at home and homely affairs. Thus the General Wellbeing tends to be poorer for such women.

Here also 'F' value for education is highly significant as in the case of Marital Adjustment indicating that General Wellbeing of the spouses of alcoholics differ with education level. The 't' values computed to assess the actual inter group differences given in Table 4.12 also reveal that all the three groups differ each other in the degree of General Wellbeing with Ss having lowest education scoring highest on PGI and having highest education level scoring lowest. These are quite comparable to the results in Table 4.9 with respect to education. The less educated are more adjusted in marriage and that is probably making them better in general wellbing and viceversa. Education make them more informative and evaluative about everything. So the quality of marital life which obviously is problematic with an alcoholic

spouse is also evaluated more critically and elaborately and hence the probability of getting dejected is also more for them that reduces the satisfaction in life and score on PGI results. The better Wellbeing of the less educated may also be due to 'illusions' as suggested by Tylor and Brawn (c.f. Feldman, 1998).

Therefore in the light of these results hypothesis 5 of the study is accepted.

SECTION B

This section verifies the 6th, 7th and 8th hypothesis of the study that Personality, Marital Adjustment and General Wellbeing among spouses of alcoholics and non alcoholics are interrelated.

Hypothesis 6

The sixth hypothesis is that Personality and Marital Adjustment are related in spouses of alcoholics and non alcoholics. For this product moment correlation was computed group wise between the scores on primary and secondary factors of 16 PF and Marital Adjustment. Table 4.13 shows the correlation coefficients between 16 primary factors and marital adjustment scores.

TABLE 4.13

Variablewise correlation coefficients between 16 PF factors and Marital Adjustment Scores

Sl. No.	Personality Variables	Combined	r ALCH	r NALCH
1	A	-0.0875	-0.1303	0.1751
2	B	0.1177	-0.0376	-0.0906
3	C	0.0298	0.1135	0.1105
4	E	0.0250	-0.0187	-0.0134
5	F	0.0601	-0.0220	0.1070
6	G	-0.1803**	-0.0810	-0.3007**
7	H	0.0730	0.0578	0.2572*
8	I	-0.1012	-0.0629	0.1004
9	L	-0.1086	-0.0912	-0.0941
10	M	-0.0552	-0.0800	-0.0462
11	N	-0.0265	-0.0724	-0.1532
12	0	-0.1242	-0.0545	-0.0502
13	Q1	-0.0182	-0.1220	-0.0128
14	Q2	0.0296	0.1055	0.0804
15	Q3	0.0796	0.1040	0.2074
16	Q4	-0.1119	-0.0639	-0.1046

** $P < 0.01$, * $P < 0.05$.

From the table it is clear that out of the 16 primary personality factors only 2 factors, G and H, are significantly related to marital adjustment. It is also seen that for the ALCH group no relationship is indicated and the

significant relations are due to the NALCH group. In the case of combined group and NALCH group factor 'G' is negatively correlated i.e., when the score on 'G' increases Marital adjustment decreases.

In the NALCH group when the conscientiousness increases their marital adjustment decreases. With their strong super ego strength they can manage their day to day life, because of their duty bound nature but at the same time their moralistic and unforgiving nature makes Marital Adjustment low. The significant relation indicated in the combined group may be due to the strong relationship between the two variables among the NALCH group. However the nature of correlation among all the three groups is negative. This suggests that, in marital adjustment too much of rigidity, group confirmity and morality are not productive.

On factor H the relationship is significant only with NALCH group and the nature of the relation is positive in all the three groups which suggests that socially bold and spontaneous nature contributes to better marital adjustment.

In order to assess the relation between second order personality factors and marital adjustment, product moment correlation coefficients were computed between the scores on the two variables as tabulated in Table 4.14.

TABLE 4.14

Correlation coefficients between Second order personality factors and Marital Adjustment

Sl. No.	Second order Personality factors	(r) Total	(r) ALCH	(r) NALCH
1	Extraversion QI	-0.0069	-0.0803	0.1684
2	Anxiety QII	-0.0910	0.0248	-0.1184
3	Toughness QIII	0.1153	0.1501	0.0774
4	Independence QIV	0.1008	0.0491	-0.0088

Results tabulated in Table 4.14 shows that none of the factors are significantly related with Marital Adjustment.

The results revealed by the two tables 4.13 and 4.14, indicate that personality characteristics do not play a significant role in marital adjustment. Therefore the 6th hypothesis of the study is rejected and the null hypothesis is accepted.

Hypothesis 7

The 7th hypothesis of the study that Personality and General Wellbeing in spouses of alcoholics and non alcoholics are related. Inorder to test this, product moment correlation was computed between the scores on primary and secondary factors of 16 PF and General Wellbeing. Table 4.15 shows the correlation coefficients.

TABLE 4.15

Correlation coefficients between 16 PF Personality factors and General Wellbeing Scores

Sl. No.	Personality Variables	Combined	r ALCH	r NALCH
1	A	-0.0209	0.0168	0.2232
2	B	0.2086**	-0.0308	0.3279**
3	C	-0.0106	0.1405	-0.0185
4	E	0.0547	-0.0184	0.1678
5	F	0.1169	0.0778	0.1146
6	G	-0.2060	-0.1597	-0.1401
7	H	0.0461	0.0051	0.3052*
8	I	-0.1711	-0.1919	-0.0860
9	L	-0.1396	-0.1883	-0.1294
10	M	-0.0315	-0.0500	-0.1156
11	N	-0.0015	-0.1131	0.0215
12	0	-0.1206	-0.0024	-0.0535
13	Q1	0.0330	-0.1072	0.0198
14	Q2	-0.0232	0.0683	0.0198
15	Q3	0.0855	0.2140	0.0863
16	Q4	-0.1226	-0.0308	-0.3185**

** P< 0.01; *P < 0.05.

From the table it is clear that factors 'B', 'H' and 'Q4' are significant in NALCH group and factor B is significant for the combined group also. Factor B indicates level of intelligence and alertness. A positive correlation,

both in combined and NALCH groups means that as the intelligence is high, their sense of General Wellbeing is also igh. But it is noteworthy that among the ALCH group the relation is in the reverse direction, i.e., the more alert and sensible they are lesser the satisfaction and hence poorer General Wellbeing. In other words for the spouse of the alcoholic ignorance and poor sensibility will make her less aware of the quality of family life and life in general which in turn leaves her less distressed.

For factor H significant positive correlation is seen only in the NALCH group. The person who scored higher on factor H is sociable, bold, ready to try new things, spontaneous and abundant in emotional response and these characteristics support her General Wellbeing. For factor Q4 a negative correlation is significant among the same group. Scoring high on this factor means they are more tense and frustrated which obviously are detrimental for the General Wellbeing.

The nature of correlation for factor H and Q4 remains the same for all the three groups which also justifies the nature of relationship, though not prominent in the two groups.

To test the relation between second order personality factors and General Wellbeing, product moment correlations were computed between the two sets of scores and the results are given in Table 4.16.

TABLE 4.16

Correlation coefficients between Second order Personality factors and General Well being scores

Sl. No.	Second order Personality factors	(r) Total	(r) ALCH	(r) NALCH
1	Extraversion QI	0.0661	0.2274	0.0540
2	Anxiety QII	-0.1341	-0.2131	0.0150
3	Toughness QIII	0.0849	0.1082	0.1307
4	Independence QIV	0.1348	0.0397	0.998

From the table it is clear that none of the coefficients are significant. Thus the results revealed by Table 4.15 and 4.16 suggest that personality does not contribute significantly to the General Wellbeing of the spouses of alcoholics and hence hypothesis 7 of the study is rejected.

Hypothesis 8

The 8th hypothesis is that Marital Adjustment and General Wellbeing are related among spouses of alcoholics and non alcoholics. For this product moment correlations were computed between the scores of Marital Adjustment and General Wellbeing. Table 4.17 gives the correlation coefficients.

TABLE 4.17

Correlation coefficients between Marital Adjustment and General Wellbeing

Combined group (N=186)	ALCH (N = 118)	NALCH (N = 68)
0.8103**	0.6294**	0.4391**

** $P < 0.01$.

The results tabulated in Table 4.17 show that Marital Adjustment and General Well being are highly significantly correlated in ALCH and NALCH groups.

The results also suggest that Marital Adjustment play a significant role in General Wellbeing of spouses of alcoholics. The high positive correlation indicate that as the Marital Adjustment increases the General Wellbeing also increases. These results also strengthens the findings in Table 4.5 and 4.6 which is a clear indication that Marital Adjustment of spouses of alcoholics is very poor when compared to spouses of non alcoholics and hence their General Wellbeing is also affected.

Penrod's (1986) statement that marriage is one of the most important indicator of wellbeing is also supporting the present findings. The present results is also in vogue with Kahler, McCardy and Epstein (2003) findings that greater psychological distress among spouses of alcoholics was most strongly associated with lower satisfaction with the marital relationship.

Besides assessing the interrelationship between the variables studied, the extent of predictability of Marital Adjustment and General Wellbeing by personality among spouses of alcoholics and non alcoholics was also estimated by computing stepwise multiple regression coefficients between the factorwise scores of subjects in both groups and total scores on Marital Adjustment and Wellbeing. Primary factors and second order factors were included in the regression analysis.

None of the personality factors is loaded for regression analysis with respect to Marital Adjustment. This can be attributed to the poor correlation between the Personality factors with Marital Adjustment shown in Tables 4.13 and 4.14.

This suggests that Personality factors are not significantly contributing to Marital Adjustment among spouses of alcoholics.

Table 4.18 gives the details of regression analysis for the nonalcoholic group.

TABLE 4.18

Regression Analysis of Marital Adjustment by 16 Personality factors for NALCH group

	Personality Factors	R^2	B	F	P
Step 1	G	0.09042	-0.338991	6.56132	0.0127
Step 2	H	0.19463	0.289515	7.85407	0.0009

Values in Table 4.18 reveal that the personality factors (G and H only), are significantly contributing to Marital Adjustment. The F values are significant at 0.01 level. Values of R^2 indicate that factor G contributes to 9% of variance in Marital Adjustment. The value of B for this factor indicates that a change of one standard deviation on factor G will bring a change of -0.338991 standard deviation on Marital Adjustment.

In the case of factor H, the value of R^2 indicates that the factor contributes to 19% of variance in Marital Adjustment. The value of B for this factor indicates that a change of one standard deviation on factor H will bring a change of 0.289515 standard deviation on Marital Adjustment.

Thus these regression analyses of the scores, when compared for spouses of alcoholics and non alcoholics, suggest that although personality has some influence on Marital Adjustment for spouses of NALCH group, among spouses of alcoholics none of the personality characteristics could significantly predict or influence their Marital Adjustment.

Regression analysis was also done to assess predictability of Wellbeing from personality factor scores. Table 4.19 gives the values for ALCH and NALCH groups.

TABLE 4.19

Regression Analysis of Wellbeing of Personality for ALCH and NALCH groups

Group	Personality Variable	R^2	B	F	P
ALCH	Q_3	0.04581	0.533784	5.52121	0.0205
NALCH	B	0.10751	0.221633	7.95076	0.0063
	Q_4	0.18379	0.195798	7.31825	0.0014

Results of regression analysis of Wellbeing by personality in Table 4.19 reveal that the only personality factor significantly contributing to Wellbeing of the ALCH group is Q_3. This can be attributed to the poor correlation between the personality factors with Wellbeing shown in Tables 4.15 and 4.16. The value of R^2 indicates that factor Q_3 contributes to 4% of variance in their Wellbeing. The value of B for this factor indicates that a change of one standard deviation on factor Q_3 will bring a change of 0.533784 Standard Deviation on their Wellbeing score. The person who scores high on factor Q_3 tends to have strong control of his emotions high self concept control and general behaviour, is inclined to be socially aware and careful. This nature is emerging as very significant for the quality of General Wellbeing.

With respect to the NALCH group the F values in table 4.19 reveal that factors B and Q_4 are significantly contributing to General Wellbeing. The value of R^2 indicates that factor B contribute to 10% variance in their General

Wellbeing. The value of B for this factor indicates that a change of one standard deviation on factor B will bring a change of 0.221633 standard deviation on General Wellbeing.

In the case of factor Q_4, the value of R^2 indicates that factor Q_4 contributes 18% of variance in their General Wellbeing. The value of B for this factor indicates that a change of one standard deviation on factor Q_4 will bring a change of 0.195798 standard deviation on General Wellbeing score.

Scores of the two groups on the second order personality factors also were subjected to regression analysis for predicting their Marital Adjustment and Wellbeing. Table 4.20 gives the details of predicting Marital Adjustment.

TABLE 4.20

Regression Analysis of Marital Adjustment by Second Order Personality factors for ALCH and NALCH group

Sl. No.	Personality Variables	ALCH		NALCH	
		R^2	B	R^2	B
1	Independence	0.02991	0.031642	0.11884	0.004314
2	Toughness	0.2991	0.034684	0.11884	-0.008823
3	Anxiety	0.2991	0.015489	0.11884	-0.028442
4	Extraversion	0.2991	0.007580	0.11884	0.0289986

All the values in table 4.20 are non significant and no value for F was obtained which clearly rules out the role of Personality in determining Marital Adjustment.

Results of regression analysis for predicting General Wellbeing are given in Table 4.21.

TABLE 4.21

Regression Analysis of General Wellbeing by Second Order Personality factors for ALCH and NALCH group

Sl. No.	Personality Variables	ALCH		NALCH	
		R^2	B	R^2	B
1	Independence	0.04242	0.21942	0.05083	-4.23383
2	Toughness	0.04242	0.088774	0.05083	-0.006851
3	Anxiety	0.04242	0.029717	0.05083	-0.021216
4	Extraversion	0.04242	-0.056183	0.05083	0.025065

Table 4.21 clearly indicates that second order factors also have no significant role in determining the General Wellbeing of the subjects studied.

Therefore results so far revealed in Tables from 4.18 to 4.21 clearly indicate that personality is not a determining variable in Marital Adjustment and General Wellbeing of the spouses of alcoholics included in the present study. These findings further confirm the results of the intercorrelation between these variables which reject hypothesis 6 and 7.

As the next step regression analysis of Marital Adjustment scores and General Wellbeing scores were done to test the predictability of General Wellbeing by Marital Adjustment scores. Results are given in Table 4.22.

TABLE 4.22

Regression Analysis of General wellbeing by Marital Adjustment for ALCH group.

Variable	R^2	B	F	P
Marital Adjustment	0.39746	0.392964	76.51857	.000

The F-value in Table 4.22 is highly significant indicating that Marital Adjustment is a determining factor in predicting the General Wellbeing of the spouses of alcoholics. Further, the value of R^2 indicates that approximately 40% variance in General Wellbeing is contributed by Marital Adjustment, and the value of B indicates that a change in one SD of MA will effect a change of 0.39 SD in the General wellbeing of these women. These results strengthen the correlation between these variables given in table 4.17 and supports hypothesis 8 of the study. These findings are eyeopeners to the understanding of the depth of the consequences of alcoholism on the spouse and family. The multidimensional stresses and strains of the woman in the relationship between spouses further affects her General Wellbeing. It may also be appropriate to assume that a wife and mother of the house with poor General Wellbeing becomes incompetent to meet the challenges of healthy child rearing.

SECTION C

Though, the main focus of the study is not to test the efficiency of intervention programmes, one of the objectives of the study is to increase the effectiveness of the counselling services extended to the spouses of alcoholics.

In connection with this objective, hypothesis 9 & 10 of this study are that Psychological counselling improves Marital Adjustment of the spouses of alcoholics by modifying their Coping styles, and also improves their General Wellbeing.

This section includes the discussion of the results obtained in comparing the pre and post counselling scores on these variables.

Hypothesis 9

The 9th hypothesis of the study is that, psychological counselling improves the Marital Adjustment of the spouses of alcoholics by modifying their Coping styles. For this purpose, a pre and post counselling assessment of Marital Adjustment was done and the mean scores obtained were compared by testing the difference by t-test. The results are tabulated in table 4.23.

TABLE 4.23

Means, SDs and 't' for Marital Adjustment before and after counselling

Variable	Mean	SD	't'	Significance
Marital Adjustment score before counselling	7.1000	1.889	17.41	0.000
Marital adjustment score after counselling	19.8500	3.514		

From the table it is clear that after counselling, the Marital Adjustment has improved considerably, nearly three times, which is a clear indication of the effectiveness of psychological counselling in helping the spouses of alcoholics. While comparing these means with the norms reported by Kumar and Rohatgi (1987) the mean of the present intervention group is much below the score of the designated 'very poor scorers' which was 15.41 and the mean after counselling has gone above the 'average group' of the normative sample which was 19.49.

In order to study the change brought in by counselling the role of coping styles in modifying the marital adjustment was examined. Pre and post scores for coping were analysed for the difference in mean, using 't' test. The results are given in Table 4.24.

TABLE 4.24

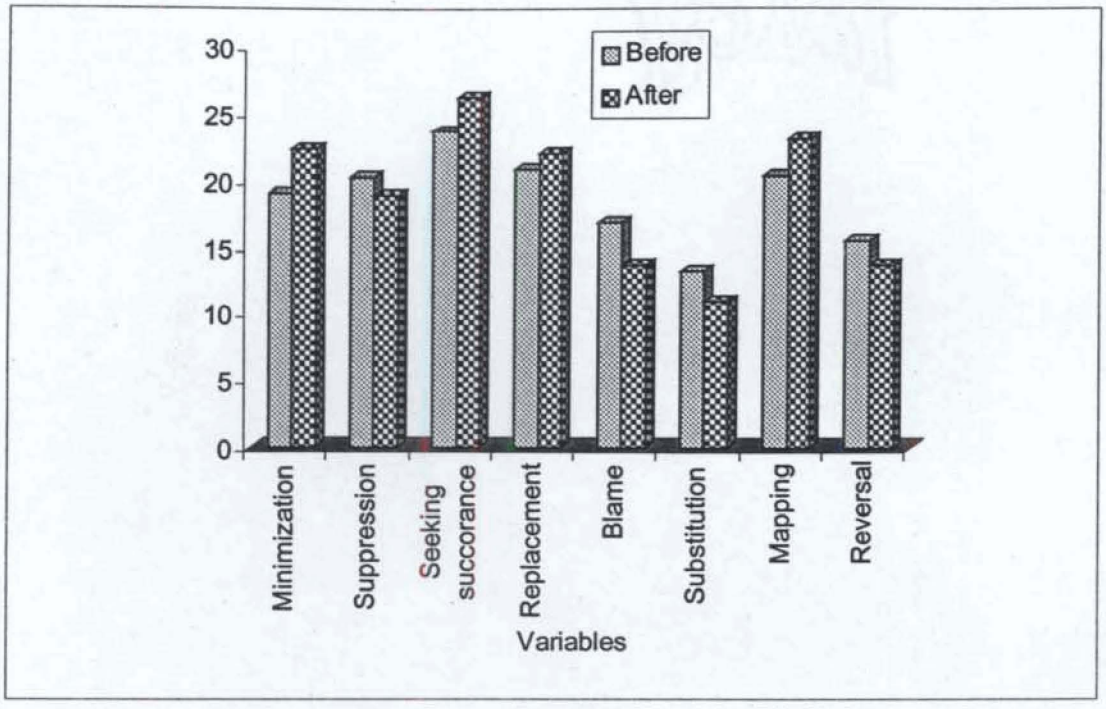
Means, SDs and 't' for Coping before and after counselling

Variables	Mean		SD		't'	Significance
	Before	After	Before	After		
Minimization	19.0500	22.3500	5.652	4.534	6.30	0.000
Suppression	20.3000	18.9500	4.669	4.489	2.44	0.025
Seeking succorance	23.7000	26.2000	4.041	3.806	6.34	0.000
Replacement	20.9500	22.0500	7.037	6.684	2.43	0.025
Blame	16.9500	13.7000	5.000	4.532	7.93	0.000
Substitution	13.2000	11.0000	5.053	5.201	6.85	0.000
Mapping	20.3500	23.1000	3.558	3.210	11.49	0.000
Reversal	15.6000	13.6500	5.443	5.509	6.25	0.000

The results reveal that positive coping styles like *minimization, seeking succorance, replacement* and *mapping* have considerably increased after counselling sessions. Meanwhile negative coping styles like suppression, blame, substitution and reversal have considerably decreased after counselling. Fig. 4.1 gives the graphical representation of the results in table 4.24.

Fig. 4.1

Graphical representation of Coping before and after counselling



So by psychological counselling the Ss have learned to modify their coping styles from unhealthy to healthy modes. Improvement in coping behavior by psychological intervention is also reported by Hansson *et al.* (2004).

This suggests that the improvement in marital adjustment as a consequence of counselling is by modifying the coping skills. Thus the 9th hypothesis of the study is accepted and the null hypothesis is rejected.

Hypothesis 10

The tenth hypothesis of the study is to study the effectiveness of counselling, to improve the general well being of the spouses of alcoholics. For this the pre and post scores of general wellbeing were analysed for their mean, SD and 't' was computed. The results are tabulated in Table 4.25.

TABLE 4.25

Means, SDs and 't' for General Wellbeing before and after counselling

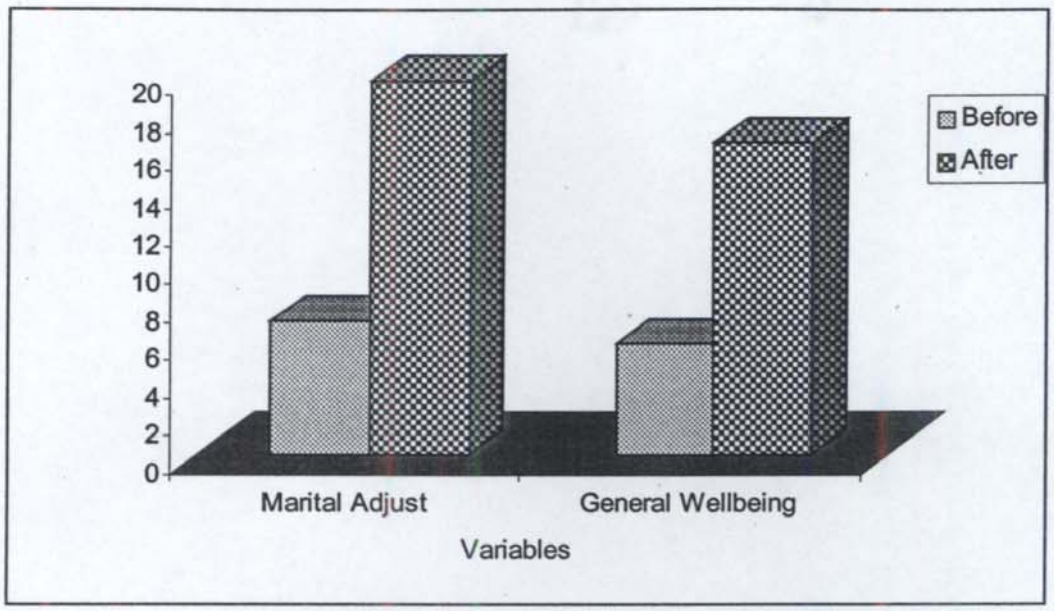
Variable	Mean	Sd	't'	Significance
General wellbeing score before counselling	5.9000	3.354	13.78	0.000
General wellbeing score after counselling	16.5000	3.561		

The results clearly reveal that after the psychological counselling the general well being of the spouses of alcoholics have increased significantly. While comparing with the norms reported (Verma & Verma, 1989), before counselling the ALCH group, was much below the mean of the normative sample and after counselling it has increased so much reaching 16.5 which is more than three times of the pre counselling score and equal to the very healthy group in the normative sample.

The results revealed in tables 4.23 and 4.25 are graphically presented in fig. 4.2.

Fig. 4.2

Graphical representation of Marital Adjustment and Wellbeing before and after counselling



Therefore the 10th hypothesis of the study is accepted.

The results revealed in Tables 4.23 and 4.24 also suggest that improvement in Marital Adjustment or quality of marital life improves the General Wellbeing of spouses of alcoholics. This also strengthens the relationship between the two as shown in table 4.17.

CHAPTER V

SUMMARY AND CONCLUSION

- Objectives
- Hypotheses
- Sample
- Tools
- Administration
- Statistical Analysis of Data
- Major Findings
- Conclusion
- Limitations of the Study
- Scope of the Study

The present study is on the topic "Alcoholism: Personality, Marital Adjustment and General Wellbeing of the Spouses".

First chapter deals with definition of alcoholism, different stages through which alcoholism progresses, biological and psychosocial effects of alcoholism, alcoholism and family, women in marriage and family, coping mechanisms in Marital Adjustment, Personality and General Wellbeing.

It is repeatedly reported that spouses of alcoholics are experiencing severe stress as a result of constant contact with the alcoholic whose communication pattern, emotional stability and interpersonal skills are maladaptive. In the second chapter, a brief review of literature and rationale for present study are presented. Third chapter gives details of tools used, sample and mode of analysis of the data followed. The fourth chapter presents the results and discussion of the results based on the theoretical and empirical literature available.

Literature shows that most of the theoretical empirical work has been focussing on the alcoholic and on the effects of alcoholism. However, major portion of the voluminous literature focuses on the health related problems of the alcoholic followed by effects of parental alcoholism in children. Of late, studies on family of alcoholics have been reported. But it is noteworthy that

problems confronted by the female spouses of alcoholics has hardly received any serious attention. This is a matter of concern specially in the Indian family set up where women of the house is endowed with almost all responsibilities related to the family members and family, probably except money making. In the changed socio cultural conditions very often 'she' is a party to earning also. This leaves the Indian wife the most stressed with multifaceted challenges. While in the joint family system there are a few more hands to share some of them, in the nuclear families the lady of the house is assisted by her spouse in a healthy relation. In the case of a family with an alcoholic husband not only the sharing is absent but he becomes the cause for additional financial and emotional challenges to the spouse.

In view of the above observations the focus of the present study is the spouse of alcoholic. There is no dearth of literature to prove that a person's general well being is one of the most important factors that enables him/her to meet the challenges of life. Therefore in the present study it is proposed primarily to assess the General Wellbeing of the spouses of alcoholics in comparison with spouses of non alcoholics and to explore the role of Personality and Marital Adjustment in her General Wellbeing. Secondly it also proposes to test the efficiency of psychological counselling in reducing her distress and improving her General Wellbeing. Thus the study has briefly designed a few objectives.

OBJECTIVES

1. To study the role of personality and coping styles as mediator variables in the effect of spousal alcoholism.
2. To study the Marital Adjustment of the female spouses of alcoholics.
3. To study the role of certain sociodemographic factors as mediator variables in the effect of spousal alcoholism.
4. To study the effectiveness of psychological counselling to enhance the General Wellbeing of the female spouses of alcoholics.

HYPOTHESES

A few hypothesis is framed to be tested in this study.

1. Personality pattern of spouses of alcoholics and spouses of non alcoholics differ.
2. Marital adjustment of spouses of alcoholics and spouses of non alcoholics differ.
3. General well being of spouses of alcoholics and spouses of non alcoholics differ.
4. Marital Adjustment of spouses of alcoholics differ with certain socio demographic factors.
5. General Wellbeing of spouses of alcoholics differ with certain socio demographic factors.

6. Personality characteristics and Marital Adjustment are significantly related in spouses of alcoholics.
7. Personality characteristics and General Wellbeing are significantly related in spouses of alcoholics.
8. Marital Adjustment and General Wellbeing are significantly related in spouses of alcoholics.
9. Psychological counselling improves the Marital Adjustment of the spouses of alcoholics by modifying their coping styles.
10. Psychological counselling improves the General Wellbeing of the spouses of alcoholics.

SAMPLE

The sample of the study consisted of two categories of population, namely the spouses of alcoholics (ALCH) and spouses of non alcoholics (NALCH). Since no alcoholic female addicts were available in the deaddiction centre from which the data was collected, here the spouses means wives of male alcoholics. The total strength of the sample was 186. The first group consisted of 118 spouses of alcoholics, and the second group consisted of 68 spouses of non alcoholics. The multistage sampling method was followed. In the first stage the subjects' motivation to undertake the tests were tested and demotivated individuals were deleted from the sample of the final study. In the second stage the selected subjects were administered all the

tools. In the third stage of the study, a selected group of subjects were given psychological counselling to modify their coping styles.

TOOLS

Tools used in this study included four standardised self report measures and a Personal Data Sheet.

1. To study the personality patterns of subjects in the samples Malayalam adaptation of 16PF form C (Rema & Anita, 1994) was used.

2. To study the Marital Adjustment of the subjects, a Malayalam version of the Marital Adjustment Questionnaire (Kumar and Rohatgi, 1987).

3. To study the General Wellbeing of the entire sample a Malayalam version of the PGI general well-being measure was used (Sareena & Anita, 2004).

4. To study the coping styles of the subjects who were given counselling a Malayalam version of the AECOM Coping Style Questionnaire (Shanty and Anita, 2006) was used.

5. A Personal Data Sheet was prepared to collect the general demographic details and some relevant informations regarding the alcoholism of the spouse.

ADMINISTRATION

All the four measures were administered individually to all the subjects in the sample.

STATISTICAL ANALYSIS OF DATA

After scoring the responses of each test, as per the directions of the authors, the scores were tabulated and was analysed statistically for testing the hypotheses formulated earlier.

For testing hypotheses 1, 2 and 3, significance of mean difference between the scores of the female spouses of alcoholics and non alcoholics were tested by computing percentages of extreme scores on the personality variables and 't' test for each variable in the study.

For testing hypotheses 4 and 5, Two way ANOVAs were computed to study the difference in Wellbeing and Marital Adjustment with respect to each demographic variable included in the study, viz., Age, Education, Religion, Employment and Family type and their interactions. For these variables and interactions yielding significance F-values, t-tests were computed between pairs of means to verify the nature and extent of differences.

Hypothesis 6, 7 and 8 were tested by Multivariate Analysis. Simple and Multiple Regression method was applied to study the nature and extent of

relationship between the variables and the extent of predictions of their independence.

With respect to the last two hypotheses mean differences between pre and post counselling test scores were tested for significance separately for each variable.

MAJOR FINDINGS

Major findings of the present investigation are as follows:

1. Personality pattern of spouses of alcoholics did not differ significantly from that of the spouses of non alcoholics.

2. Spouses of alcoholics have significantly lower Marital Adjustment as compared to those of non-alcoholics.

3. The spouses of alcoholics have significantly poorer General Wellbeing as compared to spouses of non alcoholics.

4. Personality is not significantly related to Marital Adjustment of spouses of alcoholics.

5. Personality is not significantly related to General Wellbeing of spouses of alcoholics.

6. Marital Adjustment and General Wellbeing are significantly positively related.

7. Psychological counselling improved Marital Adjustment of the spouses of alcoholics considerably.

8. Psychological counselling significantly improved the General Wellbeing of the spouses of alcoholics.

CONCLUSION

1. First hypothesis framed in the study cannot be accepted fully indicating that the spouses of alcoholics did not differ much in personality when compared to spouses of non alcoholics.

2. Second and third hypotheses stand accepted.

3. Fourth and fifth hypotheses of the study are accepted.

4. Sixth and seventh hypothesis are not accepted.

5. Eighth hypothesis of the study is accepted.

6. The nineth and tenth hypotheses of the study stand accepted.

LIMITATIONS OF THE STUDY

(1) The demographic characteristics of the subjects could not be strictly controlled.

(2) For the counselling group more follow up could not be done due to the time limit available for the work.

SCOPE OF THE STUDY

1. The results of the present study will help to highlight the problems and sufferings of the spouses of alcoholics which has received very little attention so far.

2. The results of the study suggest that treatment of alcoholism need to include counselling of the spouses of alcoholics also to enhance the effectiveness of treatments.

3. The results could be used for reorienting family therapy extended to the alcoholic families which may help to improve the General Wellbeing of the spouses of alcoholics, if not the alcoholics.

4. By improving the General Wellbeing of the spouses of alcoholics, other members of the family, especially the children of the house will be benefited whose overall development, emotional maturity and adjustment contribute to development of the future community and thus the nation.

5. The results of the study also suggest that by improving the coping skills of the spouses of alcoholics through counselling she may be able to interact with the alcoholic spouse more patiently or confidently creating a less stressful environment and relationships within the

family which may help the alcoholic to start a new life after the deaddiction treatment.

7. Thus the present study is not only beneficial for the spouses of the alcoholics but also may be a strategy for managing the problems of alcoholics holistically, reducing the negative consequences in a multidimensional perspective.

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APPENDICES

APPENDIX I

Personal Data Sheet

1. Name :
2. Age :
3. Religion :
4. Address :
5. Marital Status : Living together / Widow / Separated/ Divorce
6. Age at marriage :
7. No. of Children : Age and sex of each
8. Education :

   (a) Upto High school (b) Upto Plus two (c) Degree and above
9. Employment :

   (a) Employed (b) Unemployed
10. Family Type :

    (a) Joint family (b) Nuclear family
11. History of Alcoholism in husband's family :

    (a) Parental level (b) Close relatives (c) Distant relation
12. Duration of spouse's alcoholism :

    (a) Upto five years (b) Upto 10 years (c) Above 10 years
13. Type of treatment received :

    (a) Institutionalized (b) Non institutionalized
14. Source of Financial assistance for the De-addiction treatment.

    W.F. H.F.
15. History of

    (a) Physical illness (b) Mental illness

APPENDIX II

16 PF FORM C

Rema M.K. & Anita Ravindran

നിർദ്ദേശങ്ങൾ

നിങ്ങളുടെ താത്പര്യങ്ങളെയും സമീപനരീതികളേയും കുറിച്ചറിയാനുള്ള ഏതാനും ചോദ്യങ്ങളാണ് ഈ ചോദ്യാവലിയിൽ കൊടുത്തിരിക്കുന്നത്. മനോഭാവങ്ങളിലും താത്പര്യങ്ങളിലും ഓരോ വ്യക്തിയും വ്യത്യസ്തനായിരിക്കുന്നുവെന്നതിനാൽ ശരിയോ തെറ്റോ ആയ ഉത്തരങ്ങളില്ല.

ഓരോ ചോദ്യത്തിനും മൂന്ന് സാദ്ധ്യതകൾ ഉത്തരങ്ങളായി കൊടുത്തിട്ടുണ്ട്. അവയിൽ നിങ്ങൾക്ക് യോജിക്കുന്നത് ഉത്തരക്കടലാസിൽ നിർദ്ദിഷ്ട സ്ഥാനത്ത് (X) എന്ന് അടയാളപ്പെടുത്തി സൂചിപ്പിക്കുക. 'ബി' ഉത്തരങ്ങൾ കഴിയുന്നതും ഒഴിവാക്കുക.

ഉത്തരമെഴുതുമ്പോൾ താഴെപ്പറയുന്ന കാര്യങ്ങൾ ശ്രദ്ധിക്കുക.

1. സത്യസന്ധവും നിങ്ങളെ സംബന്ധിച്ച് ശരിയുമായ ഉത്തരങ്ങൾ നൽകുക.
2. ഇത് സമയപരിധി ഇല്ലാത്ത ഒരു ടെസ്റ്റാണെങ്കിലും കഴിയുന്നത്ര വേഗത്തിൽ ചെയ്തുതീർക്കുവാൻ ശ്രമിക്കണം. ചോദ്യങ്ങളെക്കുറിച്ച് കൂടുതൽ ചിന്തിച്ച് സമയം കളയാതെ ഓരോ ചോദ്യവും വായിക്കുമ്പോൾ തോന്നുന്ന ആദ്യത്തെ പ്രതികരണം രേഖപ്പെടുത്തണം.
3. ഉണ്ട് (എ) അല്ലെങ്കിൽ ഇല്ല (സി) എന്ന ഉത്തരങ്ങൾ തെരെഞ്ഞെടുക്കാൻ തീരെ നിർവ്വാഹമില്ലെങ്കിൽ മാത്രമേ (ബി) ഉത്തരങ്ങൾ ഉപയോഗിക്കാവൂ.
4. എല്ലാ ചോദ്യങ്ങൾക്കും ഉത്തരമെഴുതാൻ പ്രത്യേകം ശ്രദ്ധിക്കുക. നിങ്ങളുടെ ഉത്തരങ്ങൾ പ്രത്യേകം ശ്രദ്ധിക്കുക. നിങ്ങളുടെ ഉത്തരങ്ങൾ പരമരഹസ്യമായി സൂക്ഷിക്കുന്നതായിരിക്കും.

1. മുൻപുണ്ടായിരിന്നതിനേക്കാൾ കൂടുതൾ ഓർമ്മശക്തി ഇപ്പോൾ നിങ്ങൾക്കുണ്ടോ?

   (എ) ഉണ്ട് (ബി) കുറച്ച് (സി) ഇല്ല

2. മറ്റുള്ളവരിൽനിന്നകന്നു മാറി ഒരു സന്യാസിയെപ്പോലെ ഒറ്റക്ക് ജീവിക്കുവാൻ നിങ്ങൾക്ക് സാധിക്കുമോ?

   (എ) അതെ (ബി) ചിലപ്പോൾ (സി) ഇല്ല

3. ആകാശം താഴെയാണെന്നും മഞ്ഞുകാലത്ത് ചൂയാണെന്നും പറയുന്ന ഒരാൾ ഒരു കുറ്റവാളിയെ എന്തു വിളിക്കും?

   (എ) അക്രമി (ബി) പുണ്യവാളൻ (സി) മേഘം

4. വൃത്തിഹീനമായ ആളുകളെ കണ്ടാൽ നിങ്ങൾ സ്വീകരിക്കുമോ?

   (എ) സ്വീകരിക്കും (ബി) ചിലപ്പോൾ മാത്രം (സി) അവരോട് വെറുപ്പ് തോന്നും

5. പരിചാരകരുടെ ജീവിതം മെച്ചപ്പെടുന്നത് കാണാൻ നിങ്ങൾ ഇഷ്ടപ്പെടുമോ?

   (എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

6. ആഘോഷാവസാനങ്ങളിൽ തമാശയും കഥകളും മറ്റുള്ളവർ ആദ്യം പറയട്ടെ എന്നാണോ നിങ്ങൾ കരുതുക?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല

7. നിങ്ങളുടെ ദൈനംദിനാവശ്യം കഴിഞ്ഞു മിച്ചം പണമുണ്ടെങ്കിൽ മറ്റുള്ളവരെ സഹായിക്കുന്നതിനായി ഉപയോഗിക്കാറുണ്ടോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

8. എന്തെങ്കിലും ചടങ്ങിൽ നിങ്ങളെ കണ്ടുമുട്ടിയാൽ നിങ്ങളുടെ പരിചയക്കാരിൽ അത് വാസ്തവത്തിൽ സന്തോഷമുളമാക്കുമോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

9. താഴെപ്പറയുന്നതിലേതുവിധത്തിൽ വ്യായാമം ചെയ്യാൻ നിങ്ങൾ ഇഷ്ടപ്പെടും?

(എ) സൈക്കിൾസവാരിയും നീന്തലും (ബി) 'ഏ' യും 'സി' യും

(സി) കളിയും ഗുസ്തിയും

10. ആളുകളുടെ പറച്ചിലും പ്രവൃത്തിയും തമ്മിലുള്ള പൊരുത്തക്കേട് കാണുമ്പോൾ നിങ്ങൾക്ക് പരിഹാസം തോന്നാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) വല്ലപ്പോഴും (സി) ഇല്ല

11. നിങ്ങളുടെ കുട്ടിക്കാലത്ത് ഓരോ ദിവസവും സ്ക്കൂളിൽ പോകുമ്പോൾ വിഷമം തോന്നിയിട്ടുണ്ടോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

12. നിങ്ങൾ പ്രകടിപ്പിക്കുന്ന ഒരഭിപ്രായം മറ്റുള്ളവർ ശ്രദ്ധിക്കാതെ പോയാൽ നിങ്ങൾ എന്തുചെയ്യും.

(എ) സാരമില്ല എന്നു വയ്ക്കും (ബി) 'എ'ക്കും 'സി'ക്കും ഇടക്ക്

(സി) മറ്റുള്ളവർ ശ്രദ്ധിക്കുന്നതുവരെ അതാവർത്തിക്കും.

13. ആരെങ്കിലും നിങ്ങളോട് മോശമായി പെരുമാറിയെന്നു തോന്നിയാൽ നിങ്ങൾ

(എ) അതത്ര ഗൗരവമുള്ളതല്ലെന്നു കരുതി മിണ്ടാതിരിക്കും

(ബി) 'എ'ക്കും 'സി'ക്കും ഇടക്ക്

(സി) നിങ്ങളെ നിലപാട് (അഭിപ്രായം) അയാളെ വ്യക്തമായി ബോദ്ധ്യപ്പെടുത്തും

14. ആരെയെങ്കിലും നിങ്ങൾ പരിചയപ്പെട്ടാൽ

(എ) അയാളോട് നിങ്ങൾ രാഷ്ട്രീയത്തെക്കുറിച്ചും സാമൂഹിക ചിന്താഗതിയെക്കുറിച്ചും സൗഹാർദ്ദത്തോടെ സംവാദം നടത്തും.

(ബി) 'എ' ക്കും 'സി' ക്കും ഇടക്ക്

(സി) നിങ്ങളോട് തമാശ പറയാൻ അനുവദിക്കും

15. നിങ്ങൾ സ്വയം ചെയ്തുതീർക്കുമെന്ന് പ്രതിജ്ഞ ചെയ്തു ജോലികൾ പരസഹായം തേടാതെ സ്വയം ചെയ്തുതീർക്കുന്നതിൽ അഭിമാനം കൊള്ളാറുണ്ടോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

16. ഭൂതകാലത്തെക്കുറിച്ചോർക്കുന്നത് സമയം പാഴാക്കലാണെന്ന് തോന്നുന്നുണ്ടോ?

(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

17. ധാരാളം സമയമുണ്ടെന്നറിയാമെങ്കിൽക്കൂടി ഒരു തീവണ്ടിയാത്രക്കൊരുങ്ങുമ്പോൾ നിങ്ങൾ തിരിക്കിടുകയും അസ്വസ്ഥനാകുകയും ചെയ്യാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

18. മാതാപിതാക്കളോട് നൈമിഷകമായിട്ടെങ്കിലും നിങ്ങൾക്ക് വെറുപ്പ് തോന്നിയിട്ടുണ്ടോ?

(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

19. ജോലിക്കാരിൽനിന്നോ ഉപഭോക്താക്കളിൽനിന്നോ ദിവസം മുഴുവനും പരാതി കേൾക്കേണ്ടിവരുന്ന ഒരു ജോലി നിങ്ങൾ ഏറ്റെടുക്കുമോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

20. താഴെപ്പറയുന്നവയിൽ 'ഏകദേശം' എന്ന പദത്തിന്റെ വിപരീതമായിട്ടുള്ളതേത്?

(എ) യാദൃച്ഛികം (ബി) കൃത്യം (സി) ഏകദേശം

21. കൂടുതൽ ശക്തിയും ഊർജ്ജവും ആവശ്യമുള്ള സമയങ്ങളിൽ അവ ആവശ്യത്തിന് നിങ്ങൾക്കുണ്ടാകാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) കുറച്ച് (സി) ഇല്ല

22. കൂടുതൽ ലൈംഗികതയുള്ള ചലച്ചിത്രങ്ങൾകണ്ടാൽ നിങ്ങൾക്ക് ലജ്ജയും കുറ്റ ബോധവും തോന്നാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) കുറച്ച് (സി) ഇല്ല

23. ധാരാളം ആളുകൾ പങ്കെടുക്കുന്ന സൽക്കാരവേളകളിലോ ആഘോഷാവസരങ്ങളിലോ നിങ്ങൾ പോകാറുണ്ടോ

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

24. നിങ്ങളുടെ അഭിപ്രായം -

(എ) ചില ജോലികൾ മറ്റു ജോലികളുടെയത്ര ശ്രദ്ധയോടെ ചെയ്യേണ്ട ആവശ്യമില്ല

(ബി) 'എ'ക്കും 'സി'ക്കും ഇടക്ക്

(സി) ഏതു ജോലിയും ചെയ്യുന്നെങ്കിൽ നന്നായി ചെയ്യണം

25. തരുവിലൂടെ നടക്കുമ്പോൾ മറ്റുള്ളവർ നിങ്ങളെ ശ്രദ്ധിക്കുന്നത് നിങ്ങൾക്കിഷ്ടമാണോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല

26. താഴെപ്പറയുന്നതിൽ ആരായിത്തീരാനാണ് നിഘ്ണ്ടു ആഗ്രഹിക്കുന്നത്?

(എ) പുരോഹിതൽ (ബി) 'ഏ'യോ 'സി'യോ

(സി) ഉയർന്ന സൈനികോദ്യോഗസ്ഥൻ

27. ചില നിസ്സാര കാര്യങ്ങളിൽ ഒരു അയൽവാസി നിങ്ങളെ പറ്റിക്കുകയാണെങ്കിൽ അയാളെ കുറ്റപ്പെടുത്തുന്നതിനേക്കാൾ നല്ലത് അയാളുമായി ലോഹ്യത്തിൽ കഴിയുകയാണ്.

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

28. താഴെപ്പറയുന്നവയിൽ നിങ്ങൾ കാണാനിഷ്ടപ്പെടുന്നതേത്?

(എ) നല്ല പുരാണ സിനിമ (ബി) 'ഏ' യോ 'സി'യോ

(സി) സാമൂഹ്യ പുരോഗതിയെ ലക്ഷ്യമാക്കുന്ന നല്ല സിനിമയോ നാടകമോ

29. നിങ്ങളെ ഒരു ജോലിയേല്പിച്ചാൽ ഒന്നുകിൽ സ്വന്തം രീതിയിൽതന്നെ അവ ചെയ്യും. അല്ലെങ്കിൽ രാജിവയക്കും എന്ന് ശഠിക്കുമോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

30. ക്ഷീണിച്ചുപോകുമെന്നു കരുതി നിങ്ങൾ ആവേശകരമായ കാര്യങ്ങളിൽനിന്നും അകന്നു നില്ക്കാനാഗ്രഹിക്കുമോ

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

31. താഴെപ്പറയുന്നവയിൽ ഏതു കളിക്കാനാണ് നിങ്ങൾ ഇഷ്ടപ്പെടുക.

(എ) ചെസ്സ് (ബി) 'എ'യോ 'സി'യോ (സി) ഫുട്ബോൾ

32. കുഞ്ഞുങ്ങളെ വാക്സിനേറ്റു ചെയ്യുന്നതു ക്രൂരതയാണെന്നും മാതാപിതാക്കൾക്ക് അത് തടയാനുള്ള അവകാശം ഉണ്ടാകണം എന്നും നിങ്ങൾ കരുതുന്നുണ്ടോ?

(എ) അതെ (ബി) രണ്ടിനുമിടക്ക് (സി) ഇല്ല

33. താഴെപ്പറയുന്നവയിലേതിൽ വിശ്വസിക്കുനന്താണ് കൂടുതൽ നല്ലത്?

(എ) ഇനഷൂറൻസ് (ബി) രണ്ടിനുമിടക്ക് (സി) വ്യക്തിപരമായ ഭാഗ്യം

34. മനോവിഷമം പെട്ടെന്ന് മറക്കുന്ന ആളോണോ നിങ്ങൾ

(എ) അതെ (ബി) ഇടത്തരം (സി) അല്ല

35. നിങ്ങൾ ചെയ്തത് തെറ്റ്ണെന്ന് ബോധ്യമായാൽ അത് ഏറ്റുപറയാൻ പ്രയാസം തോന്നാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

36. ഒരു ഓഫീസിൽ നിങ്ങൾ പണിയെടുക്കാൻ ഇഷ്ടപ്പെടുന്നത്

(എ) സാങ്കേതികവകുപ്പിൽ (ബി) രണ്ടിനുമിടക്ക്

(സി) ഇന്റർവ്യൂ ചെയ്യുകയും ആളുകളെ ജോലിക്കെടുക്കുകയും ചെയ്യുന്ന ഭരണവകുപ്പിൽ

37. താഴെപ്പറയുന്നവയിൽ ഏത് വാക്ക് മറ്റു രണ്ടു വാക്കുകളോട് യോജിക്കുന്നില്ല.

(എ) പൂച്ച (ബി) അരികെ (സി) സൂര്യൻ

38. മോശമായ ആരോഗ്യംബലം നിങ്ങളുടെ പരിപാടികളിൽ പലപ്പോഴും മാറ്റങ്ങൾ വരുത്തേണ്ടിവരാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) മിക്കപ്പോഴും (സി) ഇല്ല

39. വ്യക്തിപരമായ ആവശ്യങ്ങൾക്ക് ജോലിക്കാരെ വക്കുന്നത് നിങ്ങൾക്കിഷ്ടമാണോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല

40. നന്നായി പെരുമാറാൻ കഴിയാത്തതുമൂലം നിങ്ങൾ കൂട്ടുകാരിൽനിന്നും ഒറ്റപ്പെടാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല

41. സദാചാരനിയമങ്ങൾ മനുഷ്യൻ കൂടുതൽ കർശനമായി പാലിക്കണമെന്ന് നിങ്ങൾക്ക് തോന്നുന്നുണ്ടോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

42. നിങ്ങൾ ചിലപ്പോഴൊക്കെ മിണ്ടാൻ കഴിയാത്തത്ര കോപിഷ്ടനാകാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) രണ്ടിനുമിടക്ക് (സി) ഇല്ല

43. ശാരീരികാദ്ധ്വാനം അധികം ആവശ്യമുള്ള പ്രവൃത്തികൾ പെട്ടെന്ന് ക്ഷീണിക്കാതെ, മറ്റുള്ളവരേക്കാൾ കൂടുതൽ ചെയ്യാൻ നിങ്ങൾക്ക് കഴിയുമോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

44. സാഹചര്യങ്ങൾ വളരെ പ്രതികൂലമാവുന്ന അവസ്ഥയിലും മിക്ക സാക്ഷികളും സത്യം പറയാൻ തയ്യാറാവുമെന്ന് നിങ്ങൾ കരുതുന്നുണ്ടോ?

(എ) അതെ (ബി) കുറയൊക്കെ (സി) ഇല്ല

45. ചിന്തിക്കുമ്പോൾ അങ്ങോട്ടുമിങ്ങോട്ടും നടക്കുന്നത് നിങ്ങളുടെ ചിന്തെ സഹായിക്കുമെന്ന് തോന്നുന്നുവോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

46. താഴെപ്പറയുന്നവയിൽ ഏത് കാര്യത്തിലാണ് നമ്മുടെ രാഷ്ട്രം കൂടുതൽ ധനം വിനിയോഗിക്കേണ്ടത്?

(എ) യുദ്ധോപകരണങ്ങൾക്കായി (ബി) രണ്ടിനം (സി) വിദ്യഭ്യാസത്തിനായി

47. ഒരു സായാഹ്നം ചെലവഴിക്കാൻ താഴെപ്പറയുന്നവയിൽ ഏതു നിങ്ങൾ ഇഷ്ടപ്പെടും.

(എ) വാശിയേറിയ ചീട്ടുകളി (ബി) രണ്ടും

(സി) കഴിഞ്ഞ അവധിക്കാല ചിത്രങ്ങൾ കാണുക

48. താഴെപ്പറയുന്നവയിൽ നിങ്ങൾ കൂടുതലായി വായിക്കാനിഷ്ടപ്പെടുന്നത്?

(എ) ഒരു നല്ല ചരിത്രനോവൽ (ബി) രണ്ടും ഒരു പോലെ

(സി) ആഗോളവിഭവങ്ങൾ എങ്ങനെ ഉപയോഗിക്കുമെന്നതിനെക്കുറിച്ച് ഒരു ശാസ്ത്രജ്ഞന്റെ ലേഖനം

49. ഈ ലോകത്തിൽ നല്ല മനുഷ്യരാണ് വിഡ്ഢികളേക്കാൾ കൂടുതലെന്ന് നിങ്ങൾ വിശ്വസിക്കുന്നുവോ?

(എ) അതെ (ബി) കുറെയൊക്കെ (സി) ഇല്ല

50. സ്വന്തം ജോലിയിൽ നിങ്ങൾ മറ്റു പലരേക്കാളും കൂടുതലായി കഴിവും സാമർത്ഥ്യവും പ്രകടിപ്പിക്കാറുണ്ടോ?

(എ) അതെ (ബി) മിക്കപ്പോഴും (സി) ഇല്ല

51. മറ്റാരേയും കാണാൻ തോന്നാത്തവിധം ദു:ഖിതരും നിരുത്സാഹവാനുമായി ചില പ്പോഴെങ്കിലും നിങ്ങൾക്ക് സ്വയം അനുഭവപ്പെടാറുണ്ടോ?

(എ) വളരെ ചുരുക്കമായി (ബി) ചിലപ്പോഴൊക്കെ (സി) മിക്കപ്പോഴും

52. നിങ്ങൾ ചെയ്യുന്നത് പൂർണ്ണ ബോദ്ധ്യമുള്ളപ്പോഴൊക്കെ അത് എളുപ്പമായി ചെയ്യാൻ നിങ്ങൾക്ക് കഴിയുമോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

53. താഴെപ്പറയുന്നവയിൽ േതു ജോലി നിങ്ങൾ ഇഷ്ടപ്പെടുന്നു.

(എ) ഓഫീസിലെ മാനേജർ (ബി) 'എ'ക്കും 'സി'ക്കും ഇടക്ക്

(സി) കെട്ടിടങ്ങളുടെ പ്ലാൻ പരക്കുന്ന ആർക്കിടെക്റ്റ്

54. കറുപ്പ് ചാരനിറത്തിനോട് എന്നപോലെ വേദനക്ക്

(എ) മുറിവ് (ബി) രോഗം (സി) അസ്വസ്ഥത

55. ഉറകത്തിൽ സംസാരിക്കുകയോ നടക്കുകയോ ചെയ്യതെ സുഖനിദ്രയുള്ള ആളാണോ നിങ്ങൾ

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല

56. സുഹൃത്തിനോട് മന:പൂർവ്വം നുണ പറഞ്ഞശെഷം നിങ്ങൾക്ക് അയാളെ ലജ്ജയി ല്ലാതെ അഭിമുഖീകരിക്കാൻ കഴിയുേമാ?

(എ) അതെ (ബി) ചിലപ്പോൾ (സി) ഇല്ല

57. സാമൂഹിക ചടങ്ങുകൾ സംഘടിപ്പിക്കുന്നതുന്നു നിങ്ങൾ എപ്പോഴെങ്കിലും ഊർജ്ജസ്വലമായി പങ്കെടുത്തിട്ടുണ്ടോ?

(എ) ഉണ്ട് (ബി) വല്ലപ്പോഴും (സി) ഇല്ല

58. നിങ്ങൾ കൂടുതൽ ആരാധിക്കുന്നത്?

(എ) ബുദ്ധിമാനായ വിശ്വസിക്കാനാവത്ത ഒരാളെ (ബി) രണ്ടിനുമിടക്ക്

(സി) പ്രലോഭനങ്ങളെ അ്തിജതീവിക്കാനുള്ള മന:ശക്തിയുള്ള ഒരു സാധാരണ ക്കാരനെ

59. ന്യായമായ ഒരു പരാതിഉന്നയിച്ചുകഴിഞ്ഞാൽ നിങ്ങൾക്ക് സാധാരണയായി സംതൃപ്തി തോന്നാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

60. നിരുത്സാഹപ്പെടുത്തുന്ന ചുറ്റുപാടുകൾ നിങ്ങളെ കരച്ചിലിന്റെ വക്കത്തുവരെ ൊത്തിക്കുമോ?

(എ) ഉണ്ട് (ബി) വല്ലപ്പോഴും (സി) ഇല്ല

61. നമ്മൾ വിചാരിക്കുന്നതിലധികം സൗഹൃദം പല വിദേശരാജ്യങ്ങൾക്കും നമ്മോടു ണ്ടെന്ന് നിങ്ങൾ കരുതുന്നുണ്ടോ?

(എ) അതെ് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

62. മറ്റുള്ളവരിൽനിന്നകന്നു സ്വന്തം ചിന്തകളിൽ മുഴുകാൻ ഇഷ്ടപ്പെടുന്ന അവസരങ്ങൾ എല്ലാ ദിവസവും ഉണ്ടാകാറുണ്ടോ?

63. ശാന്തനായിരിക്കുന്ന സമയങ്ങളിൽ നിങ്ങൾ അംഗീകരിക്കുന്ന ചെറിയ നിയമങ്ങളും നിയന്ത്രണങ്ങളും മറ്റും ചിലപ്പോൾ നിങ്ങളെ അലട്ടാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) കുറെയൊക്കെ (സി) ഇല്ല

64. ശിക്ഷക്കെതിരായുള്ള ആധുനിക രീതിയേക്കാൾ നല്ലതാണ് ശിക്ഷ നൽകിയുള്ള പഴയ വിദ്യാഭ്യാസസമ്പ്രദായം എന്ന് നിങ്ങൾ കരുതുന്നുണ്ടോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

65. നിങ്ങൾ സ്ക്കൂൾ ജീവതത്തിൽ കൂടുതലായി പഠിച്ചത്?

(എ) ക്ലാസ്സിൽ പോയിട്ട് (ബി) രണ്ടിനുമിടക്ക് (സി) പുസ്തം വായിച്ച്

66. ചെറിയ സാമൂഹിക ബാദ്ധ്യതകളിൽനിന്നും കഴിയുന്നത്ര അകന്നുനിൽക്കാണോ നിങ്ങൾ ശ്രമിക്കുക.

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

67. ഒരു പ്രശ്നം കൂടുതൽ പ്രയാസമുള്ളതായി തോന്നിയാൽ നിങ്ങൾ

(എ) വേറൊരു പ്രശ്നമെടുക്കും (ബി) 'എ'ക്കും 'സി'ക്കും ഇടക്ക്

(സി) അതേ പ്രശ്നത്തെ വേറൊരു രീതിയിൽ സമീപിക്കും

68. വ്യക്തമായ കാരണങ്ങളില്ലാതെ തന്നെ നിങ്ങൾക്ക് അതിയായ ആധി, കോപം, ചിരി, ഇവ ഉണ്ടാകാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) ചിലപ്പോചറപ (സി) ഇല്ല

69. ചില സമയങ്ങളിൽ മറ്റു സന്ദർഭങ്ങളിലുള്ളത്ര നന്നായി ശ്രദ്ധ കേന്ദ്രീകരിക്കാൻ കഴിയാറില്ലെന്ന് നിങ്ങൾക്ക് തോന്നുന്നുണ്ടോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

70. മറ്റുള്ളവരുടെ സൗകര്യം കണക്കിലെടുത്ത് നിങ്ങൾ പ്രവൃത്തികളുടെ സമയം ക്രമീകരിക്കുമോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

71. ഈ സംഖ്യാശ്രേണി പൂരത്തിയാക്കൻ നിങ്ങൾ ഏതു സംഖ്യകൾ കൂട്ടിച്ചേർക്കും?
1,2,3,4,5,6, ...

(എ) 10 (ബി) 5 (സി) 7

72. മറ്റുള്ളവരുടെ പ്രവൃത്തികളെ നിങ്ങൾ വിമർശിക്കാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) വല്ലപ്പോഴും (സി) ഇല്ല

73. അഹംഭാവികളും ഡംഭന്മാരുമായവരുടെ സാന്നിദ്ധ്യം നിങ്ങളെ അസ്വസ്ഥനാക്കാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) വല്ലപ്പോഴും (സി) ഇല്ല

74. ഏതവസരത്തിലും യാത്രചെയ്യുവാൻ നിങ്ങൾ ഇഷ്ടപ്പെടുന്നുണ്ടോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

75. പെട്ടെന്നുണ്ടായ വേദനകൊണ്ടോ രക്തം കണ്ടിട്ടോ ഏപ്പോഴെങ്കിലും നിങ്ങൾക്ക് മോഹാലസ്യംപോലെ വന്നിട്ടുണ്ടോ?

(എ) ഉണ്ട് (ബി) ചിലപ്പോഴെല്ലാം (സി) ഇല്ല

76. ആനുകാലിക പ്രശ്നങ്ങളെക്കുറിച്ച് മറ്റുള്ളവരുമായി സംസാരിച്ചിരിക്കാൻ നിങ്ങൾക്കിഷ്ടമാണോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

77. താഴെപ്പറയുന്നവയിൽ ആരാകാൻ നിങ്ങൾ ഇഷ്ടപ്പെടുന്നു?

(എ) എഞ്ചീനീയർ (ബി) രണ്ടും ഒരുപോലെ

(സി) സാമൂഹികസിദ്ധാന്തങ്ങൾ പഠിപ്പിക്കുന്ന ടീച്ചർ

78. മറ്റുള്ളവരുടെ പ്രശ്നങ്ങളിൽ ഇടപെടുകയോ അതു പരിഹരിക്കാൻ ശ്രമിക്കുകയോ ചെയ്യാനുള്ള പ്രവണത നിങ്ങൾക്ക് സ്വയം നിയന്ത്രിക്കേണ്ടിവരാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

79. നിങ്ങളുടെ അയൽക്കാരിൽ എത്രപേരാണ് സംസാരിക്കുന്നത് ബോറടിയായി നിങ്ങൾക്കനുഭവപ്പെടാറുണ്ട്?

(എ) എല്ലാവരോടും തന്നെ (ബി) ചിലരോട് (സി) ആരോടും ഇല്ല

80 നിങ്ങൾ വായിക്കുന്നതിൽ പ്രചരണത്തിന്റെ അംശങ്ങൾ ഉണ്ടെങ്കിൽ മറ്റുള്ളവർ ചൂണ്ടിക്കാണിച്ചുതരാതെ നിങ്ങളത് മനസ്സിലാക്കുമോ?

(എ) അതെ (ബി) ചിലപ്പോൾ (സി) ഇല്ല

81. ഏതു കഥയിലും ഒരു ഗുണപാഠമുണ്ടായിരിക്കണമെന്ന നിങ്ങൾ കരുതുന്നുണ്ടോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

82. ഏതു വ്യവസായത്തിലും കൂടുതൽ പ്രശ്നമുണ്ടാക്കുന്നത് താഴെ പറയുന്നവയിൽ ഏതു കൂട്ടരാണെന്നാണ് നിങ്ങളുടെ വിശ്വാസം?

(എ) നിലവിലുള്ള രീതികളെ മാറ്റുകയും വ്യത്യാസപ്പെടുത്തുകയും ചെയ്യുന്നവർ

(ബി) ഇരു തരക്കാരും

(സി) പുതിയ രീതികൾ നടപ്പിലാക്കാൻ വിസമ്മതിക്കുന്നവർ

83. പ്രായോഗികമല്ലേ എന്ന സംശ.ം കാരണം സ്വന്തം അഭിപ്രായങ്ങളും ആശങ്ങളും പ്രായോഗികമാക്കുവാൻ നിങ്ങൾ ചിലപ്പോൾ മടിക്കാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) കുറെയൊക്കെ (സി) ഇല്ല

84. നിങ്ങളെ കാണുന്നതുതന്നെ വെറുപ്പാണെന്നമട്ടിൽ ചില അഹംഭാവികളായ ആളുകൾ പെരുമാറാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

85. മറ്റുള്ളവരുടെ മുമ്പിൽ നാണക്കേടുണ്ടാകാത്തവിധം വിശ്വസനീയമായ ഓർമ്മശക്തിയുടെ ഉടമയാണോ നിങ്ങൾ?

(എ) അതെ (ബി) ഇടത്തരം (സി) ഇല്ല

86 മറ്റുള്ളവർ നിങ്ങളോട് പെരുമാറുന്നതിനേക്കാൾ മോശമായ രീതിയിലാണോ നിങ്ങൾ അവരെകരുതുക

(എ) അതെ (ബി) ചിലപ്പോൾ (സി) അല്ല

87. സംസാരിക്കുമ്പോൾ മറ്റുള്ളവരേക്കാൾ സാവധാനത്തിലാണോ നിങ്ങൾ പ്രതികരിക്കുക?

(എ) അതെ (ബി) ചിലപ്പോൾ (സി) അല്ല

88. ഒരു വാച്ചിന്റെ രണ്ടു സൂചികൾ 65 മിനുട്ട് കൂടുമ്പോൾ ഒരുമിക്കുന്നു എങ്കിൽ വാച്ച് ഓടുന്നത്?

(എ) മെല്ലെയാണ് (ബി) കൃത്യമായാണ് (സി) വേഗത്തിലാണ്.

89. മറ്റുള്ളവർക്കുവേണ്ടി കാത്തിനിൽക്കേണ്ടിവന്നാൽ നിങ്ങൾക്ക് വല്ലാതെ ക്ഷോഭം വരുമോ?

(എ) അതെ (ബി) ചുരുക്കമായി (സി) ഇല്ല

90. നിങ്ങൾ അഹംഭാവിയും അല്പനുമാണെന്ന് മറ്റുള്ളവർ കരുതാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) വല്ലപ്പോഴും (സി) ഇല്ല

91. ജോലി ചെയ്യാനുള്ള ശരിയായ സാമഗ്രികൾ കിട്ടിയിലിലെങ്കിൽ പരാതി പറയണോ എന്ന് സാവധാനത്തിലാണോ നിങ്ങൾ തീരുമാനിക്കുക.?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല

92. വീട്ടിൽ നിങ്ങൾ

(എ) വിശ്രസമയം കൊട്ടുവർത്തമാനം പറഞ്ഞ് ഉല്ലസിക്കും

(ബി) രണ്ടും (സി) പ്രത്യേക ജോലികൾ ചെയ്യുവാൻ ഉപയോഗിക്കും

93. മറ്റുള്ളവരുമായി സൗഹൃദം സ്ഥാപിക്കുന്നതിൽ നിങ്ങൾ മെല്ലെയാണോ?

(എ) അതെ (ബി) വല്ലപ്പോഴും (സി) അല്ല

94. ആളുകൾ കവതയിൽ പറയാൻ ശ്രമിക്കുന്ന കാര്യങ്ങൾ സാധാരണ ഗദ്യത്തിൽ നേര പറഞ്ഞാൽ പോരേ എന്നു നിങ്ങൾ ചിന്തിക്കാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

95. സൗഹൃദം ഭാവിക്കുമ്പോൾ ചിലപ്പോൾ ചതിക്കുമെന്ന് നിങ്ങൾ സംശയിക്കാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) കുറെയൊക്കെ (സി) ഇല്ല

96. നിങ്ങളിൽ കാര്യമായ യാതൊരു മാറ്റവുമുണ്ടാക്കാതെയാണോ നിങ്ങളുടെ ഈ വഷത്തെ ഏറ്റവും നാടകീയമായ അനുഭവങ്ങൾ കടന്നുവോകുന്നത്?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല

97. നിങ്ങൾ സാവധാനമാണോ സംസാരിക്കുക?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) അല്ല

98. നിങ്ങൾക്കു ചില കാര്യങ്ങളിൽ ഉള്ള ഭയമോ അനിഷ്ടമോ നിയന്ത്രിക്കാൻ കഴിയാതെ വരാറുണ്ടോടോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

99. ഒരു സംഘത്തിൽ താഴെ പറയുന്നവയിലേതാകാൻ നിങ്ങൾ ഇഷ്ടപ്പെടും

(എ) സാങ്കേതികപുരോഗതിക്കുവേണ്ടി പണിയെടുക്കുന്നയാൾ

(ബി) രണ്ടിലേതെങ്കിലും

(സി) റിക്കാർഡുകൾ സൂക്ഷിക്കുകയും നിയമങ്ങൾ പാലിക്കപ്പെടുന്നോ എന്ന് പരിശോധിക്കുകയും ചെയ്യുന്ന് ആൾ

100. ഒരു സാമൂഹികപ്രശ്നത്തെപ്പറ്റിയുള്ള വോട്ടെടുപ്പിൽ ഏതഭിപ്രായം രേഖപ്പെടുത്തണമെന്ന് തീരുമാനിക്കാൻ നിങ്ങൾ താഴെ പറയുന്നവയിൽ ഏതു വായിക്കും

(എ) അതേക്കുറിച്ചുള്ള ഒരു നല്ല നോവൽ വായിക്കും

(ബി) രണ്ടിലേതിലെങ്കിലും

(സി) സ്ഥിതിവിവരക്കണക്കുകളും മറ്റു വസ്തുതകളും അടങ്ങുന്ന ഒരു പുസ്തകം വായിക്കും

101. രാത്രിയിൽ നിങ്ങൾ തികച്ചും അത്ഭുതകരവും അർത്ഥശൂന്യവും ആയ സ്വപ്നങ്ങൾ കാണാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) ചിലപ്പോൾ (സി) ഇല്ല

102. വീട്ടിൽ തികച്ചും ഏകാകിയായി കുറച്ചുസമയം ചിലവഴിക്കേണ്ടിവന്നാൽ ആധിയും ഭയവുമാണ്ടാകുമോ?

(എ) അതെ (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

103. തീരെ ഇഷ്ടമില്ലാത്ത ആളുകളോട് സൗഹൃദം ഭാവിച്ച് അവരെ നിങ്ങൾ വഞ്ചിക്കാൻ ശ്രമിക്കാറുണ്ടോ?

(എ) ഉണ്ട് (ബി) ചിലപ്പോഴൊക്കെ (സി) ഇല്ല

104. ഏതാണ് മറ്റു രണ്ടിനോടും യോജിക്കാത്തത്?

(എ) ഓടുക (ബി) കാണുക (സി) തൊടുക

105. സീതയുടെ അമ്മ മോഹന്റെ അച്ഛന്റെ പെങ്ങളായാൽ മോഹൻ സീതയുടെ അച്ഛനോടുള്ള ബന്ധം

(എ) സഹോദരൻ (ബി) അനന്തിരവൻ (സി) അമ്മാവൻ/ചിറ്റപ്പൻ

APPENDIX III

MARITAL ADJUSTMENT QUESTIONNAIRE

Pramod Kumar
Sardar Patel University
Vallabh Vidyanagar

Kanchana Rohatgi
Jodhpur University
Jodhpur.

INSTRUCTION

Below are given a list of statements relating with different aspects of married life. You are requested to read each statement carefully. If the statement is true for you, you are to under line 'Yes'. If it is not true, you are to underline 'No'. As many of these statements are very personal in nature, your replies will be kept strictly confidential. Kindly answer each statement frankly and truthfully. Thanks.

Score: .....

1.	Both of you mostly prefer to go out together.	Yes	No
2.	Both of you have full confidence in each other.	Yes	No
3.	Both of you are religious-minded.	Yes	No
4.	Both of you often develop tension over family expenditure	Yes	No
5.	Both of you agree that taking care of children is a joint responsibility	Yes	No
6.	Both of you believe in family planning.	Yes	No
7.	Both of you agree that you got married at the right age.	Yes	No
8.	Both of you feel incomplete when required to live alone	Yes	No
9.	Both of you fully enjoy sex.	Yes	No
10.	Both of you like to keep some of your personal secrets to yourself	Yes	No
11.	Both of you try to squeeze out maximum possible time to be with each other.	Yes	No
12.	Both of you respect each other's family members	Yes	No

13.	Both of you are proud of each other.	Yes	No
14.	Both of you try to solve your family problems jointly.	Yes	No
15.	Both of you treat each other more as a partner (friend) than a husband or wife.	Yes	No
16.	Both of you often praise each other.	Yes	No
17.	Both of you take care of each other's interests, habits and likings	Yes	No
18.	Both of you have got similar views regarding the number of children in the family	Yes	No
19.	Both of you often have arguments taking households issues.	Yes	No
20.	Both of you take care of each other's needs and satisfactions in sexual matters	Yes	No
21.	Both of you feel that you did the right thing that you married each other.	Yes	No
22.	Both of you feel quite miserable in the absence of each other.	Yes	No
23.	Both of you agree that marriage provides the most satisfying sex.	Yes	No
24.	Both of you have got similar interests and aptitudes	Yes	No
25.	Both of you try to maintain newness in your sexual relationship	Yes	No

PERSONAL DATA:

Name: ..... Sex: .....

Age: ..... Age at marriage: .....

Education: ..... Job Status: .....

No. of children: Male ..... Female .....

2 30

MARITAL ADJUSTMENT QUESTIONNAIRE

Malini K. & Anita Ravidnran

വിവാഹ ജീവിതത്തിന്റെ വിവിധ വശങ്ങളെ സംബന്ധിച്ചുള്ള ഒരു കൂട്ടം പ്രസ്താവനകളാണ് താഴെ കൊടുത്തിരിക്കുന്നത്. ഓരോ പ്രസ്താവനകളും വായിച്ച് മനസ്സിലാക്കുയതിനു ശേഷം, താങ്കളെ സംബന്ധിച്ച് ശരിയായിട്ടുള്ള പ്രസ്താവനക്ക് നേരെ 'അതെ' എന്നും തെറ്റായ പ്രസ്താവനക്ക് നേരേ 'അല്ല' എന്നും രേഖപ്പെടുത്തുക. പ്രസ്താവനകൾ തികച്ചും വ്യക്തിപരമായതിനാൽ ഉത്തരങ്ങളുടെ രഹസ്യ സ്വഭാവം തികച്ചും ഉറപ്പു വരുത്തുന്നതാണ്. ദയവായി സത്യസന്ധമായി പ്രതികരിക്കുക. നന്ദി.

സ്കോർ ----------

	അതെ	അല്ല
1.	നിങ്ങൾ രണ്ടുപേരും മിക്കവാറും ഒരുമിച്ചു പുറത്തുപോകുവാൻ ഇഷ്ടപ്പെടുന്നു.	
2.	നിങ്ങൾക്ക് രണ്ടുപേർക്കും അന്യോന്യം പൂർണ്ണ വിശ്വാസമാണ്.	
3.	രണ്ടുപേരും ദൈവവിശ്വാസികളാണ്.	
4.	കുടുംബത്തിലെ സാമ്പത്തിക ചിലവുകളെ സംബന്ധിച്ച് നിങ്ങൾ തമ്മിൽ മിക്കാവാറും ഉരസൽ/സ്പർദ്ധ ഉണ്ടാകാറുണ്ട്	
5.	കുട്ടികളുടെ പരിപാലനം കൂട്ടുത്തരവാദിത്ത്വമാണെന്ന് നിങ്ങൾ രണ്ടുപേരും വിശ്വസിക്കുന്നു	
6.	നിങ്ങൾ രണ്ടുപേരും കുടുംബാസൂത്രണത്തിൽ വിശ്വസിക്കുന്നു	
7.	നിങ്ങളുടെ വിവാഹം നിങ്ങളെ സംബന്ധിച്ചിടത്തോളം ശരിയായ സമയത്താണെന്ന് നിങ്ങൾ രണ്ടുപേരും വിശ്വസിക്കുന്നു	
8.	പിരിഞ്ഞ്താമസിക്കുമ്പോൾ രണ്ടുപേർക്കും അപൂർണ്ണത അനുഭവപ്പെടാറുണ്ട്	
9.	ലൈംഗികബന്ധം നിങ്ങൾ രണ്ടുപേരും പൂർണ്ണമായി ആസ്വദിക്കാറുണ്ട്	
10.	നിങ്ങളുടെ വ്യക്തിപരമായ ചില രഹസ്യങ്ങൾ സ്വന്തമായി വയ്ക്കുവാൻ രണ്ടുപേരും താൽപര്യപ്പെടുന്നു	
11.	നിങ്ങൾ രണ്ടുപേരും അന്യോന്യം ഒരുമിച്ച് ചിലവഴിക്കാൻ പരമാവധി സമയം കണ്ടെത്താൻ ശ്രമിക്കാറുണ്ട്	
12.	രണ്ടുപേരും മറ്റെയാളുടെ കുടുംബാംഗങ്ങളെ ബഹമാനിക്കുന്നു.	
13.	നിങ്ങൾ രണ്ടുപേർക്കും നിങ്ങളുടെ പങ്കാളിയെക്കുറിച്ച് അഭിമാനമുണ്ട്.	
14.	കുടുംബ പ്രശ്നങ്ങൾ ഒത്തുചേർന്ന് പരിഹരിക്കാൻ ശ്രമിക്കാറുണ്ട്.	
15.	രണ്ടുപേരും അന്യോന്യം ഭാര്യാഭർത്താക്കൻമാർ എന്നതിലുപരി നല്ല സുഹൃത്തുക്കളായി കാണാറുണ്ട്.	
16.	രണ്ടുപേരും മിക്കപ്പോഴും പരസ്പരം പ്രശംസിക്കാറുണ്ട്.	

17. രണ്ടുപേരും പങ്കാളിയുടെ ഇഷ്ടങ്ങളും, സ്വഭാവങ്ങളും, താൽപര്യങ്ങളും ശ്രദ്ധിക്കാറുണ്ട്

18. കുടുംബത്തിലെ കുട്ടികളുടെ എണ്ണത്തെ സംബന്ധിച്ച് രണ്ടുപേർക്കും ഒരേ കാഴ്ചപ്പാടാണ്

19. കുടുംബത്തിലെ ദൈനംദിന പ്രശ്നങ്ങളെക്കുറിച്ച് നിങ്ങൾ തമ്മിൽ വാക്കുതർക്കമുണ്ടാകാറുണ്ട്

20. ലൈംഗിക കാര്യങ്ങളിൽ താൽപര്യങ്ങളും സംതൃപ്തിയും അന്യോന്യം ഉറപ്പുവരുത്താറുണ്ട്

21. നിങ്ങളുടെ വിവാഹം തികച്ചും ശരിയായ കാര്യമായിരുന്നെന്ന് നിങ്ങൾക്ക് രണ്ടു പേർക്കും തോന്നുന്നുണ്ട്

22. പരസ്പരം അകന്നിരിക്കുമ്പോൾ നിങ്ങൾക്ക് അസഹനീയത അനുഭവപ്പെടാറുണ്ട്

23. ഏറ്റവും തൃപ്തികരമായ ലൈംഗികബന്ധം വിവാഹത്തിലൂടെ മാത്രമേ സാദ്ധ്യമാകുകയുള്ളൂ എന്ന് നിങ്ങൾ വിശ്വസിക്കുന്നു

24. നിങ്ങൾ രണ്ടുപേരും ഒരുപോലുള്ള അഭിരുചികളും താൽപര്യങ്ങളും ഉള്ളവരാണ്

25. ലൈംഗികബന്ധത്തിൽ പുതുമ നിലനിർത്താൻ നിങ്ങൾ രണ്ടുപേരും ശ്രമിക്കാറുണ്ട്.

പേര് .....

സ്ത്രീ/പുരുഷൻ ..... വയസ്സ് ..... വിവാഹം കഴിക്കുമ്പോഴുള്ള പ്രായം .....

വിദ്യാഭ്യാസം ..... ജോലി .....

കുട്ടികളുടെ എണ്ണം: ആൺകുട്ടി ..... പെൺകുട്ടി .....

APPENDIX IV

PGI General WellbBeing Measure

S.K. Verma & Amita Verma

Name:
Age Sex
Address

INSTRUCTION: How do you feel these days (part one month)? Kindly tick (✓) in the cell against each item which is applicable on you.

☐	1.	In good spirits
☐	2.	In firm control of behaviour and feelings.
☐	3.	Fairly happing personal life.
☐	4.	Interested in life a good bit of time.
☐	5.	Sleeping fairly well.
☐	6.	Feeling emotionally stable a good bit of the time.
☐	7.	Feeling relaxed most of the time.
☐	8.	Feeling energetic most of the time.
☐	9.	Feeling cheerful most of the time.
☐	10.	Not bothered my nervousness.
☐	11.	Not bothered by anxiety or worry.
☐	12.	Not easily tired.
☐	13.	Not bothered by illness or pain.
☐	14.	Not feeling depressed or dejected.
☐	15.	Feeling satisfied with life in general.,
☐	16.	Not easily irritated most of the time.
☐	17.	Feeling useful, wanted.
☐	18.	Feeling productive, creative.
☐	19.	Having a sense of belongingness.
☐	20.	Being in good health.

Ankur Psychological Agency
22/481 Indira Nagar, Lucknow – 16.

PGI GENERAL WELLBEING MEASURE

Sareena P. & Anita Ravindran

പേര് :
വയസ്സ് :
സ്ത്രീ/പുരുഷൻ

നിർദ്ദേശം: ദൈനം ദിന ജീവിതത്തെ വിലയിരുത്താനുതകുന്ന ഏതാനും പ്രസ്താവനകൾ താഴെ കൊടുത്തിരിക്കുന്നു. കഴിഞ്ഞ ഒരു മാസത്തെ നിങ്ങളുടെ അനുഭവങ്ങളുടെ വെളിച്ചത്തിൽ സ്വീകാര്യമായി തോന്നുന്ന പ്രസ്താവനകൾക്കു നേരേ ✓' അടയാളവും രേഖപ്പെടുത്തുക. നിങ്ങളുടെ അഭിപ്രായങ്ങൾ ഗഹവേഷണത്തിന് മാത്രമേ ഉപോയഗിക്കുകയുള്ളൂ.

1. ഓജസ്സോടുകൂടിയായിരുന്നു
2. വികാരങ്ങളും പെരുമാറ്റവും പരിപൂർണ്ണനിയന്ത്രണത്തിൽ ആയിരുന്നു
3. സ്വകാര്യ ജീവിതത്തിൽ തീർത്തും സംതൃപ്തിയുണ്ട്
4. ജീവിതത്തോട് ഏറെ പ്രതിപത്തിയുണ്ട്
5. സുഖമായി ഉറങ്ങാറുണ്ട്
6. പലപ്പോഴും വൈകാരികമായ പക്വതയും സ്ഥിരതയുമുണ്ട്
7. മിക്കപ്പോഴും മാനസികസംഘർഷമില്ലാതെ വിശ്രമാവസ്ഥ അനുഭവപ്പെടുന്നു
8. മിക്കപ്പോഴും ഊർജ്ജസ്വലനാണെന്ന് അനുഭവപ്പെടുന്നു.
9. മിക്കിപ്പോഴും ഉത്സാഹവും സന്തോഷവും തോന്നുന്നു.
10. പരിഭ്രമമോ സങ്കോചമോ അലട്ടാറില്ല
11. ഉൽകണ്ഠയോ ആശങ്കയോ തോന്നാറില്ല.
12. വേഗം ക്ഷീണിക്കാറില്ല
13. വേദന, രോഗം എന്നവ വിഷമിപ്പിക്കാറില്ല
14. വിഷാദമോ സങ്കടമോ തോന്നാറില്ല
15. ജീവിതം പൊതുവെ തൃപ്തികരമാണ്
16. സാധാരണയായി പെട്ടെന്ന ശുണ്ഠി പിടിക്കാറില്ല
17. എന്നെക്കൊണ്ട് ആവശ്യമുണ്ട്. ഉപയോഗമുണ്ട് എന്നൊക്ക തോന്നാറുണ്ട്
18. ജീവിതം ക്രിയാത്മകവും ഫലപ്രദവുമാണെന്നു തോന്നുന്നു.
19. ഞനാം എല്ലാറ്റിന്റേയും ഭാഗമാണെന്നു തോന്നുന്നു.
20. ആരോഗ്യകരമായ സ്ഥിതിയിലാണ്.

APPENDIX V

AECOM COPING SCALE

Your Name ..... Age ..... Sex ..... Date .....

Instructions

Here is a list of statements describing how people behave in different situations or how they feel putting a cross in the appropriate space..

		NEVER	RARELY	SOME-TIMES	OFTEN
1.	I'm an optimist	☐	☐	☐	☐
2.	I avoid thinking about unpleasant things	☐	☐	☐	☐
3.	When I have a problem, I try to get others to help me	☐	☐	☐	☐
4.	If an illness or accident prevented me from doing my usual work, I would still find useful things to do	☐	☐	☐	☐
5.	If other people stopped making decisions for me, I could make my own	☐	☐	☐	☐
6.	When I get upset, I look for something to eat	☐	☐	☐	☐
7.	I get as much information as I can before I make decisions	☐	☐	☐	☐
8.	I try to see the funny side of upsetting situations	☐	☐	☐	☐
9.	I don't worry in advance about problems that are likely to occur	☐	☐	☐	☐
10.	I try not to think about my problems	☐	☐	☐	☐
11.	I try to be involved with people who can take care of things better than I can	☐	☐	☐	☐
12.	I exercise regularly to try to improve the shape of my body	☐	☐	☐	☐
13.	When things to wrong for me, it is someone else's fault	☐	☐	☐	☐
14.	I read fiction to take my mind of my problem	☐	☐	☐	☐

		NEVER	RARELY	SOME-TIMES	OFTEN
15.	When I have a problem, I try to think of all the different ways to take care of it	☐	☐	☐	☐
16.	I make an extra effort to be nice to people I don't like	☐	☐	☐	☐
17.	I feel that things are nor as bad as they seem to others	☐	☐	☐	☐
18.	I avoid funerals	☐	☐	☐	☐
19.	When I feel upset, I like to be taken care of	☐	☐	☐	☐
20.	If lose a friend, I try to make another one	☐	☐	☐	☐
21.	I would get more done if people didn't bother me	☐	☐	☐	☐
22.	When I get angry, I work it off by doing physical activities	☐	☐	☐	☐
23.	I try to carefully analyzed every problem	☐	☐	☐	☐
24.	When I get angry, I try to hide my feelings	☐	☐	☐	☐
25.	I ignore aches and pains	☐	☐	☐	☐
26.	I do not look at disturbing scenes in movies	☐	☐	☐	☐
27.	When I', sick I like to get in bed and be waited on	☐	☐	☐	☐
28.	When I do poorly at something. I try to improve	☐	☐	☐	☐
29.	Because other people interfere. I can't get my work done	☐	☐	☐	☐
30.	When I feel nervous. I go for a walk	☐	☐	☐	☐
31.	I try to figure out the possible good and bad outcomes before making any decision	☐	☐	☐	☐
32.	If I feel shy in a group. I still force myself to approach people	☐	☐	☐	☐
33.	I feel that problems have a way of taking care of themselves	☐	☐	☐	☐

		NEVER	RARELY	SOME-TIMES	OFTEN
34.	I avoid visiting people in the hospital	☐	☐	☐	☐
35.	I get someone else's opinions before I buy anything important	☐	☐	☐	☐
36.	When I feed sad, I try to do something that interests me	☐	☐	☐	☐
37.	I'd be better off if people stopped interfering in my life	☐	☐	☐	☐
38.	When I feel tense, I like to work with my hands	☐	☐	☐	☐
39.	I spend a lot of time thinking about how to solve my problems	☐	☐	☐	☐
40.	When I am in a tense or unpleasant situation, I try to think of something funny to say	☐	☐	☐	☐
41.	I have to be very sick to see a doctor	☐	☐	☐	☐
42.	I avoid unhappy movies.	☐	☐	☐	☐
43.	When I'm upset. I try to find someone to talk to about what is bothering me	☐	☐	☐	☐
44.	If someone close to me died I would keep busy to take my mind off the loss	☐	☐	☐	☐
45.	Other people cause my problems	☐	☐	☐	☐
46.	Going to the movies takes my mind off my problems	☐	☐	☐	☐
47.	When I have a problem. I try to figure out all the steps necessary to solve it	☐	☐	☐	☐
48.	I am the kind of person who does not complain	☐	☐	☐	☐
49.	I don't worry about things in advance because I'm sure that everything will turn out all right.	☐	☐	☐	☐
50.	I avoid taking about death	☐	☐	☐	☐
51.	I avoid being alone when I feel upset	☐	☐	☐	☐

		NEVER	RARELY	SOME-TIMES	OFTEN
34.	I avoid visiting people in the hospital	☐	☐	☐	☐
35.	I get someone else's opinions before I buy anything important	☐	☐	☐	☐
36.	When I feed sad, I try to do something that interests me	☐	☐	☐	☐
37.	I'd be better off if people stopped interfering in my life	☐	☐	☐	☐
38.	When I feel tense, I like to work with my hands	☐	☐	☐	☐
39.	I spend a lot of time thinking about how to solve my problems	☐	☐	☐	☐
40.	When I am in a tense or unpleasant situation, I try to think of something funny to say	☐	☐	☐	☐
41.	I have to be very sick to see a doctor	☐	☐	☐	☐
42.	I avoid unhappy movies.	☐	☐	☐	☐
43.	When I'm upset. I try to find someone to talk to about what is bothering me	☐	☐	☐	☐
44.	If someone close to me died I would keep busy to take my mind off the loss	☐	☐	☐	☐
45.	Other people cause my problems	☐	☐	☐	☐
46.	Going to the movies takes my mind off my problems	☐	☐	☐	☐
47.	When I have a problem. I try to figure out all the steps necessary to solve it	☐	☐	☐	☐
48.	I am the kind of person who does not complain	☐	☐	☐	☐
49.	I don't worry about things in advance because I'm sure that everything will turn out all right.	☐	☐	☐	☐
50.	I avoid taking about death	☐	☐	☐	☐
51.	I avoid being alone when I feel upset	☐	☐	☐	☐

64.	ചമ്മലുണ്ടാക്കുന്ന സന്ദർഭങ്ങളിൽ ഒന്നും സംഭവിച്ചില്ലെന്ന് നടിക്കാൻ ഞാൻ ശ്രമിക്കാറുണ്ട്.				
65.	വേവലാതിപ്പെടാൻ തക്ക പ്രശ്നങ്ങൾ ഒന്നുമില്ല എന്നെനിക്ക് തോന്നാറുണ്ട്.				
66.	അസ്വാരസ്യം ഉണ്ടാക്കുന്ന സന്ദർഭങ്ങൾ ഞാൻ ഒഴിവാക്കാറുണ്ട്.				
67.	കാര്യങ്ങൾ വിചാരിച്ചപോലെ നടക്കാതിരിക്കുമ്പോൾ എനിക്ക് എന്നോടുതന്നെ സഹതാപം തോന്നാറുണ്ട്.				
68.	എനിക്ക് അടുപ്പമുള്ള ആരെങ്കിലും മരിച്ചാൽ എന്നെപ്പോലെ വേർപാടിന്റെ ദുഖം അനുഭവിക്കുന്ന മറ്റാളുകളെ ഞാൻ സഹായിക്കും.				
69.	എന്റെ ഡോക്ടർക്ക് നന്നായി അറിയാമെങ്കിൽ അദ്ദേഹത്തിന്റെ ഉപദേശം സ്വീകരിക്കാൻ ഞാൻ സന്നദ്ധനാകും				
70.	ഉൽക്കണ്ഠ തോന്നുമ്പോൾ ഞാൻ മറ്റുള്ളവരെ ഫോണിൽ വിളിക്കും				
71.	സങ്കടമുണ്ടാവുമ്പോൾ ഞാനതൊരു പുഞ്ചിരിയിലൊളിക്കാൻ ശ്രമിക്കാറുണ്ട്..				
72.	ക്രമമായ ആരോഗ്യപരിശോധനകൾ സമയനഷ്ടമാണെന്നാണ് എന്റെ വിശ്വാസം				
73.	അലോസരപ്പെടുത്തുന്ന വാർത്തകൾ വായിക്കുന്നത് ഞാനൊഴിവാക്കാറുണ്ട്.				
74,	ഞാൻ അസ്വസ്ഥനാകുമ്പോൾ എനിക്കുണ്ടാകുന്ന വിഷമം മറ്റുള്ളവരെ അറിയിക്കാൻ ശ്രമിക്കാറുണ്ട്.				
75.	ആദ്യ തവണ ചെയ്ത ഒരു കാര്യം ശരിയായില്ലെങ്കിൽ അത് പഠിച്ചെടുക്കാൻ എത്ര സമയം ചെലവഴിക്കാനും എനിക്ക് മടിയില്ല.				
76.	മറ്റുള്ളവർ എന്നെ ചൂഷണം ചെയ്തില്ലെങ്കിൽ അവരുമായി ഒത്തു പോകാൻ എനിക്ക് കഴിയുമായിരുന്നു.				
77.	അസ്വസ്ഥനാകുമ്പോൾ ആശ്വാസത്തിനായി ഞാൻ അല്പം മദ്യം കഴിക്കാറുണ്ട്				
78.	അപകടകരമാണെന്ന് തോന്നുന്ന ഒരു കായിക വിനോദത്തിൽ പങ്കെടുക്കാൻ എനിക്ക് ആഗ്രഹം തോന്നുകയാണെങ്കിൽ ഞാനതിനുവേണ്ടി ശ്രമിക്കും				
79.	കാര്യങ്ങൾ എത്രത്തന്നെ മോശമായാലും അതെന്നെ അസ്വസ്ഥനാക്കാൻ ഞാൻ അനുവദിക്കാറില്ല				
80.	മാനസികസ്വാസ്ഥ്യമുണ്ടാക്കുന്ന സന്ദർഭങ്ങളിൽ ആശ്വാസം നൽകുന്ന മരുന്നുകൾ ഞാൻ കഴിക്കാറുണ്ട്.				
81.	പ്രശ്നങ്ങൾ നേരിടേണ്ടി വരുമ്പോൾ ഞാനാകെ തകർന്ന് പോകും				
82.	എന്റെ ശാരീരിക വൈകല്യങ്ങൾ മറയ്ക്കുന്നതരം വസത്രങ്ങളാണ് ഞാൻ വാങ്ങുക				
83.	നിരാശ തോന്നുമ്പോൾ ഞാൻ ഭക്ഷണം കഴിക്കാറുണ്ട്.				
84.	ഊഴമെത്തുമ്പോൾ നടക്കും എന്ന വിശ്വാസമുള്ളതിനാൽ വെല്ലുവിളികൾ ഏറ്റെടുക്കാൻ എനിക്ക് ഭയമില്ല.				
85.	ഒരു വിൽപത്രം തയ്യാറാക്കുക എന്ന ചിന്ത ഞാനൊഴിവാക്കാറുണ്ട്.				
86.	ആഹാരക്രമത്തിൽ ശ്രദ്ധിക്കുന്നത്കൊണ്ട് എന്റെ ശരീരവണ്ണം കൂടുന്നില്ല.				
87.	ശ്മശാനങ്ങളിൽ പോകുന്നതും ശവസംസ്കാരചടങ്ങുകളിൽ പങ്കെടുക്കുന്നതും ഞാനൊഴിവാക്കാറുണ്ട്.				

		NEVER	RARELY	SOME-TIMES	OFTEN
52.	I work hared to overcome my weaknesses	☐	☐	☐	☐
53.	I'd get along better with people if they don't argue so much	☐	☐	☐	☐
54.	When things get to be too much for me, I day dream	☐	☐	☐	☐
55.	If a doctor told me I had a serious illness I would try to learn as much about it as/ could	☐	☐	☐	☐
56.	Even if I felt nervous about saying what was on my mind in a group. I would speak up anyway	☐	☐	☐	☐
57.	When something bothers me, I can ignore it.	☐	☐	☐	☐
58.	I avoid visiting a person who is in mourning	☐	☐	☐	☐
59.	I ask other people for their advice when I am not sure about something	☐	☐	☐	☐
60.	when I feel unhappy, I try to do something that will cheer me up	☐	☐	☐	☐
61.	If others were kinder to me, I could get more done	☐	☐	☐	☐
62.	When I'm upset, reading calms me down	☐	☐	☐	☐
63.	When I have many decisions to make, I decide which is most important before I do anything	☐	☐	☐	☐
64.	When I'm in an embrassing situation. I try to act as if I am comfortable	☐	☐	☐	☐
65.	I feel that there is very little that is worth worrying about.	☐	☐	☐	☐
66.	I try to avoid unpleasant situations	☐	☐	☐	☐
67.	When things to wrong I feel sorry for myself	☐	☐	☐	☐
68.	If someone close to me died. I would help other people who had lost someone	☐	☐	☐	☐

		NEVER	RARELY	SOME-TIMES	OFTEN
69.	If my doctor knew more. I would be more willing to take his advice	☐	☐	☐	☐
70.	When I get tense, I call people on the phone	☐	☐	☐	☐
71.	When I feel sad, I try to hide it with a smile	☐	☐	☐	☐
72.	I believe that regular health check-ups are a waste of my time	☐	☐	☐	☐
73.	I avoid reading unpleasant news	☐	☐	☐	☐
74.	when I'm upset I let people know how back I feel	☐	☐	☐	☐
75.	If I can't do something at first, I am willing to spend a lot of time to learn	☐	☐	☐	☐
76.	I'd get along better with other people if they didn't take advantage of me.	☐	☐	☐	☐
77.	When I'm worried or upset, I take a couple of drinks to relax.	☐	☐	☐	☐
78.	If I wanted to engage in a sport that I thought was dangerous I would make myself try it	☐	☐	☐	☐
79.	No matter how bad things seem, I don't let them upset me.	☐	☐	☐	☐
80.	I take tranquilizers when I feel very nervous	☐	☐	☐	☐
81.	When I have a problem. I go to pieces	☐	☐	☐	☐
82.	I buy clothes that minimize unattractive parts of my body	☐	☐	☐	☐
83.	I feel when I feel depressed	☐	☐	☐	☐
84.	I'm not afraid to take risks because when your number is up it's up	☐	☐	☐	☐
85.	I avoid thinking about making a will	☐	☐	☐	☐
86.	I watch my diet so that I will not gain weight	☐	☐	☐	☐
97.	I avoid going to cemeteries	☐	☐	☐	☐

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AECOM COPING STYLE QUESTIONNAIRE (Mal.)

Shanty K.J. & Anita Ravindran

പേര്: **വയസ്സ്:** **സ്ത്രി/പുരുഷൻ** **തീയതി:**

വ്യത്യസ്ത സാഹചര്യങ്ങളിൽ ആളുകൾ എങ്ങനെയാണ് പെരുമാറുക എന്നും, വ്യത്യസ്ത കാര്യങ്ങൾ ഓരോരുത്തർക്കും എങ്ങനെയാണ് അനുഭവപ്പെടുക എന്നും വിവരിക്കുന്ന പ്രസ്താവനകളാണ് താഴെ കൊടുത്തിരിക്കുന്നത്. ഓരോ പ്രസ്താവനയും താങ്കളുമായി എങ്ങനെ ബന്ധപ്പെട്ടിരിക്കുന്നു എന്ന് സൂചിപ്പിക്കുവാൻ അനുയോജ്യമായ കോളത്തിൽ (X) എന്ന് രേഖപ്പെടുത്തുക

		ഒരിക്കലുമില്ല	അപൂർവ്വമായി	ചിലപ്പോൾ	മിക്കവാറും
1.	ഞാനൊരു ശുഭാപ്തി വിശ്വാസിയാണ്.				
2.	അസുഖകരമായ കാര്യങ്ങൾ ചിന്തിക്കുന്നത് ഞാൻ ഒഴിവാക്കാറുണ്ട്.				
3.	എനിക്ക് ഒരു പ്രശ്നമുണ്ടാകുമ്പോൾ മറ്റുള്ളവരുടെ സഹായം തേടാറുണ്ട്.				
4.	രോഗമോ അപകടമോ എന്റെ സാധാരണ ജോലികൾക്ക് തടസ്സമാവുകയാണെങ്കിൽ ഉപയോഗപ്രദമായ മറ്റെന്തെങ്കിലും പ്രവൃത്തികൾ ഞാൻ കണ്ടെത്തും				
5.	മറ്റുള്ളവർ എനിക്കുവേണ്ടി തീരുമാനങ്ങൾ എടുക്കാതിരുന്നെങ്കിൽ സ്വന്തമായ തീരുമാനങ്ങൾ എടുക്കാമായിരുന്നു.				
6.	ഞാൻ അസ്വസ്ഥനാവുന്ന സമയത്ത് എന്തെങ്കിലും ഭക്ഷിക്കും.				
7.	തീരുമാനങ്ങൾ എടുക്കുന്നതിനുമുമ്പ് കിട്ടാവുന്നത്ര വിവരങ്ങൾ ഞാൻ ശേഖരിക്കും				
8.	അസ്വാസ്ഥ്യമുണ്ടാക്കുന്ന സന്ദർഭങ്ങളുടെ രസകരമായ വശം കണ്ടെത്താൻ ഞാൻ ശ്രമിക്കാറുണ്ട്.				
9.	ഉണ്ടാവാനിടയുള്ള ബുദ്ധിമുട്ടുകളെക്കുറിച്ച് ഞാൻ മുൻകൂട്ടി വേവലാതിപ്പെടാറില്ല				
10.	എന്റെ പ്രശ്നങ്ങളെക്കുറിച്ച് ചിന്തിക്കാതിരിക്കാൻ ഞാൻ ശ്രമിക്കാറുണ്ട്.				
11.	എന്നേക്കാൾ നന്നായി കാര്യങ്ങൾ ചെയ്യാൻ കഴിവുള്ളവരുമായി ഇടപെടാൻ ശ്രമിക്കാറുണ്ട്.				
12.	എന്റെ ശരീരഭംഗിക്കായി ഞാൻ പതിവായി വ്യായാമം ചെയ്യാറുണ്ട്.				
13.	എന്റെ പലകാര്യങ്ങളും ശരിയാവാതിരിക്കുന്നത് മറ്റുള്ളവരുടെ കുറ്റം കൊണ്ടാണെന്ന് ഞാൻ വിചാരിക്കും.				
14.	പ്രശ്നങ്ങളിൽനിന്ന് മനസ്സ് തിരിക്കാനായി ഞാൻ കഥാപുസ്തകങ്ങൾ വായിക്കാറുണ്ട്.				
15.	എനിക്ക് ഒരു പ്രശ്നമുണ്ടാവുമ്പോൾ അത് പരിഹരിക്കാനായ് വ്യത്യസ്ത മാർഗ്ഗങ്ങളെക്കുറിച്ച് ഞാൻ ആലോചിക്കാറുണ്ട്.				
16.	എനിക്ക് ഇഷ്ടമില്ലാത്തവരോട് നല്ലനിലയിൽ പെരുമാറാൻ ഞാൻ വളരെയധികം ശ്രദ്ധിക്കാറുണ്ട്.				
17.	കാര്യങ്ങൾ മറ്റുള്ളവർ കരുതുന്നപോലെ അത്ര മോശമാണെന്ന് ഞാൻ കരുതുന്നില്ല.				
18.	ശവസംസ്കാരചടങ്ങുകൾ ഞാൻ ഒഴിവാക്കാറുണ്ട്.				
19.	ഞാൻ അസ്വസ്ഥനാകുമ്പോൾ മറ്റുള്ളവരുടെ ശ്രദ്ധയും പരിഗണനയും കിട്ടുന്നത് എനിക്ക് ഇഷ്ടമാണ്.				
20.	ഒരു സുഹൃത്തിനെ നഷ്ടപ്പെട്ടാൽ മറ്റൊരു സുഹൃത്തിനെ ഞാൻ കണ്ടെത്തും.				
21.	മറ്റുള്ളവർ ഇടപെടാതിരുന്നെങ്കിൽ എനിക്ക് കൂടുതൽ നേടാൻ കഴിയുമായിരുന്നു.				
22.	ദേഷ്യം വരുന്ന സമയത്ത് ശാരീരികപ്രവർത്തനങ്ങളിൽ ഏർപ്പെട്ട് ഞാനത് തീർക്കാൻ ശ്രമിക്കും				
23.	ഏതു പ്രശ്നവും ഞാൻ സൂക്ഷ്മമായി വിശകലനം ചെയ്യാറുണ്ട്.				
24.	ദേഷ്യം വരുമ്പോൾ ഞാനത് മറച്ചുവെക്കാൻ ശ്രമിക്കാറുണ്ട്				
25.	ഞാൻ എന്റെ വേദനകളും പ്രയാസങ്ങളും അവഗണിക്കാറുണ്ട്				
26,	സിനിമയിലെ മനസ്സിന് വിഷമം ഉണ്ടാക്കുന്ന രംഗങ്ങൾ ഞാൻ കാണാറില്ല.				

Original: Robert Plutchik, Ph.D. and Hop. R. Conte, Ph.D., Revised June (1985)

27.	അസുഖം വരുന്ന സമയത്ത് കിടന്ന് വിശ്രമിക്കാനും പരിചരിക്കപ്പെടാനുമാണ് എനിക്കിഷ്ടം.				
28.	ചെയ്ത ഒരു കാര്യം മോശമായാൽ ഭാവിയിൽ അത് മെച്ചപ്പെടുത്താൻ ശ്രദ്ധിക്കാറുണ്ട്.				
29.	മറ്റുള്ളവർ ഇടപെടുന്നതുകൊണ്ട് എനിക്കെന്റെ ജോലികൾ ചെയ്യാൻ കഴിയാറില്ല.				
30.	അസ്വസ്ഥതതോന്നുമ്പോൾ ഞാൻ ഒന്ന് നടക്കാൻ പോകും				
31.	ഒരു തീരുമാനമെടുക്കുന്നതിനുമുമ്പ് അതിന്റെ നല്ലതും ചീത്തയുമായ വശങ്ങൾ ഞാൻ കണക്കിലെടുക്കാറുണ്ട്.				
32.	ആൾക്കൂട്ടത്തിൽ നില്ക്കുമ്പോൾ ലജ്ജ തോന്നിയാലും കൂട്ടത്തിൽ കൂടാൻ ശ്രമിക്കാറുണ്ട്.				
33.	പ്രശ്നങ്ങൾക്ക് സ്വയം പരിഹാരമുണ്ടാവുമെന്ന് ഞാൻ വിചാരിക്കുന്നു.				
34.	ആശുപത്രയിൽ കിടക്കുന്ന രോഗികളെ സന്ദർശിക്കുന്നത് ഞാൻ ഒഴിവാക്കാറുണ്ട്.				
35.	പ്രധാനപ്പെട്ട എന്തെങ്കിലും വാങ്ങുന്നതിനുമുമ്പ് മറ്റുള്ളവരുടെ അഭിപ്രായം തേടാറുണ്ട്.				
36.	ദു:ഖമുണ്ടാകുമ്പോൾ താല്പര്യമുള്ള മറ്റെന്തെങ്കിലും കാര്യങ്ങളിൽ ഏർപ്പെടാൻ ഞാൻ ശ്രമിക്കാറുണ്ട്.				
37.	മറ്റുള്ളവർ എന്റെ ജീവിതത്തിൽ ഇടപെടുന്നത് നിർത്തിയാൽ ഞാൻ കൂടുതൽ നന്നാവുമായിരുന്നു.				
38.	മാനസികാസ്വാസ്ഥ്യം അനുഭവപ്പെടുമ്പോൾ എന്തെങ്കിലും കൈവേല ചെയ്യാൻ ഞാൻ ഇഷ്ടപ്പെടുന്നു.				
39.	പ്രശ്നങ്ങൾ പരിഹരിക്കുന്നതിനെക്കുറിച്ച് ആലോചിച്ച് ധാരാളം സമയം ഞാൻ ചിലവഴിക്കാറുണ്ട്.				
40.	അസ്വസ്ഥത ഉളവാകുന്ന സന്ദർഭങ്ങളിൽ എന്തെങ്കിലും തമാശ പറയാൻ ഞാൻ ആലോചിക്കാറുണ്ട്.				
41.	അസുഖം വളരെ കൂടിയാൽ മാത്രമെ ഞാൻ ഒരു ഡോക്ടറെ കാണുകയുള്ളൂ				
42.	സന്തോഷപ്രദമല്ലാത്ത സിനിമകൾ ഞാനൊഴിവാക്കാറുണ്ട്.				
43.	ഞാൻ അസ്വസ്ഥനാകുമ്പോൾ എന്നെ അലട്ടുന്ന കാര്യങ്ങൾ സംസാരിക്കാൻ ഒരാളെ കണ്ടെത്താറുണ്ട്.				
44.	അടുപ്പമുള്ള ആരെങ്കിലും മരിച്ചാൽ ആ നഷ്ടബോധത്തിൽനിന്ന് രക്ഷപ്പെടാൻ ഞാൻ ജോലിത്തിരക്കിൽ വ്യാപൃതനാകും.				
45.	മറ്റുള്ളവരാണ് എന്റെ പ്രശ്നങ്ങൾക്ക് കാരണം.				
46.	സിനിമകാണുമ്പോൾ എന്റെ പ്രശ്നങ്ങൾ ഞാൻ മറക്കാറുണ്ട്.				
47.	എനിക്ക് ഒരു പ്രശ്നമുണ്ടാകുമ്പോൾ അത് പരിഹരിക്കാനാവശ്യമായ എല്ലാ മാർഗ്ഗങ്ങളെക്കുറിച്ചും ഞാൻ ചിന്തിക്കും.				
48.	ഞാൻ പരാതികൾ പറയുന്ന തരക്കാരനല്ല.				
49	എല്ലാം ശരിയാകുമെന്നുറപ്പുള്ളതുകൊണ്ട് ഞാൻ ഒന്നിനെക്കുറിച്ചും മുൻകൂട്ടി ഉൽക്കണ്ഠപ്പെടാറില്ല.				
50.	മരണത്തെക്കുറിച്ചുള്ള സംസാരം ഞാൻ ഒഴിവാക്കാറുണ്ട്				
51.	അസ്വസ്ഥനാകുമ്പോൾ തനിച്ചിരിക്കുന്നത് ഞാൻ ഒഴിവാക്കാറുണ്ട്				
52.	എന്റെ കഴിവുകേടുകളെ അതിജീവിക്കാൻ ഞാൻ കഠിനപ്രയത്നം ചെയ്യാറുണ്ട്,				
53.	എന്നോട് വാദിക്കാൻ വരുന്നില്ലെങ്കിൽ അവരോട് ഒത്തുപോകാൻ എനിക്ക് സാധിക്കും.				
54.	പല കാര്യങ്ങളും എന്നെ വല്ലാതെ അലട്ടുമ്പോൾ ഞാൻ ദിവാസ്വപ്നം കാണാറുണ്ട്.				
55.	എനിക്ക് ഗുരുതരമായ അസുഖമാണെന്ന് ഡോക്ടർ പറഞ്ഞാൽ അതിനെക്കുറിച്ച് കഴിയുന്നത്ര അറിയാൻ ശ്രമിക്കും.				
56.	കൂട്ടത്തിൽ വച്ച് മനസ്സിലുള്ളത് പറയാൻ പരിഭ്രമം തോന്നിയാലും ഞാനതു പറയും				
57	എന്നെ അലട്ടുന്ന പ്രശ്നങ്ങളെ എനിക്ക് അവഗണിക്കാനാവും				
58.	ദുഖിക്കുന്നവരെ ചെന്നു കാണുന്നത് ഞാനൊഴിവാക്കാറുണ്ട്.				
59.	എനിക്ക് നന്നായിട്ടറിയാത്ത കാര്യങ്ങളെക്കുറിച്ച് ഞാൻ മറ്റുള്ളവരുടെ ഉപ.ദേശം തേടാറുണ്ട്.				
60.	വിഷാദം തോന്നുമ്പോൾ ഉന്മേഷമുണ്ടാക്കുന്ന മറ്റെന്തെങ്കിലും ചെയ്യാൻ ഞാൻ ശ്രമിക്കാറുണ്ട്				
61.	മറ്റുള്ളവർ എന്നോട് അനുഭാവം കാണിച്ചിരുന്നെങ്കിൽ എനിക്ക് കൂടുതൽ കാര്യങ്ങൾ ചെയ്യാമായിരുന്നു.				
62.	അസ്വസ്ഥനായിരുക്കുമ്പോൾ വായന എന്നെ ശാന്തനാക്കുന്നു.				
63.	കുറെയധികം തീരുമാനങ്ങൾ എടുക്കേണ്ടി വരുമ്പോൾ അവിയിലേതിനാണ് കൂടുതൽ പ്രധാന്യം കൊടുക്കേണ്ടതെന്ന് ഞാൻ ആദ്യം കണ്ടെത്തും.				