

**EFFECTIVENESS OF YOGA ON DEPRESSION AND QUALITY OF
LIFE AMONG ALCOHOL DEPENDENTS AT ATHMA
DE-ADDICTION CENTRE, TRICHY**

**A DISSERTATION SUBMITTED TO
THE TAMILNADU DR. M.G.R. MEDICAL UNIVERSITY, CHENNAI
IN PARTIAL FULFILLMENT OF THE REQUIREMENT FOR
THE DEGREE OF MASTER OF SCIENCE IN NURSING**

2014-2016

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ABSTRACT

Alcohol dependence is the most severe form of alcohol abuse. It is a chronic disease characterized by the consumption of alcohol at a level that interferes with physical and mental health as well as family and social responsibilities. An alcoholic would continue to drink despite serious health, family, or legal problems. It is influenced by both genetic and environmental factors. Yoga methods for stress reduction and self-soothing are generally cheaper than other professional interventions. Proper and regular practice of yogasana and pranayama can calm the mind and reduce stress.

Psychology Today (2016)

This study was aimed to assess the effectiveness of yoga on depression and quality of life among alcohol dependents in Athma de-addiction centre, Trichy. An evaluative approach was used to conduct the study. The design used for the present study was quasi experimental non-equivalent control group pretest and posttest design. The conceptual framework was based on **Wiedenbach's Helping Art of Clinical Nursing Theory (1969)**. A total of 60 participants were selected using convenience sampling technique. Out of which 30 were in experimental group and 30 were in control group. On the 1st week, 15 samples were selected under experimental group and pretest was conducted on the first day using Beck Depression Inventory scale to assess the level of depression and Quality of life- 26 BREF scale adopted from WHO, to assess the quality of life among alcohol dependents. The pretest was conducted for 30 minutes. Self administered questionnaires were given individually. After which yoga was taught to the experimental group, fifteen in a group, using LCD projector which lasted for 45 minutes. From the 2nd day, the participants in experimental group were made to practice the yoga under the supervision of the investigator in the morning for 1 hour 10 minutes for 28 days. On the 2nd week, next 15 samples were selected under experimental group and the same procedure was continued. On 5th and 6th week, posttest was conducted for the

experimental group. On 3rd week, 15 samples were selected in control group and pretest was conducted. On the 4th week, next 15 samples were selected under control group and the pretest was conducted. The control group participants received the routine hospital treatment. On 7th and 8th week, posttest was conducted for the control group.

The data were analyzed using descriptive and inferential statistics. For depression, the pretest and posttest mean scores were 27.833(SD \pm 6.558) and 8.166 (SD \pm 4.646) respectively. The posttest mean score was lower than the pretest mean score with the mean difference value of 20.675. The paired't' value was 14.439, which was significant at $p < 0.05$ level, which revealed that yoga was effective in reducing depression among alcohol dependents in experimental group.

The posttest mean score level of depression between experimental and control group were 8.166 (SD \pm 4.646) and 12.833 (SD \pm 4.816) respectively. The posttest mean score of experimental group was lower than the posttest mean score of control group with the mean difference value of 4.667. The independent't' value was 4.413, which was significant at $p < 0.05$ level, which revealed that yoga was effective in reducing depression among alcohol dependents in experimental group. There was no significant association between posttest level of depression and their demographic variables in experimental group.

For quality of life, the pretest and posttest mean scores in experimental group were 5.90 (SD \pm 1.347) and 7.433 (SD \pm 1.194) respectively. The posttest mean score was higher than the pretest mean score with the mean difference value of 1.533. The paired't' value was 5.275, which was significant at $p < 0.05$ level, which revealed that yoga was effective in increasing the quality of life among alcohol dependents in experimental group.

The posttest mean score level of quality of life between experimental and control group were 7.433 (SD \pm 1.194) and 6.566 (SD \pm 1.304) respectively. The independent 't' value was 2.592, which was significant at $p < 0.05$ level, which revealed that yoga was effective in improving the quality of life among alcohol dependents in experimental group.

There was a significant association at $p < 0.05$ level between the posttest level of quality of life and their demographic variables in experimental group. With regard to physical domain, the χ^2 value was 8.978 for occupation. With regard to psychological domain, the χ^2 value was 9.1 for type of family. With regard to social domain, χ^2 value was 6.05 for duration of alcohol consumption. With regard to environmental domain, the χ^2 value was 10.1 for type of family.

There was a negative correlation between posttest level of depression and quality of life among alcohol dependents in experimental group, which revealed that reduction in level of depression, improves the quality of life among alcohol dependents in experimental group.

The above study findings revealed that yoga was effective in reducing the level of depression and improve the quality of life among alcohol dependents in experimental group.

CHAPTER I

INTRODUCTION

BACKGROUND OF THE STUDY

Human are uniquely adapt at utilizing systems of symbolic communication (such as language and art) for self-expression and the exchange of ideas, and for organizing themselves into purposeful groups. Human create complex social structures composed of many cooperating and competing groups, from families and kinship networks to political states. Social interactions between human have established an extremely wide variety of values, social norms, and rituals, which together form the basis of human society.

Jon C Herron (2007)

Human behavior refers to the array of every physical action and observable emotion associated with individuals, as well as the human race as a whole. While specific traits of one's personality and temperament may be more consistent, other behaviors would change as one move from birth through adulthood. Social behaviors, a subset of human behavior, studies the considerable influence of social interaction and culture. The behavior of human (and other organisms or even mechanisms) falls within a range with some behavior being common, some unusual, some acceptable, and some outside acceptable limits.

Robert Ardery (2009)

Adaptive skills encompass a range of daily situations and usually start with a task analysis. The task analysis would reveal all the steps necessary to perform the task in the natural environment. Adaptive behaviors such as the natural occasion for the response, the independent performance of the daily activity, and the natural consequences for the response, within the context of the home/host culture.

Wikipedia (2016)

Maladaptive behavior is a type of behavior that inhibits a person's ability to adjust to a particular situation. The individual falls into these behaviors in an attempt to escape discomforts in life. Instead of helping the situation these maladaptive behaviors make things much worse. In the case of behaviors such as addiction it is a case of the cure being worse than the disease. Maladaptive coping strategies would often ease the symptoms but it may lead to deterioration in the overall problem.

Drug and alcohol rehabilitation Asia (2008)

Common maladaptive behavior are substance abuse, attention seeking behaviors, power seeking behavior, anger, withdrawing, avoidance, workaholism, revenge behaviors, exercise addiction, internet addiction, gambling addiction and sex addiction, etc.

Drug and alcohol rehabilitation Asia (2008)

Alcohol abuse is the commonly abused substance despite its negative consequences. There are two types of alcohol abuse, those who have anti-social and pleasure-seeking tendencies, and those who are anxiety-ridden people who are able to go without drinking for long periods of time but are unable to control if once it started. Binge drinking is another form of alcohol abuse.

Donald C Heth (2010)

All drugs affect a "reward mechanism" in the brain. If a person feels good each time when using a drug, it tends to make the person use the drug again and again. This common feature could explain why people abuse drugs, including alcohol.

Medi Resource (2015)

As with most drugs, though, use regularly, the body tends to require increasing amounts of the substance to achieve the same effect. This is called

tolerance, and it may be the final factor that contributes to the development of drug or alcohol dependence.

Medi Resource (2015)

The biological causes of alcohol addiction include each person's unique physiology and genetics. Normal human brain functioning and its chemistry make people vulnerable to addiction. Normal brain chemistry and functioning motivate the person to repeat behaviors that are pleasurable. When people have poor coping skills, the people are more vulnerable to addiction. People with high stress, that lack stress reduction skills, are also more vulnerable to addiction. Socio-cultural influences also contribute to the development of alcohol addiction. When a culture accepts or tolerates drunkenness, the members of that culture are more vulnerable to addiction.

Tom Horvath (2016)

People with family histories of alcoholism tend to have lower levels of endorphins- the endogenous morphine that is responsible for many of the pleasure responses - than do people genetically disinclined to alcoholism. Alcohol would slightly raise the endorphin level of people without the genetic basis for alcoholism; it would dramatically raise the endorphin level of people with that genetic basis.”

Andrew Solomon (2014)

People who consume excessive amounts of alcohol would also have an increased risk of developing arthritis, cancer, heart disease, hyper- and hypoglycemia, kidney disease, obesity, nervous disorders, psychological disturbances and malnutrition. Alcoholism can also have serious health effects on unborn children. The long-term effects of alcoholism are similar to those experienced with other drugs. When alcohol is consumed on a moderate level, individuals may run the risk of developing liver disease, pancreatitis, esophageal and oropharyngeal cancers. Alcoholism can also result in

cardiovascular problems. These risks are increased when the person stops drinking and begins to experience withdrawal symptoms. The symptoms could be severe, and in some cases could result in death.

Drug and alcohol rehabilitation guide (2016)

The heavy and regularly drinking develops some symptoms of depression and anxiety which are undiagnosed. It's that good old brain chemistry at work again. Regular drinking lowers the levels of serotonin in brain – a chemical that helps to regulate the mood.

National Health Service (2016)

Alcoholism poses a threat to every aspect of the addict's life. No matter how the addicts would suffer physical effects. Most would also suffer from psychological effects. This could include unexplained mood swings, anxiety, severe depression, suicidal thoughts and tendencies, angry outbursts and acts or violence.

Drug and alcohol rehabilitation guide (2016)

Alcohol abuse may lead to suicidality through disinhibition, impulsiveness and impaired judgment.

National Institute of Mental Health (2008)

People with alcoholism would also suffer social effects. People may begin to withdraw from family and friends. Many people with an alcohol addiction would develop a new social circle that consists of other people with a similar addiction. People would have trouble in maintaining any meaningful relationship. People with an addiction would not be able to get along with co-workers, which can lead to the loss of the job.

Drug and alcohol rehabilitation guide (2016)

“Alcohol abuse and alcoholism can worsen existing conditions such as depression or induce new problems such as serious memory loss, depression, or anxiety.”

American Psychological Association (2013)

Alcohol abuse is common among people who are battling a depressive disorder. Because alcohol is a central nervous system depressant, the use of this drug tends to trigger depression symptoms like lethargy, sadness and hopelessness. However, many depressed individuals reach for drugs or alcohol as a way to lift their spirits or to numb painful thoughts. As a result, depression and substance abuse feed into each other, and one condition would often make the other worse.

Centers for Disease Control and Prevention (2016)

Individuals with alcohol abuse or dependence generally experienced a twofold to threefold increased risk of anxiety and depressive disorders. The presence of comorbid anxiety or depressive disorders was consistently associated with moderate increases in the symptoms of alcohol abuse or dependence, alcoholism was associated with large increases in the number of depressive symptoms

Joel D Swendsen (2008)

Drinking would only make depression worse. People who are depressed and drink too much have more frequent and severe episodes of depression, and are more likely to think about suicide. Heavy alcohol use also can make antidepressants less effective.

Depression health centre (2016)

Individuals with alcohol use disorder typically report significantly poorer quality of life in physical health, psychological, social and environmental domains.

Ashley E. Muller (2016)

Males consumed significantly more alcohol and reported more drinking-related problems with more negative consequences. Psychological distress increased, and all quality of life domain scores decreased with increasing alcohol consumption. The excessive drinkers demonstrated the highest level of psychological distress and lowest quality of life in the psychological, social relationships and environment domains.

Mathiesen (2012)

The need for a focus on psychological distress and its negative impact upon all quality of life domains indicates attention should also be paid to excessive drinkers who have poor quality of life (psychological, social relationships and environment domains) and a high level of psychological distress.

Mathiesen (2012)

The alcohol use disorder, which is usually chronic, requires patients to muster all their capacities for reconstruction and adaptation. Quality of life which is a concept situated between social and clinical sciences, is a pertinent indicator to evaluate the subjective experience of the patient and to quantify the psychosocial burden of alcoholism. In alcoholic's quality of life research, the aim is to measure the alcoholic's subjective perception of their state of health and life using a standardized questionnaire.

Pierre Lahmek (2013)

Alcohol misuse is a major cause of morbidity and mortality and an important health care burden that affect the quality of life of alcohol dependents. The quality of life of alcohol-dependents is very poor. The important factors in the quality of life of alcohol-dependent subjects are psychiatric co-morbidity, social environment and disturbed sleep.

Foster JH (2012)

Among adults, the harmful use of alcohol can impact disease symptom severity and progression of common chronic illnesses, in addition to negatively affecting personal relationships, social engagement and overall quality of life. In addiction, high alcohol consumption is associated with divorce, poor family relations and problems in the work place.

Moore AA (2014)

Dependent drinking usually affects a person's quality of life and relationships. Someone loses control over their drinking and has an excessive desire to drink; it's known as dependent drinking (alcoholism).

National Health Service (2015)

The characteristics found to be associated with poorer quality of life in alcohol use disorder patients reporting depressive symptoms, being physically inactive, dissatisfied with one's physical self, and reporting some element of social isolation are vulnerabilities.

Ashley E. Muller (2016)

Symptoms of anxiety and depression accompanying alcohol addiction lead to an increase in severity of the problems associated with the addiction and have a negative effect on quality of life. Measurement of quality of life within the scope of treatment programs would help to identify treatment requirements in addicted patients.

Aslihan Yapici (2015)

Among problem drinkers in treatment, the literature suggests the measurement of quality of life can both be a motivational tool for behavior change and a measure of treatment efficacy.

Ugochuskwu C (2013)

Studies from developed countries have identified a linear or inverse J-shaped relationship between quality of life and alcohol use, such that at the

higher levels of alcohol use, including persons diagnosed with alcohol use disorders, quality of life is lower compared to moderate or low risk users and alcohol abstainers. Among problem drinkers in treatment, the literature suggests the measurement of quality of life can both be a motivational tool for behavior change and a measure of treatment efficacy.

Priscilla Martinez (2014)

Detoxification is the treatment of alcohol withdrawal symptoms, produced by the removal of the toxin (alcohol). The usual duration of uncomplicated withdrawal syndrome is 7- 14 days. The drug of choice for detoxification is usually Benzodiazepines. In addition, vitamins should also administer. The treatment includes administration of deterrent agent (Disulfiram) and anti- craving agent (Acamprosate, naltrexone, SSRIs).

Niraj Ahuja (2011)

Some of the other aspects of treatment involve motivational interviewing, group therapy, aversive conditioning, cognitive therapy, relapse prevention technique, cue exposure therapy, assertiveness training, behavior counseling, supportive psychotherapy and individual psychotherapy, alternative and complementary therapies and relaxation techniques.

Sreevani (2010)

There are individual and group counseling techniques to help with the alcoholism. Counselors are skilled professionals who understand the problem of alcoholism and can help to manage a person's individual needs while trying to quit drinking. Counseling for alcoholism can last just a few months or can go on for many years, depending on the patient's needs.

Drug and alcohol rehabilitation guide (2016)

State run treatment centers, a network of de-addiction centers run by voluntary organizations and community based treatment programs are operated throughout the country. The main thrust of these programs is to promote and

strengthen the contacts of the alcohol addicts with his family and community and to win over the confidence of the community to gain better support and cooperation in the rehabilitation of the alcohol addicts. The de-addiction centers run by non-governmental organizations employ various systems of medicine, like Allopathy, Homeopathy, Ayurveda, Naturopathy, Yoga and the like, coupled with a combination of different psychotherapies.

Department of social welfare (2015)

Relaxation techniques are a great way to help with stress management. Relaxation is a process that decreases the effects of stress on the mind and body also help to cope with everyday stress and stress related to various health problems, such as depression, anxiety, cancer and pain.

Mayo Clinic (2014)

Relaxation techniques include Yoga, Deep breathing, Hypnosis, Massage, Meditation, Tai chi, Biofeedback, Music and art therapy, Progressive muscle relaxation, and Visualization.

Hansa D Bhargava (2014)

Most of the yoga postures can help relieve depression. The practice of yoga asanas is done with awareness and coordinated breathing. This by itself relieves stress and anxiety, reduces high blood pressure, releases blocked energies and induces smooth flow of pranic energy throughout the body. Thus yogic management of depression is based on the understanding and awareness of one's own inner reality along with practice of specific asana and breathing techniques to aid in the process of bringing out the inner joy.

Art of Living (2016)

Yoga asana is one of the eight limbs of classical Yoga, which states that poses should be steady and comfortable, firm yet relaxed helping a practitioner to become more aware of their body, mind, and environment.

International Sivananda Yoga Vedanta Centres (2012)

The basic poses or asanas are much more than just stretching. They open the energy channels, chakras and psychic centers of the body while increasing flexibility of the spine, strengthening bones and stimulating the circulatory and immune systems. Along with proper breathing or pranayama, asanas also calm the mind and reduce stress. With regular practice one can ensure overall physical and mental health and the possible prevention of diseases such as diabetes, hypertension and arthritis. In time, performing the poses slowly and consciously becomes a mental exercise in concentration and meditation.

International Sivananda Yoga Vedanta Centres (2012)

Yoga is a very effective stress reduction and relaxation tool. Performance of various postures requires the tensing and stretching and then relaxing of muscle groups and joints, which effectively produces relaxation in much the same way that a massage or Progressive Muscle Relaxation (a technique used by behavioral psychologists) does. Yoga practice also draws attention towards breathing, which produces a meditative and soothing state of mind. Yoga methods for stress reduction and self-soothing are generally cheaper than other professional interventions. Pretty much safe, free of side effects, and empowering in comparison to medication alternatives

Mark Dombeck (2016)

Community involvement in the treatment and social integration of the alcohol addicts also implies that the infrastructure is created within their natural social milieu. With this in view, a number of de-addiction camps are being regularly organized at the community level, with the help of voluntary organizations, providing counseling, treatment and rehabilitation facilities to alcohol addicts in the localities where the addicts live in.

Department of social welfare (2015)

In India, an excellence of self-help programme is that of Alcoholic Anonymous groups in Bangalore, Panaji, Madras, Secunderabad, New Delhi,

Cochin, Mangalore, Nagpur, Pune and Mysore. Some religious agencies have also been extending facilities for alcohol addicts to organize and to help each other in finding solutions to their rehabilitative problems.

Department of social welfare (2015)

Alcohol policies are measures taken to control the supply and/or affect the demand for alcoholic beverages in a population, including education and treatment programs, alcohol control and harm-reduction strategies. Alcohol related policies are population based policies, problem directed policies, direct interventions, effective, comprehensive and sustainable alcohol policies.

National Alcohol Policy (2013)

In India, National alcohol policy formulated under the Constitution of India, Article 47, “The State shall regard the raising of the level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties and, in particular, the State shall endeavor to bring about prohibition of the consumption except for medicinal purposes of intoxicating drinks and of drugs which are injurious to health”

National Alcohol Policy (2013)

Indian Alcohol Policy Alliance (IAPA) was launched on May 4, 2005 by Dr. Yoganand Shastri, Honorable Minister of Health and Social Welfare, NCT Delhi, by unveiling the Logo of IAPA. The main objectives of the IAPA is to encourage and promote governmental and non-governmental efforts to prevent and reduce alcohol-related harm through effective enforcement of existing alcohol control policies, to conduct awareness programs and organize de-addiction camps, to co-operate and encourage partnership with local, national and International organizations and civil society to prevent and alleviate alcohol-related harm, to monitor advertising, marketing and other activities of alcohol beverage industry including their social aspect

organizations, to bring to the attention of governmental and non-governmental agencies and communities, the social, economic and health consequences of alcohol use, to encourage research on all aspects related to alcohol use and policies.

Dr. S. Arulraj (2010)

Psychiatric Nurses are specialized in regulating the treatment for patients addicted to alcohol and other substances. The physical effects are sometimes so severe that patients return to drugs to ease the discomfort, nurses can help to prevent by helping to manage their symptoms. Nurse must also know what psychological issues arise when patients attempt to conquer their addictions so the nurse can help patients and create strategies for coping with the impact of starting a new life. Nurse should teach patients about the dangers of alcohol abuse, including the physical and psychological effects; the damage to relationships and family life. Nurses might also educate a patient's family members about what to expect from the rehabilitation process and how the family members can support their loved one's attempt to conquer alcohol addiction.

Stephen Chavez (2016)

NEED FOR THE STUDY

Globally, there are about two billion consumers of alcoholic beverages and 76.3 million people with diagnosable alcohol-use disorders worldwide.

WHO (2014)

Globally, alcohol misuse is the fifth leading risk factor for premature death and disability; among people between the ages of 15 and 49. In the age group 20–39 years, approximately 25 percent of the total deaths are alcohol attributable

National institute of alcohol abuse and alcoholism (2012)

About 34.7 percent of 15-year-olds have had at least 1 drinks in their lives. About 8.7 million people ages 12–20 (22.8 percent of this age group) reported drinking alcohol in the past month (23 percent of males and 22.5 percent of females). Approximately 5.3 million people (about 13.8 percent) ages 12–20 were binge drinkers (15.8 percent of males and 12.4 percent of females). Approximately 1.3 million people (about 3.4 percent) ages 12–20 were heavy drinkers (4.6 percent of males and 2.7 percent of females).

National Survey on Drug Use and Health (2014)

In United States of America, the alcoholic abusers population was 14.4% of the total population. The Prevalence of alcohol use disorders and alcohol dependence in male and female was 20% and 8.50%. In United Kingdom, the total alcohol abusers were 15.60%, were in male and female population about 21.60% and 9.50%. In Canada, the high drinking practices among the adults were 12.60% of the total population. The male and female abusers were 18.20 and 7.0% respectively. In France, the male and female population of alcohol abusers was 21.16% and 8.80%. The total populations of alcohol dependence were 14.90%.

WHO (2014)

Alcoholism is the 3rd leading lifestyle-related cause of death in the Nation. Excessive alcohol use is responsible for 2.5 million years of potential life lost annually. Up to 40% of all hospital beds in the United States (except for those being used by maternity and intensive care patients) are being used to treat health conditions that are related to alcohol consumption.

United States Census Bureau (2009)

In 2012, 3.3 million deaths, or 5.9 percent of all global deaths (7.6 percent for men and 4.0 percent for women), were attributable to alcohol consumption. Alcohol contributes to over 200 diseases and injury-related health conditions, most notably alcohol dependence, liver cirrhosis, cancers,

and injuries. 5.1 percent of the burden of disease and injury worldwide (139 million disability-adjusted life-years) was attributable to alcohol consumption.

National institute of alcohol abuse and alcoholism (2012)

In Iraq, about 24.0% of the total populations were alcohol abusers, where 25.30% and 14.80% of the male and female population were alcohol dependents. In Israel, 5.50% of the populations were alcohol dependents, about 6.30% and 4.40% of male and female population were alcohol dependents. In Kuwait, the total population was 3.10%, where 3.20% and 1.90% of the male and female population were alcohol abusers.

WHO (2014)

In China, about 10.60% of the total population was alcohol dependents. The male and female population of about 13.70% and 5.20% were alcohol users. In Nepal, 15.20% and 1.80% of the male and female was alcohol dependents. About 10.50% of the total population was alcohol dependents. In Bhutan, 2.50% of the male population was alcohol dependents.

WHO (2014)

In Pakistan, about 30.0% of the total population and about 30.40% and 16.10% of the male and female population was alcohol dependents. In Sri Lanka, about 9.0% of the total population was alcohol dependents, where 9.30% and 6.90% of the male and female population was alcohol abusers.

WHO (2014)

In India, the total population drinkers were 22.30%. The alcohol drinkers of male and female population were about 23.90% and 10.40%.

WHO (2014)

India is a vast sub-continent and the drinking habits vary greatly between the different states. Alcohol abuse also amounts to huge annual losses due to alcohol-related problems in work places. Nearly 25% of the road accidents are under the influence of alcohol and it is also a significant risk factor for increased domestic violence. About 30% of Indians consume alcohol, out of which 4-13% are daily consumers and up to 50% of these, fall under the category of hazardous drinking.

WHO (2012)

The NSSO's 2011-12 consumption data splits per capita weekly consumption of alcohol into four categories – toddy, country liquor, beer and foreign/ refined liquor or wine. The average rural Indian drinks 220 ml across types of alcohol in a week or 11.4 liters in a year. Toddy is the most popular drink for rural India followed by country liquor. The average urban Indian, meanwhile, drinks 96 ml per week or 5 liters in a year, country liquor being most popular.

The Hindu (2014)

Dr P C Gupta, director of Sekhsaria Institute of Public Health, quoted a WHO report which said about 30% of Indians consume alcohol, out of which 4-13% are daily consumers and up to 50% of these fall under the category of hazardous drinking. "All of this amounts to drinking over 100 bottles of wine, or 200 liters of beer, in a year," the report stated. Interestingly, Indians featured much lower here as average consumption of pure alcohol hovered around 2.5-3 liters annually.

Sumitra Deb Roy (2015)

The WHO report says that about 30 percent of India's population, just less than a third of the country's populace – consumed alcohol regularly (as of 2010). Some 11 percent are moderate to heavy drinkers. The average Indian

consumes about 4.3 liters of alcohol per annum, says the report. The rural average is much higher at about 11.4 liters a year.

Sujatha (2015)

According to an Organization for Economic Cooperation and Development (OECD) report released in May 2015, alcoholism increased by about 55 percent between 1992 and 2012. It is a quickly rising concern among the youth of the country.

Sujatha (2015)

On the WHO's 'Years of Life Lost' (YLL) scale – a measure of premature mortality – alcohol attributed years of life lost puts India on a precarious 4 on a scale of 1 to 5. This means that a large number of people from India lose their lives early due to alcohol consumption and its fallouts.

Sujatha (2015)

India has also become one of the largest producers of alcohol – it produces 65% of alcoholic beverages in South-East Asia. People who live in this state drink an average of 8 liters per capita, and this is four times the amount of the rest of India. Other areas of the continent where people tend to drink relatively heavily include Mumbai, Punjab and Haryana. It is believed that as little as 5% of alcohol consumers are female – although this figure is higher in some states.

Drug and alcohol rehabilitation guide (2016)

In New Delhi, total population, 21.4% were reported to be current users of alcohol. Female alcohol use was low (3.2%) compared with male use (20.2%). Distribution by age documents that prevalence were approximately 23% among adults and the older age group (30 years and above) and 4.2% among adolescents and young adults (10 to 29 years).

Drug and alcohol rehabilitation guide (2016)

In Calcutta, According to the 2013 World Health Survey, the rate of heavy episodic drinking among the total population was 1.4% (total), 2.9% (males) and 0.1% (females). Heavy episodic drinking was defined as at least once a week consumption of five standard drinks in one sitting.

WHO (2014)

Kerala is among the highest alcohol consuming states in the country and secondly, about 22 percent of Kerala government's revenue gains (approximately INR 8000 crores) was reported to have come from alcohol manufacturing and sale licenses. The government of Kerala announced plans to go ahead with alcohol prohibition in phases in August 2014. Starting March 2014, alcohol licenses of bars and shops were not renewed but toddy is still sold widely.

Sujatha (2015)

In Pondicherry, the prevalence of alcohol consumption was 59.6% of the total population. The prevalence of alcohol consumption was found very high in Pondicherry compared to national levels.

Muthurajesh Easwaran (2015)

A survey conducted in 15 villages and towns across five districts viz., Cuddalore, Tiruchirapalli, Kanchipuram, Dindigul and Chennai. As much as 52 per cent of women said their spouses had been drinking for the last 10 years, the research report states 83 per cent frequency of drinking had increased during the decade.

The New Indian express (2016)

A study data shows that 70 per cent of alcoholics live within one kilometer of a TASMAL outlet. A higher percentage of men who drink everyday subject their families to physical violence as compared to those who abstain. Data obtained from government hospitals through queries on

admissions due to alcohol related health reasons showed an increasing trend from 2000 onwards, with a steep increase from 2011 onwards. The District Union Office calculated the loss due to alcoholism and costs on healthcare, that 67,444 crores per year was lost due to alcoholism in the State, which pales in comparison to 25,000 crores the State earned as revenue from its sale of liquor.

The New Indian express (2016)

The prevalence of alcoholism among rural population was 35.7%. Among only 4.5% who were aware about symptoms of chronic alcoholism had taken treatment. Reasons for not taking treatment for alcoholism among study population were mainly due to their family problems (55.2%).

Ruma Dutta (2014)

In Tamil Nadu, the NGO 'Nandini- Voice for the Deprived' found that in the rural areas, where more than 40 % of the male population are addicted to consuming liquor regularly.

Syed Ali Mujtaba (2013)

In Tamil Nadu, the survey reports that 84 percent of the regular drinkers and 64 percent were alcohol addicts in urban area.

Shivani Chaturvedi (2015)

About 46.7 per cent of males reporting of consuming alcohol, the State Tamil Nadu is sixth on a list of 17 States and Union Territories surveyed for National Family Health Surveys (NFHS) 2015-2016. The last round of NHFS had recorded that 41.5 per cent of Tamil Nadu's men consume alcohol.

Deepu Sebastian Edmond (2016)

In Tamil Nadu, Female Alcoholics has almost doubled in the last decade. The Times of India reports recorded an increase in per capita consumption of pure alcohol from 1.82 liters in 2000, to 2.46 liters in 2010. It predicts the consumption to swell up to 4.9 liters by 2050 in India. Alcohol

consumption among women is on a sharp rise. Whereas women form 30% in India, in Tamil Nadu it's only 1% of the alcoholics.

Chennaiin News (2015)

In Tamil Nadu, about 22.67% of the adolescent boys indulged in alcohol abuse at least once a month. Correspondingly alcohol was abused by 9.33% of the girls which is the most commonly abused drug of addiction. Girls are also picking up this habit, especially those living in hostels.

Ponnudurai (2013)

Depression and alcohol dependence are frequently found to co-exist but the relationship between these disorders requires further elucidation. The episode of drinking which led to admission, a diagnosis of major depression was found in the majority of patients (67%). Once detoxification from alcohol took place, only the minority (13%) met criteria for major depression.

Davidson KM (2007)

About 27% of individuals with substance abuse disorders (both alcohol and other substances) experience depression.

National institute of mental health (2008)

Yaser Alikhajeh (2011) conducted a study on effectiveness of yoga exercises on addicts' depression in rehabilitation period, Iran. The method of this investigation is semi-experimental. All new cases were evaluated on admission using a personal information questionnaire as well as beck-2 test. Participants were randomly assigned into two groups; an experimental (n= 60) and a control group (n=60). The experimental group participated in training protocol that was held for 3 sessions per week and 60 minutes each session for 5 weeks. The control group was assigned to a waiting list and did not receive yoga. Depression level in experimental group was reported 26.75 ± 8.476 before yoga and decreased to 18.92 ± 9.977 after yoga that showed significant

difference ($p=0.022$). Yoga exercises caused significant difference in depression level of experimental group in comparison with the control group in rehabilitation period ($p=0.048$).

Padmini Tekur (2010) conducted a randomized control study to assess the effect of yoga on quality of life of alcohol dependent patients. About 80 patients registered for a week long treatment at holistic health centre in Bengaluru, India. They were randomized into two groups (40 each). The yoga group practiced a specific module comprising of Asanas (physical postures), pranayama (breathing practices), meditation and lectures on yoga philosophy. The control group practiced physical exercises. Outcome measures were WHOQOL BREF for quality of life. The baseline scores in physical health domain (mean 11.9) in experimental group were lower than the scores (mean 13.8) in control group. After yoga it increased to 14.5 in control group and 15.14 in experimental group pointing to the normalizing effect of yoga on physical QOL. In psychological domain, there was a significant (20%) improvement in yoga group with non-significant change in control group. The baseline values were much lower (mean 13.0) than control group (14.7) and increased (15.2 in experimental group) similar to control group (15.5) after yoga. The mean scores in social domain changed from 13.0 to 14.8 in experimental group and 14.2 to 14.9 in control group. The mean value in environmental domain which was lower (12.8) in experimental group than control group (14.5), improved significantly to reach normalcy (14.6) after yoga and not after physical exercises.

The investigator during her clinical posting, while caring for alcohol dependents observed that most of the alcohol dependents were found to be depressed and struggling to face the problems in their day-to-day life. Their perception of the alcohol was, it is a major substance to relieve them from all their worries and problems. They also used alcohol to get rid of the problems without knowing that it would add the burden to self as well as the loved ones

around them. The clients were unaware that, alcohol is a central nervous system depressant, and it triggers the depressive symptoms. Due to the alcohol induced depression, satisfaction towards their life were affected. Hence, the dissatisfactory life style develops the relapse of alcohol consumption. The depression and dissatisfactory life style affects the physical, psychological, social and environmental aspects of the alcohol dependents. The relaxation techniques may relieve the individuals from the stress and depression. Hence, the investigator chooses one of the relaxation techniques, Yoga which is an authentic Indian traditional art and science of human life. It can be easily practiced by all the people, and one of the cheapest and most effective techniques to calm and relax the mind.

This motivated the researcher to conduct the study using yoga in reducing the level of depression and improves the quality of life among alcohol dependents.

STATEMENT OF THE PROBLEM

A study to assess the effectiveness of yoga on depression and quality of life among alcohol dependents in Athma De-addiction centre, Trichy.

OBJECTIVES

1. To assess the pretest and posttest level of depression and quality of life among alcohol dependents in experimental group.
2. To assess the pretest and posttest level of depression and quality of life among alcohol dependents in control group.
3. To compare the pretest and posttest level of depression and quality of life among alcohol dependents in experimental group.
4. To compare the posttest level of depression among alcohol dependents between experimental group and control group.
5. To compare the posttest level of quality of life among alcohol dependents between experimental group and control group.

6. To find the correlation between posttest level of depression and quality of life among alcohol dependents in experimental group.
7. To find the association between posttest level of depression among alcohol dependents and their demographic variables in experimental group.
8. To find the association between posttest level of quality of life among alcohol dependents and their demographic variables in experimental group.

OPERATIONAL DEFINITIONS

EFFECTIVENESS

Effectiveness is the ability to be successful and produce the intended results.

Cambridge University Press (2016)

In this study, effectiveness is the desired change brought out the yoga on the level of depression and quality of life among alcohol dependents which is measured by the statistical analysis.

YOGA

Yoga is “Svadyaya” a self-study that develops deep self-awareness and self-understanding and builds abilities to manage stress and pain and deal with challenges with the right attitude.

Geeta Iyer (2012)

In this study, yoga therapy includes teaching yoga to the alcohol dependents admitted in the Athma De-addiction Centre for 45 minutes using LCD projector and made them to practice it for 1 hour 10 minutes in the morning for 4 weeks in groups under supervision for 4 weeks. The yoga exercises involves warm up for 15 minutes, Pranayama for 10 minutes, yoga

exercises such as Vakrasana, Ardha matsyendrasana, Paschimottasana, Ustasana, Vajrasana for 30 minutes and Savasana for 15 minutes.

DEPRESSION

An alteration in mood that is expressed by feelings of sadness, despair and pessimism. There is a loss of interest in usual activities and somatic symptoms may be evident. Changes in appetite and sleep pattern are common.

Mary c. Townsend (2015)

In this study, depression refers to the commonly induced symptoms in sustained alcohol dependents which were measured by using Beck Depression Inventory Scale and its statistical measurements.

QUALITY OF LIFE

Quality of Life defined as individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. It is a broad ranging concept affected in a complex way by the person's physical health, psychological state, level of independence, social relationships, personal beliefs and their relationship to salient features of their environment.

WHO (2010)

In this study, Quality of life refers to the evaluation of the overall quality of life and general health, physical, psychological, social and environmental well being among alcohol dependents which were measured by using Quality of life- 26 BREF scale adopted from WHO and its statistical measurements.

ALCOHOL DEPENDENTS

An alcohol dependent is a man or a woman who suffers from alcoholism - they have a distinct physical desire to consume alcohol beyond their capacity to control it, regardless of all rules of common sense.

Christian Nordvist (2015)

In this study, alcohol dependents refer to the clients who were between the age group of 18 – 45 years.

HYPOTHESES

- H₁** : The mean posttest level of depression is significantly lower than the mean pretest level of depression among alcohol dependents in experimental group.
- H₂** : The mean posttest level of quality of life is significantly higher than the mean pretest level of quality of life among alcohol dependents in experimental group.
- H₃** : There is a significant difference between the posttest level of depression among alcohol dependents in experimental and control group.
- H₄** : There is a significant difference between the posttest level of quality of life among alcohol dependents in experimental and control group.
- H₅** : There will be a correlation between the posttest level of depression and quality of life among alcohol dependents in experimental group.
- H₆** : There will be a significant association between posttest level of depression and quality of life among alcohol dependents and their demographic variables in experimental group.
- H₇** : There will be a significant association between posttest level of depression and quality of life among alcohol dependents with their demographic variables in experimental group.

ASSUMPTIONS:

- 1) Alcohol dependents may have poor coping abilities.
- 2) Alcohol dependents may have depression because of their family and social problems.

- 3) Alcohol dependents may have difficulty in maintaining quality of life in general health, physical, psychological, social and environmental aspects.
- 4) Nurses have an important role in reducing the level of depression and improving quality of life among alcoholics.

DELIMITATIONS:

The study is delimited to,

- 1) Data collection period of 8 weeks.
- 2) Sample size is limited to 60.
- 3) Only one setting to conduct the study.

PROJECTED OUTCOME:

Practicing yoga reduces the level of depression and improving the level of quality of life in general health, physical, psychological, social, and environmental aspects among alcohol dependents. Yoga exercises helps in relaxing and promotes the calmness of the mind. It also helps to reduce the depression. Regular practice of yoga would enhance the inner calmness, awareness, balance and coping, which helps to overcome the physiological, psychological, social and environmental issues. The long term practice of yoga promotes the quality of life in day to-day activities. It also improves attention, concentration, sleep, awareness, connects body and mind interaction and well being of the individual. It promotes self control, and behavioral modifications, which would help the alcohol dependent to control the habit of consuming alcohol.

CONCEPTUAL FRAMEWORK

Conceptual framework helps to express abstract ideas in a more realistic, understandable, and precise form of the original conceptualization. The conceptual framework for this study was adapted from **Wiedenbach's Helping Art Of Clinical Nursing Theory (1969)**.

According to Ernestine Wiedenbach nursing is nurturing and caring for someone in a motherly fashion. Nursing is a helping service that is rendered with compassion, skill and understanding to those in need for care, counsel and confidence in the area of health. The practice of nursing comprises a wide variety of service each directed towards the attainment of one of its three components.

Step I: Identification of a need for help

Step II: Ministration of help needed

Step III: Validation that need for help was met

CENTRAL PURPOSE

According to the theorist, the nurse's central purpose defines the quality of health. The nurse desires to effect or sustain the patient and specifies what the nurse recognizes to be special responsibility in caring for the patient.

In this study, the central purpose is to reduce the level of depression and improves the quality of life among alcohol dependents in Athma De-addiction centre, Trichy.

STEP I: IDENTIFICATION OF A NEED FOR HELP

According to the therapist, within the identification component there are four distinct steps. First, the nurse observes the patient, looking for an inconsistency between the expected behavior of the patient and the apparent

behavior. Second, the nurse attempts to clarify what the inconsistency means. Third, the nurse determines the cause of the inconsistency. Finally, the nurse validates with the patient that her help is needed.

In this study, the general information which comprises the age, religion, education, occupation, marital status, monthly income, type of the family, area of residence, duration of alcohol consumption, nature of admission, history of previous de-addiction treatment. Pretest was done to assess the level of depression and quality of life by using Beck Depression Inventory (BDI II) scale and Quality of Life- 26 BREF scale adopted from WHO respectively.

STEP II: MINISTRATION OF THE HELP NEEDED

According to the theorist, in ministering to the patient, the nurse may give advice or information, make referral, apply a comfort measures or carry out a therapeutic procedures. The nurse would need to identify the cause and if necessary make an adjustment in the plan of action.

Ministration of help needed has two components,

1. PRESCRIPTION
2. REALITIES

1. PRESCRIPTION

According to the theorist, a prescription is directive to activity. It specifies both the nature of action that would most likely lead to fulfillment of the nurse's central purpose that determines it.

In this study, prescription was plan of care to achieve the purpose which includes teaching Yoga exercises and practicing Yoga exercises for 1 hour and 10 minutes in the morning for 4 weeks by the alcohol dependent with depression and low quality of life.

2. REALITIES

According to the theorist, the realities of situation which the nurse is to provide nursing care. Realities consist of all factors- physical, psychological, emotional and spiritual those are at play in a situation in which nursing actions occur at any given moment. Weidenbach defines five realities as the agent, the recipient, the goal, the means, and the framework.

1. AGENT

According to the theorist, the agent is the practicing nurse or delegate is characterized by personal attribute capacities, capabilities and most importantly commitment and competence in nursing.

In this study, the investigator was the agent.

2. RECIPIENT

According to the theorist, the recipient is the patient characterized by the personal attributed problem, capabilities aspirations and most important is the ability to cope with the concerns or problems being experienced.

In this study, the recipients were alcohol dependents admitted in Athma De-addiction centre, Trichy.

3. GOAL

According to the theorist, the goal is the desired outcome the nurse wishes to achieve. The goal is the end result to be attained by the nursing action.

In this study, it refers to reduction in the level of depression and improvement of quality of life among alcohol dependents, admitted in Athma De-addiction centre, Trichy.

4. MEANS

According to the theorist, the means comprise the activities and devices through which the practitioner is enabled to attain her goal. The means includes skilled techniques, procedures and devices that may be used to facilitate nursing practice.

In this study, it refers to implementation of Yoga exercises to alcohol dependents for 4 weeks.

5. FRAMEWORK

According to the theorist, the framework consists of the human, environmental, professional and organizational facilities that not only make up the context within which nursing is practiced but also constitutes currently existing limits.

In this study, it refers to the Athma De-addiction centre at Trichy.

STEP III: VALIDATION THAT NEED FOR HELP WAS MET

According to the theorist, the third component is validation. After help has been ministered, the nurse validates that the actions were indeed helpful. Evidence must come from the patient that the purpose of the nursing action has been fulfilled.

In this study, validating the need for help was met by means of post assessment of level of depression and quality of life which was done after 4 weeks of intervention. Positive outcomes were presence of minimal and mild level of depression and satisfactory and highly satisfactory level of quality of life. Negative outcomes were presence of moderate and severe level of depression and dissatisfactory level of quality of life which in turn may need ministering the needed help.

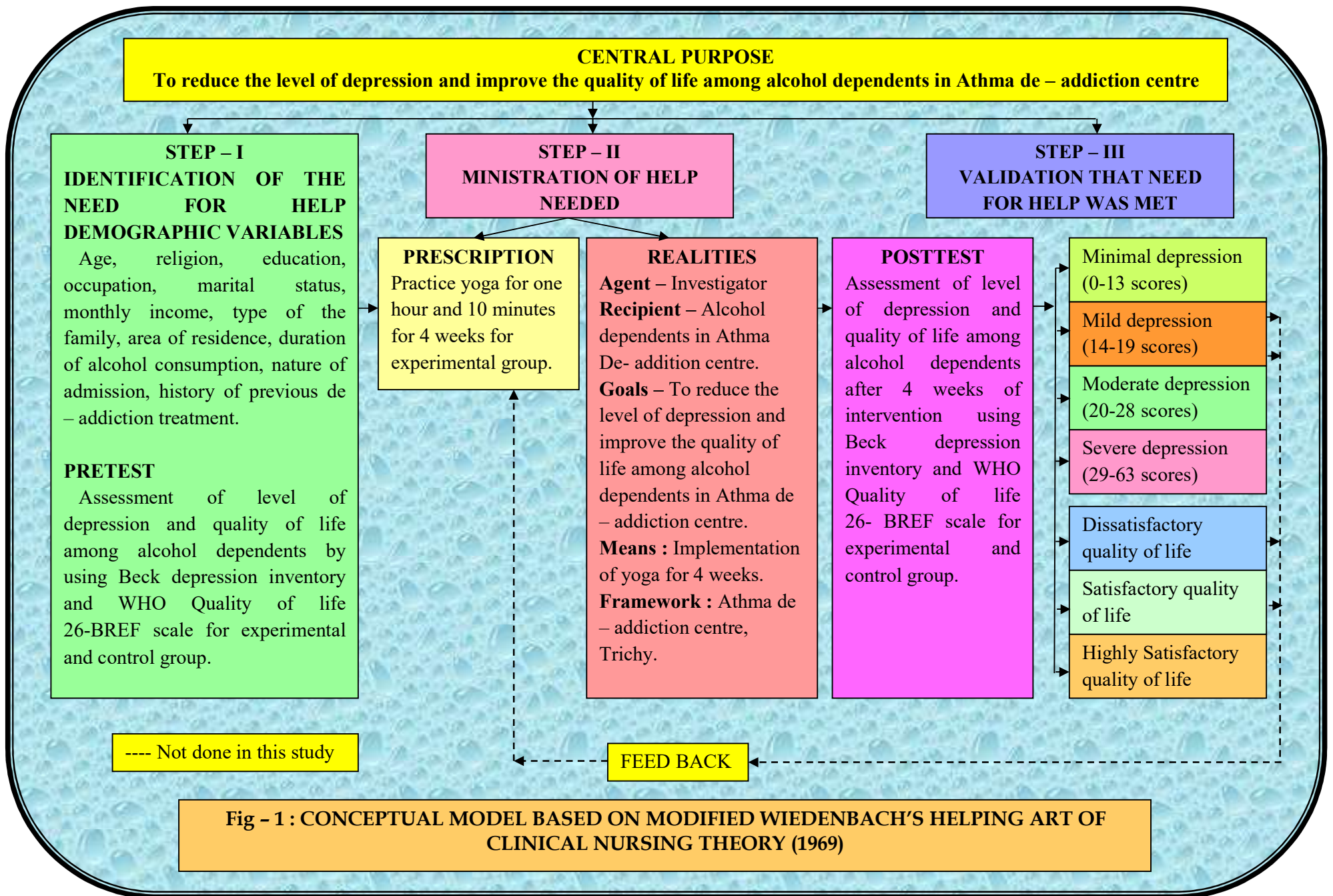


Fig - 1 : CONCEPTUAL MODEL BASED ON MODIFIED WIEDENBACH'S HELPING ART OF CLINICAL NURSING THEORY (1969)

CHAPTER II

REVIEW OF LITERATURE

This chapter deals with the related review of literature. The literatures are classified under the following headings.

PART A

Overview of

- I. Alcohol dependence
- II. Depression and alcoholism
- III. Quality of life among alcohol dependents
- IV. Yoga in relation to depression and quality of life among alcohol dependents.

PART B

SECTION I:

Studies related to prevalence and incidence of depression among alcohol dependents.

SECTION II:

Studies related to prevalence of quality of life among alcohol dependents.

SECTION III:

Studies related to effectiveness of yoga on depression and quality of life among alcohol dependents.

PART A

I. OVERVIEW OF ALCOHOL DEPENDENCE

The term substance is used in reference to any drug, medication, or toxin that shares the potential for abuse.

Sreevani (2010)

The words ‘drug addiction’ and ‘drug addict’ were dropped from scientific use due to their derogatory connotation. Instead ‘drug abuse’ or ‘drug dependence’, ‘harmful use’, misuse, and ‘psychoactive substance use disorders’ are the terms used in the current nomenclature.

Niraj Ahuja (2011)

GATEWAY DRUGS

The soft drugs lead to other strong drugs. The soft drugs are termed as gateway drug. Alcohol, tobacco, marijuana are a few examples of gateway drug.

Dr. Rashmi Agrawal (1995)

ALCOHOL

Arabic word for alcohol- alkuhl means essence.

Nupur Swarup (2011)

ALCOHOL USE DISORDER

Alcoholism is a disease characterized by the habitual intake of alcohol. It defines alcoholism is chronic alcohol use to the degree that it interferes with physical or mental health or with normal social or work behavior.

Natasha Tracy (2015)

PROCESS OF DEVELOPMENT OF ALCOHOLISM

Experimental: To begin with, persons start drinking alcohol due to peer pressure and curiosity.

Recreational: Gradually, whenever the people meet in functions like marriages, parties, conferences, used to drink occasionally.

Relaxation: Further, whenever the people want relaxation, on holidays and weekends enjoying drinking. Hence the frequency gradually increases.

Compulsive: People start drinking occasionally, starts drinking almost daily or drinking heavily for a period of time for pleasure or to avoid the discomfort of withdrawal symptoms.

Nambi (2006)

PATHOGENESIS

Pre- alcoholic phase: This phase is characteristic by use of alcohol to relieve everyday stress and tension of life.

Early alcoholic phase: This phase is characteristic by black outs, the brief periods of amnesia that occurs during or immediately following period of drinking.

The crucial period: In this phase, individual has lost control over drinking and physiological dependence is clearly evident.

The chronic phase: This phase is characteristic by emotional and physical disintegration.

Santosh Malik (2010)

SPECIES OF ALCOHOL DEPENDENCE

According to Jellinek, on the basis of the pattern of use,

Alpha: Excessive and inappropriate drinking to relieve physical and/or emotional pain, no loss of control, ability to abstain present.

Beta: Excessive and inappropriate drinking, physical complications, no dependence.

Gamma: Progressive course, physical dependence with tolerance and withdrawal symptoms, psychological dependence with inability to control drinking.

Delta: Inability to abstain, tolerance, withdrawal symptoms, social disruption is minimal.

Epsilon: Dipsomania (compulsive drinking), spree- drinking.

Niraj Ahuja (2011)

EFFECTS OF ALCOHOL DEPENDENCE

Physical problems

GI tract, Acute gastritis, Gastric ulcers, Fatty liver, Cirrhosis of liver, Esophagitis, Esophageal varices, Peptic ulcer, Cancer of liver or stomach, Pancreatitis, Alcoholic cardiomyopathy, Anemia, Malnutrition, Sexual dysfunction

Prema (2006)

Central nervous system problems

Alcoholic peripheral neuropathy, Wernicke's korsakoff syndrome, Rum fits during withdrawal, Hallucinations, Delusions, Alcohol jealousy, Peripheral neuropathy, Amnesia, Dementia, Suicidal tendency, Delirium, Tremors, Ataxia

Prema (2006)

Neuro-Psychiatric complications

Maladaptive behavior, Mood changes, Irritability, Impaired attention, Delirium tremors, Alcoholic psychosis, Morbid jealous

Nambi (2006)

Financial effects

Spending money over drugs instead of family, financial obligations not fulfilled, exhausting savings, borrowing money, selling personal articles, selling household articles and coercing money from family members, selling immovable properties, financial bankruptcy and destitution.

Niraj Ahuja (2000)

Occupational effects

Inefficacy due to decreased performance, unpunctuality, fights, quarrels, thefts, absenteeism, accidents at work place, get warnings, suspension from job, loss of job, frequent changes in job, declining status in job, loss of work habit, loss of skills, longtime unemployment and unsuitability for being meaningfully employed.

Niraj Ahuja (2000)

Familial effects

Arguments over alcohol use, neglect of family obligations, role change and conflict, quarrels and physical violence, long absences from home, frequent marital separation, divorce and ostracization of family.

Niraj Ahuja (2000)

Social effects

Peer alienation, misbehavior with others, arguments, fights, decreased social reputation, loss of position, social isolation, involvement in alcohol 'subcultures' and social ostracization.

Niraj Ahuja (2000)

Legal effects

Violation of rules, driving under influence, thefts and petty crimes, arrests and court cases, involvement in criminal gangs, and the underworld, convictions and imprisonment.

Niraj Ahuja (2000)

EFFECTS OF ALCOHOL CONCENTRATION IN THE BLOOD

- 20- 30 mg/dl: slowed motor performance and decreased thinking ability.
- 30- 80 mg/dl: increased in motor and cognitive problems.
- 80- 200mg/dl: increased in-coordination and errors in judgment, mood/ ability, deterioration in cognition.
- 200- 300mg/dl: nystagmus, market slurring speech, and alcohol blackouts.
- >300mg/dl: impaired vital signs and possible death.

Basavanthappa. B T (2007)

ALCOHOL INTOXICATION

Symptoms of intoxication include disinhibition of sexual or aggressive impulses, mood liability, impaired judgment, impaired social or occupational functioning, slurred speech, incoordination, unsteady gait, nystagmus, and flushed face. Intoxication usually occurs at blood alcohol levels between 100 and 200 mg/dl. Death has been reported at levels ranging from 400 to 700 mg/dl.

Mary C Townsend (2015)

COMMON SEQUENCES OF WITHDRAWAL

1. Tremulousness (the shakes)

- Onset 3 to 36 hours after last dose (drink)
- Symptoms tremors, anorexia, insomnia, tachycardia, agitation, increased blood pressure, anxiety, nausea and vomiting.

2. Acute hallucinations

- Onset any time after tremor begins
- Psychomotor agitation, auditory hallucination.

3. Alcohol withdrawal delirium

- Onset 24- 72 hours after last drink.
- Disorientation, delusion, hallucinations, delirium, severe agitation, fever, perspiration, tachycardia, seizures.

Norren cavan Frisch (2007)

ASSESSMENTS

Biological markers of alcoholism,

- Aspartate amino-transferase (AST)
- Alanine amino-transferase (ALT)
- Ratio of m- AST to total AST
- Gamma glutamyl-transferase (GGT)
- Mean corpuscular volume (MCV)
- Adenylate cyclase (platelet)
- Erythrocyte aldehyde dehydrogenase
- Carbohydrate deficient transferring (CDT)

Niraj Ahuja (2000)

Screening instruments and rating scales

Screening:

- MAST (Michigan Alcoholism Screening Test)
- CAGE Questionnaire

- AUDIT (Alcohol Use Disorders Inventory Test)

Scales of assessment of severity:

- ASI (Addiction Severity index)

Niraj Ahuja (2000)

FIVE GOALS IN THE MANAGEMENT OF ALCOHOLISM

- ✓ Improving supports and social relationships.
- ✓ Developing confidence and ability to change the alcohol behavior.
- ✓ Identify reasons to change the alcohol behavior.
- ✓ Developing alternative activities for coping strategies and relaxation.
- ✓ Learning to prevent relapse.

Nambi (2006)

TREATMENT

In alcohol addiction, the essential life saving drugs is,

1. Benzodiazepines like Lorazepam 10-12mg per day to start with and reduced one tablet a day after 5 or 6 days.
2. B complex vitamin (B1, B6, B12) usually given in injectable forms.
3. IV fluids, if necessary.
4. Deterrent agent: Disulfiram- this drug when taken along with alcohol acts adversely by blocking acetaldehyde dehydrogenase enzyme, which leads to accumulation of acetaldehyde in blood leading to toxic reactions such as flushing, increased heart rate, blood pressure, respiratory rate and may lead to cardiac arrest.
5. Anti- Craving: Acamproaste (333mg qds), Naltrexone (50-150mg), Topiramate (100- 200mg).

Ramakrishnan (2010)

MODELS OF COGNITIVE AND BEHAVIOR THERAPIES OF ALCOHOL DEPENDENCE

Individual psychotherapies

Psychotherapeutic interventions comprises of 1- 4 sessions. The sessions are aimed to deglamorize alcohol use, correct misconceptions regarding alcohol use and treatment, install optimism in the patients and provide a realistic feedback of the harms already caused. It emphasis the need of alcohol abstain and treatment planning.

Niraj Ahuja (2000)

Group therapies

Group therapy for alcohol dependents can be defined as an assembly of chemically dependents patients usually 5- 10 in numbers, who meet regularly under guidance of a professional leader for the purpose of promoting abstinence from all mood altering chemicals and recovery from addiction.

Niraj Ahuja (2000)

Cognitive therapy

Cognitive therapy is the reduction of alcohol use by identifying and modifying maladaptive thinking patterns.

Niraj Ahuja (2000)

Relapse prevention model

Relapse prevention model is the cognitive behavioral approach to help patients develop greater self control on order to avoid relapse.

Niraj Ahuja (2000)

Motivational interviewing

Motivational interviewing is the method of motivating patients by cognitive approach to his problem and its solutions.

Niraj Ahuja (2000)

Operant behavior therapy

It involves operant rewarding or punishing the patients for desirable (e.g. adherence to treatment) or undesirable (relapse) behaviors.

Niraj Ahuja (2000)

Contingency Management

A kind of operant behavioral therapy based on the use of predetermined positive or negative consequences to reward abstinence or punish alcohol behavior.

Niraj Ahuja (2000)

Cue Exposure therapy

Exposure to craving inducing cues and prevention of alcohol use response leads to extinction of dependence.

Niraj Ahuja (2000)

Aversion therapy

Aversion therapy is coupling alcohol use with unpleasant experience (e.g. chemically induced vomiting) to result aversion to alcohol use. Not much in use currently.

Niraj Ahuja (2000)

RELAXATION TECHNIQUES

Yoga, meditation, guided imagery, autogenic exercises, progressive muscle relaxation, art therapy, biofeedback, prayer therapies, dance therapy, humor therapy, sound and music therapy, support therapy,

Steven D Ehrlich (2015)

OTHER APPROACHES TO TREATMENT ALCOHOLISM

Self- help approach

- **Alcoholics anonymous (AA):** AA considers alcoholism as a physical, mental, and spiritual disease, a progressive one, which can be arrested but not cured. Members attend group meetings usually twice a week on a long term basis.
- **Al- Anon:** Al- Anon is a group started to support the spouses of alcohol dependents
- **Al- Ateen:** Provides support to their teenage children.

Sreevani (2010)

Social correctional approach

The social correctional approach is based on the underlying premise that problematic alcohol use is a form of social deviance and requires only correctional methods. The therapeutic communities (TCs) have been most prominent and well known social learning model that fosters behavioral and attitudinal change brought by behavioral modeling and peer pressure as a result of the client's membership in a residential community (TC).

Niraj Ahuja (2000)

Moralistic- religious approach

These approaches are based on the premise that problem use of an alcohol use occurs due to moral weakness and / or due to lack of adequate religious roots. Many programs and agencies have become sensitive to incorporating the themes of moral values and religion in their activities.

Niraj Ahuja (2000)

PROGNOSIS

Permanent Abstinence depends on

- ▲ Therapist- patient relationship
- ▲ Therapeutic alliance

- ▲ Negotiated treatment
- ▲ Enhancement of motivation
- ▲ Improved treatment compliance

Dr. K. Lalitha (2010)

II. DEPRESSION AND ALCOHOLISM

Oxford text book of psychiatry defines “depressive disorders are syndromes of depressed mood, pessimistic thinking, and lack of enjoyment, reduced energy and slowness.

K. Lalitha (2009)

International classification of diseases- 10 describes as “in depressive episodes the individual suffers from depressed mood, loss of interest and enjoyment, reduced energy leads to increased fatigability and diminished activity. The change of mood is relatively fixed and persists over a period of days, weeks or months. This change in mood affects the behavior, attitude, thinking and physiological functioning.

K. Lalitha (2009)

The feeling of unhappiness is a mood of depression. The person in depressed mood experience pessimistic thinking, lack of enjoyment, reduced energy and slowness.

R. Baby (2003)

TYPES OF DEPRESSION

Depression is broadly classified into three groups.

- ✓ According to etiology (Reactive and Endogenous)
- ✓ According to symptoms (Neurotic and Psychotic)
- ✓ According to course and time of life (Unipolar and Bipolar)

K. Lalitha (2009)

According to etiology:

Reactive depression:

Response to external factors and stressful life events. Symptoms seen are anxiety, irritability, phobia and early night insomnia.

Endogenous depression:

It is caused by factors within the individual. Biological functioning impaired. May or may not be related to life events. Symptoms seen are constipation, weight loss, reduced libido and early morning waking.

K. Lalitha (2009)

According to symptoms:

Non psychotic or Neurotic depression:

Stressful event of life, results of unconscious dynamics, result of long standing maladaptive personality, insight is well presented, at present neurotic depression is termed as dysthymia.

Psychotic depression:

Disturbance in high level of functioning such as memory, perception and thinking, loss of touch with reality, psychotic features may present such as hallucination, delusion and confusion, impairment of social and personality functioning, diurnal variations of mood, feels more sad in the morning and evening and early morning waking.

K. Lalitha (2009)

According to course and time of life:

Unipolar depression:

Repeated episodes of depression last for between 3- 12 months of duration, recovery is complete between episodes, more common in women than men.

Bipolar depression:

Repeated episodes of mood elation and depression, mania episodes usually begins suddenly, depression tends to be of longer duration, and episodes of both kinds often follow stressful life events.

K. Lalitha (2009)

ALCOHOLIC DEPRESSION

Alcoholics are more prone to develop depression. To get relief from depression some people drink, which would further aggravates the depression.

Nambi (2006)

In the initial few days of detoxification, many patients of alcoholism experience subjective symptoms and/ or demonstrate objective signs of depressive nature. It is necessary to observe the depressive features in patients of alcoholism for a period of two to four weeks before arriving to the treatment.

Niraj Ahuja (2000)

Disulfiram is known to have significant mood altering effects. In patients with significant depressive reoccurrences, use of disulfiram as treatment for alcoholism should be therefore considered sparingly and under regular close supervision. On the other hand, reoccurrence of a depressive episode can trigger a relapse of alcoholism.

Niraj Ahuja (2000)

CAUSES**1. Biological theories**

The monoamine hypothesis suggests an abnormality in the monoamine [catecholamine (norepinephrine and dopamine) and serotonin] system in the central nervous systems at one or more sites. Acetylcholine and GABA are also presumably involved. The functional decrease of amines at the synaptic cleft, decreased norepinephrine and/ or dopamine in depression.

Niraj Ahuja (2011)

2. Neuroendocrine theories

Endocrine function is often disturbed in depression, with cortisol hypersecretion.

Niraj Ahuja (2011)

3. Sleep studies

In depression, the commonly observed abnormalities include decreased REM latency, increased duration of the first REM period, and delayed sleep onset.

Niraj Ahuja (2011)

4. Recent life events

Depression always follows with the stressful life events. The life events should also be coincidental; the association might be non-specific i.e. many stressful life events in the week precedent to other illness, the person might have regarded the events as stressful to produce depression. The life events will be more stressful if it is a loss by separation or death and bereavement in the life.

R. Baby (2003)

5. Predisposing life events

Unhappy marriage, problems at work place, uncomfortable housing is prolonged stressful event causing depression. On the other hand, some vulnerable factors as lack of intimate relationship cause depression.

R. Baby (2003)

6. Physical illness

Physical illness acts as non-specific stressors in provoking depression.

R. Baby (2003)

SIGNS AND SYMPTOMS OF ALCOHOLIC DEPRESSION

The signs and symptoms of alcoholic depression includes,

Physical signs and symptoms:

- Body movements may be slower than it used to be.
- Problems with focusing, the person's concentration span may be reduced.
- Speech may be slower than it used to be.
- Eating patterns change, appetite changes.
- Low sex drive
- Lack of energy, fatigue, tiredness - even small and easy chores feel like unpleasant ordeals
- Restlessness - the patient may pace up and down more, wring hands, and find it hard to keep still.
- Unexplained aches and pains, such as headache, backache or digestive problem.
- Sleeping disturbances - the individual may find it hard to get to sleep or wakes up during the night and cannot get back to sleep.

Christian Nordqvist (2016)

Psychological signs and symptoms:

- Thoughts and feelings of worthlessness
- Persistent sadness or low mood
- Feelings of self hatred
- A feeling of hopelessness
- A feeling of helplessness
- A feeling of guilt
- Irritability - even trivial things become annoying
- Angry outbursts
- Intolerance towards others
- Persistent doubting - finding it very hard to decide on things

- Finding it impossible to enjoy life

Christian Nordqvist (2016)

Social signs and symptoms may include:

- Underperforming at work
- Avoiding keeping in touch with friends
- Abandoning interests and hobbies
- Having family/home problems.

Christian Nordqvist (2016)

PSYCHO-SOCIAL TREATMENTS FOR DEPRESSION

- Helping the patient as well as the family of the patient understand the disorder, its causes and symptoms.
- Monitoring the changes in the mood of the patient, the feelings of the patient and sleep patterns.
- Teaching the patient and related parties how to deal with the stress and reduce the effect of other stressor.
- Permitting the patients to share the experience and offer helping hands in situations where group therapy is prescribed.

K. Madhav Naidu (2009)

III. QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS

DEFINITION

Quality of Life as individuals perception of their position in life in the context of the culture and value systems in which the people live and in relation to their goals, expectations, standards and concerns.

WHO (2010)

HEALTH RELATED QUALITY OF LIFE

Health-related quality of life (HRQoL) is a multi-dimensional concept that includes domains related to physical, mental, emotional, and social

functioning. It goes beyond direct measures of population health, life expectancy, and causes of death, and focuses on the impact health status has on quality of life.

Healthy People (2016)

CONCEPTS OF HEALTH RELATED QUALITY OF LIFE

The concept of HRQOL is well-being, which assesses the positive aspects of a person's life, such as positive emotions and life satisfaction. On the individual level, HRQOL includes physical and mental health perceptions (e.g., energy level, mood) and their correlates—including health risks and conditions, functional status, social support, and socioeconomic status. On the community level, HRQOL includes community-level resources, conditions, policies, and practices that influence a population's health perceptions and functional status. On the basis of a synthesis, HRQOL is “an individual's or group's perceived physical and mental health over time.

Centers for disease control and prevention (2016)

APPROACHES OF HEALTH-RELATED QUALITY OF LIFE

- Self-rated physical and mental health
- Overall well-being
- Participation in society

Centers for disease control and prevention (2016)

ASPECTS OF HEALTH RELATED QUALITY OF LIFE

Health related Quality of life and well-being considers the physical, mental, and social aspects of a person's life. Physical quality of life and well-being relates to vigor and vitality, feeling very healthy and full of energy. Mental quality of life and well-being includes being satisfied with one's life; balancing positive and negative emotions; accepting one's self; finding purpose and meaning in one's life; seeking personal growth, autonomy, and competence; believing one's life and circumstances are under one's control;

and generally experiencing optimism. Social quality of life well-being involves providing and receiving quality support from family, friends, and others.

Centers for disease control and prevention (2016)

GENERALIZED CATEGORY OF QUALITY OF LIFE SCALES

1. Generic instruments (e.g. SF-36, Short-Form with 36 questions)
2. Disease, disorder or condition specific instruments

Centers for disease control and prevention (2016)

HEALTH RELATED QUALITY OF LIFE SCALES

- CDC HRQOL–14 "Healthy Days Measure": A questionnaire with four base questions and ten optional questions used by the Center for Disease Control and Prevention (CDC)
- Short-Form Health Survey (SF-36, SF-12, SF-8): One example of a widely used questionnaire assessing physical and mental health-related quality of life. Used in clinical trials and population health assessments.
- Manchester Short Assessment of Quality of Life: 16-item questionnaire for use in psychiatric populations.
- EQ-5D a simple quality of life questionnaire.
- WHO-Quality of life-BREF (WHOQOL-BREF): A general Quality of life survey validated for several countries.

Centers for disease control and prevention (2016)

IMPORTANCE OF MEASURING HEALTH RELATED QUALITY OF LIFE

Focusing on HRQOL as an outcome can bridge boundaries between disciplines and between social, mental, and medical services.

- HRQOL is related to both self-reported chronic diseases and their risk factors (body mass index, physical inactivity, and smoking status, substance uses).

- Measuring HRQOL can help determine the burden of preventable disease, injuries, and disabilities, and can provide valuable new insights into the relationships between HRQOL and risk factors.
- Measuring HRQOL will help monitor progress in achieving the nation's health objectives.
- Analysis of HRQOL surveillance data can identify subgroups with relatively poor perceived health and help to guide interventions to improve their situations and avert more serious consequences.

Centers for disease control and prevention (2016)

DOMAINS IN QUALITY OF LIFE

The quality of life includes the following domains,

- Overall quality of life and general health
- Physical health domain
- Psychological domain
- Social domain
- Environmental domain

WHO (2010)

FACETS IN QUALITY OF LIFE

The quality of life consists of the facets incorporated within the domains were,

Physical health domain

- ✓ Activities of daily living
- ✓ Dependence on medicinal substances and medical aids
- ✓ Energy and fatigue
- ✓ Mobility
- ✓ Pain and discomfort
- ✓ Sleep and rest

- ✓ Work and capacity

WHO (2010)

Psychological domain

- ✓ Bodily image and appearance
- ✓ Negative feeling
- ✓ Positive feeling
- ✓ Self-esteem
- ✓ Spirituality/ religion/ personal beliefs
- ✓ Thinking, learning, memory and concentration

WHO (2010)

Social domain

- ✓ Personal relationships
- ✓ Social support
- ✓ Sexual activity

WHO (2010)

Environmental domain

- ✓ Financial resources
- ✓ Freedom, physical safety and security
- ✓ Health and social care, accessibility and quality
- ✓ Home environment
- ✓ Opportunities for acquiring new information and skills
- ✓ Participation in and opportunities for recreation/ leisure activities
- ✓ Physical environment (pollution/ noise/ traffic/ climate)
- ✓ Transport

WHO (2010)

ISSUES TO FOCUS ON ALCOHOL ADDICT'S QUALITY OF LIFE:

Addressing many of the issues that comprise quality of life is central to keeping individuals in alcohol abuse

- Physical health
- Mental health
- Career
- Education
- Social life
- Family
- Intimate relationships
- Housing

Alta Mira (2016)

WAYS TO IMPROVE THE QUALITY OF LIFE ON ALCOHOLIC ADDICTS

1. Encouragement & Support

It is very thought of entering an alcohol rehabilitation treatment center brings on waves of anxiety and apprehension. Treatment staff offers ongoing encouragement and support to residents in their efforts to overcome addiction.

Alta Mira (2016)

2. Stability

Alcohol rehab treatment centers operate within a stable, structured environment that's conducive to personal growth and healing. In effect, the patient stay at an alcohol rehab treatment center becomes a type of training ground for the type of lifestyle that makes ongoing abstinence possible.

Alta Mira (2016)

3. Medical Care Treatment

Medical problems can easily aggravate a person's desire to use alcohol, especially conditions involving pain symptoms. Alcohol rehab treatment

centers offer medical care for conditions that result from ongoing alcohol use as well as chronic conditions that feed into a person's addiction problem. By addressing these types of issues, alcohol rehab treatment centers give recovering addicts the best chance at a successful recovery.

Alta Mira (2016)

4. Personal Development

While addiction treatment remains the primary focus of an alcohol rehab treatment center's efforts, a big part of this process works towards helping addicts develop the personal habits, routines and behaviors that make-up a productive lifestyle.

Personal development entails building upon one's strengths and aspirations in terms of the type of future the patient desires to have. In this way, a person comes to focus attention on positive, constructive goals as opposed to meandering and getting caught up in alcohol-related pursuits.

Alta Mira (2016)

5. Relapse Prevention Training

During the course of an addiction, alcohol becomes the focus of a person's thoughts and emotions. In the process, the mind starts to associate alcohol with certain people, places and activities. All of these factors work to drive ongoing alcohol-using behaviors. Alcohol rehab treatment centers provide relapse prevention training sessions designed to help addicts identify and avoid alcohol-using cues. These sessions also help a person develop other interests and ways of having fun that don't involve alcohol.

Alta Mira (2016)

6. Relationship-Building Skills

Once alcohol addiction sets in, a person tends to limit his associations to other addicts or else spend large amounts of time alone. A person's ability to communicate and form genuine relationships with others falls by the wayside

in the midst of an alcohol-centered social circle. A big part of the alcohol rehab treatment center process entails learning how to communicate effectively with others in constructive ways. Developing relationship-building skills also equips addicts with the tools needed to reach out for help when the urge to use alcohol seems overwhelming.

Alta Mira (2016)

7. Peer Supports

As with any important goal or life pursuit, having the support of others along the way can mean the difference between success and failure. The same goes for when the patient going through a difficult period or life stage. Alcohol rehab treatment centers place a heavy emphasis on the importance of peer supports and building a support network throughout the recovery process.

Alta Mira (2016)

8. Healthy Mindset

People who fall into the alcohol addiction lifestyle develop the type of mindset that supports this way of life. In effect, the alcohol addiction mindset accounts for why it's so difficult for addicts to maintain abstinence for any length of time. Much of patient's time spent in an alcohol rehab treatment center involves undoing the alcohol addiction mindset and developing healthy ways of thinking and interacting with the world.

Alta Mira (2016)

9. Help for Mental Health Issues

According to the Substance Abuse & Mental Health Services Administration, 45 percent of people struggling with alcohol addiction have also developed some degree of mental illness. When left untreated, mental health issues, such as depression or anxiety symptoms can quickly sabotage any efforts made towards alcohol addiction recovery. For these reasons, alcohol

rehab treatment centers make it a point to assess for mental health problems and provide treatment as needed.

Alta Mira (2016)

10. Support Groups

Support groups play a central role in the recovery process, and become even more so important the further along a person progresses in recovery. Support groups provide alcohol addicts with practical insight and guidance for overcoming addiction on a day-by-day basis. Alcohol rehab treatment centers provide alcohol addicts with a firm foundation in the support group process.

Alta Mira (2016)

IV. YOGA IN REALTION TO DEPRESSION AND QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS

Yoga derived from the Sanskrit word yuj, Yoga means union of the individual consciousness or soul with the Universal Consciousness or Spirit. Yoga is a 5000 year old Indian body of knowledge. The science of Yoga imbibe itself the complete essence of the Way of Life, including - Gyan Yoga or philosophy, Bhakti Yoga or path of devotional bliss, Karma Yoga or path of blissful action, and Raja Yoga or path of mind control. Raja Yoga is further divided into eight parts. At the heart of the Raja Yoga system, balancing and unifying these various approaches, is the practice of Yoga Asana.

Gurudev Sri Sri Ravi Shankar (2014)

HISTORICAL PERSCRIPTIVES

Historical evidences of the existence of Yoga were seen in the Pre-Vedic period (2700 B.C.), and thereafter till Patanjali's period. The main sources, from which the people get the information about Yoga practices and the related literature during this period, are available in Vedas, Upanishads, Smritis, teachings of Buddhism, Jainism, Panini, Epics , Puranas etc.

The period between 1700 - 1900 A.D. is considered as Modern period in which the great Yogacharyas- Ramana Maharshi, Ramakrishna Paramhansa, Paramhansa Yogananda, Vivekananda etc. have contributed for the development of Raja Yoga. This was the period when Vedanta, Bhakti yoga, Nathayoga or Hatha-yoga flourished. The Shadanga-yoga of Gorakshashatakam, Chaturanga-yoga of Hathayogapradipika, Saptanga-yoga of Gheranda Samhita, were the main tenents of Hatha-yoga.

Dr. Ishwar V. Basavaraddi (2015)

TYPES OF YOGA

Ashtanga: The oldest form of yoga, Ashtanga is also known as "power yoga" because it is fast-paced and rigorous.

Vinyasa: Focus is on how breathing affects the mind and body, Vinyasa is based on a series of poses called the sun salutations, in which movement is matched to the breath. While rigorous, the postures flow together smoothly.

Iyengar: This practice usually emphasizes holding poses over long periods, which is good for those with injuries or chronic illnesses who want to become more flexible.

Kundalini: Combining rapid, repetitive movements rather than drawn-out poses, Kundalini includes chanting throughout the session. Participants focus on exploring the effects of breathing on their postures.

Bikram: Also called "hot yoga" because it's done in rooms where the temperature is at least 90 degrees Fahrenheit (32 degrees Celsius), Bikram "is very acceptable to people in the West, because it omits headstands and handstands. "The heat makes the soft tissues in the body more pliable, so it's easier to do poses."

Maureen Salamon (2010)

YOGA FOR ALCOHOL ADDICTION

- ✓ Paschimottanasana -seated forward bend
- ✓ Balasana -child's pose
- ✓ Adho Mukha Svasana - Downward Facing dog
- ✓ Vakarasana - twisting the body
- ✓ Ustrasana - Camel pose - back bend
- ✓ Apanasana - knees to chest or wind producing pose seated or lying twists.
- ✓ Ardha matsyendrasana- fold the legs and twisting the body
- ✓ Viparita karani - shoulder stand variation (supported)
- ✓ Savasana - corpse pose

Art of living (2016)

YOGA FOR DEPRESSION

- ✓ Dhanurasana (Bow Pose)
- ✓ Matsyasana (Fish Pose)
- ✓ Janu Shirsasana (One-Legged Forward Bend)
- ✓ Setubandhasana (Bridge Pose)
- ✓ Marjariasana (Cat Stretch)
- ✓ Vajrasana (diamond sitting)
- ✓ Paschimottanasana (Two-Legged Forward Bend)
- ✓ Hastapadasana (Standing Forward Bend)
- ✓ Ustrasana (kneel down and bend backward)
- ✓ Adhomukha Shwanasana (Downward Facing Dog)
- ✓ Shirshasana (Headstand)
- ✓ Shavasana (Corpse Pose)

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YOGA WORKS ON BRAIN

Yogis had larger brain volume in the somatosensory cortex, which contains a mental map of our body, the superior parietal cortex, involved in directing attention, and the visual cortex. The hippocampus, a region critical to

dampening stress, was also enlarged in practitioners, as were the precuneus and the posterior cingulate cortex, areas key to our concept of self.

Stephani Sutherland (2014)

"It thickens the layers of the cerebral cortex, the part of the brain associated with higher learning, and increases neuroplasticity, which helps to learn new things and change the way of doing things.

Maureen Salamon (2010)

YOGA AND ALCOHOL ADDICTION

The use of yoga to help break addiction patterns is growing. Yoga cultivates bodily awareness in a kind, nurturing way. It allows the people to start connecting with the body and breath and learn to sit and look within. Compassion for people arises and with it, a new ability to deal with stressful situations, leading to positive change. A gentle physical yoga practice will bring steadiness to the mind and help to detoxify the body. Many of the poses have a positive effect on the areas of the body that are most often affected by abuse. Internally, organs are gently massaged and the heart and lungs can be used more efficiently. The practice of deep breathing (Pranayama) fills every cell in the body with rich oxygenated blood.

Cherie Lathey (2013)

YOGA AND DEPRESSION

People suffering from depression can benefit from yoga therapy. Exercise is an important part to any depression treatment, and yoga can be especially helpful because of its gentle, calming, and fluid nature. It can ease physical pain, combat lethargy, and improve self-esteem. It might even increase production of serotonin, the brain chemical that experts believe is deficient in people with depression.

Brian Krans (2013)

Yoga tames the stress response by priming the parasympathetic nervous system. It is established science that yoga destroys and metabolizes stress hormones. There is a meditative element of yoga that promotes mindfulness (helping us to stay in the present moment) that is effective therapy for depression.

Therese Borchard (2016)

YOGA AND QUALITY OF LIFE

Quality of life has a wide range of contexts including physical health, psychological and social well being, environmental development, employment, finance and more, but in general is defined by a person's health, comfort and happiness. Yoga plays a big part in achieving a healthy lifestyle and improving the quality of life. Yogic exercises prompt the release of mood-lifting hormones. Those hormones relieve stress and help improve a sense of well-being.

Virginia O'Connor (2015)

STEPS OF YOGA AND ITS BENEFITS

WARM-UP EXERCISES

The warm up exercises generally consists of a gradual increase in physical activity, joint mobility exercises and stretching. Warming up brings the body to a condition at which it safely responds to nerve signals for quick and efficient action. The warm up exercises includes, Foot fingers movements (to and fro), rotating the ankles, leg exercises, hand exercises, head exercises, eyes exercises, jaw movements, ear massage.

Warm up- Benefits

It increases the body temperature, dilates the blood vessels, increases the muscle temperature, mental preparation for the exercises, and improves the muscle and joint movements.

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PRANAYAMA:

Sit comfortably on flat ground. Take a deep breath through one nostril and fill the lungs with air and then exhale on another nostril. Do it for few minutes. Again inhale the air on one nostril and exhale on the same nostril, repeat the same on another nostril. Do it for few minutes. Inhale deeply and exhale completely.

Pranayama- Benefits:

It improves blood circulation, keep away the heart related problems, provide relaxation to body and mind, improves concentration, and helps to stronger the lungs. Relieve stress, depression and hypertension, cures obesity and arthritis, calms the mind. Cures throat infection, increases appetite, cure asthma, headache, migraine, neurological problems, depression, gastric problems.



Art of living (2016)

VAKRASANA

Sit erect first, stretching the legs in front together. Hands should be by the side, palm resting on the ground, fingers together pointing forward. Now slowly fold left leg at the knee and place the sole on the ground near the knee of right leg. The knee of the left leg should make 90 degrees angle straight towards sky. Now take left hand towards back, place the palm on the ground straight from the spine. Fingers should be together points backward. Now

place the right hand towards the other side of the left knee. Twist the head back towards backside and try to look back. While returning to the original position, first bring the head towards original position. Now take the right hand to its original position and then bring the left hand from the back and place it by the side of the body. Slowly stretch out the folded leg and sit erect as in first position. Practice the asana in the same way with the other leg. This makes one round of Vakrasana.

Vakrasana benefits:

It cures constipation, liver weakness and nervous weakness. It calms the mind. The asana reduces rigidity in the spine, Very useful for kidneys and other stomach diseases, reduces back aches, spine attains elasticity, and flab on the lateral side of the abdomen gets reduced.



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ARDHA MATSYENDRASANA

Sit in vajrasana position or sit straight with stretching the legs in front. Bend the left leg and try to touch the feet to right buttock. Bring the right leg outside of the left knee. Touch the feet to the ground. Keep the spine erect. Exhale and turn the upper body to the right. Hold the right feet with left hand and place the right hand behind on the ground. Breathe normally and hold this posture for 3 to 5 minutes. Now release this posture and repeat this cycle with bending right leg and bringing left leg outside of the right knee. (i.e. Twisting the opposite direction).

Ardha matsyendrasana benefits:

It stretches the back muscle and spine, cures constipation and indigestion, helps to increase oxygen supply to the lungs and brain, improves calmness, relieves the stress and tension, releases stiffness of hip joints, beneficial for slipped disc patient, cures back problems, helpful in treatment of constipation, spinal problems, cervical spondylitis, urinary tract disorder.



Art of living (2016)

PASCHIMOTTANASANA

Lie down on the back in a mat. The legs should be straight, slowly rise up the body and sit and stretch the hands upward straightly besides the ears. The fingers should be straight. Deeply inhale now. Keep the hands beside the ears. This is the first state. In this stage exhale the breath and bend the body hold the first finger in the legs with the index finger and the middle finger by making it as an anchor. In this stage exhale the breath and bend the body hold the first finger in your legs with the index finger and the middle finger by making it as an anchor. Deeply inhale and exhale once, the elbows should be beside the knee joints and it should touch the floor. The face is in between the knee joints. Be in this pose for five to ten seconds. Now sit straight and the finger should hold the big finger of the leg. As said in the first stage, sit straightly and the hands must be beside the ears. Slowly bring the body to the backside and lie down. Now take the breath normally.

Paschimottanasana benefits:

As it is an inversion (i.e. the head is lower than the heart), it calms the nervous system, and thus reduces stress, as well as eases depression and anxiety. It helps lower blood pressure which is beneficial for the circulatory system. The seated forward bend boosts your energy and relieves fatigue. By folding over, the internal organs (liver, stomach, kidneys) get a nice squeeze and massage, which helps stimulate the digestive and excretory. Lastly, it is great for the musculature system as it stretches the tight muscles of the lower back and the legs -specifically the hamstrings muscles.



Art of living (2016)

USTRASANA

Sit on knees and bend backwards. Hold right ankles or heel with right hand and left ankle or heel with left hand. Now bend the neck and head backwards as much as and push waist area slightly forward. Breathing should be normal for 6 to 10 seconds in this position. After 6 to 10 seconds return to the first position by bending forward. Release the hands from heels. This is the one round of Ustrasana. Repeat this for some more rounds.

Ustasana benefits:

It helps to increase chest size and lungs capacity, brings flexibility in chest, abdomen and neck, stimulates abdomen organs, improves the function of the respiratory system, activate whole respiratory organs and nerves, cures problems related to neck, shoulders and back, strengthens the back muscles, stimulate thyroid gland, releases back pain, increases blood circulation to brain, increases the relaxation and calmness, helps to improve posture, reduce the fats on the stomach, improve digestion.



Art of living (2016)

VAJRASANA

Sit on the flat floor and fold the legs. Keep the spine straight and close the eyes. Keep the right palm on right knee and left palm on left knee. Now start to inhale slowly then exhale. While exhales try to think that disorders are coming out from the nose. Repeat these steps for 5 minutes and take a rest. Increase the time for 15 minutes.

Vajrasana benefits:

It calms mind, reduces the depression and anxiety and bring stability in mind, cures constipation, acidity, increases digestion process, those suffering from gas problems can practice immediately after lunch or dinner, helps to get rid of back pain, cures stomach disorder, cures urinary problems, strengthens the sexual organs, increases blood circulation, it is preferred for meditation and concentration, helps to reduce obesity, strengthens the thigh muscles, acts as pain killer in arthritis patients.



Art of living (2016)

SAVASANA

Lie flat on the back, like sleeping pose. Legs should be separated. Keep the arms at side and palms faces up. Just relax. Close the eyes and breathe deeply and slowly through the nostrils. Start concentrating from the feet to head. This means that consciously relaxing the each part of the body. Don't move ahead without relaxing particular part of the body. On inhaling and exhaling think that the whole body is totally relaxing. Let the tension, stress, depression and worry run away on each exhaling. Those having good concentrations can practice for a long time and others can practice for 3-5 minutes.

Savasana benefits:

It relaxes the whole body, releases stress, fatigue, depression and tension, improves concentration, cures insomnia, relaxes your muscles, calms the mind and improves mental health, excellent asana for stimulating blood circulation.



Art of living (2016)

PART B- REVIEW OF LITERATURE

SECTION I: STUDIES RELATED TO PREVALENCE AND INCIDENCE OF DEPRESSION AMONG ALCOHOL DEPENDENTS

Chin-in Perng (2014) conducted a retrospective study on to evaluate the risk of depressive disorders among alcoholic patients in Taiwan. Cohorts of 52,725 participants were selected. The study result revealed that during the 11-year follow-up period, 395 (3.75%) alcoholic patients and 1183 (2.80%) control patients were diagnosed with depressive disorders. The incidence risk ratio of depressive disorders between alcoholic patients and control patients was 1.76 ($p<.001$). After adjusting for age, sex, and co-morbidities, alcoholic patients were 1.75 times more likely to develop depressive disorders ($p<.001$) compared with the control patients. The hazard ratios for patients younger than 60 years old (1.31) and female (1.25) indicated that each is an independent risk factor for depressive disorders in alcoholic patients. The conclusion of the study is likelihood of developing depressive disorders is greater among alcoholic patients than among patients in control group.

Rodrigue Minya L'akoa., et.,al (2013) conducted a cross-sectional study to assess the prevalence and correlation of depressive symptoms in alcohol dependent patients in Cameroon. Interviews were conducted with 100 alcohol dependent patients at three referral hospitals of Yaoundé. Depression was assessed using the nine-item patient health questionnaire (PHQ-9). A positive depression screen was defined as PHQ-9 score greater than 9. The overall prevalence of depressive symptoms among alcohol dependent patients was 63%, the majority having symptoms corresponding to moderate depression. The findings indicate a high prevalence of depressive symptoms in alcohol dependent patients.

Mary W Kuria, et.,al (2012) conducted a study on prevalence of depression on alcohol-dependent persons in Mizoram. The objective was to determine the prevalence of depression among alcohol-dependent persons before and after alcohol detoxification and rehabilitation. The design was clinical trial with pre-post measurements. The CIDI and WHO-assist were administered to 188 alcohol-dependent persons at intake and after six months. A researcher-designed socio-demographic questionnaire was also administered at intake. The result of the study revealed that the prevalence of depression among alcohol-dependent persons was high (63.8%) with a significant association between depression and the mean audit score. At posttest, depressed participants had a statistically significant craving for alcohol. The study concludes that alcohol dependence was associated with major depression.

Sudan Prasad Neupane (2012) conducted a study on prevalence and correlates of major depression among Nepalese patients in treatment for alcohol-use disorders in Kathmandu, Nepal. A cross-sectional survey was carried out among 188 consecutively admitted Alcohol Use Disorder (AUD) patients. The result of the study revealed that the lifetime and 12-month prevalence of Mood Disorders (MD) among Alcohol use disorder patients were found to be 45% and 36% respectively. Living with a spouse and low-frequency drinking (2–3 days/week) showed negative associations with reporting mood disorders in the preceding 12-month period, whereas a history of alcohol-induced blackout and problem drinking in the individual's parents were independently predictive of having a Comorbid Mood Disorders.

Helen M Pettinati (2011) conducted a study to estimate the co-occurrence of depressive disorders with the alcohol dependent in West Bengal. Recent estimation of the co-occurrence of these disorders in the general population are derived from the National Epidemiologic Survey on alcohol and related conditions, a large-scale, Nationally representative survey using DSM-IV diagnostic criteria. The prevalence rate for an independent major depressive

disorder was 20.5%. These alcohol-dependent individuals were 3.7 times more likely to have major depression than those without alcohol dependence. For those individuals with a current alcohol use disorder (abuse or dependence) who were seeking treatment, 40.7% had at least current co-morbid depression disorder.

Abdul Khalid (2010) conducted a study on prevalence and comorbidity of depression in alcohol dependence in Nepal. The sample comprised of 34 (32 males and 2 females) DSM- IV alcohol dependent patients admitted in the psychiatry ward of T.U. Teaching hospital, Kathmandu during one year study period. Severity of dependence on alcohol was assessed with the severity of alcohol dependence questionnaire and severity of depressive symptoms was rated on Hamilton Rating Scale for depression. A high prevalence of major depression (41.7%) was found for the episode of drinking which led to hospitalization. However, within a few days of detoxification from alcohol, only few of them had depressive symptoms amounting to major depression (17.64%). There was no significant correlation between severity of alcohol dependence and depression.

Palanivel Rajan (2010) conducted a cross sectional study to assess the Prevalence of tobacco and alcohol use in a rural Population of Tamil Nadu. Data collection was done by semi-structured, semi-open ended interview-based questionnaire. The result of the study, out of 1464 study participants, 244 (16.7%) were smokers. Smokeless tobacco usage was found in 168 (11.5%) study participants whereas 191 (13%) were using Beedi and 85 (5.8%) were using Cigarette. Alcohol consumption in the last 12 months was found in 207 (14.1%) study participants. Among those consuming alcohol, most of them were consuming Beer 176 (85%) followed by Rum 54 (26.1%) and Whiskey 40 (19.3%). The study concludes that prevalence of tobacco and alcohol use was high in this rural population proximal to urban area in Tamil Nadu. There is an urgent need for health promotion campaigns to raise awareness regarding

risk factors such as smoking, alcohol, overweight and encourage adoption of healthy lifestyles.

Davidson KM (2008) conducted a study to diagnose of depression in alcohol dependence: changes in prevalence with drinking status in Calcutta. The schedule for affective disorders and schizophrenia (SADS) was administered to obtain research diagnostic criteria (RDC) on 82 randomly selected alcohol dependent in-patients. Alcohol-related (severity of alcohol dependence questionnaire (SADQ), alcohol consumption and alcohol-related problems), socio-demographic variables and treatment for depression were assessed. For the episode of drinking which led to admission, a diagnosis of major depression was found in the majority of patients (67%). Once detoxification from alcohol took place, only the minority (13%) met criteria for major depression. It is suggested that depression is largely associated with the episode of drinking which led to admission in patients who are dependent on alcohol and may be due to the effect of chronic alcohol intoxication.

B. Chaudhary et.,al (2007) conducted a study on depression in alcoholics – relationship with socio demographic variables in Haryana. Subjects meeting the inclusion criteria were given, structured interview schedule. The mini mental status examination and Hamilton Depression Rating scale were administered. The result indicated that alcoholics have a greater risk for developing depression (33.3%) when compared to non-alcoholic (6.6%) and that socio demographic variables do not account for depression.

Sullivan L E (2007) conducted a study on the prevalence and impact of alcohol problems in major depression in Gambia. Thirty-five studies met criteria and revealed a median prevalence of current or lifetime alcohol problems in depression of 16% (range 5-67%) and 30% (range 10-60%), respectively. This compares with 7% for current and 16-24% for lifetime alcohol problems in the general population. The majority of the studies, 34 of

35 (97%), evaluated alcohol abuse and dependence, and 25 of 35 (71%) were conducted in psychiatric inpatients. We conclude that alcohol problems are more common in depression than in the general population, are associated with adverse clinical and health care utilization outcomes, and that antidepressants can be effective in the presence of alcohol dependence.

SECTION II: STUDIES RELATED TO LEVEL OF QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS.

Priscilla Martinez (2013) conducted a study to assess the quality of life and social engagement of alcohol abstainers and users among older adults in South Africa. Alcohol use was measured as self-reports of use over the previous seven days, and we constructed gender-specific alcohol variables. The WHO quality of life-scale was used to measure quality of life, and social engagement was measured by frequency of participation in social activities. The results revealed that there were 2572 (84.4%) lifetime abstainers, and 475 (15.6%) persons who had a drink in the last 7 days. In Bivariate analysis, quality of life was lowest among at risk drinking men compared to abstainers (OR = 0.21, $p = 0.02$), although this association was not significant in adjusted analysis.

Anja Cerne (2012) conducted a study on assessment of quality of life among alcoholics attending selected de-addiction centers, Kerala. A standardized tool was used with self administered questionnaire. 80 alcoholic subjects were selected with convenient sampling technique. The obtained chi square value 0.178 ($p > 0.05$) was not significant. Majority 57 (71.2%) alcoholics had moderate quality of life. Least number of alcoholics 23(28.8%) reported high quality of life. Results showed that association between age & quality of life, education & quality of life, income & quality of life, duration of habituation & quality of life, age of dependent life & quality of life is 0.504

($p > 0.05$), 2.03 ($p > 0.05$), 1.738 ($p > 0.05$), 0.178 ($p > 0.05$), 5.99 ($p > 0.05$) respectively.

Wagwa, Angelica K (2011) conducted a study to determine the impact of alcohol abuse on the quality of life among HIV I AIDS infected individuals in Kibera, Kenya. This study used a case-control study method to achieve the research objectives. A total of 204 participants were approached and 180 of them met the inclusion criteria. Researcher administered and was collected using three instruments namely; socio-demographic questionnaire, AUDIT and WHO quality of life tools. The results revealed that Self reported illness was found to be more common among the non-users of alcohol (88.9%) than the alcohol abusers (71.1%), $\chi^2=8.889$, $p=0.003$. Alcohol abusers considered their quality of life to be average (53.3%) as compared to 52.2% of the non-users who thought theirs was bad. Quality of life was lower among the alcohol abusers in relation to physical health, psychological wellbeing, social relationships and environment. However, statistically significant differences was found on physical health ($t=-3.071$, $df=78$, $p=0.008$), social relationships ($t=-2.754$, $df=78$, $p=0.006$) and environment ($t=-2.375$, $df=77$, $p=0.019$). The conclusion was, alcohol abuse has negative effects on the quality of life. Physical health and environment domains of an individual's life are affected by abuse of alcohol. Also, alcohol abusers had lower rating on their psychological wellbeing and social relationships which is attributable to the habit of alcohol abuse.

Catherine A Okoro MS (2009) conducted a study to examined the association between binge drinking and health-related quality of life (HRQOL) among United States, adults. Of current drinkers, 11% were frequent binge drinkers and 14% were infrequent binge drinkers. After adjusting for confounding factors, frequent binge drinkers were more likely than non-binge drinkers to experience ≥ 14 unhealthy days (physical or mental) in the past month, primarily because they had more mentally unhealthy days than non-

binge drinkers. Frequent binge drinking is associated with significantly worse HRQOL and mental distress, including stress, depression, and emotional problems. Effective interventions to prevent binge drinking should be widely adopted and may help improve quality of life.

Jean-Bernard Daeppen (2009) conducted a study to evaluate the health-related quality of life in alcohol-dependent patients in Nigeria. Health-related quality of life (HRQOL) was evaluated in a sample of alcohol-dependent patients with the 36-item medical outcome study short-form health survey (MOS-SF-36). The instrument was administered to 147 patients (77% males), aged 26–78, with a DSM-III-R diagnosis of alcohol dependence. The Hamilton Depression Scale (HDS), the severity of alcohol dependence questionnaire (SADQ), and the addiction severity index (ASI) were also administered to the first 100 patients included in the study. Compared to scores observed in the general population, MOS-SF-36 scores for alcohol-dependent patients were relatively low (indicating worse perception of HRQOL), especially in the psychological and role dimensions (range 52/100 to 55/100), but were closer to population values in the physical and functional dimensions (range 61/ 100 to 75/100). The highest correlation between MOS-SF-36 dimensions and HDS was found in the MOS-SF-36 “mental health” dimension ($r = -0.56, p = .001$); this dimension was also correlated highly with the psychiatric dimension of the ASI ($r = -.73, p < .001$). The MOS-SF-36 dimensions were 10% to 141% lower in patients with high “ASI Alcohol” scores, indicating worse HRQOL profiles with a higher severity of alcohol dependence. The results suggested that alcohol-dependent patients perceived their problems more as psychological as physical. The severity of alcohol dependence and depression seemed to influence the perception of HRQOL negatively.

Saatcioglu O (2008) conducted a study to assess the impact of quality of life, depression and anxiety in alcohol dependence in Guinea. This study

focused on the impact of severity of anxiety and depression on quality of life of 150 alcohol-dependent patients treated in hospital. Patients were classified into three groups: patients with alcohol dependence only, patients with depression and patients with anxiety. Initial evaluation conducted using the quality of life scales indicated significant differences between the three patient groups: physical health ($f = 7.92$, $p = 0.001$); psychological ($f = 32.21$, $p = 0.001$); social relationship ($f = 3.45$, $p = 0.03$); and environment ($f = 7.79$, $p = 0.001$). At weeks 3 and 6, quality of life for physical health, psychological and environment areas differed significantly between patient groups, but social relationships did not. At weeks 3 and 6, quality of life was lowest in patients with depression and highest in alcohol only-dependent patients with a low severity of depression or anxiety. Symptoms of anxiety and depression accompanying alcohol addiction lead to an increase in severity of the problems associated with the addiction and have a negative effect on quality of life.

Jalan Rasah (2007) conducted a study on quality of life and disability in alcohol and drug dependent patients undergoing treatment in Melbourne, Australia. A cross-sectional survey was done among 25 drug and 25 alcohol dependents consecutively admitted to a community based residential withdrawal service in Melbourne, Australia. The overall mean disability score derived from the WHODAS was 2.81. The overall mean disability score for the alcohol dependent group (2.81) and the drug dependent group (2.82) showed no statistical difference. The overall mean scores for WHOQOL-BREF were also not statistically significant between the alcohol (38.83) and the drug (38.33) dependent groups. The results of this study showed that those with dependence to drug or alcohol have a significantly poorer quality of life compared to the general public, as the first hypothesis suggested.

SECTION III: STUDIES RELATED TO EFFECTIVENESS OF YOGA ON DEPRESSION AND QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS.

Javnbakht (2014) conducted the study to evaluate the influence of yoga in relieving symptoms of depression in alcohol addicts in Bangladesh. All new cases were evaluated on admission using a personal information questionnaire well as Beck tests. Participants were randomly assigned into an experimental and a control group. The experimental group ($n=34$) participated in twice weekly yoga classes of 90 min duration for two months. The control group ($n=31$) was assigned to a waiting list and did not receive yoga. Both groups were evaluated again after the two-month study period. The average prevalence of depression in the experimental group pre and post Yoga intervention was 12.82 ± 7.9 and 9.79 ± 6.04 respectively, a statistically significant decrease ($p=0.13$). This study suggests that yoga can be considered as a complementary therapy or an alternative method for medical therapy in the treatment of depressive disorders in alcohol addicts.

Nasim Fooladi (2014) conducted a study comparison of depression and quality of life in alcohol abusers with normal population in Rasht. The results showed that the relationship between depression and quality of life was significant. Relationship between depression with quality of life, respectively (-0.72, -0.80, -0.58, -0.63) were obtained in all ($p>0.05$) is significant, so it can be concluded that, depression was inversely related to quality of life. Depression was found to be negatively correlated with quality of life. Based on our findings, addiction and depression were related to the formation of a vicious cycle where addicts due to the loss of prestige and hit a by stander family.

Naorem Jiteswori Devi (2014) conducted a study to assess the effectiveness of yoga on quality of life of drug abusers and to study the efficacy

of yoga on measures of depression of drug abusers in Manipal. 66 drug abused males (47 alcohol abusers) were selected by randomized control trial pre and post study. The yoga asana selected for the study were surya namaskara, vakrasana, ardhmatsyendrasana, pischimottasana, ustrasana, vajrasana, pranayama, savasana. BDI-II and WHOQOL-BREF were used to assess depression score and quality of life before and after. The study result revealed that there was significant reduction after yoga intervention in depression scores (BDI-II) 32.03 ± 10.65 and 18.57 ± 10.59 ($p=0.000$) and significant increase in quality of life domain 1, 21.75 ± 5.89 and 25.24 ± 3.81 ($p= 0.000$) domain 2, 19.47 ± 4.61 and 21.27 ± 3.88 ($p=0.043$), domain 3, 9.75 ± 2.63 and 11.15 ± 2.45 ($p=0.015$) and domain 4 $23.63 \pm 25.96 \pm 5.74$ ($p=0.089$). Regarding wait list control group, after the intervention programme, there was significant reduction in depression score, ($p=0.040$) and no significant increase in QOLBREF score in all four domains. Thus this study has shown that yoga practice can help in reducing depression symptoms and increased quality of life in alcohol abusers.

Mansueto Gomes-Neto (2014) conducted a study on effects of yoga on quality of life in alcohol addicts in Uganda. A meta-analysis was used to examine the effects of yoga on health-related quality of life (HRQOL) in alcohol addicts. The results suggested that yoga compared with control had a positive impact on HRQOL. The meta-analyses showed significant improvement in HRQOL of -12.46 (95% CI: -22.49 , -2.43 , $n = 59$) for participants in the yoga group in comparison to controls. In HRQOL, the meta-analysis showed a 24.1% increase in the yoga group. It is recognized that HRQOL is also associated with mental and physical status. Yoga is reported to improve important mental endpoints, such as anxiety and depression.

Shruti Srivastava (2013) conducted a study to measure the quality of life outcome in yoga practice of alcohol dependence. The purpose of this study was to examine the prospective change in quality of life in 56 patients aged 18-

45 years of alcohol dependence over a three months' period of yoga practice and compare it with quality of life of 150 age- and gender- matched healthy controls using WHO-Quality of life BREF. Severity of alcohol dependence and drinking parameters were assessed. Baseline domain scores of the WHO-Quality of life BREF compared with 3 months domain scores after yoga intervention were physical 21.45 ± 5.16 and 27.00 ± 3.63 , psychological 18.39 ± 4.00 and 21.34 ± 2.81 , social 9.04 ± 2.64 and 10.34 ± 1.84 , environmental 24.07 ± 4.68 and 27.25 ± 3.75 respectively. There was a significant improvement in quality of life of patients of alcohol dependence over three months' yoga practice. The physical, psychological, social, and environment domains of quality of life in alcohol dependence subjects were significantly lower before yoga initiation. The study confirms poor quality of life in patients of alcohol dependence before intervention. The regular yoga practice enables the patients achieve higher quality of life.

Abbas Rakhshani (2010) conducted a study to investigate the effects of integrated yoga on the quality of life in alcoholic dependents in Bangalore. One hundred and two alcoholic dependents between the age of 18 and 40 were randomly assigned to two groups of yoga ($n = 51$) and control ($n = 51$). Pre and post assessments were done using WHOQOL-100. The results concluded that, of the six domains of WHOQOL-100, between groups analysis showed significant improvements in the yoga group compared to the control in the physical $t = 7.64 (P = 0.001)$, psychological $t = 8.53 (P < 0.001)$, social $t = 6.87 (P = 0.003)$, and environmental domains $t = 7.54 (P = 0.001)$. The integrated yoga is an efficacious means of improving the quality of life in alcoholic dependents.

Harner et.al (2010) conducted a study to assess the effects of a twice-weekly Iyengar group yoga instruction on depression among alcohol addicts at eastern United States. The repeated-measures design was selected. Assessment used the Beck Depression Inventory (BDI-II) was administered at baseline and

during the treatment in Weeks 4, 8, and 12. The 12-week yoga intervention comprised two-hour Iyengar yoga classes held twice each week, for a total of 24 classes. The study's report showed a steady decline in unadjusted mean values for depression—from 24.90 to 7.33. BDI score decreased linearly and significantly throughout the intervention period ($p < .001$).

Uebelacker et.al., (2010) conducted a study on effects of yoga interventions in depression among alcoholic dependents in Rhode Island. The design used was mixed-methods, non controlled, open trial design. Participants were encouraged to attend the 12 beginning-level classes within an 8-week period. Depression severity was assessed pre- and post-intervention with the Quick Inventory of Depression Symptoms-Clinician Rating (QIDS). Also, a self-reporting tool for assessing depression—the Patient Health Questionnaire-9 (PHQ-9)—was administered at the four time points of 2, 4, 6, and 8 weeks. The post yoga intervention test scores reflected statistically significant improvements with both QIDS ratings ($t = 4.36$, $p < .01$, Cohen's $d = 1.35$) and PHQ-9 score ($t = 3.28$, $p < .05$, Cohen's $d = 0.80$).

Woolery A (2009) conducted a study to determine the short-term effect of yoga on mood in mildly depressed alcohol dependent patients in Jordan. Twenty-eight 18-40 year olds with mild depression were randomly assigned to an intervention group or a wait-list control group. The intervention group participated in a 5-week yoga program of two 1-hour classes per week. Measurements of depression and anxiety levels were made using the Beck Depression Inventory (BDI), and Profile of Mood States (POMS) survey instruments before classes began, midway through the program and at the program's completion. The study results revealed that Paired t-tests conducted for each group showed that, in YG participants, depression decreased from baseline to the end of the study (mean BDI scores decreased from 12.77 to 3.90; $p < .001$); depression did not change in the WCG participants during this

period ($p = .45$). The ANOVA found that reduction of depression was greater in the YG participants than in the WCG participants.

Chen K M (2008) conducted a study to test the effects of six months of silver yoga exercises in promoting the mental health of alcohol dependents in de-addiction centers in southern Taiwan, especially among the indicators of depression, and self-perception of health status. A cluster randomized trial was conducted in eight de-addiction centers; Participants were randomly assigned into either the experimental ($n = 62$) or the control ($n = 66$) group based on their attendance at selected de-addiction centers. A 70-minute silver yoga exercise program was implemented three times per week for six months as the intervention for the participants in the experimental group. Data were collected at baseline, three months, and six months. A mixed-design two-way ANOVA found that the variables Time and Group had interaction effects in the total score ($p = .001$), physical health perception ($p < .001$), mental health perception ($p < .001$), and depression state ($p < .001$). Analyses of the data showed that with the exception of sleep latency, all variables showed significant changes. The mean depression state decreased ($p < .001$); the WCG's mean depression state changed significantly depression worsened, $F = 5.13$ ($p = .010$).

CHAPTER III

RESEARCH METHODOLOGY

Research methodology includes research approach, research design, setting of the study, population, sample, criteria for sample selection, sample size, sampling technique, description of the instruments, scoring procedures and interpretation, data collection and plan for data analysis.

RESEARCH APPROACH

An evaluative approach was used to conduct the study.

RESEARCH DESIGN

The research design selected for this study was quasi experimental non-equivalent control group pretest posttest design.

SCHEMATIC PRESENTATION

GROUP	PRE-TEST	INTERVENTION	POST-TEST
Experimental group	O ₁	X	O ₂
Control group	O ₁	–	O ₂

- O₁ - Pretest to assess the level of depression and quality of life among alcohol dependents in experimental and control group.
- X - Intervention of yoga among alcohol dependents in experimental group.
- O₂ – Posttest to assess the level of depression and quality of life among alcohol dependents in experimental and control group.

SETTING OF THE STUDY

The study was conducted in Athma De-addiction centre, Trichy. Athma Institute of Mental Health and Social Sciences (AIMSS) is a licensed psychiatric hospital under the Mental Health act of 1987. It is one of the biggest NGO for psychiatric care in Tamil Nadu. It is a modernized fully equipped setting with 75 beds out of which 5 is for emergency triaging. It is also equipped with 24 hours crisis intervention and suicide prevention centre, apart from, vocational counseling, family and marital counseling centre with updated psychometric assessment tools in par with international standards. It also has a library with more than 2000 books and journals. It has a half way home with sheltered workshop, with 150 bedded capacity, special school for mentally challenged children and de-addiction centre. The average number of patients in In-Patient unit- 150 per month and in average of 250 per month in half way home with sheltered workshop.

Athma de-addiction centre is a 30 bedded residential setting with an expert mental health team, with adequate facilities along with a planned treatment schedule. The treatment takes about 30-40 days. The alcohol detoxification is done by administering drugs followed by individual counseling, family counseling, alcohol anonymous meeting every week, daily classes regarding complications of alcohol consumption and addiction, motivation therapy, Cue Exposure Therapy (CET), administration of T. Disulfiram on 25th day with counseling and signing in consent form, relaxation and recreation therapies. Average annual statistics of the de-addiction centre is of 420 clients per year.

POPULATION

The target population selected for the study was alcohol dependents.

SAMPLE

The samples were admitted in Athma De-addiction Centre, Trichy.

CRITERIA FOR SAMPLE SELECTION

INCLUSION CRITERIA

- 1) Admitted in the In-Patient setting for 5 weeks.
- 2) Age group of 18-45 years.
- 3) Only male.
- 4) Able to understand Tamil.
- 5) Willing to participate.

EXCLUSION CRITERIA

- 1) Clients with psychotic symptoms.
- 2) Poly substance abuse.
- 3) Physically challenged.

SAMPLE SIZE

The sample size for the study was 60 alcohol dependents, out of which, 30 were in experimental group and 30 were in control group, who met the inclusion criteria.

SAMPLE TECHNIQUE

Non probability Convenience sampling technique was used to select the samples for the study.

DESCRIPTION OF THE INSTRUMENTS

The instruments consists of 3 parts,

Part I

It consists of demographic variables such as age, religion, education, occupation, marital status, monthly income, type of the family, area of residence, duration of alcohol consumption, nature of admission and history of previous de-addiction treatment.

Part II

Beck Depression Inventory scale was used to assess the level of depression. The tool was adopted from Aaron T Beck (1996). It consists of 21 items among where 19 questions have 4 options and rated as 0,1,2,3, whereas 2 questions (no.16 & 18) have 7 options, which also rated as 0,1,2,3. The total score is 63.

Part III

WHO- Quality of life 26 BREF scale was used to assess the level of quality of life. The WHOQOL-BREF field version was developed to provide a quality of life assessment that looks at five domains – overall quality of life and general health, physical health, psychological, social relationship and environment. It consists of 26 questions to provide a broad and comprehensive assessment with 5- point rating scale. The 26 questions were divided as follows,

- ✓ Overall quality of life and general health- 2 ($Q_1 + Q_2$)
- ✓ Physical domain- 7 ($Q_3+Q_4+Q_{10}+Q_{15}+Q_{16}+Q_{17}+Q_{18}$)
- ✓ Psychological domain- 6 ($Q_5+Q_6+Q_7+Q_{11}+Q_{19}+Q_{26}$)
- ✓ Social domain- 3 ($Q_{20}+Q_{21}+Q_{22}$)
- ✓ Environmental domain- 8 ($Q_8+Q_9+Q_{12}+Q_{13}+Q_{14}+Q_{23}+Q_{24}+Q_{25}$)

SCORING PROCEDURE AND INTERPRETATION

Part II – Beck Depression Inventory scale (BDI –II)

The highest possible score of the scale is 63. The scores are interpreted as follows,

LEVEL OF DEPRESSION	SCORES	PERCENTAGE
Minimal depression	0-13	21%
Mild depression	14-19	30%
Moderate depression	20-28	45%
Severe depression	29-63	100%

Part III – WHOQOL- 26 BREF SCALE

The total score for each domain are, overall quality of life and general health= 10, physical domain= 35, psychological domain= 30, social domain= 15, environmental domain= 40. The scores are interpreted as follows:

Level of quality of life	Scores				
	Overall quality of life and general health	Physical domain	Psychological domain	Social domain	Environmental domain
Dissatisfied	2-4	7-16	6-14	3-7	8-18
Satisfied	5-7	17-26	15-22	8-11	19-29
Highly satisfied	8-10	27-35	23-30	12-15	30-40

Among which 3 items (no. 3, 4, 26) have reverse scoring.

VALIDITY:

The validity of the tool was obtained from three nursing experts in the field of psychiatric nursing, one psychiatrist, and one psychologist.

RELIABILITY:

The Beck depression inventory scale (BDI- II) and Quality of life- 26 BREF scale adopted from WHO were translated into Tamil language which was assessed for its stability and internal consistency.

Stability was assessed by test retest method using Karl Pearson's co-efficient formula. The r value for Beck depression inventory scale was $r = 0.905$ and the r value for Quality of life- 26 BREF scale was $r = 0.92$.

Internal consistency was assessed by split half method using Spearman Brown formula. The r value for Beck depression inventory scale was $r= 0.891$ and the r value for Quality of life- 26 BREF scale was $r= 0.946$.

PILOT STUDY:

Pilot study was conducted in Athma De-Addiction centre, Trichy. The investigator obtained permission from the Head of the institution. The purpose of the study was explained to the participants and obtained oral consent. The study was conducted for a period of 4 weeks. A total of 12 participants were selected for the study (Experimental group – 6, Control group – 6) were taken for the pilot study by using convenience sampling technique. On the first day pretest was done to assess the level of depression and quality of life using Beck Depression Inventory Scale and WHO quality of life- 26 BREF scale for both experimental and control group respectively. Yoga was taught to the participants in experimental group using LCD projector which lasted for 45 minutes. From the 2nd day, the experimental group participants were made to practice the yoga under the supervision of the investigator in the morning for 28 days. Each session lasted for 1 hour and 10 minutes. Posttest was conducted after 28 days, for both experimental and control group using the same questionnaire.

Data were analyzed by using descriptive and inferential statistics and the findings of the pilot study revealed that, in experimental group, the mean pretest and posttest level of depression were 20.333 (SD \pm 13.095) and 7.0 (SD \pm 5.138) respectively.

In control group, the mean pretest and posttest level of depression were 13.8 (SD \pm 8.843) and 10.333 (SD \pm 5.201). The mean posttest level of depression was lower in experimental group than the mean posttest level of depression in control group among alcohol dependents.

In experimental group, the paired 't' test results revealed that there was a significant difference between the pretest and posttest level of depression among alcohol dependents $t = 3.291$ (table value = 2.57) at ($p < 0.05$) level of significance.

The independent 't' test results revealed that there was no significant difference between the posttest level of depression among alcohol dependents in experimental and control group $t = 1.119$ (table value = 2.78) at ($p < 0.05$) level of significance.

In experimental group, the mean pretest level of quality of life was 6.166 (SD \pm 0.983) for overall quality of life and general health, 24.5 (SD \pm 6.774) for physical domain, 21.166 (SD \pm 6.615) for psychological domain, 9.666 (SD \pm 2.580) for social domain, and 28.833 (SD \pm 4.214) for environmental domain. The mean posttest level of quality of life was 8.5 (SD \pm 1.048) for overall quality of life and general health, 28.666 (SD \pm 4.989) for physical domain, 23.833 (SD \pm 2.785) for psychological domain, 11.333 (SD \pm 2.253) for social domain, and 32.666 (SD \pm 2.336) for environmental domain.

In control group, the mean pretest level of quality of life was 7.333 (SD \pm 1.751) for overall quality of life and general health, 24.833 (SD \pm 7.304) for physical domain, 20.5 (SD \pm 5.394) for psychological domain, 11.0 (SD \pm 3.162) for social domain and 26.833 (SD \pm 6.046) for environmental domain. The mean posttest level of quality of life was 8.666 (SD \pm 1.216) for overall quality of life and general health, 28.0 (SD \pm 5.761) for physical domain, 24.0 (SD \pm 4.427) for psychological domain, 10.666 (SD \pm 3.443) for social domain and 30.166 (SD \pm 6.337) for environmental domain. The mean posttest level of quality of life was lower in experimental group than the mean posttest level of quality of life in control group except for psychological and environmental domain among alcohol dependents.

In experimental group, the paired 't' test results revealed that there was a significant difference between pretest and posttest level of quality of life $t = 2.912$ for overall quality of life and general health among alcohol dependents (table value = 2.57) at ($p < 0.05$) level of significance. There was no significant difference between the pretest and posttest level of quality of life, $t = 1.400$ for physical domain, $t = 1.149$ for psychological domain, $t = 0.718$ for social domain, $t = 2.455$ for environmental domain among alcohol dependents (table value = 2.57) at ($p < 0.05$) level of significance.

The independent 't' test results revealed that there was no significant difference between the posttest level of quality of life among alcohol dependents in experimental and control group. The results revealed that, $t = 2.631$ for overall quality of life and general health, $t = 0.578$ for physical domain, $t = 0.714$ for psychological domain, $t = 1.123$ for social domain and $t = 2.189$ for environmental domain (table value = 2.78) at ($p < 0.05$) level of significance.

The pilot study revealed that the study was feasible and practicable to conduct main study.

DATA COLLECTION PROCEDURE:

The main study was conducted in Athma De-addiction centre, Trichy. Data collection was done for a period of 8 weeks. The investigator obtained written permission from the Head of the institution and oral consent from the participants prior to the study. The purpose of the study was explained to the participants. A total of 60 participants were selected using convenience sampling technique, out of which 30 were in experimental group and 30 were in control group. On the 1st week, 15 samples were selected under experimental group and pretest was conducted on the first day using Beck Depression Inventory scale to assess the level of depression and Quality of life- 26 BREF scale adopted from WHO, to assess the quality of life among alcohol dependents. The pretest was conducted for 30 minutes. Self administered questionnaires were given individually. After which yoga was taught to the

experimental group, fifteen in a group, using LCD projector which lasted for 45 minutes. From the 2nd day, the participants in experimental group were made to practice the yoga under the supervision of the investigator in the morning for 1 hour 10 minutes for 28 days. On the 2nd week, next 15 samples were selected under experimental group and the same procedure was continued. On 5th and 6th week, posttest was conducted for the experimental group. On 3rd week, 15 samples were selected in control group and pretest was conducted. On the 4th week, next 15 samples were selected under control group and the pretest was conducted. The control group participants received the routine hospital treatment. On 7th and 8th week, posttest was conducted for the control group. The collected data were analyzed using descriptive and inferential statistics.

PLAN FOR DATA ANALYSIS

The data was analyzed using descriptive and inferential statistics as follows,

S.NO	DATA ANALYSIS	METHODS	PURPOSE
1	Descriptive statistics	Frequency, percentage Mean, standard deviation	To describe the demographic variables of the alcohol dependents. To assess the pretest and posttest level of depression among alcohol dependents in experimental and control group. To assess the pretest and posttest level of quality of life among alcohol dependents in experimental and control group.
2	Inferential statistics	Paired 't' test	To compare the pretest and posttest level of depression among alcohol dependents in experimental group.

S.NO	DATA ANALYSIS	METHODS	PURPOSE
			To compare the pretest and posttest level of quality of life among alcohol dependents in experimental group.
		Independent't' test	To compare the posttest level of depression among alcohol dependents between experimental and control group. To compare the posttest level of quality of life among alcohol dependents between experimental and control group.
		Karl pearson's correlation	To find the correlation between posttest level of depression and quality of life among alcohol dependents in experimental group.
		Chi-square test	To find the association between posttest level of depression and their demographic variables in experimental group. To find the association between posttest level of quality of life and their demographic variables in experimental group.

PROTECTION OF HUMAN SUBJECTS

The study was approved by the ethical committee prior to the conduct of the pilot and main study. A written permission was obtained from the head of the institutions of Athma de-addiction center, Trichy and oral consent was obtained from each participant by explaining the purpose of the study before the data collection. Confidentiality of the information was maintained throughout the study.

CHAPTER IV

DATA ANALYSIS AND INTERPRETATION

This chapter deals with the description of sample characteristics, analysis and interpretation of the data collected to assess the effectiveness of yoga on depression and quality of life among alcohol dependents in Athma De-addiction centre at Trichy.

The data were collected from 60 alcohol dependents in Athma De-Addiction Centre, Trichy. The data were analyzed and presented under the following headings.

ORGANIZATION OF THE DATA

Section A: Distribution of demographic variables among alcohol dependents in experimental and control group.

Section B: Pretest and posttest level of depression among alcohol dependents in experimental and control group.

Section C: Pretest and posttest level of quality of life among alcohol dependents in experimental and control group.

Section D: Comparison between the pretest and posttest level of depression among alcohol dependents in experimental group.

Section E: Comparison between the pretest and posttest level of quality of life among alcohol dependents in experimental group.

Section F: Comparison between the posttest level of depression among alcohol dependents in experimental and control group.

Section G: Comparison between the posttest level of quality of life among alcohol dependents in experimental and control group.

Section H: Correlation between the posttest level of depression and quality of life among alcohol dependents in experimental group.

Section I: Association between the posttest level of depression among alcohol dependents and their demographic variables in experimental group.

Section J: Association between the posttest level of quality of life among alcohol dependents and their demographic variables in experimental group.

SECTION A: DISTRIBUTION OF DEMOGRAPHIC VARIABLES OF ALCOHOL DEPENDENTS IN EXPERIMENTAL AND CONTROL GROUP.

Table 1. Frequency and percentage distribution of demographic variables of alcohol dependents in experimental and control group.

n₁= 30, n₂= 30

S. NO	DEMOGRAPHIC VARIABLES	EXPERIMENTAL GROUP		CONTROL GROUP	
		f	%	f	%
1	Age in years				
	a. 18- 25 years	2	7	0	0
	b. 26- 35 years	10	33	13	43
	c. 36- 45 years	18	60	17	57
2	Religion				
	a. Hindu	25	84	24	80
	b. Christian	4	13	4	13
	c. Muslim	1	3	2	7
3	Education				
	a. Primary school education	11	37	7	23
	b. Higher secondary school education	12	40	11	37
	c. Degree holder	7	23	11	37
	d. No formal education	0	0	1	3
4	Occupation				
	a. Private employee	4	13	7	23
	b. Government employee	6	20	5	17
	c. Self- employee	18	60	18	60
	d. Unemployed	2	7	0	0

S. NO	DEMOGRAPHIC VARIABLES	EXPERIMENTAL GROUP		CONTROL GROUP	
		f	%	f	%
5	Marital status				
	a. Unmarried	8	27	6	20
	b. Married	22	73	24	80
	c. Divorced	0	0	0	0
	d. Widower	0	0	0	0
6	Monthly income				
	a. < Rs.5000 /-	7	23	8	27
	b. Rs.5000-15000 /-	21	70	13	43
	c. > Rs.15000 /-	2	7	9	30
7	Type of the family				
	a. Nuclear family	18	60	13	43
	b. Joint family	11	37	16	54
	c. Extended family	1	3	1	3
8	Area of residence				
	a. Urban	10	33	9	30
	b. Rural	14	47	12	40
	c. Semi- urban	6	20	9	30
9	Duration of alcohol consumption				
	a. < 5 years	13	43	15	50
	b. 5- 15 years	12	40	13	43
	c. > 15 years	5	17	2	7
10	Nature of admission				
	a. Voluntary admission	19	63	22	73
	b. Involuntary admission	11	37	8	27

S. NO	DEMOGRAPHIC VARIABLES	EXPERIMENTAL GROUP		CONTROL GROUP	
		f	%	f	%
11	History of previous de-addiction treatment				
	a. Yes	14	47	12	40
	b. No	16	53	18	60

Table 1 depicts the distribution of demographic variables of alcoholic dependent clients.

Regarding age, in experimental group, majority 18(60%) belonged to 36- 45 years of age, 10(33%) belonged to 26- 35 years of age, and 2(7%) belonged to 18- 25 years. In control group, majority 17(57%) belonged to 36-45 years and 13(43%) belonged to 26- 35 years. (**Fig. 2**)

Regarding religion, in experimental group, majority 25(84%) were Hindus, 4(13%) were Christians, and 1(3%) were Muslims. In control group, majority 24(80%) were Hindus, 4(13%) were Christians and 2(7%) were Muslims. (**Fig. 3**)

Regarding education, in experimental group, majority 12(40%) had higher secondary school education, 11(37%) had primary school education and 7(23%) were degree holders. In control group, majority 11(37%) had higher secondary school education, 11(37%) were degree holder, 7(23%) had primary school education and 1(3%) do not have formal education. (**Fig. 4**)

Regarding occupation, in experimental group, majority 18(60%) were self employees, 6(20%) were government employees, 4(13%) were private employees and 2(7%) were unemployed. In control group, majority 18(60%)

were self employees, 7(23%) were private employees and 5 (17%) were government employees. **(Fig. 5)**

Regarding marital status, in experimental group, majority 22(73%) were married and 8(27%) were unmarried. In control group, majority 24(80%) were married and 6(20%) were unmarried. **(Fig. 6)**

Regarding monthly income, in experimental group, majority 21(70%) of the group had Rs.5000 – 15000/- , 7(23%) of the group had < Rs.5000/- and 2(7%) of the group had > Rs. 15000/-. In control group, majority 13(43%) of the group had Rs. 5000- 15000/-, 9(30%) of the group had > Rs.15000/- and 8(27%) of the group had < Rs.5000/-. **(Fig. 7)**

Regarding type of the family, in experimental group, majority 18(60%) belonged to nuclear family, 11(37%) belonged to joint family and 1(3%) belonged to extended family. In control group, majority 16(54%) belonged to joint family, 13(43%) belonged to nuclear family and 1(3%) belonged to extended family. **(Fig. 8)**

Regarding area of residence, in experimental group, majority 14(47%) were from rural area, 10(33%) were from urban area and 6(20%) were from semi-urban area. In control group, majority 12(40%) were from rural area, 9(30%) were from urban area and 9(30%) were from semi-urban area. **(Fig. 9)**

Regarding duration of alcohol consumption, in experimental group, majority 13(43%) were consuming alcohol for < 5 years, 12(40%) were consuming alcohol for 5- 15 years and 5(17%) were consuming alcohol for > 15 years. In control group, majority 15(50%) were consuming alcohol for <5 years, 13(43%) were consuming alcohol for 5- 15 years and 2(7%) were consuming alcohol for >15 years. **(Fig. 10)**

Regarding nature of admission, in experimental group, majority 19(63%) had voluntary admission and 11(37%) had involuntary admission. In control group, majority 22(73%) had voluntary admission and 8(27%) had involuntary admission. **(Fig. 11)**

Regarding history of previous de-addiction treatment, in experimental group, majority 16(53%) did not undergo any de-addiction treatment whereas 14(47%) had past de-addiction treatment. In control group, majority 18(60%) did not undergo any de-addiction treatment whereas 12(40%) had past de-addiction treatment. **(Fig. 12)**

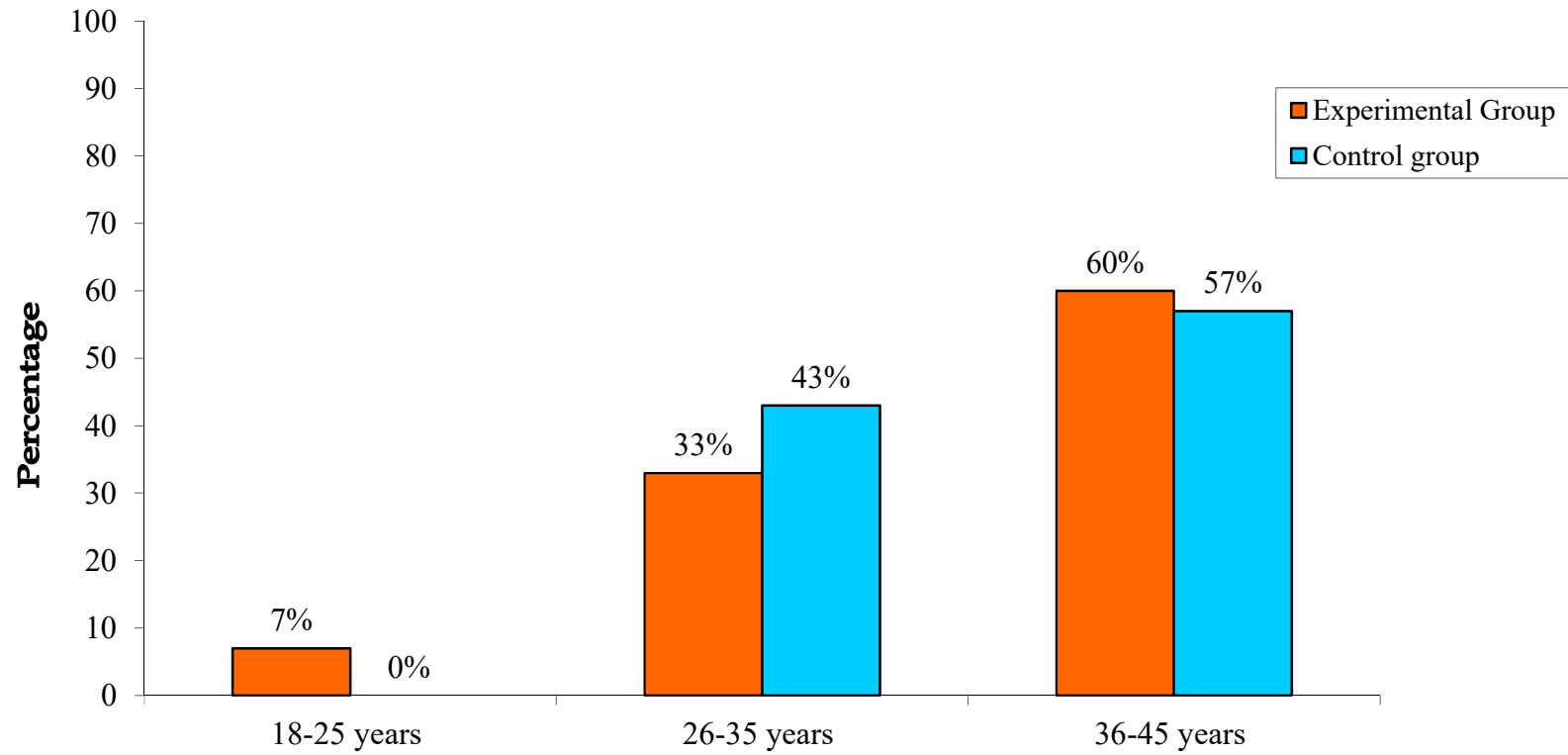


Fig 2 : Percentage distribution of Alcohol dependents according to their age in years in experimental and control group

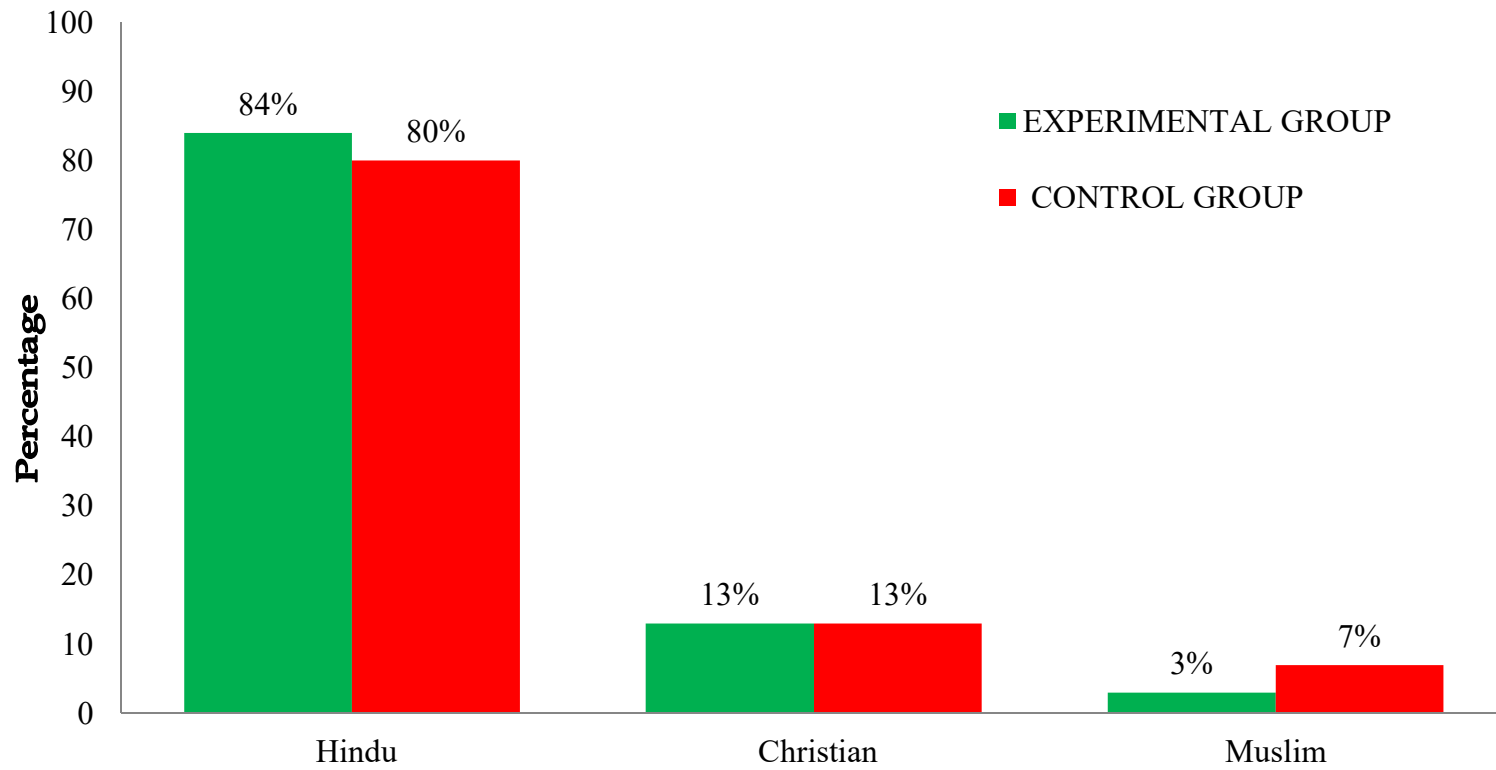


Fig 3 : Percentage distribution of Alcohol dependents according to their religion in experimental and control group

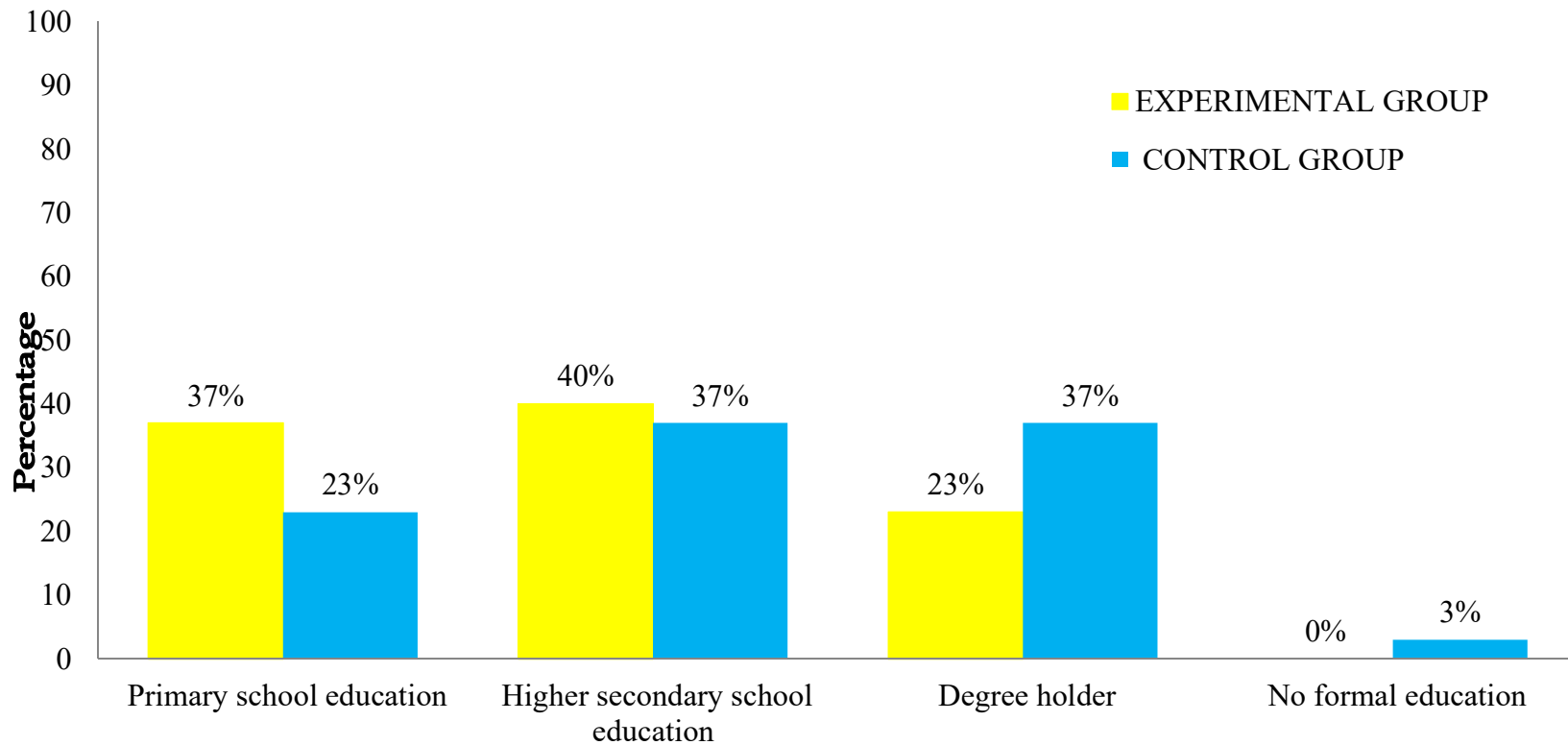


Fig 4 : Percentage distribution of Alcohol dependents according to their education in experimental and control group

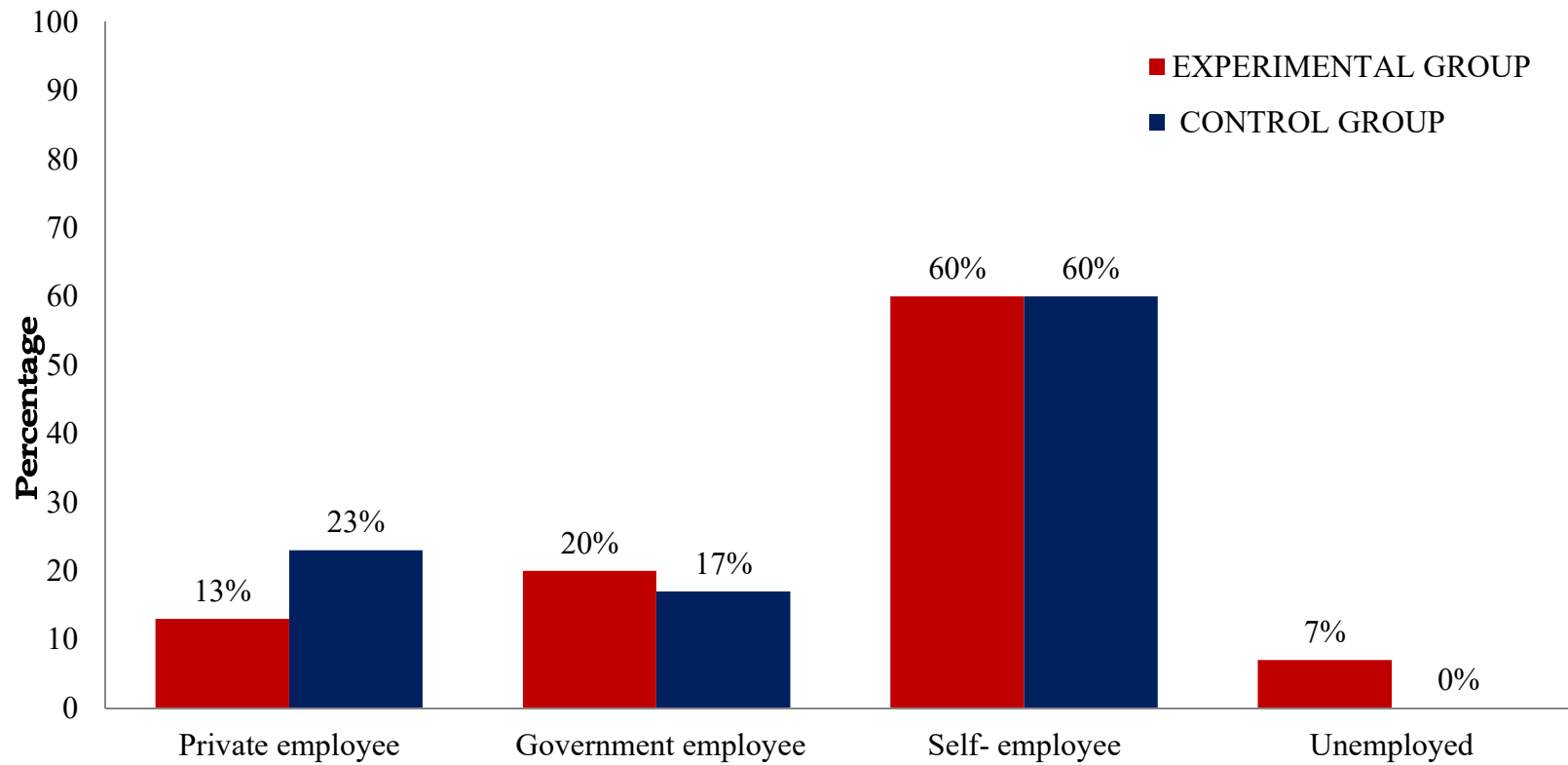


Fig 5 : Percentage distribution of Alcohol dependents according to their occupation in experimental and control group

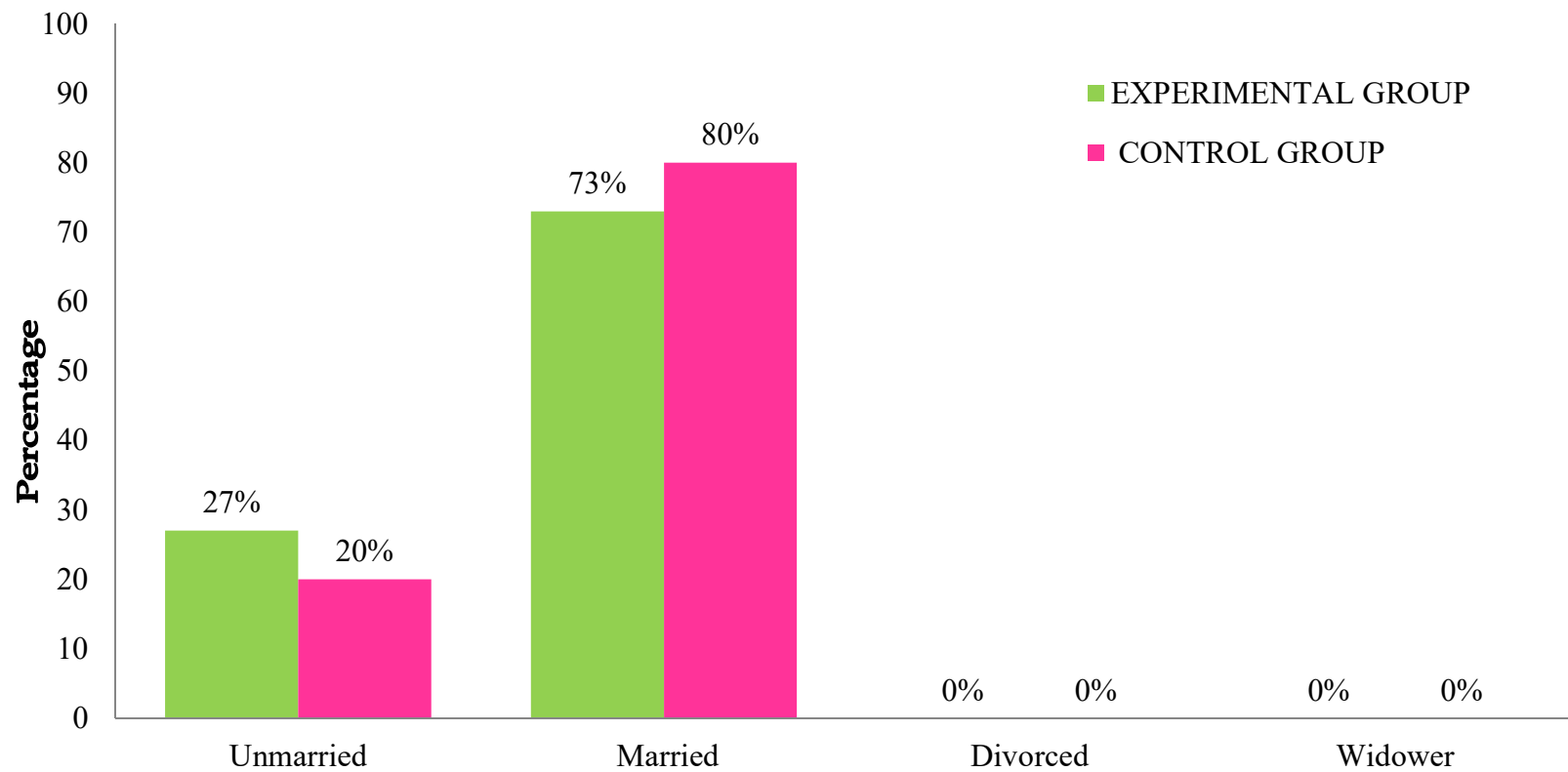


Fig 6 : Percentage distribution of Alcohol dependents according to their marital status in experimental and control group

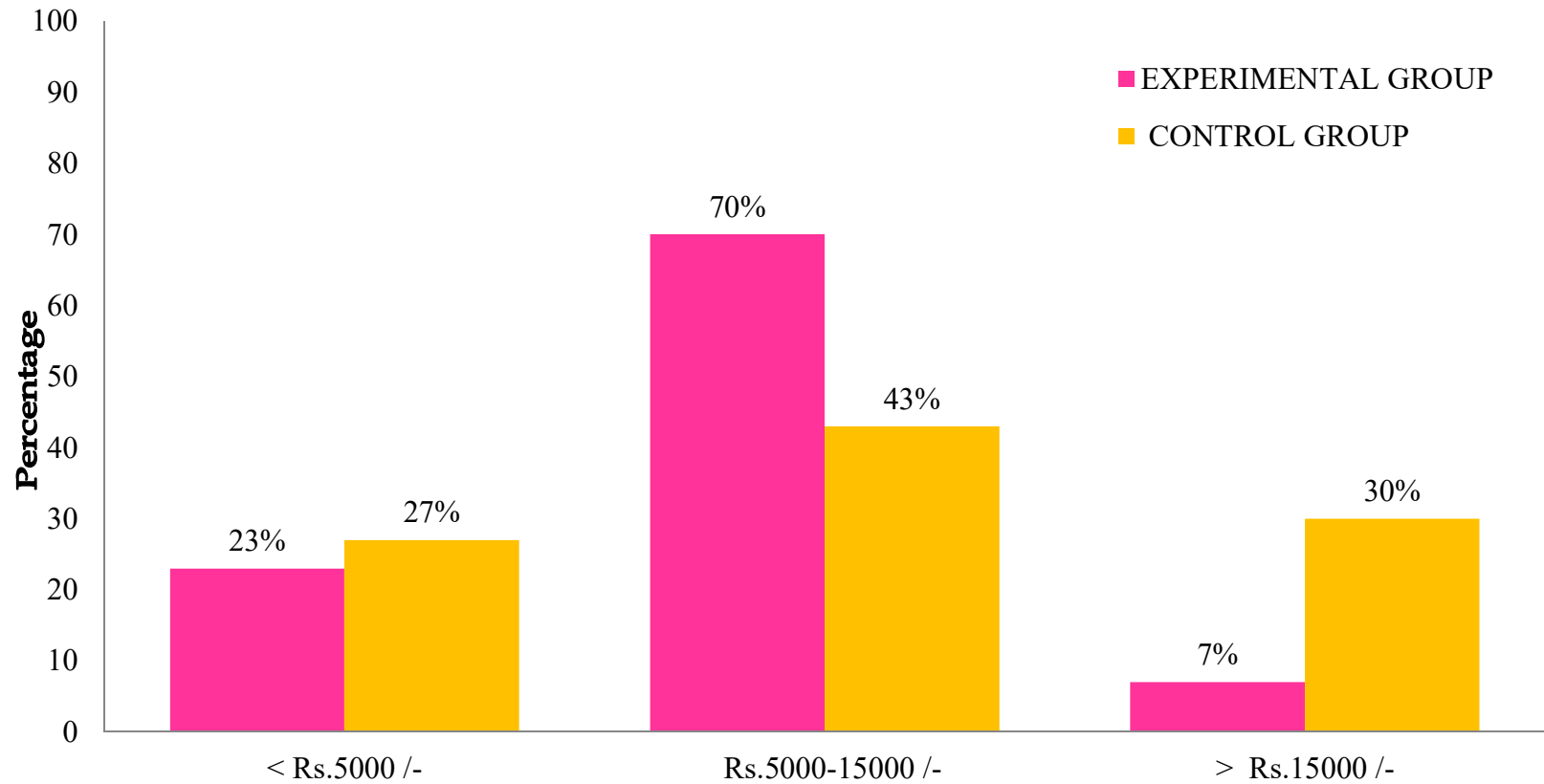


Fig 7 : Percentage distribution of Alcohol dependents according to their monthly income in experimental and control group

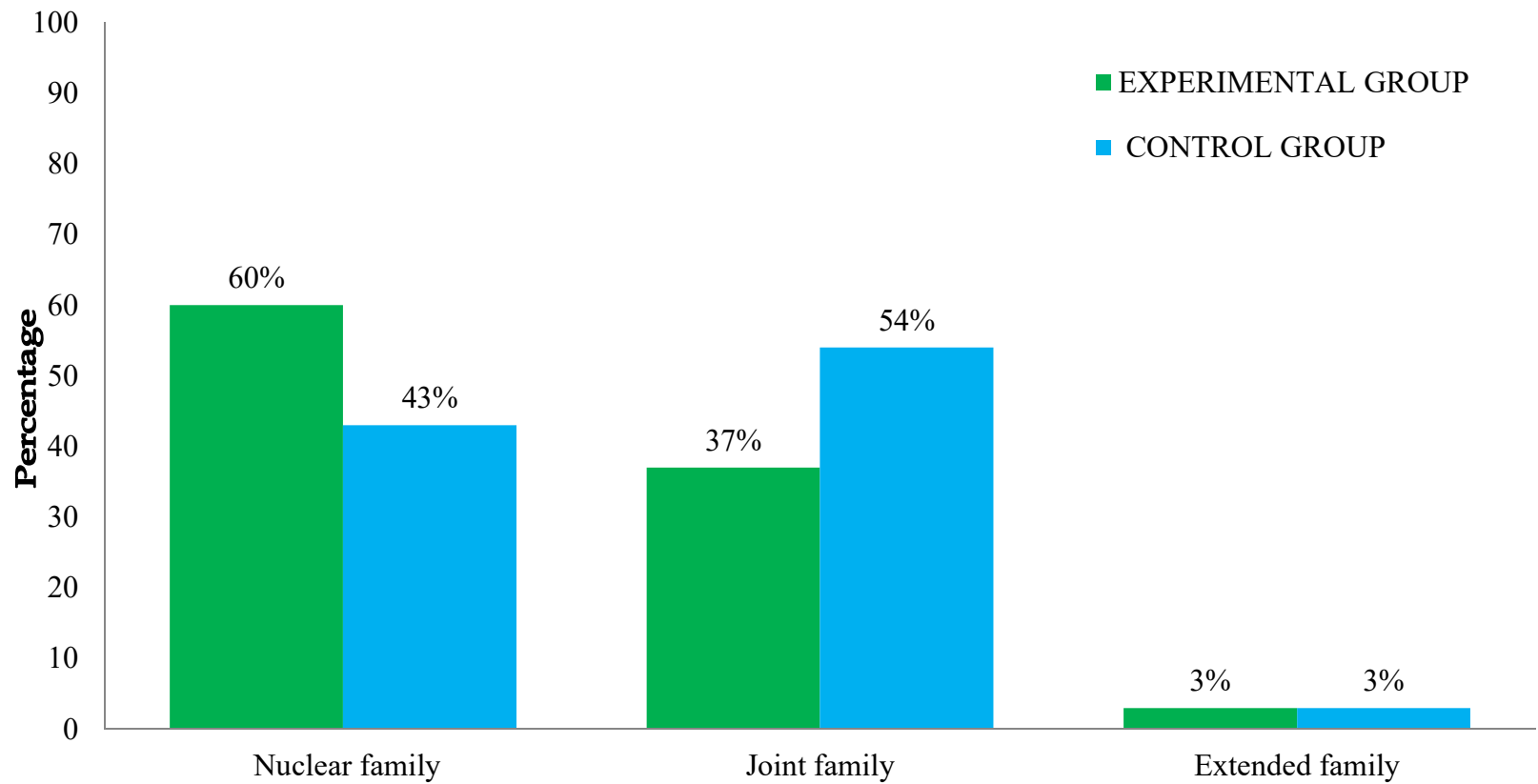


Fig 8 : Percentage distribution of Alcohol dependents according to their type of family in experimental and control group

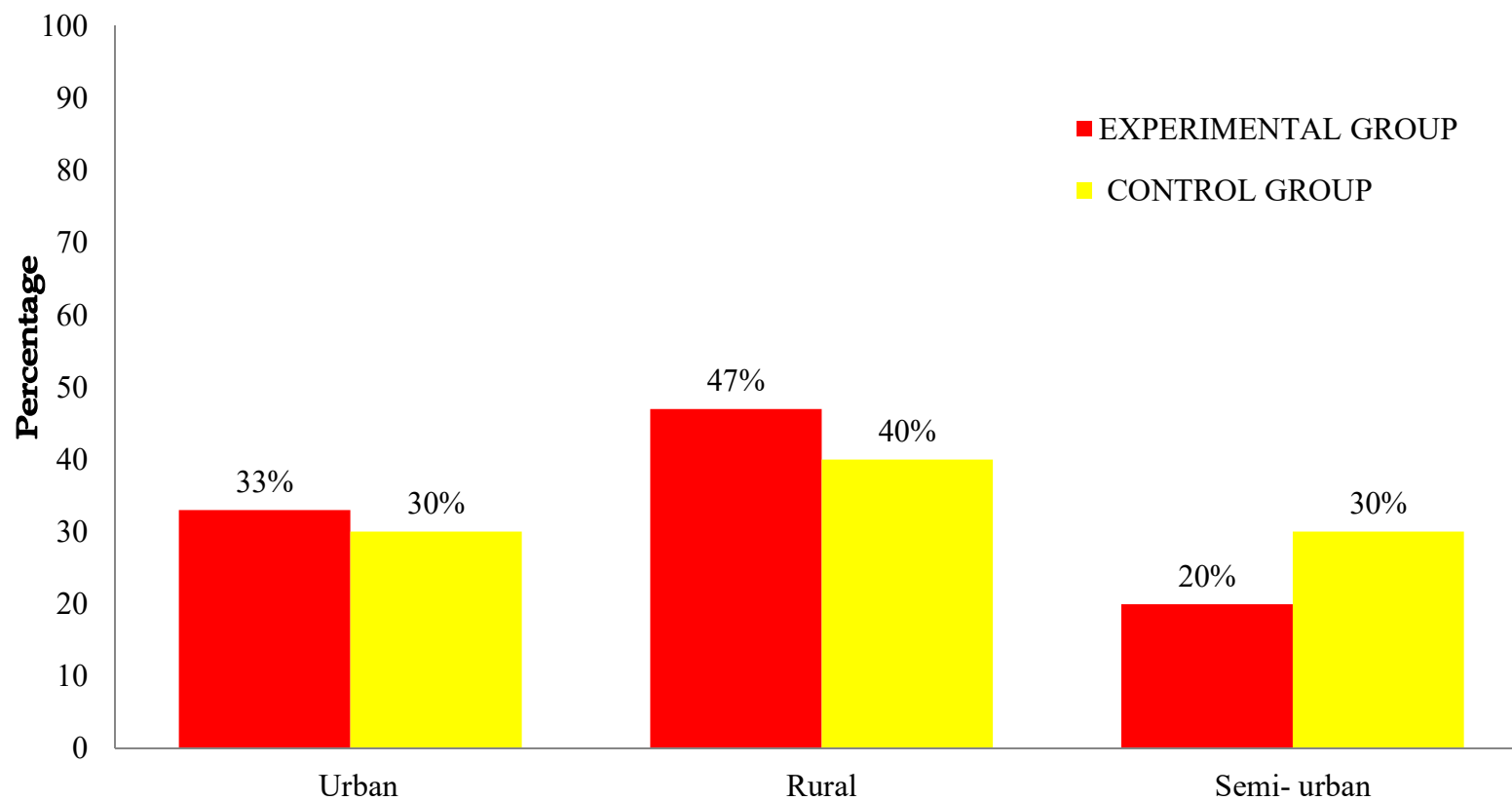


Fig 9 : Percentage distribution of Alcohol dependents according to their area of residence in experimental and control group

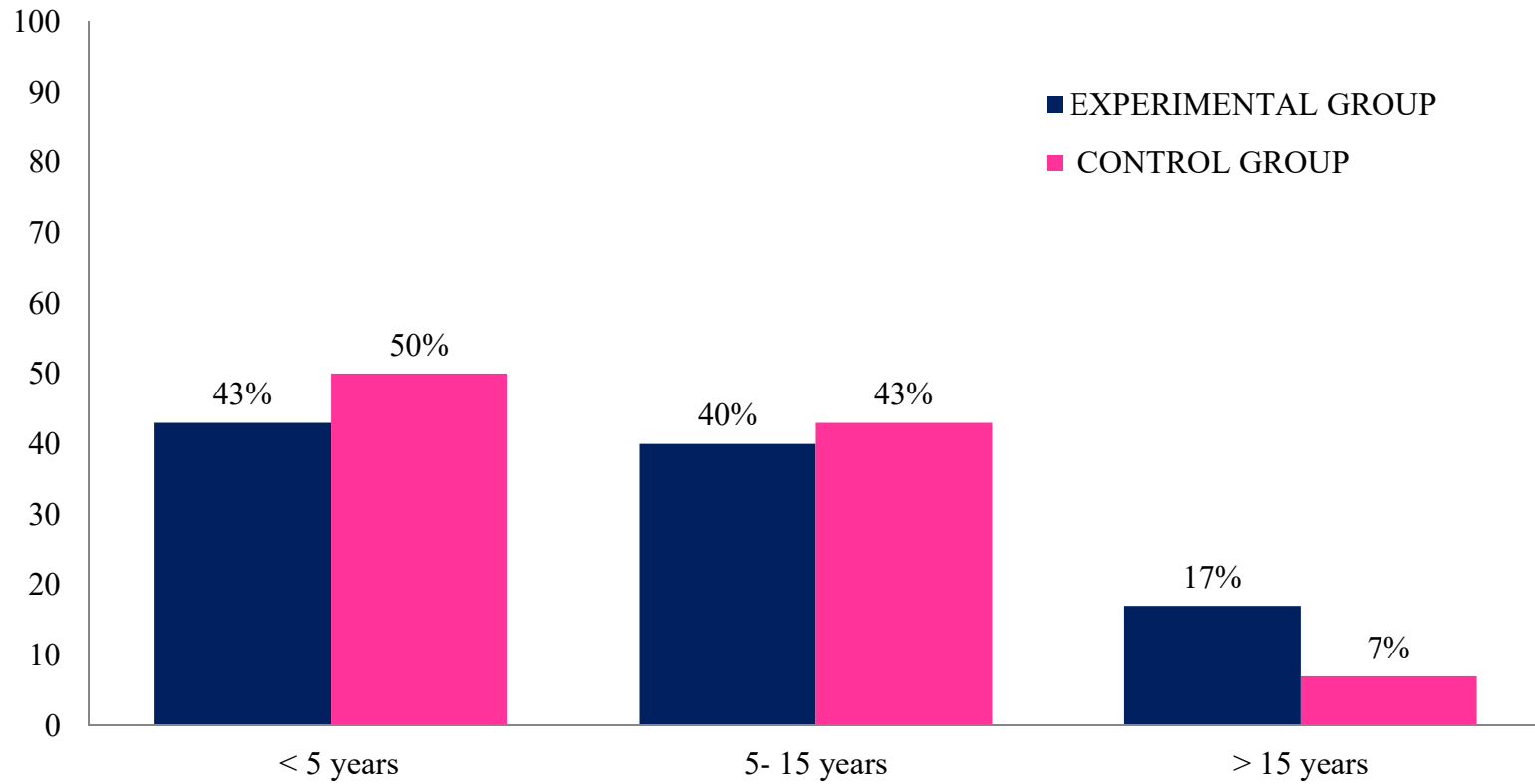


Fig 10 : Percentage distribution of Alcohol dependents according to their duration of alcohol consumption in experimental and control group

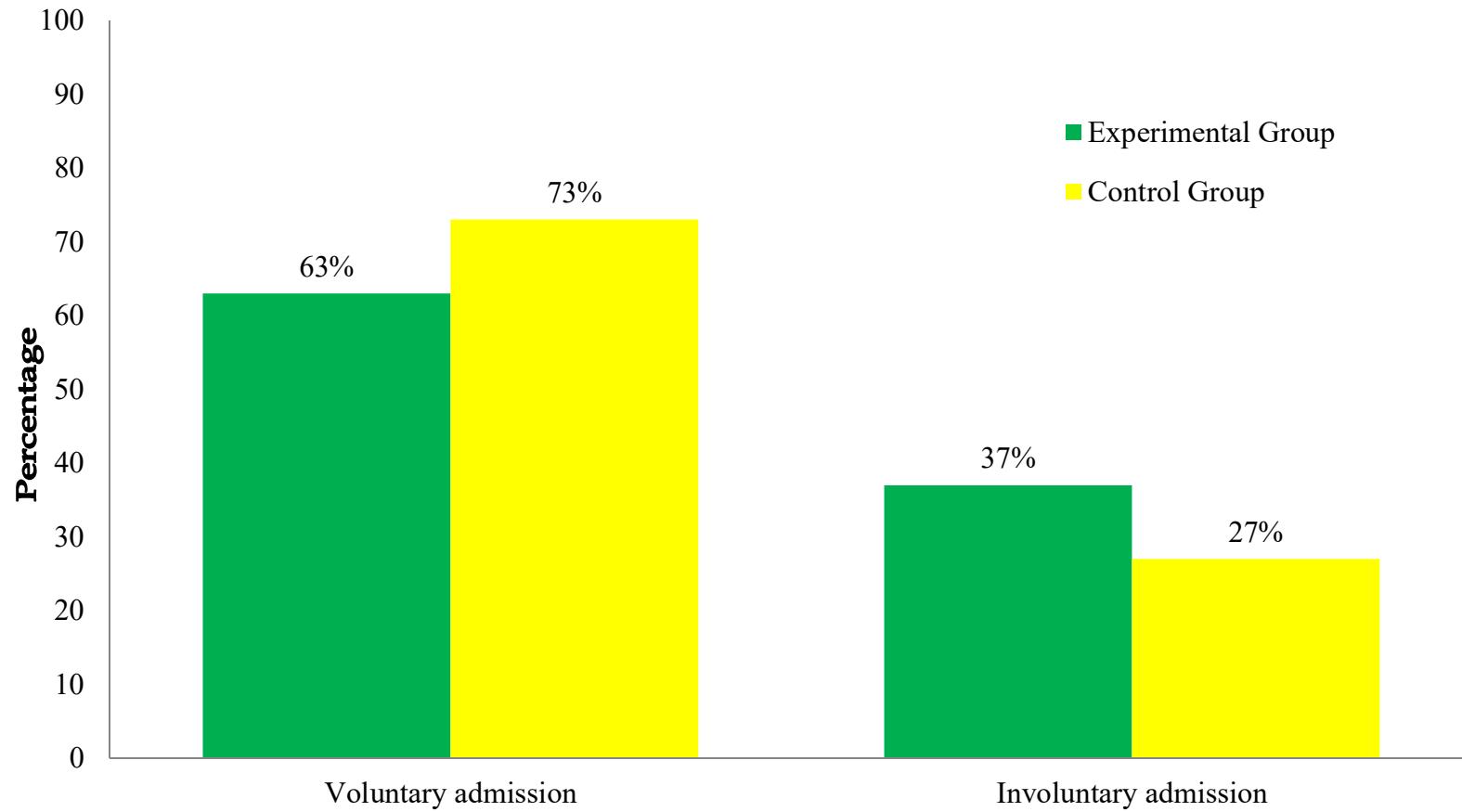


Fig 11 : Percentage distribution of Alcohol dependents according to their nature of admission in experimental and control group

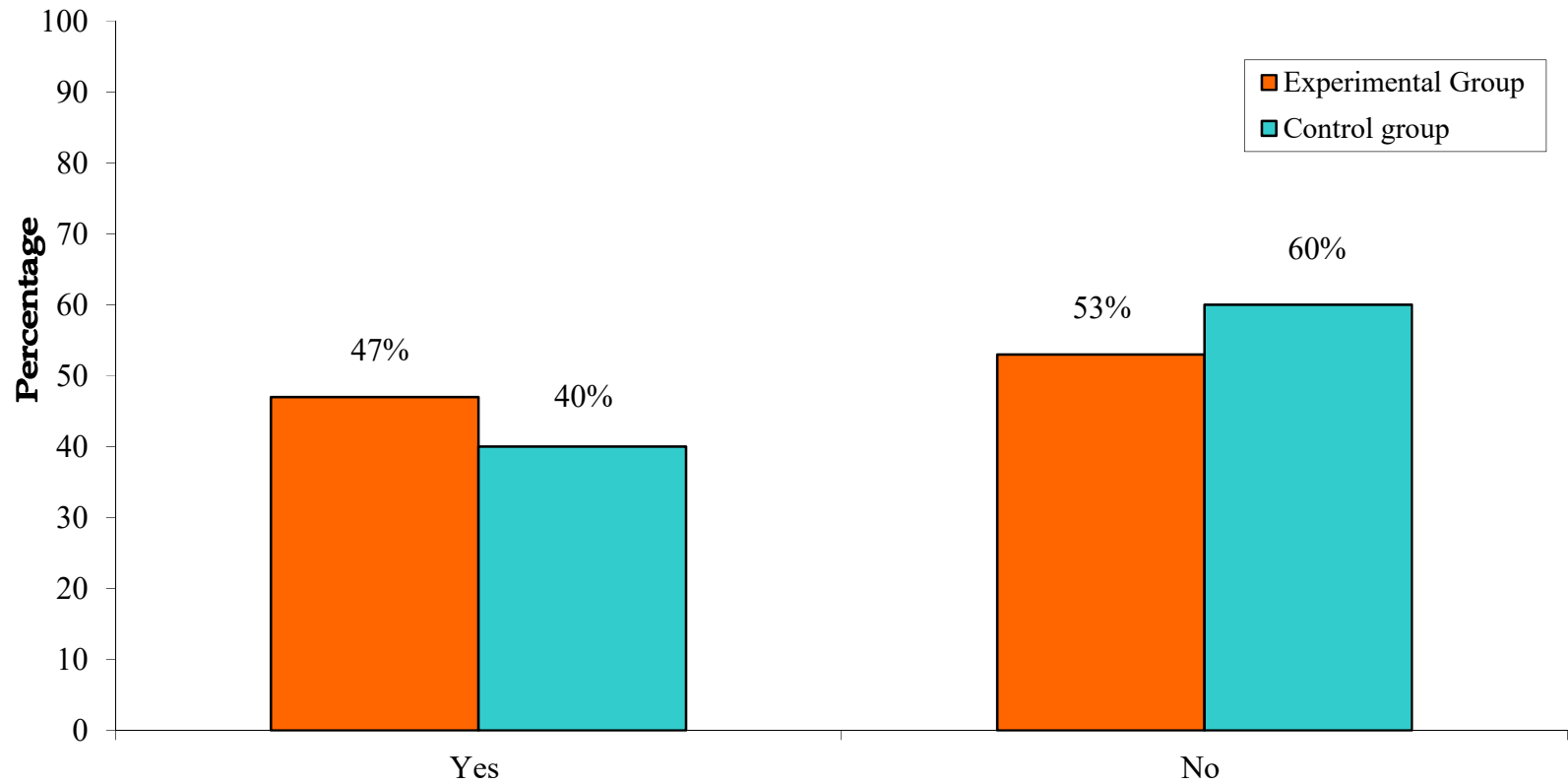


Fig 12 : Percentage distribution of Alcohol dependents according to their history of previous de-addiction treatment in experimental and control group.

SECTION B: PRETEST AND POSTTEST LEVEL OF DEPRESSION AMONG ALCOHOL DEPENDENTS IN EXPERIMENTAL AND CONTROL GROUP.

TABLE 2 : Frequency and percentage distribution of pretest and posttest level of depression among alcohol dependents in experimental and control group.

n₁= 30, n₂= 30

S.NO	LEVEL OF DEPRESSION	EXPERIEMNTAL GROUP				CONTROL GROUP			
		PRE TEST		POST TEST		PRE TEST		POST TEST	
		f	%	f	%	f	%	f	%
1	Minimal depression	-	-	27	90	-	-	20	67
2	Mild depression	-	-	3	10	1	3	8	27
3	Moderate depression	19	63	-	-	19	63	2	6
4	Severe depression	11	37	-	-	10	34	-	-

Table 2 depicts that, in experimental group pretest, majority 19(63%) had moderate level of depression and 11(37%) had severe level of depression. In posttest, majority 27(90%) had minimal level of depression and 3(10%) had mild level of depression.

In control group pretest, majority 19(63%) had moderate level of depression, 10(34%) had severe level of depression and 1(3%) had mild level of depression. In posttest, majority 20 (67%) had minimal level of depression, 8(27%) had mild level of depression and 2(6%) had moderate level of depression.

SECTION C: PRETEST AND POSTTEST LEVEL OF QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS IN EXPERIMENTAL AND CONTROL GROUPS.

TABLE 3. Frequency and percentage distribution of pretest and posttest level of quality of life among alcohol dependents in experimental and control groups.

n₁= 30, n₂= 30

Domains	Experimental group												Control group											
	Dissatisfactory				Satisfactory				Highly satisfactory				Dissatisfactory				Satisfactory				Highly satisfactory			
	Pre test		Post test		Pre test		Post test		Pre Test		Post Test		Pre test		Post test		Pre test		Post test		Pre Test		Post test	
	f	%	f	%	f	%	f	%	F	%	f	%	f	%	f	%	f	%	f	%	f	%	F	%
Overall quality of life and general health	5	17	-	-	20	66	17	57	5	17	13	43	4	13	-	-	24	80	25	83	2	7	5	17
Physical domain	8	27	-	-	22	73	6	20	-	-	24	80	8	27	-	-	22	73	17	57	-	-	13	43
Psychological domain	7	23	-	-	22	74	4	13	1	3	26	87	9	30	-	-	21	70	16	53	-	-	14	47
Social domain	25	83	-	-	5	17	4	13	-	-	26	87	15	50	-	-	15	50	20	67	-	-	10	33
Environmental domain	5	17	-	-	25	83	4	13	-	-	26	87	3	10	-	-	27	90	18	60	-	-	12	40

Table 3 depicts that, related to overall quality of life and general health, in experimental group pretest, majority 20(66%) had satisfactory quality of life, 5(17%) had highly satisfactory quality of life and 5(17%) had dissatisfactory quality of life. In posttest, majority 17(57%) had satisfactory quality of life and 13(43%) had highly satisfactory quality of life. In control group pretest, majority 24(80%) had satisfactory quality of life, 4(13%) had dissatisfactory quality of life and 2(7%) had highly satisfactory quality of life. In posttest, majority 25(83%) had satisfactory quality of life and 5(17%) had highly satisfactory quality of life.

Related to physical domain, in experimental group pretest, majority 22(73%) had satisfactory quality of life and 8(27%) had dissatisfactory quality of life. In posttest, majority 24(80%) had highly satisfactory quality of life and 6(20%) had satisfactory quality of life. In control group pretest, majority 22(73%) had satisfactory quality of life and 8(27%) had dissatisfactory quality of life. In posttest, majority 17(57%) had satisfactory quality of life and 13(43%) had highly satisfactory quality of life.

Related to psychological domain, in experimental group pretest, majority 22(74%) had satisfactory quality of life, 7(23%) had dissatisfactory quality of life and 1(3%) had highly satisfactory quality of life. In posttest, majority 26(87%) had highly satisfactory quality of life and 4(13%) had satisfactory quality of life. In control group pretest, majority 21 (70%) had satisfactory quality of life and 9 (30%) had dissatisfactory quality of life and in posttest, majority 16(53%) had satisfactory quality of life and 14(47%) had highly satisfactory quality of life.

Related to social domain, in experimental group pretest, majority 25(83%) had dissatisfactory quality of life and 5(17%) had satisfactory quality of life. In posttest, majority 26(87%) had highly satisfactory quality of life and 4(13%) has satisfactory quality of life. In control group pretest, majority 15(50%) had dissatisfactory quality of life and 15(50%) had satisfactory quality of life. In posttest, majority 20(67%) had satisfactory quality of life and 10(33%) had highly satisfactory quality of life.

Related to environmental domain, in experimental group pretest, majority 25(83%) had satisfactory quality of life and 5(17%) had dissatisfactory quality of life. In posttest, majority 26(87%) had highly satisfactory quality of life and 4(13%) had satisfactory quality of life. In control group pretest, majority 27(90%) had satisfactory quality of life and 3(10%) had dissatisfactory quality of life. In posttest, majority 18(60%) had satisfactory quality of life and 12(40%) had highly satisfactory quality of life.

SECTION D: COMPARISON BETWEEN PRETEST AND POSTTEST LEVEL OF DEPRESSION AMONG ALCOHOL DEPENDENTS IN EXPERIMENTAL GROUP

TABLE 4. Comparison of mean, standard deviation, mean difference and paired 't' value of pretest and posttest level of depression among alcohol dependents in experimental group.

n₁ = 30

Level of depression	Mean	Standard Deviation	Mean Difference	Paired 't' Value	Table Value	Inference
Pretest	27.233	6.558	20.675	14.439	2.05	Significant
Posttest	8.166	4.646				

df = 29

(p < 0.05)

Table 4 depicts that the mean pretest and posttest level of depression were 27.233 (SD ±6.558) and 8.166 (SD ±4.646) respectively. The mean posttest value was lower than the mean pretest value with the mean difference of 20.675. The paired 't' value was 14.439, with the table value of 2.05, which was significant at p < 0.05 level, where the result revealed that yoga was effective in reducing depression among alcohol dependents in experimental group.

SECTION E: COMPARISON BETWEEN PRETEST AND POSTTEST LEVEL OF QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS IN EXPERIMENTAL GROUP-

TABLE 5. Comparison of mean, standard deviation, mean difference and paired 't' value of pretest and posttest level of quality of life among alcohol dependents in experimental group.

n₁ = 30

Quality of life	Pretest		Posttest		Mean difference	Paired t Value	Table value	Inference
	Mean	Standard Deviation	Mean	Standard deviation				
Overall quality of life and general health	5.90	1.347	7.433	1.194	1.533	5.275		Significant
Physical domain	17.40	2.607	28.333	2.154	10.933	17.629		
Psychological domain	16.066	2.273	24.233	2.373	8.167	15.968	2.05	
Social domain	6.633	1.159	13.033	1.376	6.40	16.623		
Environmental domain	19.966	2.822	33.766	3.070	13.80	20.598		

df = 29

(p < 0.05)

Table 5 depicts that the mean pretest level of quality of life were 5.90 (SD \pm 1.347) for overall quality of life and general health, 17.40 (SD \pm 2.607) for physical domain, 16.066 (SD \pm 2.273) for psychological domain, 6.633 (SD \pm 1.159) for social domain and 19.966 (SD \pm 2.822) for environmental domain. The mean posttest level of quality of life were 7.433 (SD \pm 1.194) for overall quality of life and general health, 28.333 (SD \pm 2.154) for physical domain, 24.233 (SD \pm 2.373) for psychological domain, 13.033 (SD \pm 1.376) for social domain and 33.766 (SD \pm 3.070) for environmental domain. The mean posttest scores of quality of life were higher than the mean pretest scores of quality of life, with the mean difference of 1.533 for overall quality of life and general health, 10.933 for physical domain, 8.167 for psychological domain, 6.40 for social domain and 13.80 for environmental domain. The paired 't' value of quality of life were 5.275 for overall quality of life and general health, 17.629 for physical domain, 15.968 for psychological domain, 16.623 for social domain and 20.598 for environmental domain, with the table value of 2.05, which were significant at $p < 0.05$ level. The results revealed that yoga was effective in increasing the quality of life among alcohol dependents in experimental group.

SECTION F: COMPARISON BETWEEN POSTTEST LEVEL OF DEPRESSION AMONG ALCOHOL DEPENDENTS IN EXPERIMENTAL AND CONTROL GROUP.

TABLE 6. Comparison of mean scores, standard deviation, mean difference and independent't' value of posttest level of depression among alcohol dependents in experimental and control group.

n₁= 30, n₂= 30

Groups	Mean	Standard deviation	Mean difference	Independent 't' value	Table Value	Inference
Experimental group	8.166	4.646				
Control group	12.833	4.816	4.667	4.413	2.02	Significant

df = 58

(p <0.05)

Table 6 depicts that the mean posttest level of depression in experimental and control group were 8.166 (SD ±4.646) and 12.833 (SD ±4.816) respectively. The mean posttest score of experimental group was lower than the mean posttest score of control group with the mean difference value of 4.667. The independent't' value was 4.413, with the table value of 2.02, which was significant at p <0.05 level. The result revealed that yoga was effective in reducing the level of depression among alcohol dependents in experimental group.

SECTION G: COMPARISON BETWEEN POSTTEST LEVEL OF QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS IN EXPERIMENTAL AND CONTROL GROUP.

TABLE 7. Comparison of mean scores, standard deviation, mean difference and independent't' value of posttest level of quality of life among alcohol dependents in experimental and control group.

n₁ = 30, n₂ = 30

Quality of life	Experimental group		Control Group		Independent 't' value	Table value	Inference
	Mean	Standard Deviation	Mean	Standard deviation			
Overall quality of life and general health	7.433	1.194	6.566	1.304	2.592		
Physical domain	28.333	2.154	26.733	2.523	2.807		significant
Psychological domain	24.233	2.373	22.70	2.151	2.833	2.02	
Social domain	13.033	1.376	10.933	1.638	4.437		
Environmental domain	33.766	3.070	29.466	3.047	5.890		

df = 58

(p <0.05)

Table 7 depicts that, in experimental group, the mean posttest level of quality of life were 7.433 (SD ±1.194) for overall quality of life and general

health, 28.333(SD \pm 2.154) for physical domain, 24.233 (SD \pm 2.373) for psychological domain, 13.033 (SD \pm 1.376) for social domain and 33.766 (SD \pm 3.070) for environmental domain. In control group, the mean posttest level of quality of life were 6.566 (SD \pm 1.304) for overall quality of life and general health, 26.733 (SD \pm 2.523) for physical domain, 22.70 (SD \pm 2.151) for psychological domain, 10.933 (SD \pm 1.638) for social domain and 29.466 (SD \pm 3.047) for environmental domain respectively. The independent ‘t’ value of quality of life were 2.592 for overall quality of life and general health, 2.807 for physical domain, 2.833 for psychological domain, 4.437 for social domain and 5.890 for environmental domain, with the table value of 2.02, which were significant at $p < 0.05$ level. The results revealed that yoga was effective in increasing quality of life among alcohol dependents in experimental group.

SECTION H: CORRELATION BETWEEN POSTTEST LEVEL OF DEPRESSION AND QUALITY OF LIFE AMONG

ALCOHOL DEPENDENTS IN EXPERIMENTAL GROUP.

TABLE 8. Correlation between post-test level of depression and quality of life among alcohol dependents in experimental group.

n₁ = 30

Quality of life	Quality of life		Depression		Correlation value	Table value	Inference
	Mean	Standard Deviation	Mean	Standard deviation			
Overall quality of life and general health	7.433	1.194			-0.222		
Physical domain	28.333	2.154			-0.291		
Psychological domain	24.233	2.373	8.166	4.466	-0.301	0.36	NS
Social domain	13.033	1.376			-0.195		
Environmental domain	33.766	3.070			-0.158		

df= 28

(p <0.05)

(NS- Non significant)

Table 8 depicts that there was a negative correlation between depression and quality of life among alcohol dependents. The mean and standard deviation of depression was 8.166 (SD ± 4.466) and the quality of life were 7.433 (SD ± 1.194) for overall quality of life and general health, 28.333 (SD ± 2.154) for physical domain, 24.233 (SD ± 2.373) for psychological domain, 13.033

(SD \pm 1.376) for social domain and 33.766 (SD \pm 3.070) for environmental domain respectively. The negative correlation value (r) for depression and quality of life were -0.222, -0.291, -0.301, -0.195 and -0.158, with the table value of 0.36 respectively. The findings revealed that the yoga was effective in decreasing the level of depression and improving the level of quality of life among alcohol dependents in experimental group.

**SECTION I: ASSOCIATION BETWEEN THE POSTTEST
LEVEL OF DEPRESSION AMONG ALCOHOL**

DEPENDENTS AND THEIR DEMOGRAPHIC VARIABLES

TABLE 9. Association between the mean posttest level of depression among alcohol dependents and their demographic variables.

n₁ = 30

S. No	Demographic variables	Level of Depression				χ^2 value	Table value	Inference
		minimal depression		mild depression				
		n	%	n	%			
1	Age a. 18- 25 years b. 26- 35 years c. 36- 45 years	2	7	-	-	2.212	5.99 (df=2)	NS
2	Religion a. Hindu b. Christian c. Muslim	22	74	3	10	0.660	5.99 (df=2)	NS
3	Education a. Primary school education b. Higher secondary school education c. Degree holder d. No formal education	10	33	1	3	4.010	5.99 (df=2)	NS

S.	Demographic	Level of Depression	χ^2	Table	Inference
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No	variables	minimal depression		mild depression		value	Value	
		n	%	n	%			
4	Occupation							
	a. Private employee	4	13	-	-	5.122	7.82 (df=3)	NS
	b. Government employee	6	20	-	-			
	c. Self employee	16	54	2	7			
	d. Unemployed	1	3	1	3			
5	Marital status							
	a. Unmarried	6	20	2	7	2.670	3.84 (df=1)	NS
	b. Married	21	70	1	3			
	c. Divorced	-	-	-	-			
	d. Widower	-	-	-	-			
6	Monthly income							
	a. < Rs.5000/-	5	17	2	7	3.450	5.99 (df=2)	NS
	b. Rs.5000- 15000/-	20	66	1	3			
	c. > Rs.15000/-	2	7	-	-			
7	Type of family							
	a. Nuclear family	16	54	2	7	0.142	5.99 (df=2)	NS
	b. Joint family	10	33	1	3			
	c. Extended family	1	3	-	-			
8	Area of residence							
	a. Urban	10	33	-	-	4.790	5.99 (df=2)	NS
	b. Rural	13	44	1	3			
	c. Semi- urban	4	13	2	7			

S.	Demographic	Level of Depression	χ^2	Table	↔ ↻
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No	variables	minimal depression		mild depression		value	Value	
		n	%	n	%			
9	Duration of alcohol consumption a. < 5 years b. 5- 15 years c. > 15 years	12	40	1	3	1.197	5.99 (df=2)	NS
		10	33	2	7			
		5	17	-	-			
10	Nature of admission a. Voluntary admission b. Involuntary admission	18	60	1	3	1.270	3.84 (df=1)	NS
		9	30	2	7			
11	History of previous de-addiction treatment a. Yes b. No	12	40	2	7	0.510	3.84 (df=1)	NS
		15	50	1	3			

(NS- Non significant)

(p < 0.05)

Table 13 depicts the Chi square values calculated to find the association between posttest level of depression and their demographic variables among alcohol dependents. The findings revealed that there was no significant association between the posttest level of depression and with their demographic variables among alcohol dependents.

SECTION J: ASSOCIATION BETWEEN THE POSTTEST LEVEL OF QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS AND THEIR DEMOGRAPHIC VARIABLES

Table 10. Association between the posttest level of quality of life among alcohol dependents and their demographic variables.

n₁ = 30

S. No	Demographic Variables	Table value	Overall Quality of life and general health				Physical domain				Psychological domain				Social domain				Environmental domain													
			Satisfaction		Highly satisfaction		χ^2 alue	significance	Satisfaction		Highly satisfaction		χ^2 value	significance	Satisfaction		Highly satisfaction		χ^2 value	significance	Satisfaction		Highly satisfaction		χ^2 value	Significance						
			N	%	n	%			n	%	n	%			n	%	n	%			n	%	n	%								
1.	Age																															
	a) 18-25 yrs	5.99	1	3	1	3	1.090	NS	-	-	2	7	1.75	NS	1	3	1	3	5.17	NS	1	3	1	7	3.62	NS	1	3	1	3	3.62	NS
	b) 26-35yrs	(df = 2)	7	24	3	10			1	3	9	30			-	-	10	33			1	3	9	30			1	3	9	30		
	c) 36-45 yrs		9	30	9	30			5	17	13	43			3	10	15	51			2	6	16	54			2	7	16	54		
2.	Religion																															
	a) Hindu	5.99	14	47	11	37	1.971	NS	5	17	20	67	0.31	NS	3	10	22	74	0.717	NS	3	10	22	74	0.717	NS	3	10	22	74	0.717	NS
	b) Christian	(df = 2)	3	10	1	3			1	3	3	10			1	3	3	10			1	3	3	10			1	3	3	10		
	c) Muslim		-	-	1	3			-	-	1	3			-	-	1	3			-	-	1	3			-	-	1	3		

Table 10. Association between the posttest level of quality of life among alcohol dependents and their demographic variables (cont)

n₁ = 30

S. No	Demographic Variables	Table value	Overall Quality of life and general health				Physical domain				Psychological domain				Social domain				Environmental domain												
			Satisfaction		Highly satisfaction		χ^2 value	significance	Satisfaction		Highly satisfaction		χ^2 value	significance	Satisfaction		Highly satisfaction		χ^2 value	significance	Satisfaction		Highly satisfaction		χ^2 value	Significance					
			N	%	n	%			n	%	n	%			n	%	n	%			n	%	n	%			n	%			
3.	Education	(df = 2) 5.99																													
a) Primary School education	8		27	3	10	4	13	7	23	1	3	10	32	-	-	11	37	1	3	10	33										
b) Higher Secondary school education	5		17	7	23	2.222	NS	-	-	12	40	4.96	NS	2	8	10	33	0.25	NS	3	10	9	30	3.02	NS	2	8	10	33	0.25	NS
c) Degree holder	4		13	3	10			2	7	5	17			1	3	6	20			1	3	6	20			1	3	6	20		
d) No formal education	-	-	-	-			-	-	-	-			-	-	-	-			-	-	-	-			-	-	-	-			
4.	Occupation	(df = 3) 7.82																													
a) Private employee	3		10	1	3	1	3	3	10	8.978	S	-	-	4	13	1	3	3	10	-	-	4	13	2.91	NS	-	-	4	13		
b) Government employee	2		7	4	13	3.478	NS	1	3	5	17			2	7	4	13	2.99	NS	-	-	6	20	1.88	NS	-	-	6	20		
c) Self – employee	10		33	8	27			2	7	16	53			2	7	16	53			3	10	15	50			4	13	14	47		
d) Unemployed	2	7	-	-			2	7	-	-			-	-	2	7			-	-	2	7			-	-	2	7			

Table 10. Association between the posttest level of quality of life among alcohol dependents and their demographic variables (cont)

n₁= 30

S. No	Demographic Variables	Table value	Overall Quality of life and general health				Physical domain				Psychological domain				Social domain				Environmental domain												
			Satisfaction		Highly satisfaction		χ^2 value	significance	Satisfaction		Highly satisfaction		χ^2 value	significance	Satisfaction		Highly satisfaction		χ^2 value	significance	Satisfaction		Highly satisfaction		χ^2 value	Significance					
			N	%	n	%			n	%	n	%			n	%	n	%			n	%	n	%			n	%			
5.	Marital status																														
	a) Unmarried	3.84	4	13	4	13	0.19	NS	1	3	7	23	0.37	NS	1	3	7	23	0.004	NS	2	7	5	16	0.004	NS	-	-	4	13	
	b) Married	(df=1)	13	4	9	30			5	17	17	57			2	7	19	64			2	7	19	63			-	-	6	20	
	c) Divorced		-	-	-	-			-	-	-	-			1	3	1	3			-	-	2	7			4	13	14	47	
	d) Widower		-	-	-	-			-	-	-	-			-	-	-	-			-	-	-	-			-	-	2	7	
6.	Monthly income																														
	a) < Rs.5000	5.99	5	17	2	7	2.86	NS	2	7	5	16	3.74	NS	1	3	6	20	3.74	NS	2	7	5	16	1.96	NS	1	3	6	20	
	b) Rs.5000-15000	(df=2)	10	33	11	36			2	7	19	63			2	7	19	64			2	7	19	63			3	10	18	60	
	c) > Rs.15000		2	7	-	-			2	7	-	-			1	3	1	3			-	-	2	7			-	-	2	7	
7.	Type of family																														
	a) Nuclear family	5.99	8	27	10	33	3	NS	3	10	15	50	0.64	NS	2	7	16	54	9.1	S	2	7	16	53	0.69	NS	1	3	17	57	
	b) Joint family	(df=2)	8	27	3	10			3	10	8	27			1	3	10	33			2	7	9	30			2	7	9	30	
	c) Extended family		1	3	-	-			-	-	1	3			1	3	-	-			-	-	1	3			1	3	-	-	

Table 10. Association between the posttest level of quality of life among alcohol dependents and their demographic variables (cont)

n₁ = 30

S. No	Demographic Variables	Table value	Overall Quality of life and general health				Physical domain				Psychological domain				Social domain				Environmental domain													
			Satisfaction		Highly satisfaction		χ^2 value	significance	Satisfaction		Highly satisfaction		χ^2 value	significance	Satisfaction		Highly satisfaction		χ^2 value	significance	Satisfaction		Highly satisfaction		χ^2 value	Significance						
			N	%	n	%			n	%	n	%			n	%	n	%			n	%	n	%			n	%				
8.	Area of Residence																															
	a) Urban	5.99	6	20	4	13	1.67	NS	1	3	9	30	1.243	NS	2	7	8	27	0.877	NS	1	3	9	30	0.8	NS	1	3	9	30	0.147	NS
	b) Rural	(df = 2)	9	30	5	17			3	10	11	37			1	3	13	43			1	3	13	44			2	7	12	40		
	c) Semi – urban		2	7	4	13			2	7	4	13			1	3	5	17			2	7	4	13			1	3	5	17		
9.	Duration of alcohol consumption																															
	a) < 5 years	5.99	7	23	6	20	1.11	NS	1	3	12	40	2.4	NS	1	3	12	40	4.17	NS	4	13	9	30	6.05	S	2	7	11	37	0.583	NS
	b) 5- 15 years	(df = 2)	8	27	4	30			4	13	8	28			1	3	11	37			-	-	12	40			1	3	11	37		
	c) > 15 years		2	7	3	10			1	3	4	13			2	7	3	10			-	-	5	17			1	3	4	13		

Table 10. Association between the posttest level of quality of life among alcohol dependents and their demographic variables (cont)

n₁ = 30

S. No	Demographic Variables	Table value	Overall Quality of life and general health				Physical domain				Psychological domain				Social domain				Environmental domain													
			Satisfaction		Highly satisfaction		χ^2 alue	significance	Satisfaction		Highly satisfaction		χ^2 value	significance	Satisfaction		Highly satisfaction		χ^2 value	significance	Satisfaction		Highly satisfaction		χ^2 value	Significance						
			N	%	n	%			n	%	n	%			n	%	n	%			n	%	n	%								
10.	Nature of Admission	3.84 (df = 1)																														
	a) Voluntary admission		11	38	8	27	0.037	NS	2	7	17	57	2.82	NS	3	10	16	54	0.239	NS	2	7	17	56	0.39	NS	2	7	17	56	0.39	NS
	b) Involuntary admission		6	20	5	17			4	13	7	23			1	3	10	33			2	7	9	30			2	7	9	30		
11.	History of previous De-addiction	3.84 (df = 1)																														
	a) Yes		8	27	6	20	0.002	NS	3	10	11	37	0.026	NS	2	7	12	40	0.024	NS	1	4	13	43	0.83	NS	1	4	13	43	0.83	NS
	b) No		9	30	7	23			3	10	13	43			2	7	14	46			3	10	13	43			3	10	13	43		

Table 10 depicts the chi square values calculated to find out the association between the posttest level of quality of life and their demographic variables. The findings revealed that there was a significant association at $p < 0.05$ level between the posttest level of quality of life and their demographic variables among alcohol dependents in experimental group, with regard to physical domain, the χ^2 value was 8.978 for occupation. With regard to psychological domain, the χ^2 value was 9.1 for type of family. With regard to social domain, χ^2 value was 6.05 for duration of alcohol consumption. With regard to environmental domain, the χ^2 value was 10.1 for type of family.

CHAPTER V

DISCUSSION

This chapter deals with sample characteristic and objective of the study. The aim of this present study was to evaluate the effectiveness of yoga in depression and quality of life among alcohol dependents at Athma de-addiction centre, Trichy.

Distribution of sample characteristics:

Regarding age, in experimental group, majority 18(60%) belonged to 36- 45 years of age, 10(33%) belonged to 26- 35 years of age, and 2(7%) belonged to 18- 25 years. In control group, majority 17(57%) belonged to 36- 45 years and 13(43%) belonged to 26- 35 years.

Regarding religion, in experimental group, majority 25(84%) were Hindus, 4(13%) were Christians, and 1(3%) were Muslims. In control group, majority 24(80%) were Hindus, 4(13%) were Christians and 2(7%) were Muslims.

Regarding education, in experimental group, majority 12(40%) had higher secondary school education, 11(37%) had primary school education and 7(23%) were degree holders. In control group, majority 11(37%) had higher secondary school education, 11(37%) were degree holder, 7(23%) had primary school education and 1(3%) do not have formal education.

Regarding occupation, in experimental group, majority 18(60%) were self employees, 6(20%) were government employees, 4(13%) were private employees and 2(7%) were unemployed. In control group, majority 18(60%) were self employees, 7(23%) were private employees and 5 (17%) were government employees.

Regarding marital status, in experimental group, majority 22(73%) were married and 8(27%) were unmarried. In control group, majority 24(80%) were married and 6(20%) were unmarried.

Regarding monthly income, in experimental group, majority 21(70%) of the group had Rs.5000 – 15000/- , 7(23%) of the group had < Rs.5000/- and 2(7%) of the group had > Rs. 15000/-. In control group, majority 13(43%) of the group had Rs. 5000- 15000/-, 9(30%) of the group had > Rs.15000/- and 8(27%) of the group had < Rs.5000/-.

Regarding type of the family, in experimental group, majority 18(60%) belonged to nuclear family, 11(37%) belonged to joint family and 1(3%) belonged to extended family. In control group, majority 16(54%) belonged to joint family, 13(43%) belonged to nuclear family and 1(3%) belonged to extended family.

Regarding area of residence, in experimental group, majority 14(47%) were from rural area, 10(33%) were from urban area and 6(20%) were from semi-urban area. In control group, majority 12(40%) were from rural area, 9(30%) were from urban area and 9(30%) were from semi-urban area.

Regarding duration of alcohol consumption, in experimental group, majority 13(43%) were consuming alcohol for < 5 years, 12(40%) were consuming alcohol for 5- 15 years and 5(17%) were consuming alcohol for > 15 years. In control group, majority 15(50%) were consuming alcohol for <5 years, 13(43%) were consuming alcohol for 5- 15 years and 2(7%) were consuming alcohol for >15 years.

Regarding nature of admission, in experimental group, majority 19(63%) had voluntary admission and 11(37%) had involuntary admission. In

control group, majority 22(73%) had voluntary admission and 8(27%) had involuntary admission.

Regarding history of previous de-addiction treatment, in experimental group, majority 16(53%) did not undergo any de-addiction treatment whereas 14(47%) had past de-addiction treatment. In control group, majority 18(60%) did not undergo any de-addiction treatment whereas 12(40%) had past de-addiction treatment.

THE FINDINGS OF THE STUDY ARE DISCUSSED ACCORDING TO THE OBJECTIVES AS FOLLOWS

1. To assess the pretest and posttest level of depression and quality of life among alcohol dependents in experimental group.
2. To assess the pretest and posttest level of depression and quality of life among alcohol dependents in control group.
3. To compare the pretest and posttest level of depression and quality of life among alcohol dependents in experimental group.
4. To compare the posttest level of depression among alcohol dependents between experimental group and control group.
5. To compare the posttest level of quality of life among alcohol dependents between experimental group and control group.
6. To find the correlation between posttest level of depression and quality of life among alcohol dependents in experimental group.
7. To find the association between posttest level of depression among alcohol dependents and their demographic variables in experimental group.
8. To find the association between posttest level of quality of life among alcohol dependents and their demographic variables in experimental group.

OBJECTIVE 1

To assess the pretest and posttest level of depression and quality of life among alcohol dependents in experimental group.

Among alcohol dependents, in experimental group pretest, majority 19(63%) had moderate level of depression and 11(37%) had severe level of depression. In posttest, majority 27(90%) had minimal level of depression and 3(10%) had mild level of depression.

These findings were consistent with the findings of **Abdul Khalid (2010)** who reported that there was high prevalence of major depression (41.7%) for the episode of drinking of alcohol.

In experimental group related to overall quality of life and general health, in pretest majority 20(66%) had satisfactory quality of life, 5(17%) had highly satisfactory quality of life and 5(17%) had dissatisfactory quality of life. In posttest, majority 17(57%) had satisfactory quality of life and 13(43%) had highly satisfactory quality of life.

In physical domain pretest, majority 22(73%) had satisfactory quality of life and 8(27%) had dissatisfactory quality of life. In posttest, majority 24(80%) had highly satisfactory quality of life and 6(20%) had dissatisfactory quality of life.

In psychological domain pretest, majority 22(74%) had satisfactory quality of life, 7(23%) had dissatisfactory quality of life and 1(3%) had highly satisfactory quality of life. In posttest, majority 26(87%) had highly satisfactory quality of life and 4(13%) had dissatisfactory quality of life.

In social domain pretest, majority 25(83%) had dissatisfactory quality of life and 5(17%) had satisfactory quality of life. In posttest, majority 26(87%) had highly satisfactory quality of life and 4(13%) had dissatisfactory quality of life.

In environmental domain pretest, majority 25(83%) had satisfactory quality of life and 5(17%) had dissatisfactory quality of life. In posttest, majority 26(87%) had highly satisfactory quality of life and 4(13%) had satisfactory quality of life.

These findings were consistent with the findings of **Wagwa, Angelica K (2011)** who stated that quality of life was lower among the alcohol abusers in relation to physical health, psychological wellbeing, social relationships and environment. However, statistically significant differences was found on physical health ($t=-3.071$, $df=78$, $p=0.008$), social relationships ($t=-2.754$, $df=78$, $p=0.006$) and environment ($t=-2.375$, $df=77$, $p=0.019$).

OBJECTIVE 2

To assess the pretest and posttest level of depression and quality of life among alcohol dependents in control group.

Among alcohol dependents, in control group pretest, majority 19(63%) had moderate level of depression, 10(34%) had severe level of depression and 1(3%) had mild level of depression. In posttest, majority 20 (67%) had minimal level of depression, 8(27%) had mild level of depression and 2(6%) had moderate level of depression.

These findings were consistent with the findings of **Davidson KM (2008)** who reported that the episode of drinking which has led to admission was found in the majority of patients (67%) with major depression.

In control group related to overall quality of life and general health the pretest majority 24(80%) had satisfactory quality of life, 4(13%) had dissatisfactory quality of life and 2(7%) had highly satisfactory quality of life. In posttest, majority 25(83%) had satisfactory quality of life and 5(17%) had highly satisfactory quality of life.

In physical domain pretest, majority 22(73%) had satisfactory quality of life and 8(27%) had dissatisfactory quality of life. In posttest, majority 17(57%) had satisfactory quality of life and 13(43%) had highly satisfactory quality of life.

In psychological domain pretest, majority 21 (70%) had satisfactory quality of life and 9 (30%) had dissatisfactory quality of life and in posttest, majority 16(53%) had satisfactory quality of life and 14(47%) had highly satisfactory quality of life.

In social domain pretest, majority 15(50%) had dissatisfactory quality of life and 15(50%) had satisfactory quality of life. In posttest, majority 20(67%) had satisfactory quality of life and 10(33%) had highly satisfactory quality of life.

In environmental domain pretest, majority 27(90%) had satisfactory quality of life and 3(10%) had dissatisfactory quality of life. In posttest, majority 18(60%) had satisfactory quality of life and 12(40%) had highly satisfactory quality of life.

These findings were consistent with the findings of **Jean-Bernard Daeppen (2009)** who reported that alcohol-dependent patients were relatively low in their quality of life, especially in the psychological and role dimensions (range 52/100 to 55/100), and physical and functional dimensions (range 61/100 to 75/100).

OBJECTIVE 3

To compare the pretest and posttest level of depression and quality of life among alcohol dependents in experimental group.

The analyzed data revealed that the mean pretest and posttest level of depression was 27.833 (SD \pm 6.558) and 8.166 (SD \pm 4.646) respectively. The

mean posttest value was lower than the mean pretest value with the mean difference of 20.675. The paired 't' value was 14.439, with the table value of 2.05, which was significant at $p < 0.05$ level, where the result revealed that yoga was effective in reducing depression among alcohol dependents in experimental group.

These findings were consistent with the findings of **Javnbakht (2014)** who reported that the average prevalence of depression in the experimental group pre and post Yoga intervention was 12.82 ± 7.9 and 9.79 ± 6.04 respectively, a statistically significant decrease ($p=0.13$).

Therefore the research hypothesis **H₁** that is the mean posttest level of depression is significantly lower than the mean pretest level of depression among alcohol dependents in experimental group was accepted.

Further analysis revealed that the mean pretest level of quality of life were 5.90 (SD ± 1.347) for overall quality of life and general health, 17.40 (SD ± 2.607) for physical domain, 16.066 (SD ± 2.273) for psychological domain, 6.633 (SD ± 1.159) for social domain and 19.966 (SD ± 2.822) for environmental domain. The mean posttest level of quality of life were 7.433 (SD ± 1.194) for overall quality of life and general health, 28.333 (SD ± 2.154) for physical domain, 24.233 (SD ± 2.373) for psychological domain, 13.033 (SD ± 1.373) for social domain and 33.766 (SD ± 3.070) for environmental domain. The mean posttest scores of quality of life were higher than the mean pretest scores of quality of life, with the mean difference of 1.533 for overall quality of life and general health, 10.933 for physical domain, 8.167 for psychological domain, 6.40 for social domain and 13.80 for environmental domain. The paired 't' value of quality of life were 5.275 for overall quality of life and general health, 17.629 for physical domain, 15.968 for psychological domain, 16.623 for social domain and 20.598 for environmental domain, with the table value of 2.05, which were significant at $p < 0.05$ level. The results

revealed that yoga was effective in increasing the quality of life among alcohol dependents in experimental group.

These findings were consistent with the findings of **Abbas Rakhshani (2010)** who reported that there was a significant improvements in the yoga group compared to the control in the physical $t=7.64(p = 0.001)$, psychological $t=8.53(p < 0.001)$, social $t= 6.87 (p = 0.003)$, and environmental domains $t= 7.54(p = 0.001)$.

Therefore, the research hypothesis **H₂** that is the mean posttest level of quality of life is significantly higher than the mean pretest level of quality of life among alcohol dependents in experimental group was accepted.

OBJECTIVE 4

To compare the posttest level of depression among alcohol dependents between experimental group and control group.

The analyzed data revealed that the mean posttest level of depression in experimental and control group were 8.166 (SD ± 4.646) and 12.833 (SD ± 4.816) respectively. The mean posttest score of experimental group was lower than the mean posttest score of control group with the mean difference value of 4.667. The independent 't' value was 4.413, with the table value of 2.02, which was significant at $p < 0.05$ level. The result revealed that yoga was effective in reducing the level of depression among alcohol dependents in experimental group.

These findings were consistent with the findings of **Yaser Alikhajeh (2011)** who reported that the level of depression in experimental group was reported 26.75 ± 8.476 before yoga and decreased to 18.92 ± 9.977 after yoga that showed significant difference ($p=0.022$). Yoga exercises caused significant difference in the depression level of experimental group in comparison with the control group in rehabilitation period ($p=0.048$).

Therefore, the research hypothesis **H₃** that is there is a significant difference between the posttest level of depression among alcohol dependents in experimental and control group was accepted.

OBJECTIVE 5

To compare the posttest level of quality of life among alcohol dependents between experimental group and control group.

The analyzed data revealed that, in experimental group, the mean posttest level of quality of life were 7.433 (SD ±1.194) for overall quality of life and general health, 28.333 (SD ±2.154) for physical domain, 24.233 (SD ±2.373) for psychological domain, 13.033 (SD ±1.376) for social domain and 33.766 (SD ±3.070) for environmental domain. In control group, the mean posttest level of quality of life were 6.566 (SD ±1.304) for overall quality of life and general health, 26.733 (SD ±2.523) for physical domain, 22.70 (SD ±2.151) for psychological domain, 10.933 (SD ±1.638) for social domain and 29.466 (SD ±3.047) for environmental domain respectively. The independent 't' value of quality of life were 2.592 for overall quality of life and general health, 2.807 for physical domain, 2.833 for psychological domain, 4.437 for social domain and 5.890 for environmental domain, with the table value of 2.02, which were significant at $p < 0.05$ level. The results revealed that yoga was effective in increasing quality of life among alcohol dependents in experimental group.

These findings were consistent with the findings of **Padmini Tekur (2010)** who reported that the baseline scores in physical health domain (mean 11.9) in experimental group were lower than the scores (mean 13.8) in control group. After yoga it increased to 14.5 in control group and 15.14 in experimental group pointing to the normalizing effect of yoga on physical QOL. In psychological domain, there was a significant (20%) improvement in yoga group with non-significant change in control group. The baseline values were much lower (mean 13.0) than control group (14.7) and increased (15.2 in

experimental group) similar to control group (15.5) after yoga. The mean scores in social domain changed from 13.0 to 14.8 in experimental group and 14.2 to 14.9 in control group. The mean value in environmental domain which was lower (12.8) in experimental group than control group (14.5), improved significantly to reach normalcy (14.6) after yoga and not after physical exercises.

Therefore, the research hypothesis **H₄** that is there is a significant difference between the posttest level of quality of life among alcohol dependents in experimental and control group was accepted.

OBJECTIVE 6

To find the correlation between posttest level of depression and quality of life among alcohol dependents in experimental group.

The analyzed data revealed that there was a negative correlation between depression and quality of life among alcohol dependents. The mean and standard deviation of depression was 8.166 (SD \pm 4.466) and the quality of life were 7.433 (SD \pm 1.194) for overall quality of life and general health, 28.333 (SD \pm 2.154) for physical domain, 24.233 (SD \pm 2.373) for psychological domain, 13.033 (SD \pm 1.376) for social domain and 33.766 (SD \pm 3.070) for environmental domain respectively. The negative correlation value(r) for depression and quality of life were -0.222, -0.291, -0.301, -0.195 and -0.158, with the table value of 0.36 respectively. The findings revealed that the yoga was effective in decreasing the level of depression and improving the level of quality of life among alcohol dependents in experimental group.

These findings were consistent with the findings of **Nasim Fooladi (2014)** who reported that the relationship between depression and quality of life is significant. Relationship between depression with quality of life respectively (-0.72, -0.80, -0.58, -0.63) were obtained in all ($p > 0.05$) is significant, so it can be concluded that, depression was inversely related to quality of life and

depression was found to be negatively correlated with quality of life in alcohol addicts.

Therefore, the research hypothesis **H₅** that is, there is a correlation between the posttest level of depression and quality of life among alcohol dependents in experimental group was accepted.

OBJECTIVE 7

To find the association between the posttest level of depression among alcohol dependents with their demographic variables in experimental group.

The Chi square values were calculated to find the association between posttest level of depression and their demographic variables among alcohol dependents. The findings revealed that there was no significant association between the posttest level of depression and their demographic variables among alcohol dependents.

These findings were consistent with the findings of **B. Chaudhary et.,al (2007)** who reported that socio demographic variables do not account for depression.

Therefore the research hypothesis **H₆** that, there will be a significant association between posttest level of depression among alcohol dependents and their demographic variables in experimental group were rejected.

OBJECTIVE 8

To find the association between the posttest level of quality of life among alcohol dependents with their demographic variables in experimental group.

The chi square values were calculated to find the association between the posttest level of quality of life and their demographic variables. The

findings revealed that there was a significant association between the posttest level of quality of life and their selected demographic variables among alcohol dependents. With regard to physical domain, the χ^2 value was 8.978 for occupation. With regard to psychological domain, the χ^2 value was 9.1 for type of family. With regard to social domain, χ^2 value was 6.05 for duration of alcohol consumption. With regard to environmental domain, the χ^2 value was 10.1 for type of family.

These findings were consistent with the findings of **Anja Cerne (2012)** who reported that there was a significant association between age & quality of life, education & quality of life, income & quality of life, duration of habituation & quality of life, age of dependent life & quality of life is 0.504 ($p>0.05$), 2.03 ($p>0.05$), 1.738 ($p>0.05$), 0.178 ($p>0.05$), 5.99 ($p>0.05$) respectively.

Therefore, the research hypothesis **H₇** that is, there will be a significant association between posttest level of quality of life and their demographic variables were accepted.

CHAPTER VI
SUMMARY, CONCLUSION, IMPLICATIONS,
RECOMMENDATIONS,
AND LIMITATIONS

This chapter is discussed under 5 headings

1. Summary
2. Conclusion
3. Implications
4. Recommendations
5. Limitations

SUMMARY OF THE STUDY

The aim of the study was to assess the effectiveness of yoga on depression and quality of life among alcohol dependents at Athma de-addiction centre, Trichy. An evaluative approach was used to conduct the study. The design used for the present study was quasi experimental non-equivalent control group pretest posttest design. The conceptual framework was based on **Wiedenbach's Helping Art of Clinical Nursing Theory (1969)**. A total of 60 participants were selected using convenience sampling technique. Out of which 30 were in experimental group and 30 were in control group. On the 1st week, 15 samples were selected under experimental group and pretest was conducted on the first day using Beck Depression Inventory scale to assess the level of depression and Quality of life- 26 BREF scale adopted from WHO, to assess the quality of life among alcohol dependents. The pretest was conducted for 30 minutes. Self administered questionnaires were given individually. After which yoga was taught to the experimental group, fifteen in a group, using LCD projector which lasted for 45 minutes. From the 2nd day, the participants in experimental group were made to practice the yoga under the supervision of the investigator in the morning for 1 hour 10 minutes for 28 days. On the 2nd week, next 15 samples were selected under experimental group and the same

procedure was continued. On 5th and 6th week, posttest was conducted for the experimental group. On 3rd week, 15 samples were selected in control group and pretest was conducted. On the 4th week, next 15 samples were selected under control group and the pretest was conducted. The control group participants received the routine hospital treatment. On 7th and 8th week, posttest was conducted for the control group.

The collected data were analyzed using descriptive and inferential statistics.

MAJOR FINDINGS OF THE STUDY

The major findings are,

Regarding age, in experimental group, majority 18(60%) belonged to 36- 45 years of age, 10(33%) belonged to 26- 35 years of age, and 2(7%) belonged to 18- 25 years. In control group, majority 17(57%) belonged to 36- 45 years and 13(43%) belonged to 26- 35 years.

Regarding religion, in experimental group, majority 25(84%) were Hindus, 4(13%) were Christians, and 1(3%) were Muslims. In control group, majority 24(80%) were Hindus, 4(13%) were Christians and 2(7%) were Muslims.

Regarding education, in experimental group, majority 12(40%) had higher secondary school education, 11(37%) had primary school education and 7(23%) were degree holders. In control group, majority 11(37%) had higher secondary school education, 11(37%) were degree holder, 7(23%) had primary school education and 1(3%) do not have formal education.

Regarding occupation, in experimental group, majority 18(60%) were self employees, 6(20%) were government employees, 4(13%) were private

employees and 2(7%) were unemployed. In control group, majority 18(60%) were self employees, 7(23%) were private employees and 5 (17%) were government employees.

Regarding marital status, in experimental group, majority 22(73%) were married and 8(27%) were unmarried. In control group, majority 24(80%) were married and 6(20%) were unmarried.

Regarding monthly income, in experimental group, majority 21(70%) of the group had Rs.5000 – 15000/- , 7(23%) of the group had < Rs.5000/- and 2(7%) of the group had > Rs. 15000/-. In control group, majority 13(43%) of the group had Rs. 5000- 15000/-, 9(30%) of the group had > Rs.15000/- and 8(27%) of the group had < Rs.5000/-.

Regarding type of the family, in experimental group, majority 18(60%) belonged to nuclear family, 11(37%) belonged to joint family and 1(3%) belonged to extended family. In control group, majority 16(54%) belonged to joint family, 13(43%) belonged to nuclear family and 1(3%) belonged to extended family.

Regarding area of residence, in experimental group, majority 14(47%) were from rural area, 10(33%) were from urban area and 6(20%) were from semi-urban area. In control group, majority 12(40%) were from rural area, 9(30%) were from urban area and 9(30%) were from semi-urban area.

Regarding duration of alcohol consumption, in experimental group, majority 13(43%) were consuming alcohol for < 5 years, 12(40%) were consuming alcohol for 5- 15 years and 5(17%) were consuming alcohol for > 15 years. In control group, majority 15(50%) were consuming alcohol for <5 years, 13(43%) were consuming alcohol for 5- 15 years and 2(7%) were consuming alcohol for >15 years.

Regarding nature of admission, in experimental group, majority 19(63%) had voluntary admission and 11(37%) had involuntary admission. In control group, majority 22(73%) had voluntary admission and 8(27%) had involuntary admission.

Regarding history of previous de-addiction treatment, in experimental group, majority 16(53%) did not undergo any de-addiction treatment whereas 14(47%) had past de-addiction treatment. In control group, majority 18(60%) did not undergo any de-addiction treatment whereas 12(40%) had past de-addiction treatment.

Regarding depression, in experimental group pretest, majority 19(63%) had moderate level of depression and 11(37%) had severe level of depression. In posttest, majority 27(90%) had minimal level of depression and 3(10%) had mild level of depression among alcohol dependents.

Related to quality of life, in experimental group pretest, in overall quality of life and general health, the pretest majority 20(66%) had satisfactory quality of life, 5(17%) had highly satisfactory quality of life and 5(17%) had dissatisfactory quality of life. In posttest, majority 17(57%) had satisfactory quality of life and 13(43%) had highly satisfactory quality of life among alcohol dependents.

Related to physical domain, in experimental group pretest, majority 22(73%) had satisfactory quality of life and 8(27%) had satisfactory quality of life. In posttest, majority 24(80%) had highly satisfactory quality of life and 6(20%) had satisfactory quality of life among alcohol dependents.

Related to psychological domain, in experimental group pretest, majority 22(74%) had satisfactory quality of life, 7(23%) had dissatisfactory quality of life and 1(3%) had highly satisfactory quality of life. In posttest,

majority 26(87%) had highly satisfactory quality of life and 4(13%) had satisfactory quality of life among alcohol dependents.

Related to social domain, in experimental group pretest, majority 25(83%) had dissatisfactory quality of life and 5(17%) had satisfactory quality of life. In posttest, majority 26(87%) had highly satisfactory quality of life and 4(13%) has satisfactory quality of life among alcohol dependents.

Related to environmental domain, in experimental group pretest, majority 25(83%) had satisfactory quality of life and 5(17%) had dissatisfactory quality of life. In posttest, majority 26(87%) had highly satisfactory quality of life and 4(13%) had satisfactory quality of life among alcohol dependents.

Regarding depression, in control group pretest, majority 19(63%) had moderate level of depression, 10(34%) had severe level of depression and 1(3%) had mild level of depression. In posttest, majority 20 (67%) had minimal level of depression, 8(27%) had mild level of depression and 2(6%) had moderate level of depression among alcohol dependents.

Related to quality of life, in control group pretest, in overall quality of life and general health the pretest majority 24(80%) had satisfactory quality of life, 4(13%) had dissatisfactory quality of life and 2(7%) had highly satisfactory quality of life. In posttest, majority 25(83%) had satisfactory quality of life and 5(17%) had highly satisfactory quality of life among alcohol dependents.

Related to physical domain, in control group pretest, majority 22(73%) had satisfactory quality of life and 8(27%) had dissatisfactory quality of life. In posttest, majority 17(57%) had satisfactory quality of life and 13(43%) had highly satisfactory quality of life among alcohol dependents.

Related to psychological domain, in control group pretest, majority 21 (70%) had satisfactory quality of life and 9 (30%) had dissatisfactory quality of life and in posttest, majority 16(53%) had satisfactory quality of life and 14(47%) had highly satisfactory quality of life among alcohol dependents.

Related to social domain, in control group pretest, majority 15(50%) had dissatisfactory quality of life and 15(50%) had satisfactory quality of life. In posttest, majority 20(67%) had satisfactory quality of life and 10(33%) had highly satisfactory quality of life among alcohol dependents.

Related to environmental domain, in control group pretest, majority 27(90%) had satisfactory quality of life and 3(10%) had dissatisfactory quality of life. In posttest, majority 18(60%) had satisfactory quality of life and 12(40%) had highly satisfactory quality of life among alcohol dependents.

In relation to depression, the mean pretest and posttest level of depression were 27.833 (SD \pm 6.558) and 8.166 (SD \pm 4.646) respectively. The mean posttest value was lower than the mean pretest value with the mean difference of 20.675. The paired 't' value was 14.439, with the table value of 2.05, which was significant at $p < 0.05$ level, where the result revealed that yoga was effective in reducing depression among alcohol dependents in experimental group.

In relation to quality of life, the mean pretest level of quality of life were 5.90 (SD \pm 1.347) for overall quality of life and general health, 17.40 (SD \pm 2.607) for physical domain, 16.066 (SD \pm 2.273) for psychological domain, 6.633 (SD \pm 1.159) for social domain and 19.966 (SD \pm 2.822) for environmental domain. The mean posttest level of quality of life were 7.433 (SD \pm 1.194) for overall quality of life and general health, 283.33 (SD \pm 2.154) for physical domain, 24.233 (SD \pm 2.373) for psychological domain, 13.033 (SD \pm 1.376) for social domain and 33.766 (SD \pm 3.070) for

environmental domain. The mean posttest scores of quality of life were higher than the mean pretest scores of quality of life, with the mean difference of 1.533 for overall quality of life and general health, 10.933 for physical domain, 8.167 for psychological domain, 6.40 for social domain and 13.80 for environmental domain. The paired 't' value of quality of life were 5.275 for overall quality of life and general health, 17.629 for physical domain, 15.968 for psychological domain, 16.623 for social domain and 20.598 for environmental domain, with the table value of 2.05, which were significant at $p < 0.05$ level. The results revealed that yoga was effective in increasing the quality of life among alcohol dependents in experimental group.

In comparison, the mean posttest level of depression in experimental and control group were 8.166 (SD ± 4.646) and 12.833 (SD ± 4.816) respectively. The mean posttest score of experimental group was lower than the mean posttest score of control group with the mean difference value of 4.667. The independent 't' value was 4.413, with the table value of 2.02, which was significant at $p < 0.05$ level. The result revealed that yoga was effective in reducing the level of depression among alcohol dependents in experimental group.

In experimental group, the mean posttest level of quality of life were 7.433 (SD ± 1.194) for overall quality of life and general health, 28.333 (SD ± 2.154) for physical domain, 24.233 (SD ± 2.373) for psychological domain, 13.033 (SD ± 1.376) for social domain and 33.766 (SD ± 3.070) for environmental domain. In control group, the mean posttest level of quality of life were 6.566 (SD ± 1.304) for overall quality of life and general health, 26.733 (SD ± 2.523) for physical domain, 22.70 (SD ± 2.151) for psychological domain, 10.933 (SD ± 1.638) for social domain and 29.466 (SD ± 3.047) for environmental domain respectively. The independent 't' value of quality of life were 2.592 for overall quality of life and general health, 2.807 for physical domain, 2.833 for psychological domain, 4.437 for social domain and 5.890 for

environmental domain, with the table value of 2.02, which were significant at $p < 0.05$ level. The results revealed that yoga was effective in increasing quality of life among alcohol dependents in experimental group.

The negative correlation was found between depression and quality of life among alcohol dependents. The mean and standard deviation of depression was 8.166 (SD \pm 4.466) and the quality of life were 7.433 (SD \pm 1.194) for overall quality of life and general health, 28.333 (SD \pm 2.154) for physical domain, 24.233 (SD \pm 2.373) for psychological domain, 13.033 (SD \pm 1.376) for social domain and 33.766 (SD \pm 3.070) for environmental domain respectively. The negative correlation r value for depression and quality of life were -0.222, -0.291, -0.301, -0.195 and -0.158 respectively. The above findings revealed that the yoga was effective in decreasing the level of depression and improving the level of quality of life among alcohol dependents in experimental group.

An association between posttest level of depression and their demographic variables among alcohol dependents using chi square value findings revealed that there was no significant association between the posttest level of depression and their demographic variables.

An association between the posttest level of quality of life and their demographic variables among alcohol dependents using chi square value findings revealed that there was a significant association at $p < 0.05$ between the posttest level of quality of life and their demographic variables among alcohol dependents in experimental group. With regard to physical domain, the χ^2 value was 8.978 for occupation. With regard to psychological domain, the χ^2 value was 9.1 for type of family. With regard to social domain, χ^2 value was 6.05 for duration of alcohol consumption. With regard to environmental domain, the χ^2 value was 10.1 for type of family.

CONCLUSION

The present study was conducted to assess the effectiveness of yoga on depression and quality of life among alcohol dependents at Athma de-addiction centre, Trichy. There is a significant difference between the pretest and posttest level of depression, the paired 't' value was 14.439, with the table value of 2.05, which was significant at $p < 0.05$ level, among alcohol dependents in experimental group. There is a significant difference between the pretest and posttest level of quality of life, the paired 't' value of quality of life were 5.275 for overall quality of life and general health, 17.629 for physical domain, 15.968 for psychological domain, 16.623 for social domain and 20.598 for environmental domain, with the table value of 2.05, which were significant at $p < 0.05$ level, among alcohol dependents in experimental group. There is a significant difference between the posttest level of depression in experimental and control group, the independent 't' value was 4.41, with the table value of 2.02, which was significant at $p < 0.05$ level among alcohol dependents. There is a significant difference between the posttest level of quality of life in experimental and control group, the independent 't' value of quality of life were 2.592 for overall quality of life and general health, 2.807 for physical domain, 2.833 for psychological domain, 4.437 for social domain and 5.890 for environmental domain, with the table value of 2.02, which were significant at $p < 0.05$ level among alcohol dependents. There was a negative correlation between depression and quality of life among alcohol dependents. The negative correlation values (r) for depression and quality of life were -0.222, -0.291, -0.301, -0.195 and -0.158, with the table value of 0.36 respectively. The study results concluded that yoga was effective in reducing the level of depression and improving the level of quality of life among alcohol dependents in experimental group.

IMPLICATIONS

The findings of the study have certain important implication for nursing services, nursing education, nursing administration and nursing research.

Nursing service:

Nursing professionals are in the best position to provide yoga exercises to alcohol dependents.

Nurses should be trained on yoga exercises to practice regularly on alcohol dependents.

Nurses as the change agent, can introduce the yoga exercises in improving quality of life and reducing the depression among alcohol dependents.

Nursing education:

Impart the concepts of relaxation therapies to the nursing students in reducing the depression among alcohol dependents.

Impart the concepts of complementary and alternative medicine to the nursing students.

Nursing students can utilize the relaxation techniques such as yoga, to give health education in hospitals and communities.

Nursing administration:

Nurse administrator can organize the in-service education programme regarding yoga for the health care personnel in hospitals and community.

Nurse administrator can arrange the health awareness program on yoga exercises in hospitals and communities.

Nursing research:

The study findings can be baseline for further studies in improving the body of knowledge in nursing.

The study findings can be effectively utilized by the emerging researchers to conduct further studies.

RECOMMENDATIONS

Based on the findings the following recommendations are stated,

- ▲ The same study can be conducted on a larger sample to generalize the results.
- ▲ A study can be conducted to evaluate the effectiveness of yoga on anxiety among alcohol dependents.
- ▲ A study can be conducted to evaluate the effectiveness of yoga on stress among alcohol dependents.
- ▲ A study can be conducted to evaluate the effectiveness of yoga on insomnia among alcohol dependents.
- ▲ A study can be conducted to assess the level of knowledge on nursing personnel on complementary and alternative therapies.
- ▲ A study can be conducted to assess the level of knowledge and attitude on relaxation therapies among alcohol dependents to reduce depression.
- ▲ The study can be replicated in different settings with similar facilities.
- ▲ A longitudinal study could be done to assess quality of life among alcohol dependents after yoga therapy and its impact on rehabilitation and relapse.

LIMITATIONS

The yoga intervention was time consuming due to explaining the yoga positions and exercise technique to the participants.

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APPENDIX – A
ETHICAL COMMITTEE CLEARANCE CERTIFICATE

We, the Undersigned Chairman/ Members of the Ethical Committee, functioning in Bishop's College of Nursing, Dharapuram, have studied the proposed research Subject/ Project of Ms. E. R. Bency Carolin I year M.Sc.,(N), a candidate applying for provisional registration and hereby give the certificate of clearance of approval by this Ethical Committee.

Topic: "A study to assess the effectiveness of yoga on depression and quality of life among alcohol dependents at Athma de-addiction centre, Trichy",

Station:

Date:



[Signature]
Signature of the Chairman/ Members

of the Ethical Committee:

Name of the Institution:

[Signature]
PRINCIPAL,
Seal: BISHOP'S COLLEGE OF NURSING,
C.S.I. MISSION COMPOUND,
DHARAPURAM-638 656,
TIRUPUR DISTRICT



BISHOP'S COLLEGE OF NURSING

(C.S.I. Trichy - Tanjore Diocese)
C.S.I. Mission Compound, DHARAPURAM - 638 656,
Tiruppur District.

☎ Off: 04258 - 221224
223962

Fax : 04258 221224

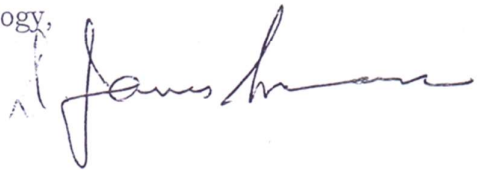
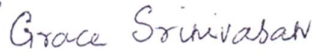



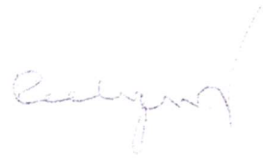
E - Mail : Principalbcndpm@gmail.com

Ref:

Date.....

Ethical Committee Members

Signature

1. Rt.Rev.Dr.Daniel James Srinivasan,
B.A., Philosophy., B.D., P.G.Dip Theology,
M.Th., Ed.D.,
Former Bishop, Theologian,
C.S.I.Nagar,
Dharapuram. 
2. Mrs.Grace Srinivasan, B.Sc., M.A., M.Ed.,
Former Bishop Amma,Rotarian,
C.S.I.Nagar,
Dharapuram. 
3. Dr.Divamathi,M.B.B.S.,D.G.O.,
Nivetha Hospital,
114 Udumalpet Road,
Dharapuram. 
4. Mr.Dhanapal,M.Sc.,(Statistics)
Statistician,
82/12/2.Ganga Nagar,
Pachapali Road,
Railway Colony (PO),
Erode. 
5. Mr.Kalaichaezhian,B.A.,B.L., ML., 
Advocate,
Dharapuram.
6. Dr.Udayakumar,M.Com.,M.Phil.,P.hd.,
Principal,
Bishop Thorp College,
Dharapuram. 

APPENDIX – B

LETTER SEEKING PERMISSION FOR CONDUCTING THE STUDY



BISHOP'S COLLEGE OF NURSING

(C.S.I. Trichy - Tanjore Diocese)
C.S.I. Mission Compound, **DHARAPURAM** - 638 656,
Tiruppur District.

☎ Off: **04258 - 221224**
223962

Fax : **04258 221224**

E - Mail : Principalbcndpm@gmail.com

Ref:

Date.....
14.01.2016

To

The Director,
Athma Institute of Mental Health and Social Science,
12-B, 10th Cross East, Thillai Nagar,
Trichirappalli- 620 018.

Respected Sir,

This is to certify that Ms. E.R.Bency Carolin is a bonafide student of our college doing her M.Sc.,(N) programme II year. As part of her requirement, she has to do a Project on "A Study to assess the Effectiveness of yoga on depression and quality of life among alcoholic clients at Athma de-addiction centre, Trichy."

Kindly permit her to carry out the study in your Hospital.

Thanking you,

Yours faithfully,

Respected Sir

J. N. Arunkumar
20/1/2016

Dr. N. ARUNKUMAR, MD., DNB.,
Consultant Psychiatrist
Reg. No: 82196
Athma Hospitals & Research
12-B, 10th Cross, Thillai Nagar, Trichy-18.

[Signature]
PRINCIPAL,
BISHOP'S COLLEGE OF NURSING,
C.S.I. MISSION COMPOUND,
DHARAPURAM-638 656,
TIRUPUR DISTRICT

APPENDIX – C

LETTER SEEKING EXPERTS OPINION FOR CONTENT VALIDITY

From,

E. R. Bency Carolin,
M.Sc., (Nursing) II Year,
Bishop's college of Nursing,
Dharapuram.

To,

Respected Madam/ Sir,

SUB: Requisition for content validity

I am doing M.Sc.,(Nursing) II in Bishop's college of Nursing, Dharapuram, under The Tamil Nadu Dr. M.G.R Medical University, Guindy, Chennai. As a partial fulfillment of my M.Sc.,(Nursing) Degree Programme, I am conducting a research on, "**A study to assess the effectiveness of yoga on depression and quality of life among alcohol dependents at Athma de-addiction center, Trichy**". A tool has been developed for the research study. I am sending the above stated for your expert and valuable opinion. I will be thankful for your kind consideration. Kindly return it to the undersigned.

Thanking you,

Yours sincerely,

E. R. Bency Carolin

Enclosure:

- 1) Certificate of content validity
- 2) Statement of the problem, objectives, operational definitions, hypothesis
- 3) Description of the tool and tool for data collection
- 4) Self addressed envelope

APPENDIX –D
LIST OF EXPERTS FOR CONTENT VALIDATION

1. **Dr. N. Arun Kumar, MD., DNB.,**
Consultant psychiatrist,
Athma Institute of Mental Health and Social Sciences,
Trichy.
2. **Mrs. S. Geetha**
Psychologist,
Athma Institute of Mental Health and Social Sciences,
Trichy.
3. **Mrs. S. Prabhavathi, M.Sc (N)., PG. Dip (Stat)., M.A (YHE)., Ph.D (N).,**
Principal,
Vellalar College of Nursing,
Erode.
4. **Mr. C. Mahibalan, M.Sc (N),**
Associate Professor,
Doctor's College of Nursing,
Pudukottai.
5. **Mr. Anslin Sugil Kames, M.Sc (N),**
Reader,
Sri Aurobindu College of Nursing,
Karur.
6. **Mrs. S. Muthulakshmi, M.Sc (N),**
Lecturer
Vellalar of College of Nursing,
Erode.

APPENDIX – E
CERTIFICATE FOR VALIDITY

This is to certify that the rating scales on “**A STUDY TO ASSESS THE EFFECTIVENESS OF YOGA ON DEPRESSION AND QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS AT ATHMA DE – ADDICTION CENTER, TRICHY**” has been validated by me and found appropriate with mentioned suggestions.

SIGNATURE:



NAME:

Dr. N. ARUNKUMAR, MD., DNB.,
Consultant Psychiatrist
Reg. No: 82196
Athma Hospitals & Research
12-B, 10th Cross, Thillai Nagar, Trichy-18

DESIGNATION:

COLLEGE/

INSTITUTION:

CERTIFICATE FOR VALIDITY

This is to certify that the rating scales on “A STUDY TO ASSESS THE EFFECTIVENESS OF YOGA ON DEPRESSION AND QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS AT ATHMA DE – ADDICTION CENTER, TRICHY” has been validated by me and found appropriate with mentioned suggestions.

SIGNATURE:



NAME:

DESIGNATION:

COLLEGE/

INSTITUTION:

S.GEETHA
PSYCHOLOGIST
ATHMA INSTITUTE OF MENTAL
HEALTH AND SOCIAL SCIENCES
42B, 10th Cross East, Thillai Nagar
TIRUCHIRAPALLI-620 018.

CERTIFICATE FOR VALIDITY

This is to certify that the rating scales on “A STUDY TO ASSESS THE EFFECTIVENESS OF YOGA ON DEPRESSION AND QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS AT ATHMA DE – ADDICTION CENTER, TRICHY” has been validated by me and found appropriate with mentioned suggestions.

SIGNATURE:



NAME:

PEABHAVATHI. S.

DESIGNATION:

Principal
Vellalar College Of Nursing
Maruthi Nagar,
Thindal, Erode - 12.

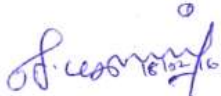
COLLEGE/

INSTITUTION:



CERTIFICATE FOR VALIDITY

This is to certify that the rating scales on “A STUDY TO ASSESS THE EFFECTIVENESS OF YOGA ON DEPRESSION AND QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS AT ATHMA DE – ADDICTION CENTER, TRICHY” has been validated by me and found appropriate with mentioned suggestions.

SIGNATURE: 
NAME: Mr. MAHIBALAN. C
DESIGNATION: Asst. Professor
COLLEGE/
INSTITUTION: Doctor's College of Nursing
Pudukottai.

CERTIFICATE FOR VALIDITY

This is to certify that the rating scales on “A STUDY TO ASSESS THE EFFECTIVENESS OF YOGA ON DEPRESSION AND QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS AT ATHMA DE – ADDICTION CENTER, TRICHY” has been validated by me and found appropriate with mentioned suggestions.

SIGNATURE:



NAME:

MR. ANSHU SUGIL KAMESH

DESIGNATION: READER

COLLEGE/

INSTITUTION:

SRI AUROBINDO COLLEGE
OF NURSING, KARUR.

CERTIFICATE FOR VALIDITY

This is to certify that the rating scales on “**A STUDY TO ASSESS THE EFFECTIVENESS OF YOGA ON DEPRESSION AND QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS AT ATHMA DE – ADDICTION CENTER, TRICHY**” has been validated by me and found appropriate with mentioned suggestions.

SIGNATURE:



NAME:

S. Muthulakshmi

DESIGNATION:

COLLEGE/

VELLALAR COLLEGE
OF NURSING

INSTITUTION:



APPENDIX – F
CERTIFICATE FOR ENGLISH EDITING

This is to certify that the dissertation work on “**A STUDY TO ASSESS THE EFFECTIVENESS OF YOGA ON DEPRESSION AND QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS AT ATHMA DE – ADDICTION CENTER, TRICHY**” done by **Ms. E.R. Bency Carolin., M.Sc., (N)**, II year student of Bishop’s College of Nursing, Dharapuram is edited for English language appropriateness by _____.

Date

Address



A. N. Kelleer
Signature
ASHRAM MATRIC HR. SEC. SCHOOL
KOLLAMPALAYAM, ERODE-2.

APPENDIX – G
CERTIFICATE FOR TAMIL EDITING

This is to certify that the dissertation work on “**A STUDY TO ASSESS THE EFFECTIVENESS OF YOGA ON DEPRESSION AND QUALITY OF LIFE AMONG ALCOHOL DEPENDENTS AT ATHMA DE – ADDICTION CENTER, TRICHY**” done by **Ms. E.R. Bency Carolin., M.Sc., (N)**, II year student of Bishop’s College of Nursing, Dharapuram is edited for Tamil language appropriateness by _____.

Date *

Address



Dr. N. N. N.

Signature

ASHRAM MATRIC HR. SEC. SCHOOL
KOLLAMPALAYAM, ERODE-2.

APPENDIX – H
TRAINING CERTIFICATE FOR YOGA

Vazhga Vaiyagam		Vazhga Valamudan
		
THE WORLD COMMUNITY SERVICE CENTRE 26, Second Seaward Street, Valmiki Nagar, Thiruvanmiyur, Chennai - 600 041. Regd. No. 84/1958 & 22/1993 under T.N.S.R. Act 27/75 Ph : 044 - 24571153 E-Mail : chennai.wsc@vethathiri.edu.in Affiliated Trust Address : TEMPLE OF CONSCIOUSNESS ERODE MANAVALAKKALAI MANDRAM TRUST.		
KAYAKALPA COURSE CERTIFICATE		
This is to certify that		
Thiru / Tmt / Selvan / Selvi. <u>E.R. BENCY CAROLIN</u>		
has successfully participated in the		
KAYAKALPA COURSE		
held at <u>ERODE</u>		
on <u>- 3 JAN 2016</u>		
Be Blessed by the Divine Power  For President The World Community Service Centre		

APPENDIX – I
TOOL – ENGLISH

EFFECTIVENESS OF YOGA DEPRESSION AND QUALITY OF LIFE
DEMOGRAPHIC VARIABLES

1. Age
 - a) 18-25 years
 - b) 26-35 years
 - c) 36-45 years

2. Religion
 - a) Hindu
 - b) Christian
 - c) Muslim

3. Education
 - a) Primary school education
 - b) Higher secondary education
 - c) Degree holder
 - d) No formal education

4. Occupation
 - a) Private employee
 - b) Government employee
 - c) Self employment
 - d) Unemployed

5. Marital status
 - a) Unmarried
 - b) Married
 - c) Divorced
 - d) Widower

6. Monthly income
 - a) < Rs. 5000/-
 - b) Rs. 5000-15000/-
 - c) >Rs. 15000/-

7. Type of the family
 - a) Nuclear family
 - b) Joint family
 - c) Extended family

8. Habitat
 - a) Urban
 - b) Rural
 - c) Semi urban

9. Duration of alcohol consumption
 - a) <5 years
 - b) 5-15 years
 - c) >15 years

10. Nature of the admission
 - a) Voluntary admission
 - b) Involuntary admission

11. History of previous de-addiction treatment
 - a) Yes
 - b) No

If yes,

Number of admissions:

BECK DEPRESSION INVENTORY (BDI II) SCALE

The following questions ask about how much you have experienced certain things in the **last two weeks**,

1. **Sadness**

- 0) I do not feel sad.
- 1) I feel sad much of the time.
- 2) I am sad all the time.
- 3) I am so sad or unhappy that I can't stand it.

2. **Pessimism**

- 0) I am not discouraged about my future.
- 1) I feel more discouraged about my future than I used to be.
- 2) I do not expect things to work out for me.
- 3) I feel my future is hopeless and will only get worse.

3. **Past failure**

- 0) I do not feel like a failure.
- 1) I have failed than I should have.
- 2) As I look back, I see a lot of failure.
- 3) I feel I am a total failure as a person.

4. **Loss of pleasure**

- 0) I get as much pleasure as I ever did from the things I enjoy.
- 1) I don't enjoy things as much as I used to.
- 2) I get little pleasure from the things I used to enjoy.
- 3) I can't get any pleasure from the things I used to enjoy.

5. Guilty feelings

- 0) I don't feel particularly guilty.
- 1) I feel guilty over many things I have done or should have done.
- 2) I feel quite guilty most of the time.
- 3) I feel guilty all of the time.

6. Punishment feelings

- 0) I don't feel I am being punished.
- 1) I feel I may be punished.
- 2) I expect to be punished.
- 3) I feel I am being punished

7. Self- dislike

- 0) I feel the same about myself as ever.
- 1) I have lost confidence in myself.
- 2) I am disappointed in myself.
- 3) I dislike myself.

8. Self- criticalness

- 0) I don't criticize or blame myself more than usual.
- 1) I am more critical of myself than I used to be.
- 2) I criticize myself for all of my faults.
- 3) I blame myself for everything bad that happens.

9. Suicidal thoughts or wishes

- 0) I don't have any thoughts of killing myself.
- 1) I have thoughts of killing myself, but I would not carry them out.
- 2) I would like to kill myself.
- 3) I would kill myself if I had the chance.

10. Crying

- 0) I don't cry anymore than I used to.
- 1) I cry more than I used to.
- 2) I cry over every little thing.
- 3) I feel like crying, but I can't.

11. Agitation

- 0) I am no more restless or wound up than usual.
- 1) I feel more restless or wound up than usual.
- 2) I am so restless or agitated that it's hard to stay still.
- 3) I am so restless or agitated that I have to keep moving or doing something.

12. Loss of interest

- 0) I have not lost interest in other people or activities.
- 1) I am less interested in other people or things than before.
- 2) I have lost most of my interest in other people or things.
- 3) It's hard to get interested in anything.

13. Indecisiveness

- 0) I make decisions about as well as ever.
- 1) I find it more difficult to make decisions than usual.
- 2) I have much greater difficulty in making decisions than I used to.
- 3) I have trouble in making any decisions.

14. Worthlessness

- 0) I do not feel I am worthless
- 1) I don't consider myself as worthwhile and useful as I used to.
- 2) I feel more worthless as compare to other people.
- 3) I feel utterly worthless.

15. Loss of energy

- 0) I have as much energy as ever.
- 1) I have less energy than I used to have.
- 2) I don't have enough energy to do very much.
- 3) I don't have enough energy to do anything.

16. Changes in sleeping pattern

- 0) I have not experienced any changes in my sleeping pattern.
- 1) a. I sleep somewhat more than usual.
b. I sleep somewhat less than usual.
- 2) a. I sleep a lot more than usual.
b. I sleep a lot less than usual.
- 3) a. I sleep most of the day.
b. I wake up 1- 2 hours early and can't get back to sleep.

17. Irritability

- 0) I am no more irritable than usual.
- 1) I am more irritable than usual.
- 2) I am much more irritable than usual.
- 3) I am irritable all the time.

18. Changes in appetite

- 0) I have not experienced any changes in my appetite.
- 1) a. My appetite is somewhat less than usual.
b. My appetite is somewhat greater than usual.
- 2) a. My appetite is much less than before.
b. My appetite is much greater than usual.
- 3) a. I have no appetite at all.
b. I crave food all the time.

19. Concentration

- 0) I can concentrate as well as ever.
- 1) I get more tired or fatigued more easily than usual.
- 2) I am too tired or fatigued to do a lot of the things I used to do.
- 3) I am too tired or fatigued to do most of the things I used to do.

20. Tiredness or fatigue

- 0) I am no more tired or fatigued than usual.
- 1) I get more tired or fatigued more easily than usual.
- 2) I am too tired or fatigued to do a lot of the things I used to do.
- 3) I am too tired or fatigued to do most of the things I used to do.

21. Loss of interest in sex

- 0) I have not noticed any recent change in my interest in sex.
- 1) I am less interested in sex than I used to be.
- 2) I am much less interested in sex now.
- 3) I have lost interest in sex completely.

SCORE INTERPRETATION:

The highest possible score of the scale is 63. The scores are interpreted as follows,

LEVEL OF DEPRESSION	SCORES	PERCENTAGE
Minimal depression	0-13	21%
Mild depression	14-19	30%
Moderate depression	20-28	45%
Severe depression	29-63	100%

**WHO- QUALITY OF LIFE
(26- BREF SCALE)**

The following questions ask about how much you have experienced certain things in the **last two weeks**,

S. No	Questions	Very poor	Poor	Neither poor nor good	Good	Very good
1	How would you rate your quality of life?	1	2	3	4	5
		Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
2	How satisfied are you with your health?	1	2	3	4	5
		Not at all	A little	A moderate amount	Very much	An extreme amount
3	To what extent do you feel that physical pain prevents you from doing what you need to do?	1	2	3	4	5
4	How much do you need any medical treatment to function in your daily life?	1	2	3	4	5
5	How much do you enjoy life?	1	2	3	4	5
6	To what extent do you feel your life to be meaningful?	1	2	3	4	5
7	How well are you able to concentrate?	1	2	3	4	5
8	How safe do you feel in your daily life?	1	2	3	4	5

9	How healthy is your physical environment?	1	2	3	4	5
		Not at all	A little	Mode rately	Mostly	Comple tely
10	Do you have enough energy for everyday life?	1	2	3	4	5
11	Are you able to accept your bodily appearance?	1	2	3	4	5
12	Have you enough money to meet your needs?	1	2	3	4	5
13	How available to you is the information that you need in your day- to-day life?	1	2	3	4	5
14	To what extent do you have the opportunity for leisure activities?	1	2	3	4	5
		Very poor	Poor	Neither poor nor good	Good	Very good
15	How well are you able to get around?	1	2	3	4	5
		Very dissatisfied	Dissatisfied	Neither satisfied	Satisfie d	Very satisfied
16	How satisfied are you with your sleep?	1	2	3	4	5
17	How satisfied are you with your ability to perform your daily living activities?	1	2	3	4	5
18	How satisfied are you with your capacity for work?	1	2	3	4	5

19	How satisfied are you with yourself?	1	2	3	4	5
20	How satisfied are you with your personal relationship?	1	2	3	4	5
21	How satisfied are you with your sex life?	1	2	3	4	5
22	How satisfied are you with the support you get from your friends?	1	2	3	4	5
23	How satisfied are you with the conditions of your living place?	1	2	3	4	5
24	How satisfied are you with your access to health services?	1	2	3	4	5
25	How satisfied are you with your transport?	1	2	3	4	5
		Never	Seldom	Quite often	Very often	Always
26	How often do you have negative feelings such as blue mood, despair, anxiety, depression?	1	2	3	4	5

SCORE INTERPRETATION:

The total score of each domain are, overall quality of life and general health= 10, physical domain= 35, psychological domain= 30, social domain = 15, environmental domain= 40. The scores are interpreted as follows:

Level of quality of life	Scores				
	Overall quality of life and general health	Physical domain	Psychological domain	Social domain	Environmental domain
Dissatisfied	2-4	7-16	6-14	3-7	8-18
Satisfied	5-7	17-26	15-22	8-11	19-29
Highly satisfied	8-10	27-35	23-30	12-15	30-40

TOOL – TAMIL
தன் குறிப்பு - அ

1. வயது
 - அ) 18 - 25 வயது
 - ஆ) 26 - 35 வயது
 - இ) 36 - 45 வயது
2. மதம்
 - அ) இந்து
 - ஆ) கிறிஸ்துவர்
 - இ) முஸ்லீம்
3. படிப்பு
 - அ) ஆரம்ப கல்வி
 - ஆ) மேல்நிலை கல்வி
 - இ) பட்டதாரி
 - ஈ) படிக்காதவர்
4. வேலை
 - அ) தனியார் அலுவலர்
 - ஆ) அரசு அலுவலர்
 - இ) சுய தொழில்
 - ஈ) வேலை இல்லாதவர்
5. திருமணம்
 - அ) திருமணம் ஆகாதவர்
 - ஆ) திருமணம் ஆனவர்
 - இ) விவாகரத்து ஆனவர்
 - ஈ) விதவை

6. மாத வருமானம்
- அ) < ரூ.5000/-
- ஆ) ரூ. 5000 - 15000/-
- இ) > ரூ.15000/-
7. குடும்ப நிலை
- அ) தனி குடும்பம்
- ஆ) கூட்டு குடும்பம்
- இ) பெரிய குடும்பம்
8. இருப்பிடம்
- அ) மாநகரம்
- ஆ) கிராமம்
- இ) நகரம்
9. குடி பழக்கம்
- அ) < 5 வருடம்
- ஆ) 5 - 15 வருடம்
- இ) > 15 வருடம்
10. மருத்துவமனையில் சேர்ப்பு
- அ) சுய விருப்புடன்
- ஆ) வழக்கட்டாயமாக
11. இதற்கு முன் குடிப்பழக்கத்தின் சிகிச்சைக்கு சென்று இருக்கிறீர்களா?
- அ) ஆம்
- ஆ) இல்லை
- ஆம், என்றால்,
எவ்வளவு முறை : _____

பெக், மன அழுத்தமத் பரிசோதனை - பகுதி ஆ

பெயர் :

தேதி :

1. துக்கம்

0. நான் துக்கமாயிருப்பதில்லை
1. நான் துக்கமாயிக்கிறேன்
2. நான் எப்போதும் துக்கமாயிக்கிறேன், அதிலிருந்து என்னால் விடுபட முடியவில்லை
3. நான் தாங்க முடியாத அளவிற்கு துக்கமாயிருக்கிறேன்.

2. எதிர்காலத்தைப் பற்றிய எண்ணம்

0. நான் குறிப்பாக எதிர்காலத்தைப்பற்றி அதைரியப்படுவதில்லை
1. நான் எதிர்காலத்தைப் பற்றி அதைரியப்படுகிறேன்
2. நான் எதிர்நோக்குவதற்கு ஏதும் இல்லாதவனாய் இருப்பதாக உணருகிறேன்
3. நான் எதிர்காலத்தை நம்பிக்கை இல்லாததும் முன்னேற்றமற்ற ஒன்றாகவும் உணர்கிறேன்.

3. கடந்த கால தோல்வி

0. வாழ்க்கை தோல்வியாக அமையவில்லை எனக்கு
1. ஒரு சாதாரண மனிதனைவிட அதிக தோல்விகள் நான் அடைந்துள்ளேன்
2. என் வாழ்க்கையைத் திரும்பி பார்க்கும்போது அதிகத் தோல்விகளைத் தான் பார்த்திருக்கிறேன்.
3. என் வாழ்க்கை முழுத் தோல்வியாகத் தான் உள்ளது.

4. திருப்தியின்மை

0. நான் வழக்கம்போல் எல்லாவற்றிலிருந்தும் திருப்தி அடைகிறேன்
1. நான் முன்போல் எதையும் ரசிப்பதில்லை
2. எனக்கு இப்போது எதிலும் முழுத் திருப்தி இல்லை
3. எவற்றிலும் நான் அதிருப்தியும், கருத்தின்மையுமாக இருக்கிறேன்.

5. குற்ற உணர்ச்சி
 0. குறிப்பாக நான் குற்ற உணர்வு அடையவில்லை
 1. நான் கணிசமான நேரங்களில் குற்ற உணர்வு அடைவதுண்டு
 2. பெரும்பான்மையான நேரங்களில் நான் குற்ற உணர்வு அடைகிறேன்
 3. நான் எல்லா நேரங்களிலும் குற்ற உணர்வு அடைகிறேன்.

6. தண்டனை உணர்ச்சி
 0. நான் தண்டிக்கப்படுவதாக உணரவில்லை
 1. நான் தண்டிக்கப்படலாம் என்று உணர்கின்றேன்
 2. நான் தண்டிக்கப்படுவேன் என எதிர்ப்பார்க்கிறேன்
 3. நான் தண்டிக்கப்படுகிறேன் என உணர்கின்றேன்

7. சுய ஏமாற்றம்
 0. நான் என்னில் ஏமாற்றம் அடைவதாக உணரவில்லை
 1. நான் என்னிடம் ஏமாற்றம் அடைகிறேன்
 2. நான் என்னிடம் அருவெறுப்பு கொள்கிறேன்
 3. நான் என்னையே வெறுக்கிறேன்.

8. சுய விமர்ச்சனம்
 0. நான் பிறரைக் காட்டிலும் மோசமானவன் அல்ல என்று உணர்கின்றேன்
 1. என்னுடைய பலவீனங்களுக்கும், தவறுகளுக்கும் காரணமாக என்னையே நான் நொந்து கொள்கிறேன்.
 2. நான் எல்லா நேரமும் என்னுடைய தவறுகளுக்கு என்னையே கடிந்து கொள்கிறேன்.
 3. எல்லா தீய சம்பவங்களுக்கும் என்னையே கடிந்து கொள்கிறேன்.

9. தற்கொலை எண்ணம்
 0. எனக்கு தற்கொலை செய்து கொள்ளும் எண்ணங்கள் ஏதும் கிடையாது
 1. எனக்கு தற்கொலை செய்து கொள்ளும் எண்ணம் உண்டு, நான் அவ்வாறு செய்ய மாட்டேன்.
 2. நான் தற்கொலை செய்து கொள்ள விரும்புகிறேன்
 3. எனக்கு சந்தர்ப்பம் கிடைக்குமானால் தற்கொலை செய்து கொள்வேன்

10. அழுகை

0. நான் வழக்கத்தைவிட அதிகமாக அழுவதில்லை
1. நான் வழக்கத்தைவிட இப்போது அதிகமாக அழுகிறேன்
2. தற்போது எந்நேரமும் அழுகிறேன்
3. என்னால் அழ முடிந்திருந்தது. ஆனால் தற்போது அழ நினைத்தாலும் முடிவதில்லை

11. எரிச்சல்

0. நான் முன்பைவிட அதிக எரிச்சல் அடைவதில்லை
1. நான் முன்பைவிட எளிதாக எரிச்சலும் வெறுப்பும் அடைகிறேன்
2. தற்போது எந்நேரமும் எரிச்சலுணர்வு அடைகிறேன்
3. நான் மிகவும் எரிச்சல் அடைவதினால், எதாவது செய்துக்கொண்டே இருக்கிறேன்.

12. விருப்பமின்மை

0. நான் மற்ற மக்கள் மீதுள்ள அக்கறையை (விருப்பத்தை) இழக்கவில்லை
1. நான் முன்பைவிட குறைவாக மற்றவர்கள் மீது அக்கறை (விருப்பம்) கொண்டுள்ளேன்.
2. நான் மற்றவர்கள் மீதுள்ள அக்கறையை (விருப்பத்தை) அதிகமான அளவு இழந்து விட்டேன்.
3. நான் மற்றவர்கள் மீதுள்ள அக்கறையை (விருப்பத்தை) யாவற்றையும் இழந்து விட்டேன்.

13. தீர்மானங்கள் எடுப்பது

0. நான் எப்போதும் போலவே தீர்மானங்கள் எடுக்கிறேன்.
1. தீர்மானங்கள் எடுப்பதை முன்பைவிட அதிகமாகத் தள்ளிப் போடுகிறேன்
2. தீர்மானங்கள் எடுக்க அதிக கஷ்டப்படுகிறேன்
3. ஒரு தீர்மானம் கூட என்னால் எடுக்க முடிவதில்லை

14. தகுதி குறைவு

0. நான் முன்பைவிட அழகுக் குறைந்து காணப்படவில்லை என நினைக்கிறேன்.
1. நான் வயோதிகமாகவும், கவர்ச்சி இல்லாமலும் தோன்றுகிறேன் என கவலைப்படுகிறான்.
2. என்னுடைய தோற்றத்தில் ஏற்பட்டுள்ள நிலையான மாறுதல்களே என்னை கவர்ச்சி இல்லாமல் தோற்றமளிக்கச் செய்கின்றன என்று உணர்கிறேன்.
3. நான் முழுவதுமாக அழகற்று (எல்லோரும் வெறுக்கத்தக்க அளவு) இருப்பதாக நம்புகிறேன்.

15. ஆற்றல் குறைவு

0. என்னால் முன்பைப் போலவே நன்றாக வேலை செய்ய முடிகிறது.
1. நான் எந்த வேலையைத் துவக்குவதற்கும் அதிகப்படியான முயற்சி எடுக்க வேண்டியிருக்கிறது.
2. நான் எதைச் செய்தாலும் என்னை நான் உந்திக்கொண்டு செய்ய வேண்டியுள்ளது.
3. என்னால் எந்த வேலையையும் செய்ய முடியவில்லை

16. தூக்கத்தில் மாறுபாடு

0. என்னால் வழக்கம்போல் நன்றாக தூங்க முடிகிறது
1. அ. நான் வழக்கத்திற்கு மாறாக அதிகமாக தூங்குகிறேன்
ஆ. நான் வழக்கத்திற்கு மாறாக குறைவாக தூங்குகிறேன்.
2. அ. நான் வழக்கத்தைவிட அதிகமாக தூங்குகிறேன்
ஆ. நான் வழக்கத்தைவிட குறைவாக தூங்குகிறேன்
3. அ. நான் ஒரு நாளில் அதிக நேரம் தூங்குகிறேன்
ஆ. நான் வழக்கத்தைவிட ஒன்று அல்லது இரண்டு மணி நேரம் முன்னமாக விழித்துக் கொள்கிறேன். அதன் பின் மறுபடியும் தூங்கப் போவது கடினமாக உள்ளது

17. சோர்வு

0. நான் வழக்கத்தைவிட அதிகமாக சோர்வு அடைவதில்லை.
1. நான் முன்பைவிட மிகவும் சீக்கிரத்தில் சோர்வு அடைகிறேன்
2. நான் அநேகமாக எதைச் செய்தாலும் சோர்வு அடைகிறேன்
3. நான் எதைச் செய்வதற்கும் முடியாத அளவிற்கு சோர்வாயிருக்கிறேன்.

18. பசியில் மாறுபாடு

0. என்னுடைய பசியில் எந்த மாற்றமும் இல்லை
1. அ. என்னுடைய பசி வழக்கத்திற்கு மாறாக குறைவாக உள்ளது
ஆ. என்னுடைய பசி வழக்கத்திற்கு மாறாக அதிகமாக உள்ளது
2. அ. என்னுடைய பசி வழக்கத்திற்கு மாறாக குறைவாக உள்ளது.
ஆ. என்னுடைய பசி வழக்கத்தைவிட மிகவும் குறைவாக உள்ளது.
3. அ. எனக்கு பசி என்பதே கிடையாது
ஆ. எனக்கு எல்லா நேரமும் உணவில் அதிக ஆர்வம் உள்ளது.

19. கவனக்குறைவு

0. என்னால் அதிக அளவு கவனம் செலுத்த முடிகிறது.
1. என்னால் எப்போதும் போல கவனம் செலுத்த முடிவதில்லை
2. எனக்கு தொடர்ந்து நீண்ட நேரம் கவனம் செலுத்துவது கடினமாக இருக்கிறது
3. என்னால் எதிலும் கவனம் செலுத்த முடிவதில்லை

20. உடல் நலத்தை பற்றிய கவலை

0. என் உடல் நலத்தைப்பற்றி முன்பைவிட அதிகமாக கவலைப்படுவதில்லை
1. என்னுடைய உடல் உபாதைகளைப்பற்றி உதாரணமாக வலிகள், நோவு அல்லது வயிற்றுப்புரட்சி, மலச்சிக்கள் ஆகியவற்றைப் பற்றி கவலைப்படுகிறேன்.
2. நான் உடல் உபாதைகளைப் பற்றி அதிகக் கவலைப்பட்டுக் கொண்டிருப்பதால் மற்றவைகளைப் பற்றி சிந்திப்பது கடினமாக உள்ளது.
3. நான் உடல் உபாதைகளைப் பற்றி அதிகக் கவலைப்பட்டுக் கொண்டிருப்பதால் என்னால் எதைப்பற்றியும் சிந்திக்க முடிவதில்லை.

21. பால் உணர்ச்சியில் மாற்றம்

0. பால் உணர்ச்சி (செக்ஸ்) விஷயங்களில் சமீபத்தில் எந்த மாறுதலும் இல்லை
1. நான் முன்பைவிட பால் உணர்ச்சி விஷயங்களில் விருப்பம் குறைந்தவனாக உள்ளேன்.
2. நான் முன்பைவிட பால் உணர்ச்சி விஷயங்களில் அதிக விருப்பம் குறைந்தவனாக உள்ளேன்
3. பால் உணர்ச்சி விஷயங்களில் எனக்கு விருப்பம் இல்லை

பகுதி - இ

வாழ்க்கை தர பரிசோதனை

பின்வரும் பகுதியை கவனமாக படித்து, பொருத்தமான பதிலை குறிப்பிடுக

வி. எண்	கேள்வி	ஒரு போதும் இல்லை	சிறிதளவு	குறிப்பிட்டதக்க அளவு	அதிக அளவு	மிகவும் அதிகம்
1.	உங்கள் வாழ்க்கை தரத்தை எப்படி மதிப்பிடுகிறீர்கள்?					

வி. எண்	கேள்வி	மிகவும் திருப்தி இல்லை	திருத்த இல்லை	குறிப்பிட்டு சொல்ல இயலவில்லை	திருப்தி	மிகவும் திருப்தி
2.	உங்கள் உடல் நலத்தை குறித்து எவ்வளவு திருப்தி அடைகிறீர்கள்?					

வி. எண்	கேள்வி	ஒரு போதும் இல்லை	சிறிதளவு	குறிப்பிட்டதக்க அளவு	அதிக அளவு	மிகவும் அதிகம்
3.	உங்கள் வலி உங்களது செயல்பாடுகளை எந்த அளவு பாதிப்பதாக நினைக்கிறீர்கள்?					
4.	உங்கள் தினசரி வாழ்விற்கு எந்த அளவு மருத்தவ உதவி அவசியம் என்ற நினைக்கிறீர்கள்?					
5.	உங்கள் வாழ்வு எவ்வளவு விரும்பத்தக்கதாக இருக்கிறது.					
6.	உங்கள் வாழ்வு எவ்வளவு அர்த்தமுள்ளதாக இருக்கிறது?					

7.	உங்களால் எந்த அளவு கவனத்துடன் செயல்பட முடிகிறது?					
8.	உங்கள் தினசரி வாழ்வில் நீங்கள் எந்த அளவு பாதுகாப்பாக உணர்கிறீர்கள்?					
9.	உங்கள் சுற்றுப்புறம் எவ்வளவு ஆரோக்கியமாக இருக்கிறது?					

வி. எண்	கேள்வி	ஒரு போதும் இல்லை	சிறிதளவு	குறிப்பிடத்தக்க அளவு	அதிக அளவு	முழுவதும்
10.	உங்கள் தினசரி வாழ்விற்குத் தேவையான உடற்சக்தி இருக்கிறது?					
11.	உங்கள் உடல் தோற்றத்தை உங்களால் ஏற்றுக்கொள்ள முடிகிறது?					
12.	உங்கள் தேவைகளை பூர்த்தி செய்ய போதுமான உணவு பணம் இருக்கிறது?					
13.	உங்கள் தினசரி வாழ்விற்கு தேவையான செய்திகள் எவ்வளவு போதுமானதான இருக்கிறது?					
14.	உங்கள் ஒய்வு நடவடிக்கைகளுக்கு எவ்வளவு வாய்ப்பு கிடைக்கிறது?					

வி. எண்	கேள்வி	மிகவும் குறைவு	குறைவு	குறிப்பிட்ட இயல்வில்லை	நன்று	மிகவும் நன்று
15.	உங்களால் பிறருடன் எவ்வளவு நன்றாக பழக முடிகிறது?					

வி. எண்	கேள்வி	மிகவும் திருப்தி இல்லை	திருப்தி இல்லை	குறிப்பிட்டு சொல்ல இயலவில்லை	திருப்தி	மிகவும் திருப்தி
16.	உங்கள் தூக்கம் குறித்து எவ்வளவு திருப்தியாக இருக்கிறீர்கள் ?					
17.	உங்கள் தினசரி நடவடிக்கைகள் குறித்து எவ்வளவு திருப்தியாக இருக்கிறீர்கள் ?					
18.	உங்களை குறித்து நீங்கள் எவ்வளவு திருப்தியாக இருக்கிறீர்கள் ?					
19.	உங்கள் வேலைத்திறன் குறித்து நீங்கள் எவ்வளவு திருப்தியாக இருக்கிறீர்கள் ?					
20.	உங்கள் தனிப்பட்ட உறவுகள் குறித்து எவ்வளவு திருப்தியாக இருக்கிறீர்கள் ?					
21.	உங்கள் பாலுறவு குறித்து எவ்வளவு திருப்தியாக இருக்கிறீர்கள் ?					
22.	உங்கள் நண்பர்களில் உதவி குறித்து எவ்வளவு திருப்தியாக இருக்கிறீர்கள் ?					
23.	உங்கள் வாழிடம் குறித்து எவ்வளவு திருப்தியாக இருக்கிறீர்கள் ?					
24.	உங்கள் மருத்துவ வசதிகள் குறித்து எவ்வளவு திருப்தியாக இருக்கிறீர்கள் ?					
25.	உங்கள் போக்குவரத்து குறித்து எவ்வளவு திருப்தியாக இருக்கிறீர்கள் ?					

வி. எண்	கேள்வி	ஒருபோதும் இல்லை	அரிதாக	அவ்வப்போது	அடிக்கடி	எப்போதும்
26.	எவ்வளவு முறை உங்களுக்கு எதிர்மறை எண்ணங்கள் (கோபம், மன அழுத்தம், மன சோர்வு) தோன்றுகிறது.					

APPENDIX – J
PHOTOS







