A STUDY TO EVALUATE THE EFFECTIVENESS OF GROUP THERAPY ON DEPRESSION AMONG ALCOHOLICS AT A SELECTED DE- ADDICTION CENTRE IN MADURAI.

M.Sc (NURSING) DEGREE EXAMINATION
BRANCH –V MENTAL HEALTH NURSING
JAINEE COLLEGE OF NURSING, DINDIGUL.

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Registration Number: 681420537

A DISSERTATION SUBMITTED TO THE TAMILNADU
DR.MGR MEDICAL UNIVERSITY, CHENNAI,
IN PARTIAL FULFILLMENT FOR THE DEGREE OF
MASTER OF SCIENCE IN NURSING

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OCTOBER 2018

CERTIFICATE

This is to certify that this dissertation titled**, "A STUDY TO EVALUATE THE EFFECTIVENESS OF GROUP THERAPY ON DEPRESSION AMONG ALCOHOLICS AT SELECTED DE-ADDICTION CENTRE IN MADURAI"** is a bonafide work done by **Mrs.THULASI,** M.Sc (N) Student, Jainee College of Nursing, Dindigul, submitted to THE TAMILNADU DR.M.G.R. MEDICAL UNIVERSITY, CHENNAI in partial fulfillment of the university rules and regulations towards the award of the degree of **MASTER OF SCIENCE IN NURSING, Branch V, Mental Health Nursing,** under our guidance and supervision during the academic period from 2016—2018.

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ABSTRACT

Title: A study to evaluate the effectiveness of group therapy on depression among alcoholics at a selected de-addiction centre in Madurai. **Objectives:** To assess level of depression comparing between the control and experimental before Interventation, to assess the level of depression comparing between control and experimental after Interventation, to assess the effectiveness between the control and experimental group, to assess the pre test associated between the demographical variable and level of depression. **Hypotheses:** There significant difference in the level of depression before and after group therapy among alcohol dependency, there is a statistically significant association between level of depression and demographic variable. **Methodology:** Quasi experimental research design (Pre-test and post-test control group design was used 60 adults were selected at de-addiction centre in Madurai, pre test was conducted on first day after obtaining consent, group therapy was given for 1 ½ hours daily in the morning for 10 consecutive days and post test on 11th day by using beck depression inventory scale. **Findings:** The group therapy improved the level of depression among alcoholics, there was a significant association between post test level of depression and adult age educational status, monthly income, amount of alcohol taken per day, occupational. **Conclusion:** The present study assessed the effectiveness of group therapy on depression among adults in selected in de-addiction centre in Madurai. The result of the study concluded that group therapy has reduced the depression among alcoholics, it will enhances an overall sense of will being as well as improvement in the quality of life

Key words: Group therapy, depression among alcoholics.

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CHAPTER I
INTRODUCTION

CHAPTER I

INTRODUCTION

"First the man takes a drink
Then the drink takes a drink
And then drink takes the man"
(Japanese proverb)

Alcoholism is a chronic disease manifested by repeated drinking that produces injury to the drinker's, health or to social or economic functioning. – Nambi, S.

Alcohol use can slide into abuse and then dependence. People who are dependent on alcohol or drugs may build up tolerance and need increasing amounts to feel the same effects. They may spend more time obtaining and using them, as well as recovering from their effects. They may find themselves repeatedly unable to quit using substances, even once they recognize that they have a problem. When they do quit, they can go into withdrawal, which is sometimes life threatening.

Alcohol use is widely prevalent in Indian society and consequently results in widespread losses in the form of injurious physical health outcomes like cirrhosis of liver, heart disease, diabetes as well as leads to absenteeism, road traffic accidents and various mental health and behavioural problems. Alcohol is one of the leading causes of death and disability globally and the same is true for our country India. A total of 3.2% of deaths worldwide are caused by alcohol every year. As per World Health Organization One fourth to One third of male population drinks alcohol in India and neighbouring south Asian countries and the use amongst women in increasing.

Depression is a state of aversion even to daily activities or showing symptoms like restlessness, disturbed sleep, extreme guilt, difficulties with concentration or decision making. An estimated 20% of the world _ s adolescents have a mental health

or behavioral problem. The World Health Organization(WHO) stated that depression is the fourth leading cause of worldwide disease in causing more disability than either coronary vascular disease or Cerebra vascular disease. By the year 2020, depression is projected to reach second place ranking of Disability- Adjusted Life Year (DALY) calculated for all ages and sex. Depression is an insidious disease & difficult to recognize in children as they have higher rates of internalization & symptoms are masked by depressive equivalents like hyperactivity aggressiveness and irritability.

Alcohol Use Disorder is the continuous use of alcohol despite evidence of harm and repeated attempts to cut down the use. It includes tolerance to alcohol which means higher amount is needed progressively to have the same effect and a characteristic cluster of mental and behavioural symptoms appearing when one does not take alcohol i.e., withdrawal. Alcohol use disorder results in harm and damage to one's physical and mental health, affects one's functioning at work and results in relational conflicts and social and legal problems.

Prevalence and Extent of Problem in India

Alcohol use is quite common in India both in rural and urban areas with prevalence rates as per various studies varying from 23% to 74% in males in general and although it's not that common in females but it has been found to be prevalent at the rate 24% to 48 % in females in certain sections and communities.

In 2005 the estimated numbers of people using alcohol in India was 62.5 million with 17.4 % of them (10.6 million) having alcohol use disorder and of all hospital admissions in India 20-30% are due to alcohol related problems.

Alcoholism and drug addiction are diseases. The craving that an alcoholic or addict feels for their substance of choice can be as strong as the need for food or water. They will continue using despite serious family, health, or legal problems. Alcohol and/or drug use doesn't necessarily have to affect your ability to function academically to be a problem. Consider also how it affects your health, relationships, and overall behaviour. According to recent research by WHO, alcohol abuse or dependence may increase a person's risk for developing depression in the first place. One explanation is that alcohol might trigger a genetic vulnerability for the disorder. Also, because alcohol is a depressant, this may lead to depressed mood among people who already abuse or depend on alcohol. Also, having a family member who's struggled with alcoholism or depression increases your risk for both disorders.

The relationship of alcohol and depression has always been a subject of clinical and scientific interest. Though many studies have been carried out to clarify the mode of this relationship it still remains in its complexity an area for further research. The two basic ideas of a possible connection are on one hand symptomatic alcoholism with a pre-existing depression and on the other hand alcoholism leading to a symptomatic depression.

1.1 Need for study

Alcohol use is an important public health problem, especially in developing countries like India. It is estimated that 20–40% of men between 15 and 60 years of age consume alcohol regularly.3 In 2012, worldwide 3.3 million people die every year due to harmful use of alcohol, representing 5.9% of all deaths. In India (May 2014), WHO found that 32% of men and fewer than 11% of women over the age of 15 drink alcohol.4 In Puducherry, as per Indian Journal of Psychiatry dated March 20, 2015,

around 30–50% of male suicides were under the influence of alcohol and many wives have been driven to suicide by their alcoholic husbands. Alcoholism is a major public health problem in Puducherry. studies have found that group therapy focusing on social skills, coping styles education about the addiction, interpersonal dynamics and the treatment of self deficits is useful in achieving and retaining recovery from alcohol. Group therapy allows to learn from the experiences of others with similar problems and also allow to better understand how people vary from one's view about the world and interact with others.

Cognitive- behavioral perspective has given the most influential theories about roots, causes and treating of depression in recent years. The cognitive model of depression was developed by Aaron Beck, a psychiatrist who became disenchanted with psychodynamic theories of depression early in his career and developed his own cognitive theory of depression. Whereas the most prominent symptoms of depression have generally been considered to be the affective or mood symptoms, Beck hypothesized that the cognitive symptoms of depression may often precede and cause the affective or mood symptoms rather than vice versa.

This study investigated the relationship between the TCI dimensions, neuroticism and extraversion and symptoms of depression and anxiety among 441 participants from the general population survey, and also between neuroticism and extraversion and MDD in a cohort of 193 secondary level care MDD patients as compared with the general population.

The specific aims of the study were as follows

I. To investigate among the general population, 1) whether Harm Avoidance would have a positive and Self-Directedness a negative correlation with both depressive and anxiety symptoms, 2) whether these dimensions would predict

the use of health care services for mental disorders, and 3) whether Harm Avoidance but not Self-Directedness would be associated with self-reported family history of mental disorders.

II. To investigate among the general population, 1) whether neuroticism would have a positive and extraversion a negative correlation with depressive and anxiety symptoms, and 2) whether both dimensions would be related to the use of health care services for psychiatric reasons.

III. To investigate, 1) whether neuroticism and extraversion would be affected by depression (the 'state effect'), 2) and/or be shaped by the recurrence or relapse of depressive episodes (the 'scar effect') and finally, 3) whether these dimensions would act as risk factors for depression ('trait effect').

IV. To investigate among MDD patients, 1) whether a dose-exposure relationship would exist between standardized levels of neuroticism and extraversion and the type and number of co morbid axis I and II disorders, and 2) to investigate the standardized scores of neuroticism and extraversion among pure MDD and with co morbid axis I or II disorders.

Hoffman T et.al conducted a study on Bibliotherapy to treat mild to moderate depression, as a sole or supplementary therapy. The patient works through a structured book, independently from the doctor. The role of the doctor is to support and motivate the patient as they continue through the book and to help clarify any questions or concerns the patient may have. Relevant books can be purchased or often borrowed from a library, with limited cost and good accessibility from a patient perspective. Patients need to have a reading age above 12 years and have a positive attitude toward self-help. Bibliotherapy has got evidence of efficacy and no serious adverse effects have been reported. (Hoffman T, Pirotta M. A study on Bibliotherapy

to treat mild to moderate depression or sub threshold depressive symptoms, as a sole or supplementary Therapy. Clinical Psychology and Psychotherapy. Nov 2010).

Yang Wang conducted a study on efficacy of Bibliotherapy to the coping method and social support of Chinese patients with depression in rehabilitation. A total of 362 patients with depression were randomly assigned to study group with Bibliotherapy [n=184] and control group without Bibliotherapy [n=178] for 4 weeks. The subjects were randomized into groups with 9 to 12 individuals in each group. Members of each group underwent Bibliotherapy every day. The length of time reading each day was 2 [or 1] hours and consisted of a free-reading period for 40 minutes and a communication period [one group is one unit] for 20 minutes. The study results revealed that the differences of decreased scores were significant in the two groups on retarder's factors, hopeless factors and total score of Hamilton depression rating scale. (Yang Wang. Bibliotherapy for Chinese Patients with Depression in Rehabilitation, Department of Psychiatry. School of Medicine Shandong University. March 2012.)

Hence the depression is common among adults; it causes thought distortion among them and also the previous research study shows that Bibliotherapy will be the effective one to make the elderly to change the distorted thought. This made the investigator to assess the effectiveness of Bibliotherapy on depression among adults.

1.2 Statement of the problem

A study to evaluate the effectiveness of group therapy on depression among the alcoholics in selected Deaddiction Centre at Madurai

1.3 Objectives of the study

- To assess level of depression comparing between the control and experimental before Interventation.
- To assess the level of depression comparing between control and experimental after Interventation.
- To assess the effectiveness between the control and experimental group.
- To assess the pre test associated between the demographical variable and level of depression.

1.4 Hypotheses

- H1 – There significant difference in the level of depression before and after group therapy among alcohol dependency
- H2 - There is a statistically significant association between level of depression and demographic variable (age, religion, marital status, level of education, types of family, monthly family income, residential area, occupation and amount of alcohol taken per day, hobbies).

1.5 Operational definition

Evaluate

In this study it refers to determine the level of depression among alcoholics by using beck depression inventory in Wisdom Hospital and Deaddiction Centre in Madurai

In this study it refers to scientific methods to assess the design, implementation, improvement or outcome of a program.

Effectiveness

Effectiveness refers to the significant improvement in the level of depression achieved by group therapy that is measured by structured interview scheduled.

Alcoholics

Habitual intoxication prolonged and excessive intake of alcoholic drinks leading to a breakdown in health and an addiction to alcohol such that abrupt deprivation leads to severe withdrawal symptoms.

Depression

The depression is a common and serious medical illness that negatively affects how you feel, the way you think and how you act, it is also treatable depression causes feelings of sadness or loss of interest in activities once enjoyed that it as lead to a variety of emotional and physical problems and can degrease a person's ability to function at work and at home.

Group therapy:

The group therapy is a form of psycho social treatment where a small group of patients meet regularly to talk, interact and discuss problems each others.

De- addiction centre:

This is a place where psychiatric and psychological assistance is given to overcome alcohol dependence.

1.6 Assumptions

- Alcoholic dependents may have depression
- Group therapy will help to prevent relax of alcoholic dependents.
- Group therapy may be a effective method to reduce the depression.

1.7 Delimitation

- The study is limited to 60 adults
- The study period is limited to 4 weeks
- The study is limited only to male

1.8 Project Outcome

- The study will help to identify the level of depression among alcoholics in the adults group admitted in Deaddiction Centre in Madurai
- Group therapy will improve the depression among the alcoholics.
- The findings of the study will help the counselor and other health care professionals to practice in community and use it in health care setting.

CHAPTER II
REVIEW OF LITERATURE

CHAPTER II

REVIEW OF LITERATURE

A study conducted on assessing the severity of depressive status in recently detoxified alcoholics. This study summarizes this controversy and discusses its implication for developing improved measures of depression severity among alcoholics. The beck depression inventory responses of 130 alcoholic applicants applying for inpatient care were evaluated using a two- parameter normal item response model. This study demonstrates that a single dimension of depression severity accounts for patient response well, but that seven BDI items were relatively poor markers of syndrome severity for these alcoholics. The study documents growing consensus among investigator as to which BDI items constitute a fair scale of depression severity among alcoholic patients the availability of " unbiased criteria " for assessing the severity of depression among alcoholics applying for inpatient treatment will enable investigators clinicians to recognize patient with concomitant alcoholism and affective disorder for special attention or treatment.

A study conducted on the reliability and variability of the inventory to diagnose depression in alcohol dependent men and women. They were used inventory to diagnose depression, beck depression inventory, and structured clinical interview for the DSM, method. They conclude internal reliability and item – total correlation were generally good and the IDD severity score correlated highly with the BDI.

A study conducted on symptoms and diagnosis of depression in alcoholics. They examined depressive symptoms, using the beck depression, in a group of 50 alcoholic patients, diagnosed according to DSM- III criteria during active drinking, withdrawal, and abstinence. DSM- III diagnoses of major depression were made in 16

(32%) of the patients. The diagnoses were made using the NIMH diagnostic interview schedule between the 10th and 24th day after the patients last drink. Depressive symptom decreased markedly as the patient progressed from active drinking to abstinence. Alcoholic patient having a diagnosis of major depression and higher BDI scores than those not having a diagnosis of major depression.

MANAGEMENT OF ALCOHOLISM MODELS OF ALCOHOLISM:

Alcoholism has been defined in a number of ways, each of them making assumption about the cause of the disorder and suggesting a specific course of treatment. What we view as attributes of alcoholism determines what should be studied to understand it and what should be done to treat it. Hence the investigator feels that an evaluation of various models and treatment would throw more light into the present enquiry to find out the efficacy of AA partnership and relaxation training in managing stress and maladjustment among alcoholics.

Moral model is the oldest and deep - rooted view regarding alcoholism. It holds that drinking behaviour is either due to the failure of the individual's will power or is due to the influence of an external evil force. The contemporary manifestation of this view stresses personal failure or willful sin. As per this model alcoholic is considered to be personally responsible for the problem.

Medical model holds that alcoholism is a disease, runs a fairly predictable course and has a biological origin. Jellinek (1960) is one of the most important advocates of this view. Although he considered this model as a working hypothesis, other writers treated this disease concept as the final word.

Psychologists have proposed two different models, the Psychodynamic model and the Behaviouristic model. Social learning phenomenon is viewed as causal factor

in both these models. Psychodynamic model emphasis on emotional mental states as explanation for drinking behaviour. On the other hand. behaviorism looks to contemporary environmental contingencies . The history of reinforcement and the role of alcohol in avoiding negative emotional reaction is emphasized in this model. Social model holds that alcoholism is not evenly distributed across societies and demographic groups; and the judgment that someone is an alcoholic is made with reference to the existing social norms and standards. Social expectations play a significant role in the genesis of alcoholism. A society which permits utilitarian use of alcohol is likely to have higher rate of alcoholism compared to a society which restricts its use. Women alcoholics are less in number since they are discouraged from taking alcohol by social norms (James. 1982)

Based on the different models discussed above specific treatment programmes for alcoholism had been put forth. Some of the major classes of interventions are discussed here.

Pharmacotherapy

The conception of alcoholism as a disease has fostered investigation of a laze number of medicines as potential agencies for therapy. Antidispotropics include a class of drugs that are prescribed with the aim of creating an adverse physical reaction when the perscln consumes alcohol. Disulfiram is the most important drug of this kind. A person [akin? optimum doze of Disulfiram develops and extremely unpleasant physical reaction on ingestion of alcohol due to the accumulation of acetaldehyde in the body which leads to nausea vomiting skin rashes and other forms of allergy reactions due to the possible potential side effects, cognitive impairment and

deleterious health effects, the wisdom of choosing his drug as a routine agent is being questioned recently (Miller and Hester, 1988).

Psychotropic's form another group of medicines used in the treatment of alcoholism, assuming that by treating the underlying psychopathology which presumably causes excessive drinking, alcohol abuse could. Controlled. Drug therapy is indeed indispensable when the alcoholic patient show persistent psychotic features, but the volume of research does not substantiate psychotmpics as primary therapeutic agent for alcoholism (Since 1988).

Aversion Therapy

Aversion therapies have their common goal, the altering of an individual's attraction towards alcohol. Through counter conditioning procedures, alcohol is paired with variety of unpleasant experiences. The oldest form of aversion therapy pairs alcohol with the experience of nausea induced by chemicals while the person takes his favorite drinks. Due to its lesser side effects and economy, pairing alcohol with electric shock has gained popularity recently. A terrifying type of aversion called Apnea - was practiced in 1960s. The aversive stimulus was an injection which induces paralysis for 60 seconds, and alcohol is placed on the lips of the paralyzed patient. The crude and inhuman nature of treatment raised criticism and its application was quickly discouraged,. Convert sensitization which is relatively new among aversion therapies. Is conducted entirely in imagination, pairing of aversive scenes with drinking imagery.

Psychotherapy and counseling

A large number of psychotherapeutic and counseling techniques have been proposed as appropriate for alcoholics. The aim of all psychotherapies and counseling

is to help the patient to learn newer and relatively more adaptive ways of thinking, feeling and behaving and to relieve distress caused by their earlier maladaptive patterns. Since such an approach demands much time and self discipline, alcoholics often show reluctance to submit themselves to dynamic psychotherapy. But researches have reported that psychodynamic group therapy is effective in the management of alcoholism (Brandsma et al. 1988)

Since many of the alcoholics tend to deny or fail to recognize reality of their problem. It becomes necessary that the therapist has to confront them with the reality and persuade into treatment. But research did not support the use of an argumentative style as optimal for inspiring behavioral change. Miller (1985) put forward an alternative feedback model in which the client is given information on his current health status and 1s advised to reduce alcohol consumption. Another form of feedback is video tape self - confrontation (VSC) in which the client is videotaped under intoxication and it is later presented before his. Confrontation in general is stressful and has potential for precipitating dropouts. Negative emotional states. Lowered self esteem and proximal relapse (Faia & Shean. 1976).

Alcoholism Education

An important element that has become common in alcoholism treatment centers is an educational component. Usually it consists of a series of lectures, films, readings or discussion of the topics related to alcohol and alcoholism. Typical content includes the negative effects of alcohol on health and behaviour. In USA, drinking drivers are assigned to education programmes on hazards of drinking and driving (Malfetti, 1975).

Marital and Family Therapy

Alcoholics are not only problematic to themselves, but also are problematic to their family and the community as a whole. Emotional climate in the family and marital problems influence an individual's drinking and viz. Hence the established patterns of family interrelationships support the disorder or undermines the cure. Ganesan (1990) has found that marital problems in the form of sexual inadequacies in the case of males may result in alcohol consumption. For them, the sexual confrontation is more threatening and drinking behaviour is used as an 'escape' mechanism. Recently therapies have increasingly included spouse and other family members in the treatment programme. Researchers have given positive findings which indicates that marital therapy is a worthwhile modality to consider for inclusion in alcoholism treatment (Corder et al. 1972, 0' Farrel and Cutter, 1982).

Controlled Drinking

Controlled drinking is not a treatment method. But an outcome or a goal of treatment. Even when the goal of treatment has been total abstention, some of the clients have been reported to be non abstinent but have found improved. This made clinicians to start moderation oriented treatment for alcoholism. Problem drinkers receiving behavioral self - control training shows marked reduction in consumption. Miller and Munoz (1982) have reported that self - directed Bibliotherapy intervention based on a self help manual was as effective as therapist directed counterpart.

The Literature was searched from extensive review from various sources and was depicted under the following headings.

- **Literature related to depression among alcoholics**
- **Literature related to group therapy**
- **Literature related to management technique.**

2.1 Literature related to depression among alcoholics

Camatta and Nagoshi (1995), found that impulsivity and venture someness were more significantly correlated with quantity and frequency of alcohol use, but not with occurrence of alcohol use problems. Depression, stress and irrational beliefs were significantly correlated with alcohol related problems; but not with alcohol use. Further analysis revealed that effect of stress on alcohol problems was mediated by depression whereas the effect of depression in turn was mediated by irrational beliefs.

Extent of Brain damage and related emotional changes in drug addition was the area of study for Sahni and Bhargava (1990). They reported that psychoactive substances affect a person's mood, feeling, thinking and behaviour and may produce altered states of consciousness. In times of turmoil and stress, drugs are often used as a means of alleviating. anxiety and for coping with problems. Many drug problems today result from use and misuse of multiple drugs that can interact to produce a variety of drastic effects including brain damage and death. Findings of the study indicated that significant difference exist between drug addicts and new addicts on Bender Visual Motor gestalt test scores. The authors attempted to explain the personality variance seen among alcoholics in terms of brain dysfunction.

An experiment was conducted by Hull and Young (1983) to test the proposition that alcohol is consumed as a function of the quality of past performance and the individual's level of private self consciousness. As predicted, high self conscious subjects who have received failure feed back drank significantly more wine than did high self - conscious subjects who received success feedback. Consumption by low self conscious subjects fell between these extremes and did not vary as a function of success or failure. In addition, the data indicated that these results were

mediated by differential sensitivity to the implications of success and failures by high and low self conscious subjects. The results are discussed in terms of their implications for theoretical accounts of the psychological antecedents of alcohol consumption. But further studies didn't totally agree to these findings.

Chassin et al. (1988) conducted a study to evaluate Hull's theory (1983) suggesting that alcohol use may be motivated by a desire to avoid painful states of self awareness. The findings did not support the earlier predictions of self awareness. Goreman and Peters (1990) analysed those life events occurred in the year before the onset of alcohol dependence in 23 patients. Results showed that individuals may enter the initial stages of alcohol dependence in response to stressful life events.

Stewart (1996), in a critical review of literature on alcoholism and exposure to trauma, has observed a strong relationship that exist between exposure to traumatic events and alcohol problems. The relationship is reported to be more concrete between diagnosis of post traumatic stress disorder (PTSD) and alcoholism. Brislin et al. (1995) proposed a model of stress and alcohol use that includes coping preference as an important moderator of women's drinking. The result of the study was consistent with the notion that stress could influence alcohol consumption.

Altonen and Make1 (1994) attempted to understand how male and female alcoholics describe their drinking problems and reported that "the drinking man is threatened by feeling of inferiority, the drinking women by shame and guilt". Durnka and Rossa (1995) conducted a study to find out the role of stress and family relations in mediating problem drinking and father's personal adjustment. Father's problem drinking was found contributing to family stress and father's diminished personal adjustment. Family stress was found related to reduce marital adjustment and personal

adjustment. Dunn et al. (1987) reported that a causal relationship exists between alcohol and marital stress.

Crowe and George (1989) has reviewed the wast literature investigating the relationship between alcohol and human sexuality and concluded that (a) alcohol disinherits psychological sexual arousal and suppresses physiological responding (b) distribution is both pharmacological and psychological (c) expectancies and cognitive impairment can disinherit separately or jointly.

Kline (1990) made an attempt to contemplate the relationship between the beliefs about the behavioural effects of alcohol and pattern of alcohol use. Beliefs that alcohol enhances sexuality, reduces stress, improves sociability and elevates mood were found to be the best predictors of multiple negative drinking related consequences.

Historically wives of alcoholics have been described as having disturbing. Pathological personalities that are instrumental in causing and maintaining - their husband's drinking.

Kogan et a1.(1968) reported that wives of alcoholics exibit more generalized personality distress. Denikar et al. (1964) found that most common traits of wives of alcoholics were dependency, frigidity and other manifestations of neuroticism. Several studies have reported high neurotise among wives of alcoholics (Chakravarthy and Ranganathan, 1985, Kodandararn 1993). Montgomery and Johnson (1992) reported that (a) the behaviour of wives of alcoholics reflects their stressful circumstances. (B) the women in the study reported interpersonal, extra personal and intrapersonal stressors; the most frequently reported and highest ranked

stressor was their relationship with their husbands (c) sobriety doesn't necessarily mean that stressors disappear.

A recent investigation undertaken by Kalarani et al. (1997) attempted to identify the contribution of the husband's alcoholism on the spouse's stress proneness. Wives of chronic alcoholics, occasional drinkers and new drinkers were compared and results showed that spouse's stress proneness is directly related to the severity of husband's drinking.

Limited research has examined the relationship between financial strain and alcohol use. Peirce et al. (1994) reported that the affect regulation model of financial strain and alcohol use was found existing. Generally, depression mediates the relationship between financial strain and drinking to cope. And drinking to cope mediates the relationship between depression and alcohol use. In addition. Both gender and race moderate the relationships.

Peirce et al. (1996) examined whether specific facts of social support moderates the relationship between stress and alcohol involvement. Results supported the buffering influence of tangible support on stress-alcohol involvement relationship.

Boxer and Wild (1993) studied the psychological distress and alcohol consumption among the fire fighters. The findings reveal that 41% of fire fighters experience significant distress which is higher than expected in a typical community of working population. Positive relations were observed between alcohol consumption and the 10 most highly ranked work stressors. Crum et al. (1995) conducted a longitudinal study on 571 subjects which supported the earlier proposition that occupational stress is significantly related to risk of alcohol dependence.

Johnson (1994) in a study among Indian population in America, identified certain problems faced by Indians which are multifaceted and interacting. They bear directly on the community and individual's self-esteem. The four major points of these problems are stress, depression, alcohol drug dependence and racism.

Levenson et al. (1987) studied, the effects of high doze of alcohol on physiological and self-report responses on two stressors (electric shock and self disclosing speech) were compared with the effects of a placebo in three groups of non alcoholic subjects, considered to be at heightened risk for alcoholism by virtue of their (a) having an alcoholic parent (parental risk) or (b) matching a free alcoholic personality profile. These high risk groups were tested with appropriate controls for drinking experience. For female subjects, phase of menstrual cycle was also considered. Results indicated that positively reinforcing effect of alcohol (its capacity to attenuate physiological responses to stress) was more pronounced in high risk group than in low risk group. This relations were found for both parental risk and personality risk factors and in both male and female subjects.

Pehorecky (1991) had reviewed last 10 years' literature on stress and alcoholism. The review covered selected aspects of the interaction of alcohol and stress. Important findings are presented below:- (1) Most of the review focused on the role of stress on alcohol ingestion. Retrospective research based on data from the health and nutrition examination definitely indicated an increase in alcohol consumption with anxiety in certain groups of, as yet not well characterized, individuals. For example, although still insufficiently documented, stress does not appear to play a significant role in alcohol ingestion by women and the elderly. By contrast, stress does appear to play a role in the control of alcohol ingestion by adolescents. Prospective studies employing questionnaire-interview formats generally

support an effect of stress on alcohol ingestion. However, studies employing male college aged social drinkers did not find a correlation between levels of stress and ingestion of alcohol. Alcoholics also differ in the reasons for drinking alcohol, but generally ingest alcohol to lessen anxiety stress. It is clear that the Tension Reduction Hypothesis alone as originally postulated is no longer adequate. Many new models based on an interaction of alcohol and stress have been proposed to explain the control of alcohol consumption. Considering the control of alcohol ingestion, it is unlikely that a single model could possibly be a relevant model to alcohol consumption under specific conditions, or for specific populations. (2) Alcohol has been reported to decrease anxiety in agoraphobic. The self-medication by agoraphobic may contribute significantly to their alcohol abuse. (3) Alcohol has also been reported to decrease tremor of the hands in stressed subjects as well 2s in patients with essential tremor. (4) Although a number of studies have employed electro dermal activity to understand the interaction of alcohol and stress, the results have been rather inconsistent. (5) The controversy on the reported beneficial effect of alcohol on the cardiovascular system persists. A number of studies have shown a J or U shaped relationship between alcohol and stress induced coronary heart disease. Alcohol may also influence stress induced changes in blood pressure in individuals ingesting less than two drinks per day compared with abstainers of heavy alcohol imbibes, the evidence is not conclusive. (6) it is not clear whether the interaction of alcohol and stress involves alternation in plasma catecholamine's.

2.2 Literature related to group therapy

Brennan et a1.(1994): conducted a longitudinal analysis of the late life problem drinkers on personal and environmental risk factors as predictors of alcohol use, depression and treatment seeking. Study concluded that personal risk factors such

as prior function, male unmarried. Early onset of drinking and avoidance coping are independently predictive of poor outcomes. Among environmental risk factors, negative life events, chronic health, spouse stressors and having more friends who approved of drinking were independent predictors of poorer follow-up functioning and treatment seeking. Interaction between personal and environmental risk factors helped to predict subsequent alcohol consumption and treatment seeking.

Maharaj (1990): investigated the relationship between alcoholism, depression. Life event, stress. And purpose in life. Thirty-five first admission alcoholics nnd an equal number of Alcoholic Anonymous members were assessed on alcoholism, depression. >tress and purpose in life using objective measures. The results indicated significant differences between the two groups on drinking behaviour, depression and purpose in life. However, no difference was noted between groups on stress. Positive correlation was obtained between drinking behaviour and depression, life events and purpose in life. McCann (1990) reported significantly higher prevalence rates of depression and obesity among family members of alcoholics compared to that of non alcoholics.

Windele and Biller (1990): reported that depression was significantly associated with problem drinking. Akerlind and Hornquist (1990) in a detailed evaluation of 78 alcoholics concluded that change in loneliness was accompanied by change in well-being, mood related psychiatric variables and satisfaction with autonomy and life as a whole.

Grant BF and Harford TC (1995): The authors made a study on Co morbidity between DSM-IV alcohol use disorders and major depression using a representative sample of the United States. In this study the association between

alcohol dependence and major depression was greater than the association between abuse and major depression and the association between alcohol abuse and major depression was consistently greater for females and blacks compared to their male and non-black counterparts. Implications of the results are discussed in terms of professional help seeking, the self-medication hypothesis, and differential social control theory.

Gatti, E. et al (2008): To assess the social, personality and behaviors of alcoholics using Virtual Reality (VR) evaluated the difference between assessment methods by comparing the VR assessment protocol with the SCID -Structured Clinical Interview for DSM-IV Axis I Disorders - in a sample of 20 alcohol-dependent individuals (10 experimental group + 10 control group) entering a non-pharmacological outpatient treatment. The data, obtained using both qualitative and quantitative analyses, confirm the possibility of using the VR protocol in the assessment of alcohol-dependent patients. Further, the VR group reported a significant improvement in the motivation for change after the assessment protocol, not found in the SCID group: apparently, the experiential approach required by VR makes the patient more active and involved in the processes of introspection and change.

Stewart, S.H & Connors, G.J.(2007): A cross-sectional survey of 50 clinically recognized and subsequently confirmed alcohol-dependent patients admitted to general internal medicine teaching services with no evidence of chronic cognitive functional deficits was conducted by Stewart, S.H & Connors, G.J.(2007) to find out the perceived health status, alcohol-related problems, and readiness to change among medically hospitalized, alcohol-dependent patients. This study evaluated the correlations of readiness to change drinking behaviour with perceived physical and

mental health status and specific alcohol-related consequences of medical inpatients. They concluded that among alcohol-dependent patients with acute medical illness requiring hospitalization, poorer perceived health status was associated with increased recognition of drinking problems and thoughts about changing drinking behaviour.

Ilhan, I.O (2007): In a study conducted by Ilhan, I.O(2007) investigated the psychosocial correlates of alcohol use related problems in a sample of 581 working adolescents (N = 4405), recruited from five vocational schools in Ankara in June 2004 with the CAGE questionnaire, The Beck Depression Inventory, the Beck Hopelessness Scale, the Spielberg State Anxiety Scale, and the Coppersmith Self-Esteem Inventory. Using a multivariate analysis, the anxiety and hopelessness scores, and the length of stay in Ankara were found to be related to alcohol-use problems of the working youth.

Oei, TP.etal. (2007): A number of studies have suggested that task specific self-efficacy has more influence over behavior than general self-efficacy. However, little research has compared the impact of task-specific self-efficacy beliefs to the impact of general self-efficacy in predicting alcohol consumption. Oei,TP.etal.(2007) conducted a study aimed to compare the contribution of general self-efficacy and drinking refusal self-efficacy to volume and frequency of alcohol consumption. Regression analyses were performed in samples of community (n = 298) and clinical (n = 296) drinkers. Overall, drinking refusal self- efficacy was found to be a significant predictor of alcohol consumption in the community sample, while general self-efficacy was found to be a significant predictor of drinking in the clinical sample. These differences highlight the differential roles of general and task specific self-efficacy in governing drinking behavior and suggest future directions for prevention and treatment of alcohol problems.

Shreedevi, Gangadhariah and Bengal (2001): Carried out an exploratory survey on domestic violence, stress and coping in spouses of alcoholic dependents. Data were collected from 75 wives of alcohol dependents individual of NIMAHNS inpatient de-addiction center using a socio-demographic information schedule, perceived stress scale, coping with drinking questionnaire on domestic violence. The findings of the study showed that the commonest domestic violence was intellectual violence followed by emotional violence, social violence, physical violence, economic violence and sexual violence. Wives with higher level of domestic violence showed higher level of stress and the major coping styles reported were avoidance (53%), discard (51.5%), fearful withdrawal (40.4%) and sexual withdrawal (25.8%).

Joseph M. Boden and David M. Fergusson (2011): In their study on Alcohol and Depression. They find out AUD(Alcohol Use Disorder) and MD(Major Depression) is one in which AUD increases the risk of MD, rather than vice versa. Potential mechanisms underlying these causal linkages include neuro physiological and metabolic changes resulting from exposure to alcohol.

Darshan MS et al.(2013): In their study on A study on professional stress, depression and alcohol use among Indian IT professionals. A total of 129 subjects participated in the study. 43.4% of the study population were found to be at risk for developing depression. Subjects who were at risk for developing depression had 4.1 times higher prevalence of harmful alcohol use compared with those who were not at risk for developing depression. Higher rates of professional stress, risk for developing depression and harmful alcohol use among software engineers could hinder the progress of IT development and also significantly increase the incidence of psychiatric disorders.

2.3 Literature related to management technique

Different therapeutic techniques have claimed their efficacy in managing alcoholism. But we are still not sure as to (a) what treatment methods are most effective (b) How to match a particular individual for a specific technique (c) Ho\v IS the effectiveness influenced by length. Intensity and settings of treatment.

Aversion therapy was the most widely used techniques in the past. Kishore and Durr (1986) conducted a study with sixty patients in two groups. One group was given electric aversion therapy and other group was given psychotherapy in addition to aversion therapy. Results indicated that both groups showed remarkable abstinence and improvement. Smith and Frawley (1 991) has reported that a multimodal alcoholism treatment program utilizing aversion therapy was at least as acceptable to patients as counseling centered programmes, and can be expected to give increased abstinence rates. Chakravarthy and Mishra (1990) studied the efficacy of aversion therapy in the management of alcoholism using faradic aversion therapy and covert sensitization. Significant improvement was noted at the end of the treatment. Aversion therapy was experimentally evaluated in the context of alcoholism treatment and was found that it was not more effective than placebo in controlling drinking habit (Miller et al. 1973; Hedberg & Campbell, 1974; Wilson et al, 1975). Wilson (1978) has questioned the empirical justification for continued use of aversion therapy as a treatment alternative.

Since different aversion agents like electric shock, and emetics produce unwanted side effects, Ganesan (1985) pioneered the use of alcohol itself as an aversive agent against problem drinking.

The application of psychotherapeutic techniques in the management of alcoholism has attained currency from researchers and clinicians. Therapeutic approaches including psychoanalysis, T.A, family therapy, confrontation and counseling, group therapy etcare widely used. The efficacy of these techniques is generally accepted. (Wallagren and Barry, 1970; Nietzel et al. 1977. Rachman and Wilon 1980; Saunders. 1990). Sobell and Sobe11 (1973) conducted a major outcomes study comprising behavioural approaches with hospital treatment alone in groups having either an abstinence or a moderation goal. Within the controlled drinking goal, patients receiving the bahavioural treatment were reported to show superior outcome as compared with control subjects at follow ups ranging to 3 years.

Drummond and Glautier (1994) evaluated the effectiveness of cue exposure treatment (CE) in alcoholic dependence. 35 men who were detoxified and purely alcohol dependent received either cue exposure or relaxation control (RC) treatment. CE subjects had 40 minutes exposure to the sight and smell of preferred drink. RC subjects were given relaxation therapy. In a 6 months follow-up, it was found that CE subjects came out with significantly favorable results in terms of latency to relapse and total alcohol consumption. The result pointed out to the importance of cue exposure as a treatment for addictive behaviour.

Botwin et al. (1990) observed a significant prevention effect in the alcohol and other drug use through a multi model cognitive behavioural approach. Saunders (1990) in an exhaustive review found that the efficacy of cognitive behavioural strategies is well documented in the short term and cue exposure response prevention offers promise. It has been theorized that respondent conditioning in past and underlying desire for alcohol contribute to relapse. One implication of this theory is that relevant conditional responses could lie eliminated by respondent extinction.

However. it is also noted that smell of alcohol is not always sufficient to elicit desire for alcohol. In view of this, it has been suggested that introspective cues such as mood states are also important. Extensive studies conducted by Litter a1.(1990) showed that (a) exposure to alcohol cues had no effect on desire for alcohol when subject was in relaxed and neutral mood, (b) negative mood states alone can produce desire for alcohol, regardless whether alcohol was presented or not. The study suggests that reactivity to alcohol cues may be substantially reduced by relaxation.

The efficacy of bio feedback therapy on sobriety outcome in alcoholism treatment was studied by Denney et a1.(1991). The results showed that the frequency of sobriety for those patients with at least 6 sessions was significantly better than those with less or no training. The effect was most prominent with those receiving the highest level of bio-feedback training. Black (1967) found that 12 months improvement rate with electrical aversion (50%) could be improved (59%) by addition of relaxation training.

A study to compare the differential efficacy of anxiety management and relaxation training with respect to their impact on anxiety levels and alcohol consumption among people attending an alcohol treatment unit was undertaken by Ormord and Budd (1991). It was hypothesized that anxiety management would have a greater effect on outcome measures than could relaxation training. The two treatment groups were found to be significantly low on anxiety. Anxiety management was found most effective, however. both had no impact on alcohol consumption.

Alcoholic Anonymous (AA) is another technique in which alcoholics learn themselves, to abstain from alcohol. It is found effective in the management of chronic alcoholic, since AA takes into account the rehabilitation and resocialization

aspect in Deaddiction therapy (Saunders, 1990). Researchers have poured praise on AA and its activities from time to time. Fox and Lyon (1955) called AA "remarkable success", a "shining example" and so on. Beldon (1962) wrote that it has been well established that many alcoholics benefit most from joining the AA. Hayman (1956) after polling psychiatrists has reported that 99% of his respondents approved of AA and 97% has referred patients to it. Of patients, they know in AA, 40% has been abstinent upto one year. Stone (1962) wrote "it seems generally argued the most successful therapeutic treatment for alcoholism has been formulated and established by AA. Black (1962) called AA" Wonderful and inspiring,". In professional literature, AA has been described as an adjunct to other alcoholism treatment programmes (Chwelos et al. 1959, Robson et al. 1965).

Strayer (1961) reported that 29 patients in prolonged group therapy did better after some what disassociating themselves from AA. Mc Ginnis (1963) found that those patients exposed to professionally directed group therapy grew far in ego strength than those imposed to AA. Haertzen et a1 (1968) reported after using personality, habit and attitude tests that membership in AA was "non significant" in their sample of hospitalized alcoholics.

In spite of criticism raised against XA reports for lack of methodological sophistication. Leach (1969) after an exhaustive review of AA studies,, concluded that "AX really does work

McPeak? ct al. (1991) held the \iew that attaining altered states of consciousness is a human motive. The substance dependent population pursue these states destructively by inappropriate use of alcohol and drugs. Despite a body of available literature, the alcohol and drug treatment programmes fail to address this

motive due to lack of social approval, means-end confusion and lack of trained professionals. On the other hand Alcoholic Anonymous directs it members towards an altered state of consciousness called spiritual awakening. Failure to address the patient's need for attaining altered states of consciousness can account for a part of relapses. At the Back Hill hospital, New Hampshire, the authors had introduced Altered State of Consciousness Therapy (ASCT) programme in which patients were taught to consciously manipulate affect and cognition to achieve a new consciousness.

Denney and Baugh (1992) studied the relationship between subjective symptom reduction and sobriety on a large sample of male alcoholics who had completed an impatient alcoholism treatment which included biofeedback or relaxation sessions. Specific symptom reflect for anxiety was significantly correlated with sobriety. In addition, the reduction of symptoms showed a positive trend with sobriety. Chaney et al. (1978) reported that relaxation techniques not only improved interpersonal functioning but also resulted in sequentially reduced alcohol intake in one year follow up.

Mac Nab et al. (1989) determined the family involvement in the treatment of alcoholism. The study observed strong association between greater family involvement and abstinence: later family relationship and positive feelings about self. Zavjalov (1991) proposed Clinical psychological approach to alcoholism and related problem in which the patient and his views and opinion were of prime importance. Collins et al. (1991) pointed out that a structured outpatient treatment programme is safe and effective in alcoholism since it obviate the need for many patients to be admitted as inpatients.

2.4 Conceptual frame work based on Wiedenbach's helping art clinical nursing theory (1964)

A conceptual framework or a model is making up of concepts, which are the mental images of the phenomenon. These concepts are linked together to express the relationship between them. A model is used to express the relationship between them. A model is used to denote symbolic representation of concepts. One of the important purposes of the conceptual framework is to communities clearly the interrelationship of various concepts. It guides an investment to know what data need to be collected and given direction to the entire research process by Ruby L.Wesly. **(Ruby L. Wesly. Nursing theories and models. 2nd edition. Springhouse Corporation Pennsylvani: 2009)**

The study is based on the concepts of administering the Bibliotherapy for adults in the Deaddiction centre will enable the effective reduction on level of depression. The investigator adopted the Wiedenbach's Helping Art Clinical Nursing Theory as a base for developing the conceptual framework. This theory as 3 factors

- Central purpose
- Prescription
- Realities

CENTRAL PURPOSE

It refers to activities taken by the investigator to accomplish the goal. This is a prescriptive theory which directs actions towards an explicit goal. The investigator develops a prescription based on a central purpose and implements it according to the realities of the situation. In this present study, the central purpose was effective reduction on level of depression among adult in a selected Deaddiction centre.

The conceptualization of nursing practice according to this theory consists of three steps as follows

Step 1: Identifying the need for help

Step 2: Ministering the needed help

Step 3: Validating whether the need was met

Step 1: Identifying the need for help

The determination of the need for help is by the process of sample selection on the basis of inclusion and exclusion criteria followed by the pretest assessment on level of depression among adult people in Deaddiction study group and control group by using the beck depression scale.

Step 2: Ministering the needed help

This refers to the provision of required help to fulfill the identify need. It has two components

1. Prescription

2. Realities

1. Prescription

It refers the care to achieve the purpose. This includes the administration of Bibliotherapy, explanation of procedure to the adults and administration of Bibliotherapy to the study group.

2. Realities

It refers to the factor that influences the nursing action in the particular situation. It includes

Agent

The investigator is the agent.

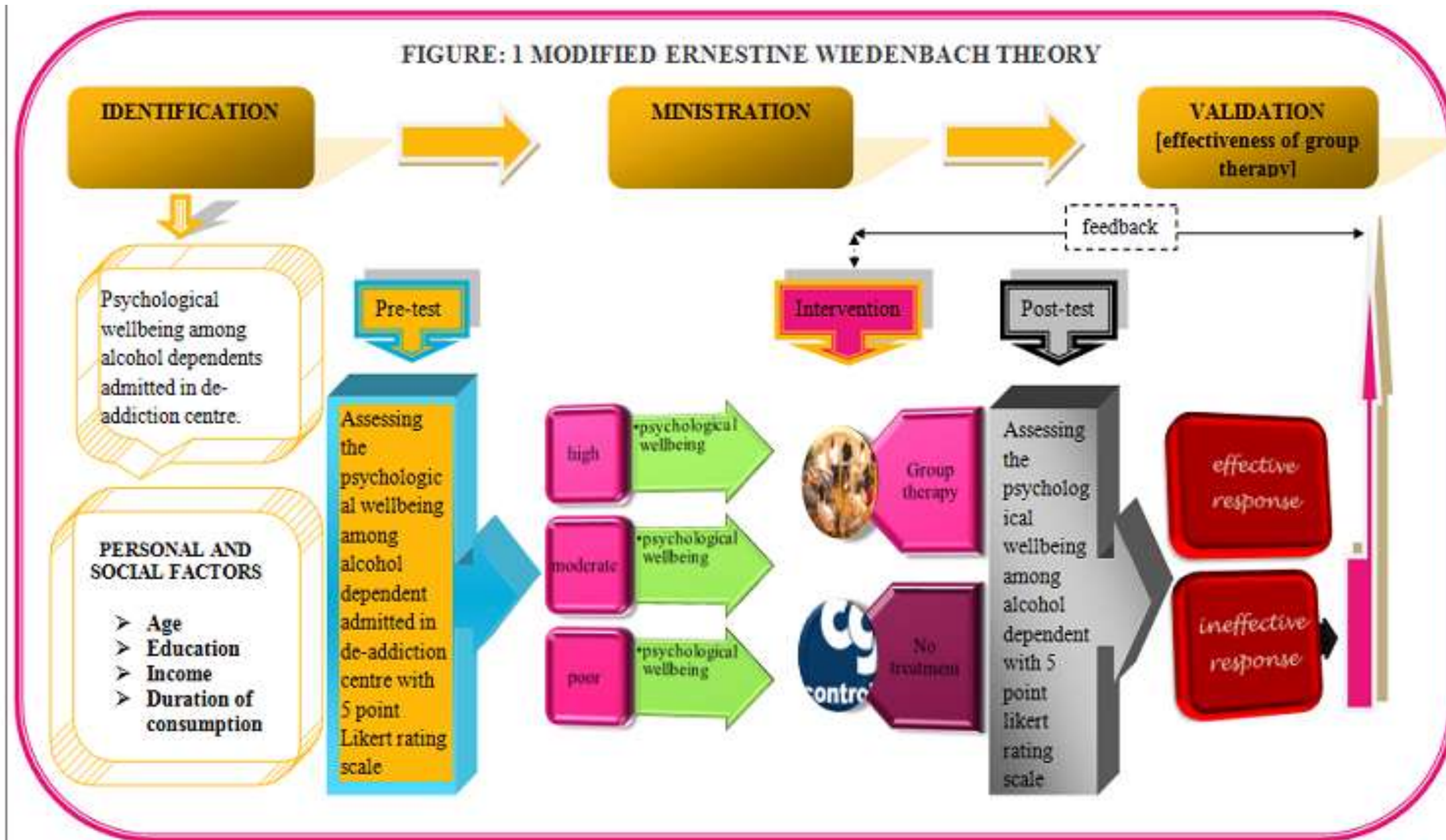
Recipient

Adults in a selected De-addiction centre are the recipient.

Goal

Refers to effective reduction on level of depression by administration of group therapy for 1 hour per day for 4 weeks.

CONCEPTUAL RAMEWORK BASED ON WIEDENBACH'S HELPING ART OF CLINICAL NURSING THEORY (1964)



CHAPTER III

RESEARCH METHODOLOGY

CHAPTER III

RESEARCH METHODOLOGY

The methodology of research indicates the general pattern of organizing the procedure for assembling valid and reliable data for investigation. This chapter provides a brief explanation of the method adopted by the investigator in this study. It includes the research approach, research design, and variables, setting of the study, population, sample and sample size, sampling technique, description of the tool, pilot study, data collection procedure and plan for data analysis.

The present study aimed to "A study to evaluate the effectiveness of group therapy on depression among alcoholics at a selected de-addiction centre in Madurai".

3.1 Research approach

A Quantitative approach was used for analyzing the effectiveness of group therapy.

3.2 Research design

Quasi experimental research design (Pre-test post test control group design)

The diagrammatic representation of research design is given below:

Group	Pre assessment of depression	Group therapy	Post assessment of depression
Experimental group	O1	X	O2
Control group	O1		O2

Key: O1 = Pre assessment depression, X= Group therapy, O2= Post assessment depression

3.3 Variables

Dependent Variable: Assess the level of depression

Independent Variable: Group therapy inventory

3.4 Settings of the study

The study was conducted in selected Deaddiction Centre, Madurai. This is one of the oldest institutions in Madurai. So many patients were admitted in this hospital. There are 60 patients are admitted hospital among them 60 male adults in chronic alcoholism having depression.

3.5 Population

Target population

The study population comprises of all adults society.

Accessible population

The adults those who are admitted in Wisdom Hospital and Deaddiction Centre, Madurai.

3.6 Sample

The study population comprised of adults who are study in selected Deaddiction Centre, Madurai, and those who fulfilled the inclusion criteria.

3.7 Sample size

The sample size is 60 adults.

3.8 Sampling technique

A non probability convenience sampling technique was used in this study.

3.9 Criteria for sample selection

The study sample was selected by the following inclusion and exclusion criteria.

Inclusion criteria

- Those person who is diagnosed as alcohol dependence syndrome
- Adult who were between 20-55 years of age.
- Adult those who could speak and understand Tamil.
- Those who are willing to participate of the study.

Exclusion criteria

- Those who are not available at the time of data collection
- Those who are not in the position to participated in the study

3.10 Research tool and technique

Section I: Socio Demographic data.

Section II: Beck Depression scale.

Section-I (Socio demographic data)

This section includes socio demographic variables such as sex, age, religion, type of family, monthly family income, residential area, occupational, marital status, number of children, educational staces.

Section-II: **Beck Depression Inventory-Second Edition (BDI-II)**

The Beck Depression Inventory (BDI) is a self report inventory that is one of the most widely used instruments for measuring the severity of depression. The BDI

is widely used as an assessment tool by healthcare professionals and researchers in a variety of settings. There are three versions of BDI – The original BDI, first published in 1961 and later revised in 1971 as the BDI-1A, and the BDI-II, published in 1996. The BDI-II is a 21-item self-administered inventory designed to measure the intensity of depressive symptoms in psychiatric and nonpsychiatric populations of both adults and adolescents (Beck et al., 1996). It consists of items relating to depression symptoms such as hopelessness and irritability, cognitions such as guilt or feelings of being punished, as well as physical symptoms related items as fatigue, weight loss, and lack of interest in sex. Each item contains a header that is intended to focus the examinee on the general purpose of the response options. Directly below this label are four statements listed in order of increasing severity. Respondents are instructed to choose the alternative that best describes how they felt during the "past two weeks, including today.'' When the test is scored, Items are rated on a 4-point scale (0 to 3) and total scores are obtained by tallying the ratings for all 21 items. Scores range from 0 to 63, with higher scores reflecting increased depressive severity. BDI-II requires approximately 5 to 10 minutes to complete and may be administered to individuals from 13 to 80 years of age. Although this instrument is typically self-administered, it can also be administered orally with only slight modification to the instructions.

3.11 Scoring interpretation:

Section II: – Beck Depression Scale

A 21 item questionnaire, which were rated below. Scores are calculated by summing the scores for the given items. The scores of the each respondent over the scales are then evaluated as per the severity rating index below.

Raw Scores	Depression Severity
0-13	Indicates minimal depression
14-19	Indicates mild depression
20-28	Indicates moderate depression
29-63	Indicates severe depression

3.12 Reliability of the tool

The reliability of an instrument is the degree of consistency with which it measures the attribute and it is supposed to be measuring over a period of time. The tool was a standardized one which underwent test retest for reliability.

3.13 Validity of the tool

The tool used in this study was Beck Depression scale and Socio Demographic profile preformed, which were validated by 5 nursing experts including 1 medical expert in the field of Mental health and Psychotric department based on suggestion given by the experts few modification were incorporated in the tool after getting consensus from all experts. The tool was first drafted in English. Tool was translated to Tamil by an expert. Language validity was established by retranslation of tool in to English.

3.14 Pilot study

A pilot study was conducted at Wisdom Hospital and Deaddiction Centre in Madurai, who fulfilled the inclusion criteria with regard to the setting, with the cooperation of the adults and the availability of the sample, in a manner in which a final study was done. It was carried over for the period of 7 days from 22.02.2018 to

02.03.2018. The structured interview schedule was found to be appropriate for the study. The pilot study findings revealed that the study was feasible and practicable.

3.15 Procedures for data collection

Formal permission was obtained from the Professor and Head of the Department, Department of psychiatry, Jainee College of Nursing, Dindigul, Principal and Head of the department in college of nursing, Chief Medical officer and Head counselor, to conduct the study in Wisdom Hospital and Deaddiction Centre in Madurai. Before conducting the study, a brief self-introduction and explanation regarding the nature and purpose of the intervention was given to the patients. Oral consent was obtained from the patient family members of all the subjects. 12 sessions were selected per week. Pre-test was conducted by using Beck depression scale to assess the level of depression among alcoholics on day 1.

Activity in each section in as follows:

- 5 minutes established rapport with adult and adult motivated and adults to read the materials
- 40 minutes free reading period
- 15 minutes discuss and got emotional experience after reading the materials

The same activities given to group on the alternative days for the period of 4 weeks, at the end of the study psychotherapy was given to the control group as an ethical consideration, the post test level of depression was assessed on 6th day by using the same scale.

3.16 Plan for data analysis

The data analysis involved the translation of information collected during the course of research project into an interpretable and managerial form. It involved the

use of statistical procedures to give an organization and meaning to the data. To compute the data, a master sheet was prepared by the investigator. Descriptive and inferential statistics used for data analysis.

Descriptive statistics

1. Frequency and percentage distribution to describe the socio demographic variables.

2. Mean, median, mode and standard deviation presenting distribution was used to assessing the existing level of depression of adults

Inferential statistics

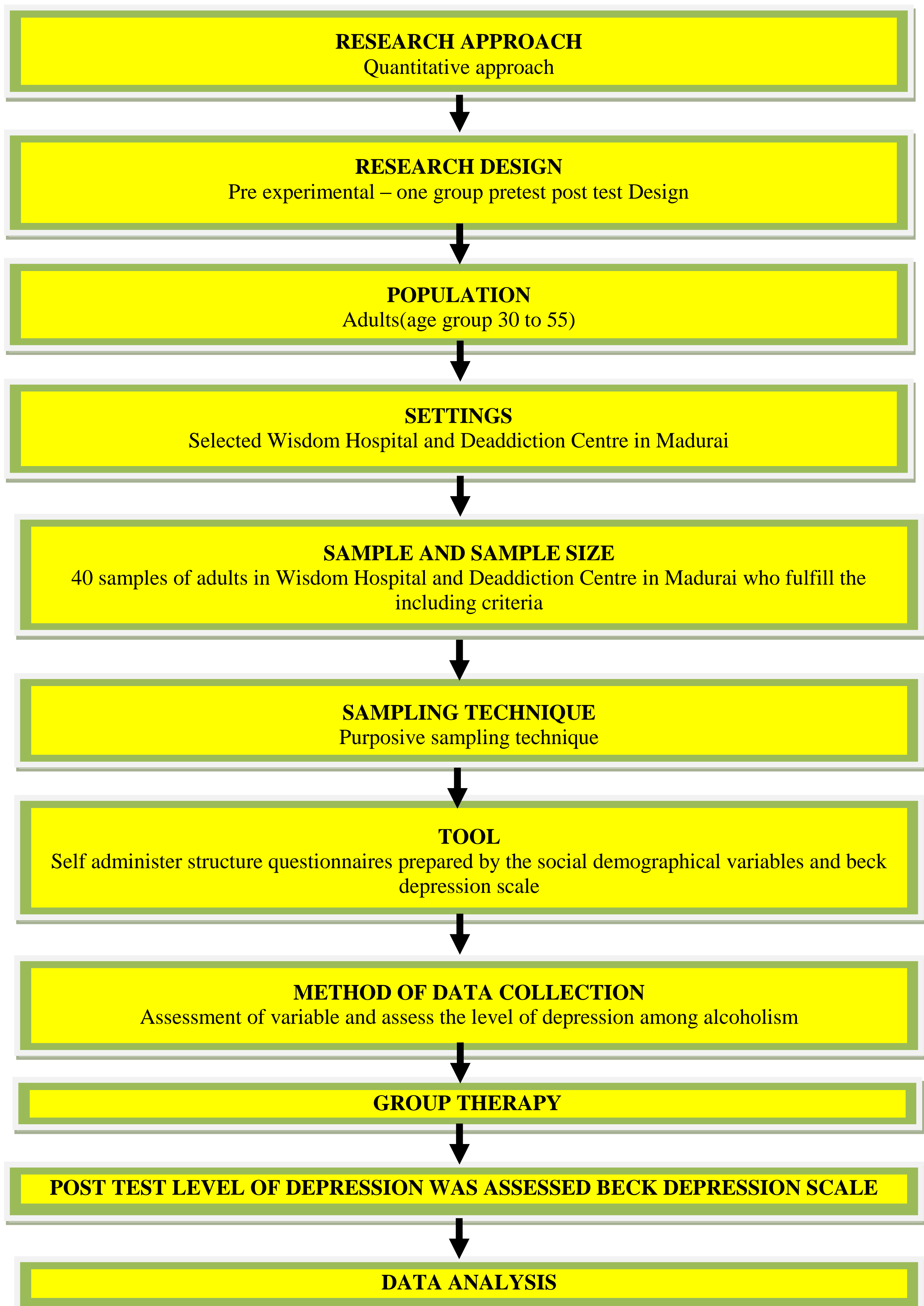
1. Paired t-test was used to examine the pre-test and post-test level of depression among alcoholism by using Beck Depression inventory in Wisdom Hospital and Deaddiction Centre in Madurai.

2. Chi-square analysis was used to find out the association between level of depression among alcoholism by using Beck Depression inventory in Wisdom Hospital and Deaddiction Centre in Madurai.

3.17 Protection of human rights

The investigator obtained approval from dissertation committee of Jainee College of Nursing, Professor and Head of the Department, Department of psychiatry, Jainee College of Nursing Dindigul. To conduct the study in Wisdom Hospital and Deaddiction Centre in Madurai. Each individual patient was informed about the purpose of the study and confidentiality was promised and ensured. Verbal consent was obtained data collected was kept confidential. Confidentiality and Anonymity was maintained throughout the study.

Figure 2: Schematic representation of research methodology



CHAPTER IV
DATA ANALYSIS AND INTERPRETATION

CHAPTER IV

DATA ANALYSIS AND INTERPRETATION

This chapter deals with the description of sample, analysis, and interpretation of the data collected to evaluate the achievement of the objectives of the study. The data collected is tabulated and described as follows, In this chapter the data collected were edited, tabulated, analyzed and interpreted. The findings were organized and presented in the following orderly sections.

The data collected were interpreted under the following sections

Section I

Distribution of adult according to their socio demographic variables

Section II

Distribution to evaluate the effectiveness of group therapy on depression among the alcoholics.

Section III

The frequency and percentage views distribution to evaluate the effectiveness of group therapy on depression.

Section IV

Association between level of depression in control group and experimental group of pre test and post selected the demographical data.

SECTION I

Table: 4.1.1: Frequency and percentage wise distribution to evaluate the effectiveness of group therapy on depression among the alcoholics in selected De-addiction Centre at Madurai according to their demographic data.

Demographic variables	Control group (n=30)		Experimental group (n=30)	
	f	**%**	**f**	**%**
1.Age (in years):				
20-30 years	10	33.3	5	16.7
31-40 years	11	36.7	10	33.3
41-50 years	7	23.3	9	30
51-55 years	2	6.7	6	20
2.Religion:				
Hindu	24	80	26	86.7
Christian	1	3.3	3	10
Muslim	5	16.7	1	3.3
3. Marital status:				
Single	10	33.3	8	26.7
Married	18	60	22	73.3
Separated	1	3.3	0	0
Widowed	1	3.3	0	0
4.level of education :				
No formal education	6	20	7	23.3
Primary education	8	26.7	6	20
High school education	9	30	10	33.3
Graduate	1	3.3	4	13.3
post graduate	6	20	3	10
5.type of family:				
Nuclear family	21	70	15	50
Joint family	7	23.3	14	46.7
Extended family	1	3.3	1	3.3
Broken family	1	3.3	0	0

6.Monthly family income :				
<3000	0	0	0	0
3001-5000	5	16.7	3	10
5001-10000	10	33.3	13	43.3
>10000	15	50	14	46.7
7.Residence area :				
Urban	1	3.3	1	3.3
Rural	11	36.7	13	43.3
Sub urban	18	60	16	53.3
8.Occupation :				
Cooly	6	20	9	30
Private employee	12	40	11	36.7
Government employee	5	16.7	5	16.7
Business	3	10	1	3.3
Unemployed	4	13.3	4	13.3
9.Hobbies :				
Reading	4	13.3	6	20
Watching TV	24	80	18	60
Listening Music	0	0	1	3.3
Sports	2	6.7	5	16.7
Gardening	0	0	0	0
10. Amount of Alcohol :				
Below 100	19	63.3	19	63.3
100-200ml	10	33.3	9	30
200-300ml	0	0	1	3.3
300ml above	1	3.3	1	3.3
11. How many years drinking alcohol:				
Less than 5 years	13	43.3	10	33.3
6-10 years	8	26.7	9	30
11-16 years	7	23.3	8	26.7
More than 16 years	2	6.7	3	10
12. Drinking alcohol:				
Every day	12	40	8	26.7
Weekly twice	12	40	14	46.7
Money available	5	16.7	6	20
Monthly twice	1	3.3	2	6.7

Table 1 portrays that majority of adults F1 = 2 (6.7%), F2= 6(20%) were in the age group of 51 to 55 years, F1= 7(23.3%) F2= 9 (30%), age group 45 to 55 years, F1= 11(36.7%), F2= 10(33.3%) 31 to 40 years age group, F1= 10(33.3%) F2= 5(16.7%) age group 20 to 30 years.

Regarding religion, majority of adults f1=24(80%) f2= 26(86.7%) were Hindus, f1= 1(3.3%) f2= 3(10%) were Christians and f1= 5(16.7%) f2= 1(3.3.%) was Muslim.

While comparing the marital status the majority of the adults f1 = 1(3.3%) f2 = 0(0%) widows, f1 = 1(3.3%) f2=0(0%) separated, f1 = 80(60%) f2 = 22(73.3%) married, f1 = 10(33.3%) f2 = 8(26.7%) single.

While comparing the educational status majority of the adults f1 = 6(20%) f2 =3(10%) post graduated, f1 = 1(3.3%) f2= 4(13.3%) graduated, f1 =9(30%) f2 = 10(33.3%) high school education, f1 = 8(26.7%) f2 =6(20%) primary education, f1 = 6(20%) f2 = 7(23.3%) no formal education.

While comparing the family types majority f1 = 1(3.3%) f2 = 0(0%) broken family, f1 = 1(3.3%) f2=1(3.3%) extended family, f1=7(23.3%) f2=14(43.7%) joined family, f1=21(70%) f2=15(50%) nuclear family.

While comparing monthly family income f1=15(50%) f2=14(46.7%) earning more than 10000, f1=10(33.3%) f2=13(43.4%) earning 5001 to 10000, f1=5(16.7%) f2=3(10%) earning 3001 to 5000, f1=0(0%) f2=0(0%) earning less than 3000.

Regarding the residential area, majority f1=18(60%) f2=16(53.3%) were hailed from sub urban, f1=11(36.7%) f2=13(43.3%) were hailed from rural, f1=1(3.3%) f2=1(3.3%) were hailed from urban.

While comparing the occupation majority of adults f1=4(13.3%) f2=4(13.3%) unemployed, f1=3(10%) f2=1(3.3%) business, f1=5(16.5%) f2=5(16.7%) in government employees, f1=12(40%) f2=11(36.7%) in private employees, f1=6(20%) f2=9(30%) in Cooley.

While comparing the hobbies majority of adults f1=0(0%) f2=0(0%) gardening, f1=2(6.7%) f2=5(16.7%) sports, f1=0(0%) f2=1(3.3%) listening music, f1=24(80%) f2=18(60%) watching tv, f1=4(13.3%) f2=6(20%) reading.

While comparing the amount of alcohol majority of adults f1=1(3.3%) f2=1(3.3%) in above 300ml, f1= 0(0%) f2=1(3.3%) in 200 to 300ml, f1=10(33.3%) f2=9(30%) in 100 to 200ml, f1=19(63.3%) f2=90(63.3%) below 100ml.

While comparing the years of alcohol drinking majority of adults f1=2(6.7%) f2=3(10%) more than 16 years, f1=7(23.3%) f2=8(26.7%) 11 to 16 years, f1=8(26.7%) f2=9(30%) 6 to 10 years, f1=13(43.3%) f2 = 10(33.3%) less than 5 years.

While comparing the drinking alcohol majority of adults F1=1(3.3%) F2=2(6.7%) monthly twice, F1=5(16.7%) F2=6(20%) money available, F1=12(40%) F2=14(46.7%) weekly twice, F1=12(40%) F2=8(26.7%) every day.

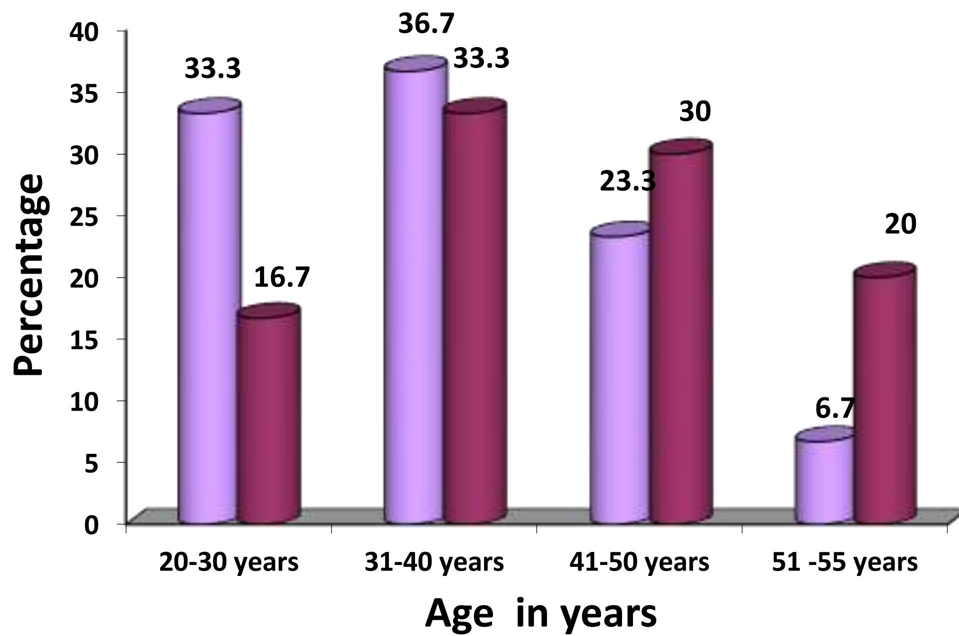


Fig.4.1.1.Multiple Cylinder diagram showing percentage wise distribution of group therapy on depression among the alcoholics according to their age.

The above diagram dispatches majority of adults f1 = 2 (6.7%), f2= 6(20%) were in the age group of 51 to 55 years, f1= 7(23.3%) f2= 9 (30%), age group 45 to 55 years, f1= 11(36.7%), f2= 10(33.3%) 31 to 40 years age group, f1 = 10(33.3%) f2= 5(16.7%) age group 20 to 30 years.

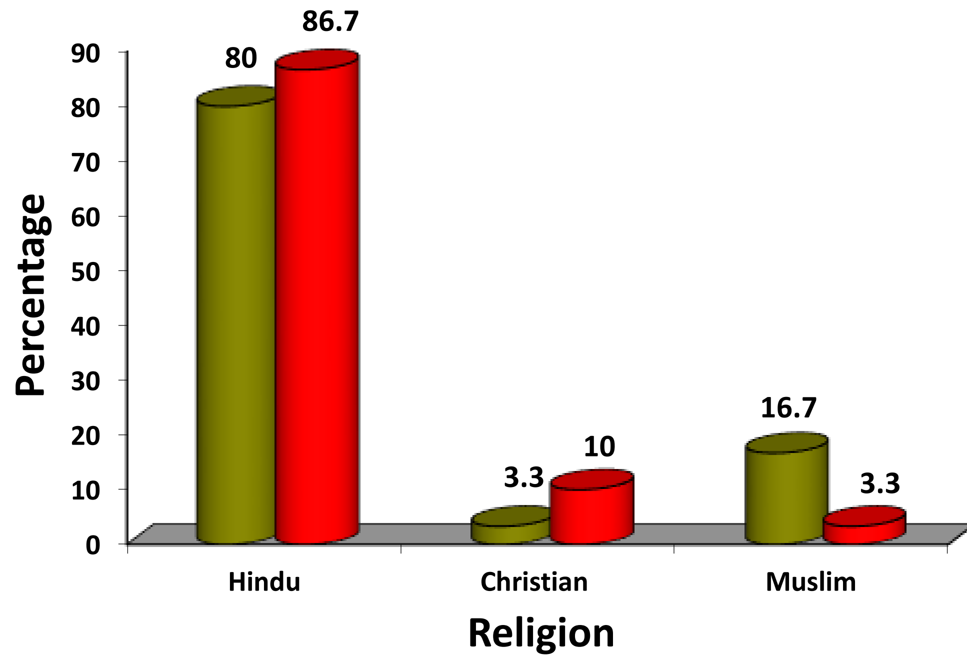


Fig.4.1.2.Multiple Cylinder diagram showing percentage wise distribution of group therapy on depression among the alcoholics according to their religion.

The above the diagram shows that majority of adults f1=24(80%) f2= 26(86.7%) were Hindus, f1= 1(3.3%) f2= 3(10%) were Christians and f1= 5(16.7%) f2= 1(3.3.%) was Muslim.

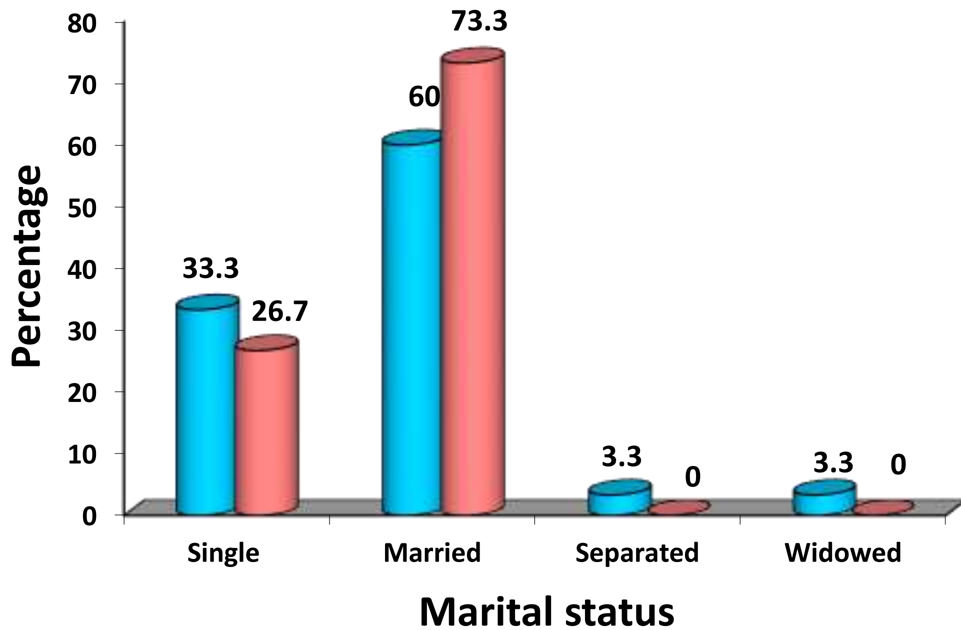


Fig.4.1.3.Multiple Cylinder diagram showing percentage wise distribution of group therapy on depression among the alcoholics according to their marital status.

The above diagram show majority of the adults f1 = 1(3.3%) f2 = 0(0%) widows, f1 = 1(3.3%) f2=0(0%) separated, f1 = 80(60%) f2 = 22(73.3%) married, f1 = 10(33.3%) f2 = 8(26.7%) single.

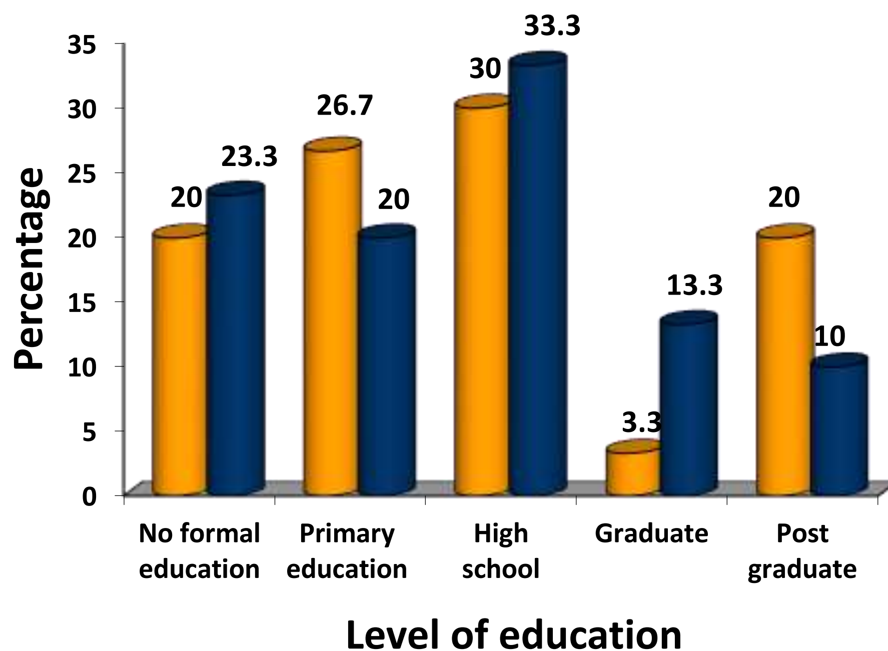


Fig.4.1.4.Multiple Cylinder diagram showing percentage wise distribution of group therapy on depression among the alcoholics according to their level of education.

The above the diagram majority of the adults f1 = 6(20%) f2 =3(10%) post graduated, f1 = 1(3.3%) f2= 4(13.3%) graduated, f1 =9(30%) f2 = 10(33.3%) high school education, f1 = 8(26.7%) f2 =6(20%) primary education, f1 = 6(20%) f2 = 7(23.3%) no formal education.

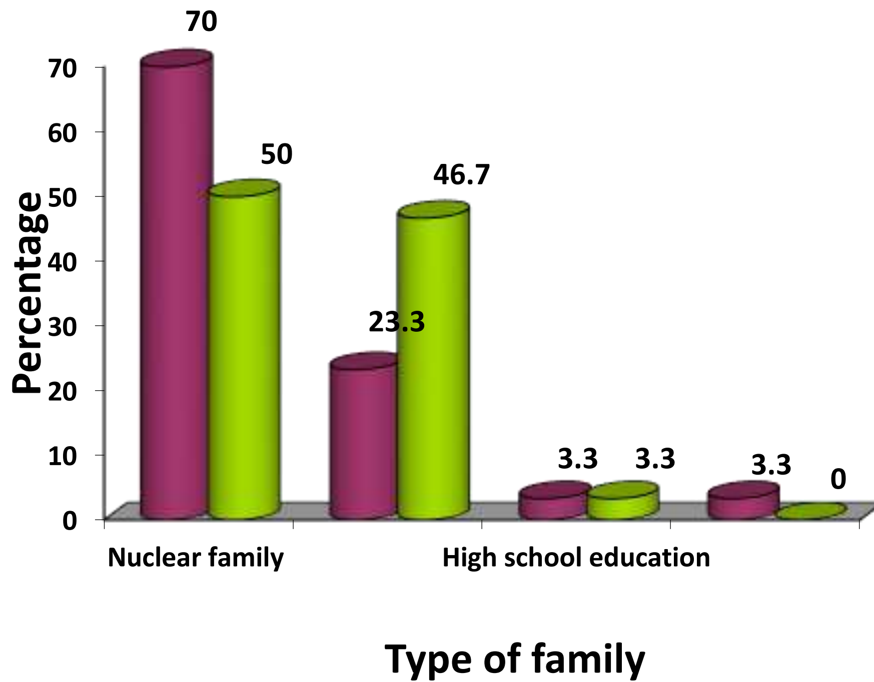


Fig.4.1.5.Multiple Cylinder diagram showing percentage wise distribution of group therapy on depression among the alcoholics according to their type of family.

The above diagram show the family types majority f1 = 1(3.3%) f2 = 0(0%) broken family, f1 = 1(3.3%) f2=1(3.3%) extended family, f1=7(23.3%) f2=14(43.7%) joined family, f1=21(70%) f2=15(50%) nuclear family.

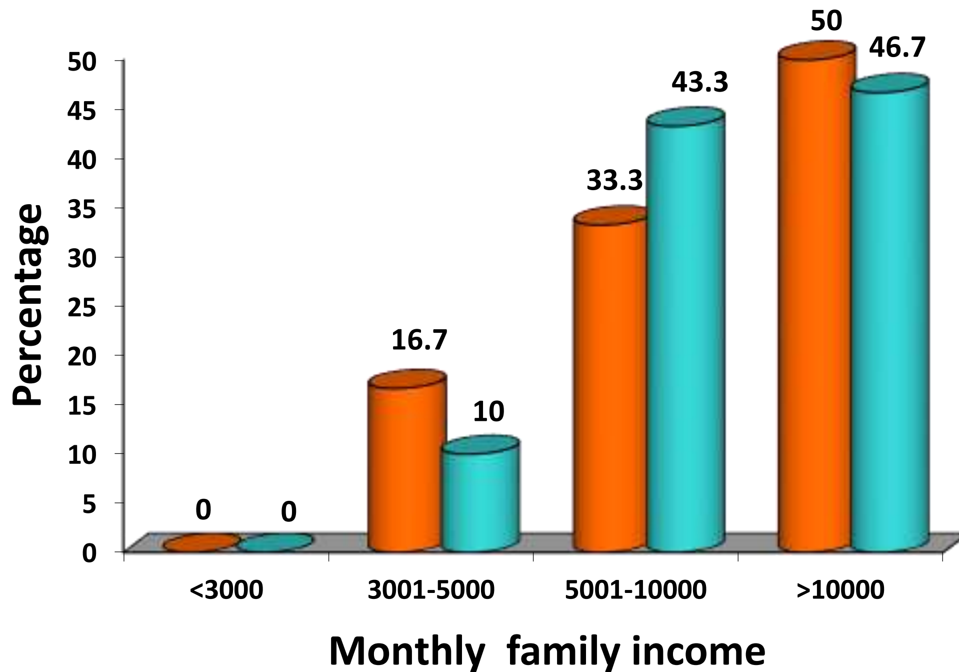


Fig.4.1.6.Multiple Cylinder diagram showing percentage wise distribution of group therapy on depression among the alcoholics according to their monthly family income.

The above diagram show monthly family income f1=15(50%) f2=14(46.7%) earning more than 10000, f1=10(33.3%) f2=13(43.4%) earning 5001 to 10000, f1=5(16.7%) f2=3(10%) earning 3001 to 5000, f1=0(0%) f2=0(0%) earning less than 3000.

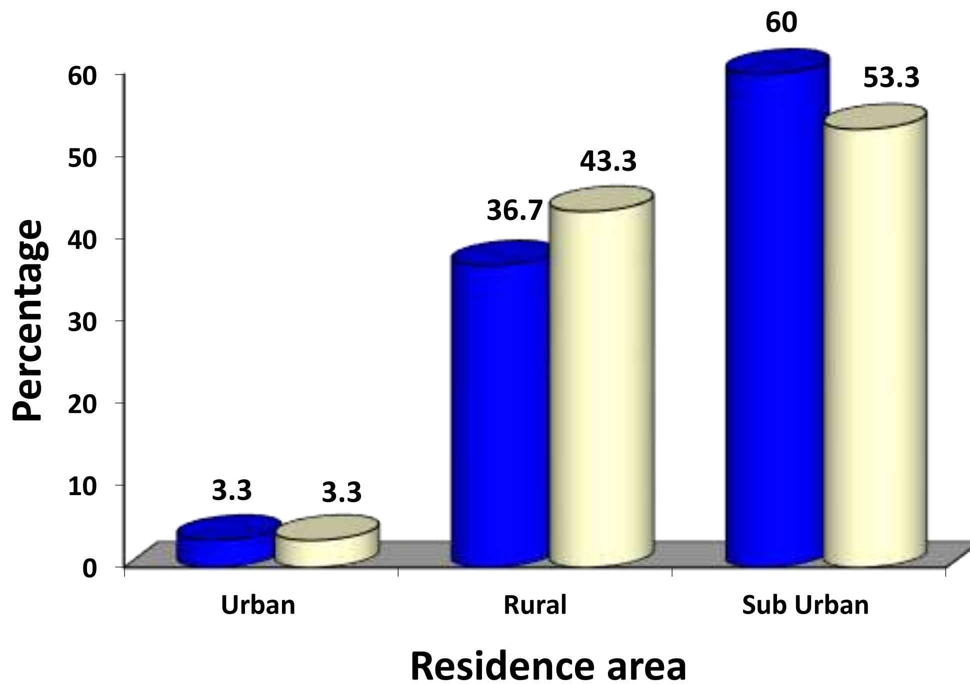


Fig.4.1.7.Multiple Cylinder diagram showing percentage wise distribution of group therapy on depression among the alcoholics according to their residence area.

The above diagram show the residential area, majority f1=18(60%) f2=16(53.3%) were hailed from sub urban, f1=11(36.7%) f2=13(43.3%) were hailed from rural, f1=1(3.3%) f2=1(3.3%) were hailed from urban.

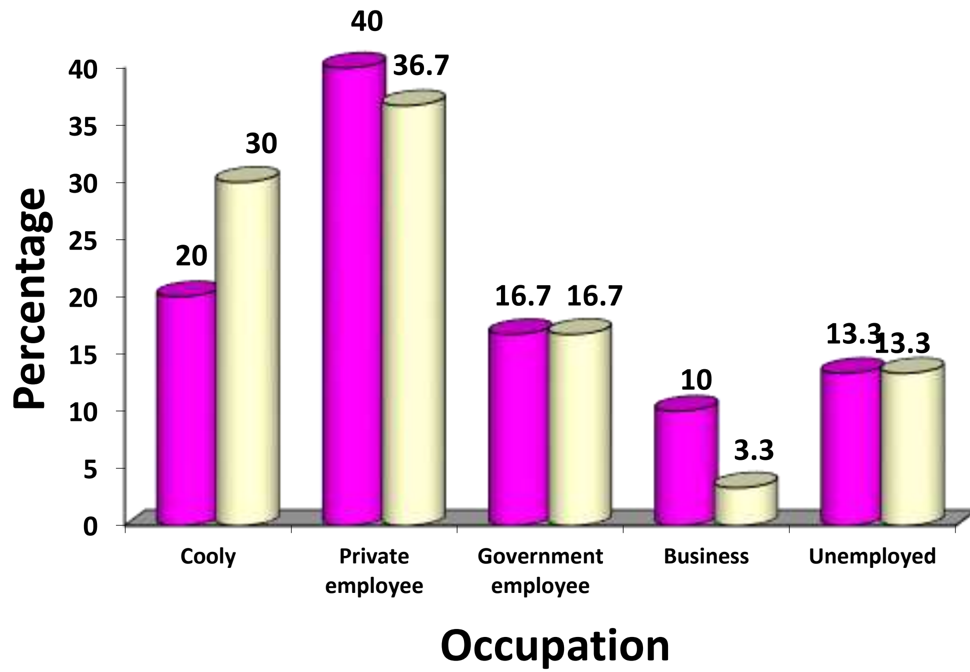


Fig.4.1.8.Multiple Cylinder diagram showing percentage wise distribution of group therapy on depression among the alcoholics according to their occupation.

The above diagram show the occupation majority of adults f1=4(13.3%) f2=4(13.3%) unemployed, f1=3(10%) f2=1(3.3%) business, f1=5(16.5%) f2=5(16.7%) in government employees, f1=12(40%) f2=11(36.7%) in private employees, f1=6(20%) f2=9(30%) in Cooley.

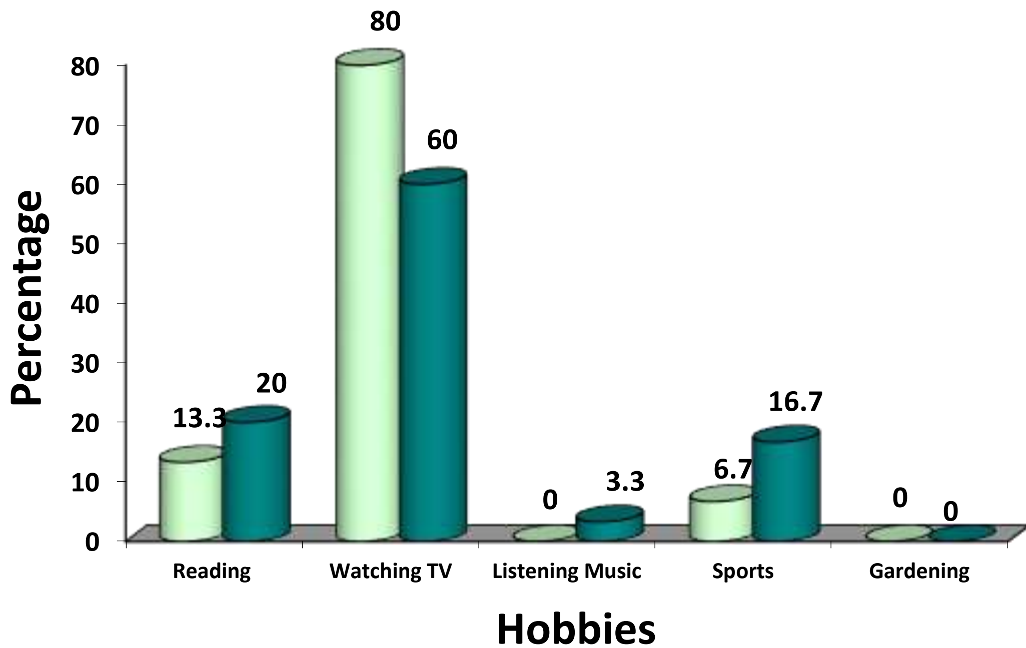


Fig.4.1.9.Multiple Cylinder diagram showing percentage wise distribution of group therapy on depression among the alcoholics according to their hobbies.

The above diagram show the hobbies majority of adults f1=0(0%) f2=0(0%) gardening, f1=2(6.7%) f2=5(16.7%) sports, f1=0(0%) f2=1(3.3%) listening music, f1=24(80%) f2=18(60%) watching tv, f1=4(13.3%) f2=6(20%) reading.

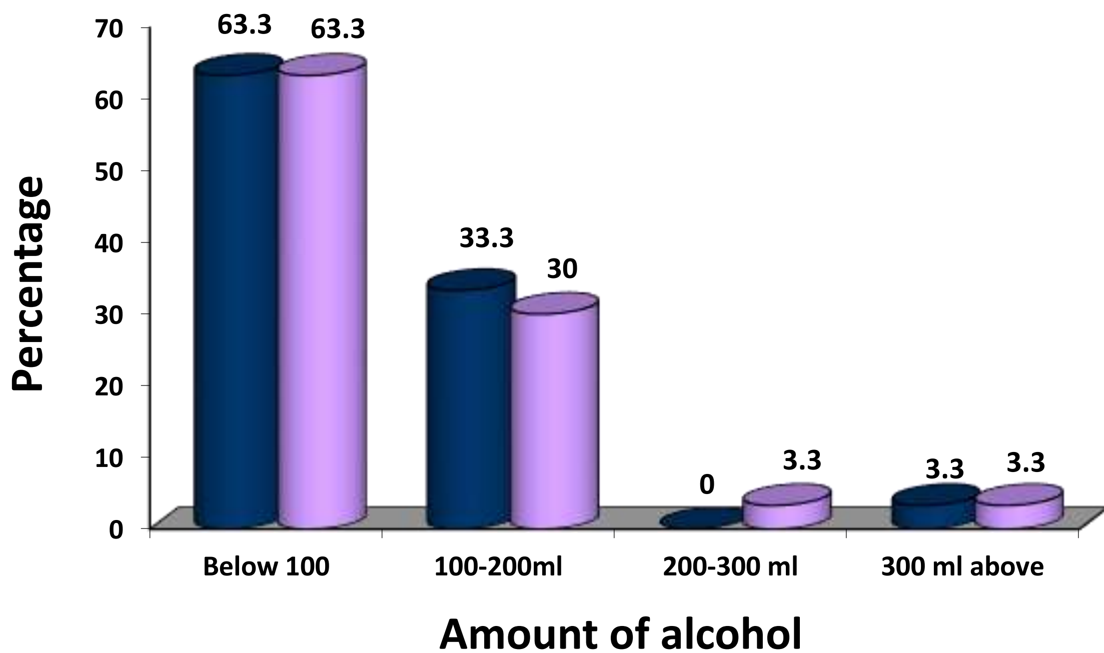


Fig.4.1.10.Multiple Cylinder diagram showing percentage wise distribution of group therapy on depression among the alcoholics according to their amount of alcohol.

The above diagram show the amount of alcohol majority of adults f1=1(3.3%) f2=1(3.3%) in above 300ml, f1= 0(0%) f2=1(3.3%) in 200 to 300ml, f1=10(33.3%) f2=9(30%) in 100 to 200ml, f1=19(63.3%) f2=90(63.3%) below 100ml.

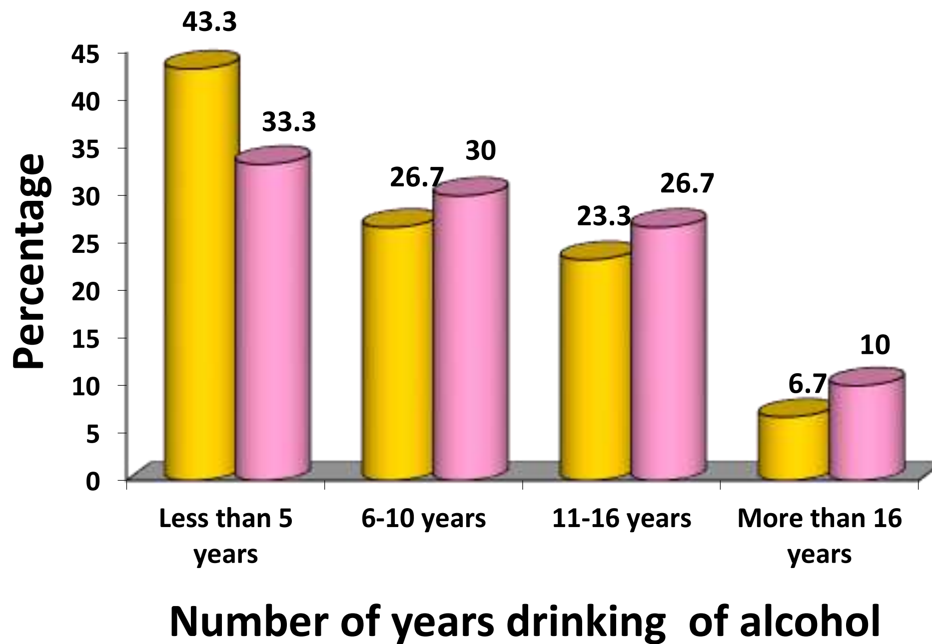


Fig.4.1.11.Multiple Cylinder diagram showing percentage wise distribution of group therapy on depression among the alcoholics according to their how many times drinking of alcohol.

The above diagram show the years of alcohol drinking majority of adults f1=2(6.7%) f2=3(10%) more than 16 years, f1=7(23.3%) f2=8(26.7%) 11 to 16 years, f1=8(26.7%) f2=9(30%) 6 to 10 years, f1=13(43.3%) f2 = 10(33.3%) less than 5 years.

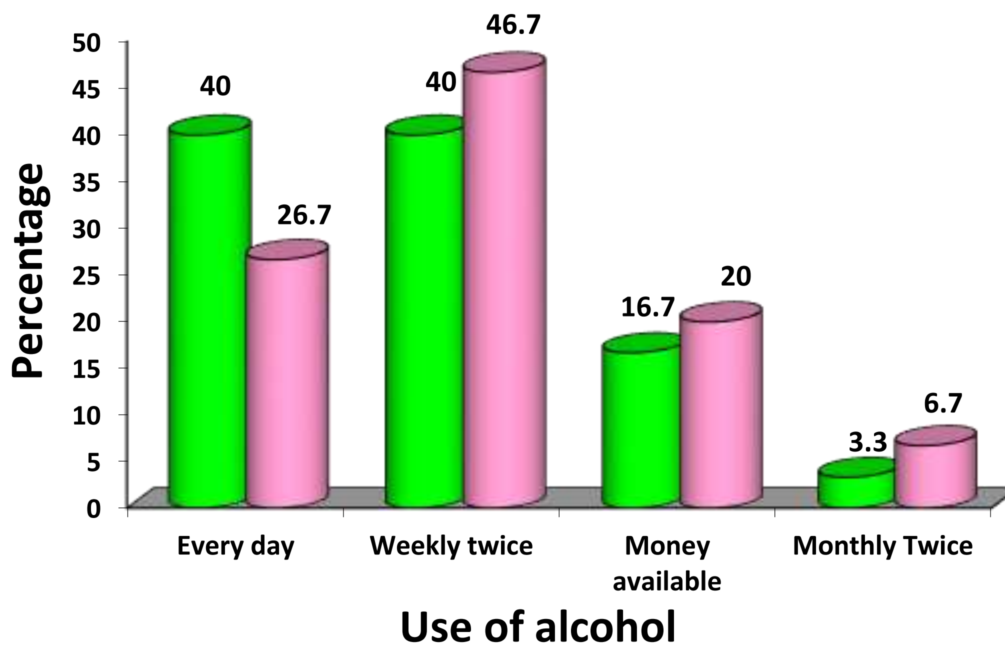


Fig.4.1.12.Multiple Cylinder diagram showing percentage wise distribution of group therapy on depression among the alcoholics according to their drinking of alcohol.

The above diagram show the drinking alcohol majority of adults F1=1(3.3%) F2=2(6.7%) monthly twice, F1=5(16.7%) F2=6(20%) money available, F1=12(40%) F2=14(46.7%) weekly twice, F1=12(40%) F2=8(26.7%) every day.

SECTION II

Distribution to evaluate the effectiveness of group therapy on depression among the alcoholics in selected De-addiction Centre at Madurai.

Table-4.2.1: Mean, SD and mean% to evaluate the effectiveness of group therapy on depression among the alcoholics in selected De-addiction Centre at Madurai.

Level of depression	Max score	Control-pre test scores			Control- Post test scores			Difference in Mean%
		Mean	SD	Mean%	Mean	SD	Mean%	
Overall	**63**	25.7	2.36	41	24.6	3.49	39	2

Table-4.2.2: Mean, SD and mean% to evaluate the effectiveness of group therapy on depression among the alcoholics in selected De-addiction Centre at Madurai.

Level of depression	Max score	Experimental -pre test scores			Experimental - Post test scores			Difference in Mean%
		Mean	SD	Mean%	Mean	SD	Mean%	
Overall	**63**	26.67	1.89	42	13.83	3.56	22	20

Table-4.2.3: Mean, SD and mean% to evaluate the effectiveness of group therapy on depression among the alcoholics in selected De-addiction Centre at Madurai.

Knowledge	Max score	Control -pre test scores			Experimental - pre test scores			Difference in Mean%
		Mean	SD	Mean%	Mean	SD	Mean%	
Overall	**63**	25.7	2.36	41	26.67	1.89	42	1

Table-4.2.4: Mean, SD and mean% to evaluate the effectiveness of group therapy on depression among the alcoholics in selected De-addiction Centre at Madurai.

Knowledge	Max score	Control -post test scores			Experimental - post test scores			Difference in Mean%
		Mean	SD	Mean%	Mean	SD	Mean%	
Overall	**63**	24.6	3.49	39	13.83	3.56	22	17

SECTION III

Table-4.3.1: Frequency and percentage wise distribution to evaluate the effectiveness of group therapy on depression among the alcoholics in selected De-addiction Centre at Madurai

Depression	Control group				Experimental group			
	Pre test		Post test		Pre test		Post test	
	f	%	f	%	f	%	f	%
Minimal	-	-	-	-	-	-	13	43.3
Mild	1	3.3	3	10	-	-	17	56.7
Moderate	29	96.7	27	90	30	100	-	-
Severe	-	-	-	-	-	-	-	-
Total	30	100	30	100	30	100	30	100

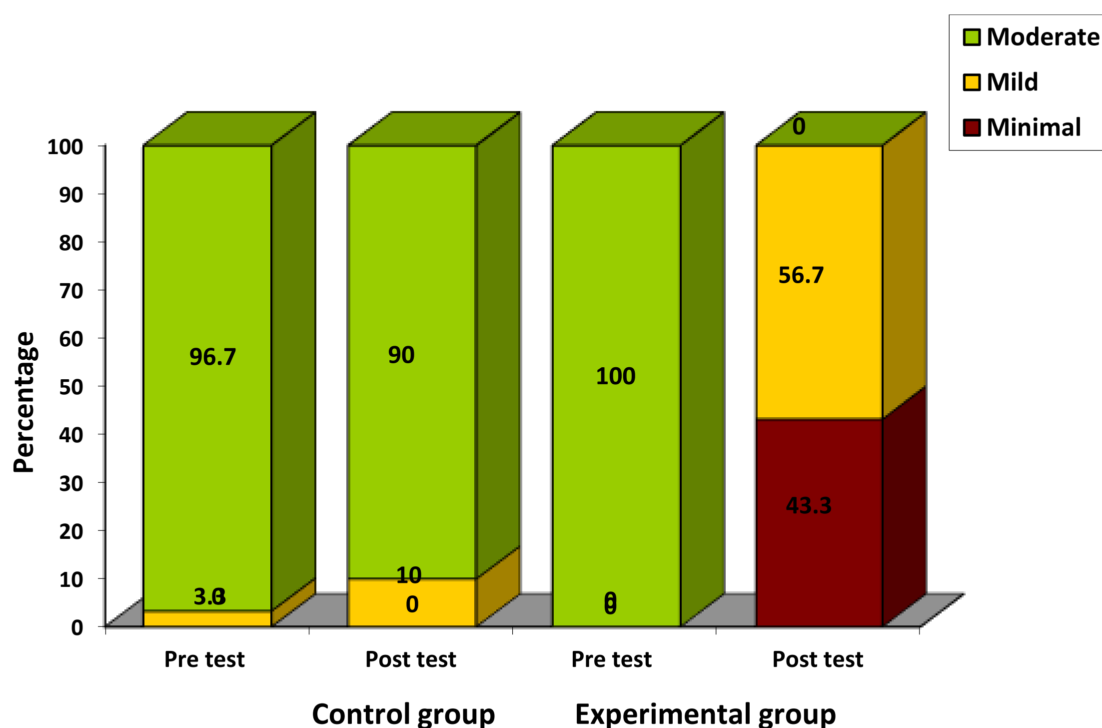


Fig 4.1.13 Distribution on Adults according Level of knowledge

Table-4.4.1: paired "t"-test was found in control group to evaluate the effectiveness of group therapy on depression among the alcoholics in selected De-addiction Centre at Madurai

Area	Control pre test		Control post test		Mean difference	't'-value	P-value
	Mean	SD	Mean	SD			
Overall	25.7	2.36	24.6	3.48	1.1	1.67	**0.105**

*-P<0.05 , significant and **-P<0.01 &***-P<0.001 , Highly significant

Table-4.4.2: paired "t"-test was found in experimental group to evaluate the effectiveness of group therapy on depression among the alcoholics in selected De-addiction Centre at Madurai

Area	Experimental pre test		Experimental post test		Mean difference	't'-value	P-value
	Mean	SD	Mean	SD			
Overall	26.67	1.89	13.83	3.56	12.83	16.19	**p<0.001**

*-P<0.05 , significant and **-P<0.01 &***-P<0.001 , Highly significant

Table-4.4.3: Unpaired "t"-test was found in pre test of between control and experimental group to evaluate the effectiveness of group therapy on depression among the alcoholics in selected De-addiction Centre at Madurai.

Area	Control pre test		Experimental pre test		Mean difference	't'-value	P-value
	Mean	SD	Mean	SD			
Overall	25.7	2.36	26.67	1.89	0.97	1.745	**0.086**

*-P<0.05 , significant and **-P<0.01 &***-P<0.001 , Highly significant

Table-4.4.4: Unpaired "t"-test was found in post test of between control and experimental group to evaluate the effectiveness of group therapy on depression among the alcoholics in selected De-addiction Centre at Madurai

Area	Control post test		Experimental post test		Mean difference	't'-value	P-value
	Mean	SD	Mean	SD			
Overall	24.6	3.48	13.83	3.56	10.77	11.82	**p<0.001**

*-P<0.05, significant and **-P<0.01 &***-P<0.001, Highly significant

SECTION IV

Association between level of depression in control group and experimental group of pre test and post selected the demographical data

Table No 4.5.1: Association between level of depression in control group of pre test and Selected Demographic data.

Demographic variables	Minimal		Mild		Moderate		χ2 (df)	p-value (N/NS)
	f	%	f	%	f	%		
1.Age (in years):								
20-30 years	-	-	1	3.3	9	30		
31-40 years	-	-	0	0	11	36.7	2.06	0.558
41-50 years	-	-	0	0	7	23.3	(df=3)	NS
51-55 years	-	-	0	0	2	6.7		
2.Religion:								
Hindu	-	-	1	3.3	23	76.7		
Christian	-	-	0	0	1	3.3	0.26	0.879
Muslim	-	-	0	0	5	16.7	(df=2)	NS
3. Marital status:								
Single	-	-	0	0	10	33.3		
Married	-	-	1	3.3	17	56.7	0.68	0.876
Separated	-	-	0	0	1	3.3	(df=3)	NS
Widowed	-	-	0	0	1	3.3		
4.level of education :								
No formal education	-	-	0	0	6	20		
Primary education	-	-	0	0	8	26.7	4.14	0.388
High school education	-	-	0	0	9	30	(df=4)	NS
Graduate	-	-	0	0	1	3.3		
post graduate	-	-	1	3.3	5	16.7		
5.type of family:								
Nuclear family	-	-	1	3.3	20	66.7		
Joint family	-	-	0	0	7	23.3	0.4433	0.931
Extended family	-	-	0	0	1	3.3	(df=6)	NS
Broken family	-	-	0	0	1	3.3		

6.Monthly family income :								
<3000	-	-	0	0	0	0		
3001-5000	-	-	0	0	5	5	2.07	0.355
5001-10000	-	-	1	3.3	9	30	(df=2)	NS
>10000	-	-	0	0	15	50		
7.Residence area :								
Urban	-	-	0	0	1	3.3	0.68	0.708
Rural	-	-	0	0	11	36.7	(df=2)	NS
Sub urban	-	-	1	3.3	17	56.7		
8.Occupation :								
Cooly	-	-	0	0	6	20	1.15	0.817
Private employee	-	-	1	3.3	11	36.6	(df=4)	NS
Government employee	-	-	0	0	5	16.67		
Business	-	-	0	0	3	10		
Unemployed			0	0	4	13.3		
9.Hobbies :								
Reading	-	-						
Watching TV	-	-	0	0	4	13.3	2.12	0.346
Listening Music	-	-	1	3.3	23	76.7	(df=2)	NS
Sports	-	-	0	0	2	6.7		
Gardening	-	-	0	0	0	0		
10. Amount of Alcohol :								
Below 100	-	-	1	3.3	18	60	0.59	0.741
100-200ml	-	-	0	0	10	33.3	(df=2)	NS
200-300ml	-	-	0	0	0	0		
300ml above	-	-	0	0	1	3.3		
11. How many years drinking alcohol:								
Less than 5 years	-	-	1	3.3	12	40	1.35	0.717
6-10 years	-	-	0	0	8	26.7	(df=3)	NS
11-16 years	-	-	0	0	7	23.3		
More than 16 years	-	-	0	0	2	96.67		
12. Drinking alcohol:								
Every day	-	-	0	0	12	40	1.55	0.670
Weekly twice	-	-	1	3.3	11	36.7	(df=3)	NS
Money available	-	-	0	0	5	16.7		
Monthly twice	-	-	0	0	1	3.3		

NS-Not significant, S-significant.

Table No 4.5.1: Association between level of depression in control group of post test and Selected Demographic data.

Demographic variables	Minimal		Mild		Moderate		$\chi2$ (df)	p-value (N/NS)
	f	%	f	%	f	%		
1.Age (in years):								
20-30 years	-	-	0	0	10	33.3		
31-40 years	-	-	1	3.3	10	33.3	4.03	0.259
41-50 years	-	-	2	6.7	5	16.7	(df=3)	NS
51-55 years	-	-	0	0	2	6.7		
2.Religion:								
Hindu	-	-	3	10	21	70	0.83	0.659
Christian	-	-	0	0	1	3.3	(df=2)	NS
Muslim	-	-	0	0	5	16.7		
3. Marital status:								
Single	-	-	.0	0	10	33.3	2.22	0.528
Married	-	-	3	10	15	50	(df=3)	NS
Separated	-	-	0	0	1	3.3		
Widowed	-	-	0	0	1	3.3		
4.level of education :								
No formal education	-	-	1	3.3	5	16.7	3.45	0.484
Primary education	-	-	0	0	8	26.7	(df=4)	NS
High school education	-	-	2	6.7	7	23.3		
Graduate	-	-	0	0	1	3.3		
post graduate	-	-	0	0	6	20		
5.type of family:								
Nuclear family	-	-	2	6.7	19	63.3	0.374	0.946
Joint family	-	-	1	3.3	6	20	(df=3)	NS
Extended family	-	-	0	0	1	3.3		
Broken family	-	-	0	0	1	3.3		
6.Monthly family income :								
<3000	-	-	0	0	0	0	0.74	0.690
3001-5000	-	-	0	0	5	16.7	(df=2)	NS
5001-10000	-	-	1	3.3	9	30		
>10000	-	-	2	6.7	13	43.3		

7.Residence area :								
Urban	-	-	0	0	1	3.3	0.15	0.930
Rural	-	-	1	3.3	10	33.3	(df=2)	NS
Sub urban	-	-	2	6.7	16	53.3		
8.Occupation :								
Coolly	-	-	0	0	6	20		
Private employee	-	-	0	0	12	40	8.33	0.08
Government employee	-	-	2	6.7	3	10	(df=4)	NS
Business	-	-	0	0	3	10		
Unemployed	-	-	1	3.3	3	10		
9.Hobbies :								
Reading	-	-	0	0	4	13.3	0.83	0.659
Watching TV	-	-	3	10	21	70	(df=2)	NS
Listening Music	-	-	0	0	0	0		
Sports	-	-	0	0	2	6.7		
Gardening	-	-	0	0	0	0		
10. Amount of Alcohol :								
Below 100	-	-	2	6.7	17	56.7	0.117	0.946
100-200ml	-	-	1	3.3	9	30	(df=2)	NS
200-300ml	-	-	0	0	0	0		
300ml above	-	-	0	0	1	3.3		
11. How many years drinking alcohol:								
Less than 5 years	-	-	0	0	13	43.3	2.12	0.346
6-10 years	-	-	2	6.7	6	20	(df=2)	NS
11-16 years	-	-	1	3.3	6	20		
More than 16 years	-	-	0	0	2	6.7		
12. Drinking alcohol:								
Every day	-	-	0	0	13	43.3	3.81	0.283
Weekly twice	-	-	2	6.7	6	20	(df=3)	NS
Money available	-	-	1	3.3	6	20		
Monthly twice	-	-	0	0	2	6.7		

NS-Not significant, S-significant.

Table No 4.5.1: Association between level of depression in experimental group of pre test and Selected Demographic data.

Demographic variables	Minimal		Mild		Moderate		χ2 (df)	p-value (N/NS)
	f	%	f	%	f	%		
1.Age (in years):								
20-30 years	-	-	-	-	5	16.7	0	1 NS
31-40 years	-	-	-	-	10	33.3		
41-50 years	-	-	-	-	9	30		
51-55 years	-	-	-	-	6	20		
2.Religion:								
Hindu	-	-	-	-	26	86.7	0	1 NS
Christian	-	-	-	-	3	10		
Muslim	-	-	-	-	1	3.3		
3. Marital status:								
Single	-	-	-	-	8	26.7	0	1 NS
Married	-	-	-	-	22	73.3		
Separated	-	-	-	-	0	0		
Widowed	-	-	-	-	0	0		
4.level of education :								
No formal education	-	-	-	-	7	23.3	0	1 NS
Primary education	-	-	-	-	6	20		
High school education	-	-	-	-	10	33.3		
Graduate	-	-	-	-	4	13.3		
post graduate	-	-	-	-	3	10		
5.type of family:								
Nuclear family	-	-	-	-	15	50	0	1 NS
Joint family	-	-	-	-	14	46.7		
Extended family	-	-	-	-	1	3.3		
Broken family	-	-	-	-	0	0		
6.Monthly family income :								
<3000	-	-	-	-	0	0	0	1 NS
3001-5000	-	-	-	-	3	10		
5001-10000	-	-	-	-	13	43.3		
>10000	-	-	-	-	14	46.7		

7.Residence area :								
Urban	-	-	-	-	1	3.3	0	1
Rural	-	-	-	-	13	43.3		NS
Sub urban	-	-	-	-	16	53.3		
8.Occupation :								
Cooly	-	-	-	-	9	30		
Private employee	-	-	-	-	11	36.7		1
Government employee	-	-	-	-	5	16.7	0	NS
Business	-	-	-	-	1	3.3		
Unemployed	-	-	-	-	4	13.3		
9.Hobbies :								
Reading	-	-	-	-	6	20		
Watching TV	-	-	-	-	18	60	0	1
Listening Music	-	-	-	-	1	3.3		NS
Sports	-	-	-	-	5	16.7		
Gardening	-	-	-	-	0	0		
10. Amount of Alcohol :								
Below 100	-	-	-	-	19	63.3		
100-200ml	-	-	-	-	9	30	0	1
200-300ml	-	-	-	-	1	3.3		NS
300ml above	-	-	-	-	1	3.3		
11. How many years drinking alcohol:								
Less than 5 years	-	-	-	-	10	33.3		
6-10 years	-	-	-	-	9	30	0	1
11-16 years	-	-	-	-	8	26.7		NS
More than 16 years	-	-	-	-	3	10		
12. Drinking alcohol:								
Every day	-	-	-	-	8	26.7		
Weekly twice	-	-	-	-	14	46.7	0	1
Money available	-	-	-	-	6	20		NS
Monthly twice	-	-	-	-	2	6.7		

NS-Not significant, S-significant.

Table No 4.5.1: Association between level of depression in experimental group of post test and Selected Demographic data.

Demographic variables	Minimal		Mild		Moderate		χ2 (df)	p-value (N/NS)
	F	%	f	%	f	%		
1.Age (in years):								
20-30 years	5	16.7	0	0	-	-	11.72	0.008**
31-40 years	2	6.7	8	26.7	-	-	(df=3)	S
41-50 years	2	6.7	7	23.3	-	-		
51-55 years	4	13.3	2	6.7	-	-		
2.Religion:								
Hindu	12	40	14	46.7	-	-	0.97	0.615
Christian	1	3.3	2	6.7	-	-	(df=2)	NS
Muslim	0	0	1	3.3	-	-		
3. Marital status:								
Single	5	16.7	3	10	-	-	1.63	0.201
Married	8	26.7	14	46.7	-	-	(df=1)	NS
Separated	0	0	0	0	-	-		
Widowed	0	0	0	0	-	-		
4.level of education :								
No formal education	1	3.3	5	16.7	-	-	3.45	0.484
Primary education	0	0	8	26.7	-	-	(df=4)	NS
High school education	2	6.7	7	23.3	-	-		
Graduate	0	0	1	3.3	-	-		
post graduate	0	0	6	20	-	-		
5.type of family:								
Nuclear family	6	20	9	30	-	-	1.09	0.581
Joint family	7	23	7	23.3	-	-	(df=2)	NS
Extended family	0	0	1	3.3	-	-		
Broken family	0	0	0	0	-	-		
6.Monthly family income :								
<3000	0	0	0	0	-	-		
3001-5000	1	3.3	2	6.7	-	-	2.12	0.346
5001-10000	5	16.7	8	26.7	-	-	(df=2)	NS
>10000	7	23.3	7	23.3	-	-		

7.Residence area :								
Urban	1	3.3	0	0	-	-	1.43	0.488
Rural	5	16.7	8	26.7	-	-	(df=2)	NS
Sub urban	7	23.3	9	30	-	-		
8.Occupation :								
Cooly	5	16.7	4	13.3	-	-	1.90	0.754
Private employee	5	16.7	6	20	-	-	(df=4)	NS
Government employee	2	6.7	3	10	-	-		
Business	0	0	1	3.3	-	-		
Unemployed	1	3.3	3	10				
9.Hobbies :								
Reading	2	6.7	4	13.3	-	-	3.89	0.273
Watching TV	7	23.3	11	36.7	-	-	(df=3)	NS
Listening Music	0	0	1	3.3	-	-		
Sports	4	13.3	1	3.3	-	-		
Gardening	0	0	0	0	-	-		
10. Amount of Alcohol :								
Below 100	10	33.3	9	30	-	-	2.56	0.454
100-200ml	3	10	6	20	-	-	(df=3)	NS
200-300ml	0	0	1	3.3	-	-		
300ml above	0	0	1	3.3	-	-		
11. How many years drinking alcohol:								
Less than 5 years	6	20	4	13.3	-	-		
6-10 years	1	3.3	8	26.7	-	-	6.26	0.10
11-16 years	5	16.7	3	10	-	-	(df=3)	NS
More than 16 years	1	3.3	2	6.7	-	-		
12. Drinking alcohol:								
Every day	2	6.7	6	20	-	-	1.49	0.684
Weekly twice	7	23.3	7	23.3	-	-	(df=3)	NS
Money available	3	10	3	10	-	-		
Monthly twice	1	3.3	1	3.3	-	-		

NS-Not significant, S-significant.

CHAPTER V
DISCUSSION

CHAPTER V

DISCUSSION

This chapter deals with the discussion of the results of the data analyzed based on the objective of the study. The problem statement was "A study to evaluate the effectiveness of group therapy on depression among alcoholics at a selected de-addiction centre in Madurai."

The research design was quasi-study pre test post test design with experimental and control group. It was decided to do the study on 60 samples in which 30 were given group therapy and the other 30 were followed with the routine activities. The study was done among adult residing in selected de-addiction centre in Madurai."

5.1 Description of adults according to their socio demographic variables

The according to the age majority of adults F1 = 2 (6.7%), F2= 6(20%) were in the age group of 51 to 55 years, F1= 7(23.3%) F2= 9 (30%), age group 45 to 55 years, F1= 11(36.7%), F2= 10(33.3%) 31 to 40 years age group, F1= 10(33.3%) F2= 5(16.7%) age group 20 to 30 years.

Regarding religion, majority of adults f1=24(80%) f2= 26(86.7%) were Hindus, f1= 1(3.3%) f2= 3(10%) were Christians and f1= 5(16.7%) f2= 1(3.3.%) was Muslim.

While comparing the marital status the majority of the adults f1 = 1(3.3%) f2 = 0(0%) widows, f1 = 1(3.3%) f2=0(0%) separated, f1 = 80(60%) f2 = 22(73.3%) married, f1 = 10(33.3%) f2 = 8(26.7%) single.

While comparing the educational status majority of the adults f1 = 6(20%) f2 =3(10%) post graduated, f1 = 1(3.3%) f2= 4(13.3%) graduated, f1 =9(30%) f2 = 10(33.3%) high school education, f1 = 8(26.7%) f2 =6(20%) primary education, f1 = 6(20%) f2 = 7(23.3%) no formal education.

While comparing the family types majority f1 = 1(3.3%) f2 = 0(0%) broken family, f1 = 1(3.3%) f2=1(3.3%) extended family, f1=7(23.3%) f2=14(43.7%) joined family, f1=21(70%) f2=15(50%) nuclear family.

While comparing monthly family income f1=15(50%) f2=14(46.7%) earning more than 10000, f1=10(33.3%) f2=13(43.4%) earning 5001 to 10000, f1=5(16.7%) f2=3(10%) earning 3001 to 5000, f1=0(0%) f2=0(0%) earning less than 3000.

Regarding the residential area, majority f1=18(60%) f2=16(53.3%) were hailed from sub urban, f1=11(36.7%) f2=13(43.3%) were hailed from rural, f1=1(3.3%) f2=1(3.3%) were hailed from urban.

While comparing the occupation majority of adults f1=4(13.3%) f2=4(13.3%) unemployed, f1=3(10%) f2=1(3.3%) business, f1=5(16.5%) f2=5(16.7%) in government employees, f1=12(40%) f2=11(36.7%) in private employees, f1=6(20%) f2=9(30%) in Cooley.

While comparing the hobbies majority of adults f1=0(0%) f2=0(0%) gardening, f1=2(6.7%) f2=5(16.7%) sports, f1=0(0%) f2=1(3.3%) listening music, f1=24(80%) f2=18(60%) watching tv, f1=4(13.3%) f2=6(20%) reading.

While comparing the amount of alcohol majority of adults f1=1(3.3%) f2=1(3.3%) in above 300ml, f1= 0(0%) f2=1(3.3%) in 200 to 300ml, f1=10(33.3%) f2=9(30%) in 100 to 200ml, f1=19(63.3%) f2=90(63.3%) below 100ml.

While comparing the years of alcohol drinking majority of adults f1=2(6.7%) f2=3(10%) more than 16 years, f1=7(23.3%) f2=8(26.7%) 11 to 16 years, f1=8(26.7%) f2=9(30%) 6 to 10 years, f1=13(43.3%) f2 = 10(33.3%) less than 5 years.

While comparing the drinking alcohol majority of adults F1=1(3.3%) F2=2(6.7%) monthly twice, F1=5(16.7%) F2=6(20%) money available, F1=12(40%) F2=14(46.7%) weekly twice, F1=12(40%) F2=8(26.7%) every day.

5.2 Discussion of the study based on its objectives

The first objective to evaluate the effectiveness of group therapy on depression by comparing pre and post test score among alcoholics at a selected de-addiction centre in Madurai.

Pre test

Assessment of pre test level of depression among adult in experimental group was all 30[100%] patients are mildly depressed and none of them were normal or severely depressed. Assessment of pretest level of depression among elderly in control group was all the 30[100%] patients are mildly depressed. None of them are normal and severely depressed.

The mean and standard deviation of pre test level of depression among adult in experimental group revealed that, the mean value 26.67 with SD 1.89 and the mean value of 0.086 projects Unpaired' value as 1.745 which is statistically not significant.

Post test

Assessment of post test level of depression among adults in experimental group 13[43.3%] adults' persons is minimal; 17[56.7%] persons are mildly depressed

and none of them were severely depressed. Assessment of posttest level of depression among adults in control group was all the 30[100%] patients are mildly depressed. Comparison of pre and post test reveals no improvement in control group.

The mean and standard deviation of post test level of depression among adults in experimental group and control group depicted that, the mean value of 25.7 with SD 2.36 and the mean value of 24.6 with SD 3.48 of post test levels in control group projects Unpaired 't' value as 11.82 which is statistically significant at p=0.000 level.

The Second objective of to assess the pre test and post test level of depression among alcoholics:

Determine the effectiveness of group therapy among alcoholics on depression among adults in experimental group Analysis reveals that the mean value was 26.67 with standard deviation 1.89 of pretest level of depression in experimental group and the mean value was 13.83 with standard deviation 3.56 of posttest level of depression in experimental group. Whereas in control group the mean value was 25.7 with standard deviation 2.36 of pretest level of depression and posttest mean value was 24.6 and standard deviation was 3.49 There is a statistical significant difference between the Pre and Post- test level of depression among adults in the experimental group at P=0.086.There is no statistical significant difference between the Pre and Post- test level of depression among adults in the control groups.

Hence the stated hypotheses-H1 "There is a difference in the level of depression before and after group therapy among alcohol dependency".

The third objectives of to find out the level of depression with selected demographical variable:

The according to the age majority of adults F1 = 2 (6.7%), F2= 6(20%) were in the age group of 51 to 55 years, F1= 7(23.3%) F2= 9 (30%), age group 45 to 55 years, F1= 11(36.7%), F2= 10(33.3%) 31 to 40 years age group, F1= 10(33.3%) F2= 5(16.7%) age group 20 to 30 years.

Regarding religion, majority of adults f1=24(80%) f2= 26(86.7%) were Hindus, f1= 1(3.3%) f2= 3(10%) were Christians and f1= 5(16.7%) f2= 1(3.3.%) was Muslim.

While comparing the marital status the majority of the adults f1 = 1(3.3%) f2 = 0(0%) widows, f1 = 1(3.3%) f2=0(0%) separated, f1 = 80(60%) f2 = 22(73.3%) married, f1 = 10(33.3%) f2 = 8(26.7%) single.

While comparing the educational status majority of the adults f1 = 6(20%) f2 =3(10%) post graduated, f1 = 1(3.3%) f2= 4(13.3%) graduated, f1 =9(30%) f2 = 10(33.3%) high school education, f1 = 8(26.7%) f2 =6(20%) primary education, f1 = 6(20%) f2 = 7(23.3%) no formal education.

While comparing the family types majority f1 = 1(3.3%) f2 = 0(0%) broken family, f1 = 1(3.3%) f2=1(3.3%) extended family, f1=7(23.3%) f2=14(43.7%) joined family, f1=21(70%) f2=15(50%) nuclear family.

While comparing monthly family income f1=15(50%) f2=14(46.7%) earning more than 10000, f1=10(33.3%) f2=13(43.4%) earning 5001 to 10000, f1=5(16.7%) f2=3(10%) earning 3001 to 5000, f1=0(0%) f2=0(0%) earning less than 3000.

Regarding the residential area, majority f1=18(60%) f2=16(53.3%) were hailed from sub urban, f1=11(36.7%) f2=13(43.3%) were hailed from rural, f1=1(3.3%) f2=1(3.3%) were hailed from urban.

While comparing the occupation majority of adults f1=4(13.3%) f2=4(13.3%) unemployed, f1=3(10%) f2=1(3.3%) business, f1=5(16.5%) f2=5(16.7%) in government employees, f1=12(40%) f2=11(36.7%) in private employees, f1=6(20%) f2=9(30%) in Cooley.

While comparing the hobbies majority of adults f1=0(0%) f2=0(0%) gardening, f1=2(6.7%) f2=5(16.7%) sports, f1=0(0%) f2=1(3.3%) listening music, f1=24(80%) f2=18(60%) watching tv, f1=4(13.3%) f2=6(20%) reading.

While comparing the amount of alcohol majority of adults f1=1(3.3%) f2=1(3.3%) in above 300ml, f1= 0(0%) f2=1(3.3%) in 200 to 300ml, f1=10(33.3%) f2=9(30%) in 100 to 200ml, f1=19(63.3%) f2=90(63.3%) below 100ml.

While comparing the years of alcohol drinking majority of adults f1=2(6.7%) f2=3(10%) more than 16 years, f1=7(23.3%) f2=8(26.7%) 11 to 16 years, f1=8(26.7%) f2=9(30%) 6 to 10 years, f1=13(43.3%) f2 = 10(33.3%) less than 5 years.

While comparing the drinking alcohol majority of adults F1=1(3.3%) F2=2(6.7%) monthly twice, F1=5(16.7%) F2=6(20%) money available, F1=12(40%) F2=14(46.7%) weekly twice, F1=12(40%) F2=8(26.7%) every day.

As mentioned by the investigator in the first phase of conceptual frame work (identifying need for help) the investigator assessed the pretest level of depression by using geriatric depression scale and screened mild depressive elderly for both study and control group thereby the need was assessed.

After assessing the need in the first phase the investigator ministered the need by providing Bibliotherapy for the study group. In validating phase, investigator compared the pre and post level of depression in study and control group by using

paired "t" test the investigator found that there was a significant difference in the study group which proved the effectiveness of Bibliotherapy. And by positive outcome were reinforced and the negative outcome were reassessed.

Third objective of the study was to find the association between the posttest level of depression among elderly with their demographic variables and clinical variable in study and control group

Analysis of the association between the post test level of depression among elderly with their demographic, personal and clinical variables in the Study and Control group shows that post test level of depression was associated with their demographical variable of income of elderly in study group at p=0.01 and it was not associated with other variables in study and control group.

Hence the research hypothesis RH2stating that "There is a significant association between post-test level of depression among elderly with their demographic, personal and clinical variables in study and control group at p"0.05." was accepted for demographic variable of income in study group and was not accepted to other variables in study group and control group.

This association was supported by a cross sectional study conducted by National Institute of Mental Health and the Neuro Science on the prevalence of geriatric depression among 1000 participants aged over 65 years from Kaniyambadi block, Vellore, India. Results were prevalence of geriatric depression was 12.7% and the low income, experiencing hunger, and medical conditions were significantly associated with geriatric depression

Hence the conceptual framework supported the present study by acting as a skeleton which supports the study by proving that Bibliotherapy has improved the level of depression among elderly.

The present study assessed the effectiveness of Bibliotherapy on depression among elderly residing in selected old age homes, Dindigul District. The result of the study concluded that Bibliotherapy has reduced the depression among elderly.

Hence the stated Hypotheses-H2 " There is as statistically significant association between level of depression with demographic variable(age, religion, marital status, level of education, types of family, monthly family income, residential area, occupation and among of alcohol taken per day and hobbies" was accepted.

CHAPTER VI
SUMMARY AND CONCLUSION

CHAPTER VI

SUMMARY, CONCLUSION, IMPLICATIONS, RECOMMENDATIONS AND LIMITATIONS

This chapter is devoted to the consideration of the findings, understanding, limitations and interpretations of the results and recommendations that incorporate the implications such as nursing practice, nursing education, nursing administration, nursing research for further nursing research are presented. It also gives meaning to the results obtained in the study.

6.1 Summary of the Study

The present study was undertaken to evaluate the effectiveness of group therapy on depression among alcoholics at a selected de-addiction centre in Madurai. The study carried out the following objectives

6.1.1 The objectives of the study were

- To assess level of depression comparing between the control and experimental before Interventation.
- To assess the level of depression comparing between control and experimental after Interventation.
- To assess the effectiveness between the control and experimental group.
- To assess the pre test associated between the demographical variable and level of depression.

6.1.2 Research hypotheses

- H1 – There significant difference in the level of depression before and after group therapy among alcohol dependency

- H2 - There is a statistically significant association between level of depression and demographic variable (age, religion, marital status, level of education, types of family, monthly family income, residential area, occupation and amount of alcohol taken per day, hobbies).

6.1.3 The assumptions of the study

- Alcoholics dependants may have depression
- Group therapy will help to prevent and relax of alcoholic dependants.
- Group therapy may be a effective method to reduce the depression.

6.2 Major findings of the study

Assessment of pre test level of depression among adult in experimental group was all 30[100%] patients are mildly depressed and none of them were normal or severely depressed.

Assessment of pretest level of depression among elderly in control group was all the 30[100%] patients are mildly depressed. None of them are normal and severely depressed.

The mean and standard deviation of pre test level of depression among adult in experimental group revealed that, the mean value 26.67 with SD 1.89 and the mean value of 0.086 projects Unpaired' value as 1.745 which is statistically not significant.

There was no significant association between the post test level of depression and the other socio demographical variable such as: age, religion, medical status, level of education, types of family, monthly family income, residential area, occupational and among alcohol taken per day and hobbies.

The group therapy was effective in reduce the depression level among alcoholic in studying in selected de-addiction centre in Madurai.

6.3 CONCLUSION

The present study assessed the effectiveness of group therapy on depression among adults in selected in de-addiction centre in Madurai. The result of the study concluded that group therapy has reduced the depression among alcoholics.

This shows that the imperative need to understand the purpose of administration of group therapy in reducing depression among alcoholics in Deaddiction centre and it will enhances an overall sense of will being as well as improvement in the quality of life.

6.4 NURSING IMPLICATIONS

This section of the research report that focuses on nursing implication, which includes specific suggestion for nursing practice, nursing education, nursing administration and nursing research.

6.4.1 Nursing Practice

- As a member of health team, nurses play a vital role in reducing the depression among adults.
- Nurses should develop skill in implementing group therapy.
- Nurses should create awareness and motivate others in the team to use this approach in reducing the depression among adults people.
- Teach the staff nurses about the effectiveness of group therapy to reduce the depression among adult people.
- The assessment of level of depression will help the nurses to serve the public for preventing further complication of adults depression.

6.4.2 Nursing Education

- A continuing nursing education program can be arranged on the group therapy.
- A nurse educator should give education and motivate to use group therapy as a method of reducing depression among adult people.
- Student nurses have to update their knowledge regarding new treatments like therapies which are practiced by different countries.
- A nurse educator should make use of available literatures and studies related to the measures of reducing depression among adults.
- A nurse educator should encourage the students for effective utilization of research based practice.

6.4.3 Nursing Administration

- Conduct in-service education program on the effectiveness management of adults depression.
- Arrange and conduct workshop, conferences and seminars on adults depression and its management by psychological therapies.
- Provide opportunity for nurses to attend training programmes on management of depression among adults.
- Nurse administrators should motivate the public to involve in scientific meetings regarding group therapy.

6.4.4 Nursing Research

- As a nurse researcher, promote more research on reducing depression among adults.
- Disseminate the findings of the research through conferences, seminars and publishing in nursing journal.
- Promote effective utilization of research findings on the management of depression among adults.

6.5 RECOMMENDATIONS

- A similar study can be under taken to know the effectiveness of group therapy on depression among adults who are hospitalized.
- A comparative study can be done on assessment of depression between alcoholics in and adults in de-addiction centre.
- The same study can be done with large sample size so that the results can be generalized.

6.6 LIMITATIONS

- The investigator found difficulty in getting adequate literature related to the study in national context.
- Investigator control the extraneous variables such as support from the family members and friends, mass media and other relaxation activities(games, watching tv, simple exercise)

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APPENDICES

APPENDIX – I

LETTER SEEKING PERMISSION FOR VALIDATION OF CONTENT AND TOOL

From:

G. Thulasi
II Year M.Sc Nursing
Jainee College of Nursing
Dindigul

To:

Mrs. Jancy Rachel Daisy
Lecturer,
CSC College of Nursing
Madurai.

Through the proper channel,

Respected Madam,

Sub: Requesting to validate my content and tool-Reg.

I am G. Thulasi studying in Jainee College of Nursing Dindigul. Here with I am sending my content and tool, kindly validate my content and tool.

Thanking You

Yours faithfully

Madurai.

APPENDIX – II

CONTENT VALIDITY CERTIFICATE

CERTIFICATE OF VALIDATION

CERTIFICATE FOR VALIDATION

This is to certify that the content and tool

Section - A: Socio Demographic data

Section - B: Beck depression scale

Prepared for data collection by Mrs. G. Thulasi, II Year M.Sc Nursing, Jainee College of Nursing Dindigul, who has undertaken the study field on thesis entitled **"A Study to evaluate the effectiveness of group therapy on depression among alcoholics at a selected De-addiction Centre in Madurai"** has been validated by me.

Name: V. Jesinda Vedanayagi

Signature of the expert

Designation: Professor

Institution: Sacred heart nursing college.

G. Thulasi – Msc (Psychiatric) 2nd year

CERTIFICATE OF VALIDATION

CERTIFICATE FOR VALIDATION

This is to certify that the content and tool

Section - A: Socio Demographic data

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R-Jancy Rachel Daisy

Name: PROF. DR. R. JANCY RACHEL DAISY, Signature of the expert

Designation: PROFESSOR

Institution: C.S.I. JEYARAJ ANNAPACKIAM COLLEGE OF NURSING,
PASUMALAI,
MADURAI - 4.

APPENDIX – III

LETTER SEEKING AND GRANTING PERMISSION TO CONDUCT THE PILOT STUDY AT WISDOM HOSPITAL AND DE-ADDICTION, MADURAI.

FROM
G.Thulasi
II Year M.Sc(N),
Jainee collage of nursing,
Dindigul.

TO

The Chief Doctor,
Wisdom Hospital and De-addiction Centre,
Sakkimangalam,
Madurai.

Through the proper channel,

Respected Sir,

Sub: Requesting Permission to conduct Pilot study in Wisdom Hospital and De-addiction Centre, Madurai – Regarding,

As per the curriculum recommended by the Indian Nursing Council and Tamilnadu Dr. MGR Medical University all the M.Sc (N) students are requested to conduct a pilot study for the partial fulfillment of the course.

I have selected a study on **"A study to evaluate the effectiveness of group therapy on depression among alcoholics at selected de-addiction centre in Madurai"** for my study, I would like to conduct the pilot study in Wisdom Hospital and De-addiction Centre Madurai, **From 21.02.2018 to 30.03.2018.** So I kindly request you to consider, guide and allow me to conduct the study.

Thanking you.

Madurai

15.02.2018

Permission Granted

Yours sincerely,

Mrs. Thulasi

LETTER SEEKING AND GRANTING PERMISSION TO CONDUCT THE PILOT STUDY AT WISDOM HOSPITAL AND DE-ADDICTION, MADURAI.

FROM
G.Thulasi
II Year M.Sc(N),
Jainee collage of nursing,
Dindigul.

TO
Dr. Gnaneswaran, M.S. (Psy. Therapy)
Wisdom Trust Hospital and De-addiction Centre,
Sakkimangalam,
Madurai.

Through the proper channel,
Respected Sir,

Sub: Requesting Permission to conduct Pilot study in Wisdom Hospital and De-addiction Centre, Madurai – Regarding,

As per the curriculum recommended by the Indian Nursing Council and Tamilnadu Dr. MGR Medical University all the M.Sc (N) students are requested to conduct a pilot study for the partial fulfillment of the course.

I have selected a study on **"A study to evaluate the effectiveness of group therapy on depression among alcoholics at selected de-addiction centre in Madurai"** for my study, I would like to conduct the pilot study in Wisdom Hospital and De-addiction Centre Madurai, **From 21.02.2018 to 30.03.2018.** So I kindly request you to consider, guide and allow me to conduct the study.

Thanking you.

Madurai

15.02.2018

Permission Granted

Yours sincerely,

Mrs. Thulasi

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APPENDIX – IV

SOCIO DEMOGRAPHIC DATA – ENGLISH

SECTION-A

SOCIODEMOGRAPHIC PERFORMA OF ADULTS

Sample No:

Date: Place:

1. Age

a) 20 – 30 years

b) 31 - 40 years

c) 41 – 50 years

d) 51 - 55 years

2. Religion

a) Hindu

b) Christian

c) Muslim

3. Marital Status

a) Single

b) Married

c) Separated

d) Widowed

4. Level of education

a) No formal education

b) Primary education

c) High school education

d) Graduate / Post graduate

5. Type of Family

a) Nuclear Family

b) Joint Family

c) Extended family

d) Broken family

6. Monthly family income

a) < Rs3000

b) Rs3001-5000

c) Rs5001-10000.

d) > Rs 10000

7. Residential area

a) Urban

b) Rural

c) Sub urban

8. Occupation

a) Cooley

b) Private employee

c) Government employee

d) Business

e) Unemployed

9. Hobbies

a) Reading

b) Watching TV

c) Listening Music

d) Sports

e) Gardening

10. Amount of alcohol taken per day

a) Below 100ml

b) 100ml to 200ml

c) 200ml to 300ml

d) 300ml and above

11. Number of years have you been drinking alcohol?

a) Less than 5 years

b) 6 to 10 years

c) 11 to 16 years

d) more than 16 years

12. Do you always use of alcohol?

a) Everyday

b) Weekly twice

c) money available

d) monthly twice

APPENDIX – V

RESEARCH TOOL - ENGLISH

BECK DEPRESSION INVENTORY SCALE

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1. Sadness

0 I do not feel sad.

1 I feel sad

2 I am sad all the time and I can't snap out of it.

3 I am so sad and unhappy that I can't stand it.

2. Pessimism

0 I am not particularly discouraged about the future.

1 I feel discouraged about the future.

2 I feel I have nothing to look forward to.

3 I feel the future is hopeless and that things cannot improve.

3. Past failure

0 I do not feel like a failure.

1 I feel I have failed more than the average person.

2 As I look back on my life, all I can see is a lot of failures.

3 I feel I am a complete failure as a person.

4. Loss of pleasure

0 I get as much satisfaction out of things as I used to.

1 I don't enjoy things the way I used to.

2 I don't get real satisfaction out of anything anymore.

3 I am dissatisfied or bored with everything.

5. Guilty feelings

0 I don't feel particularly guilty

1 I feel guilty a good part of the time.

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 don't feel disappointed in myself.

1 I am disappointed in myself.

2 I am disgusted with myself.

3 I hate myself.

8. Self - criticalness

0 I don't feel I am any worse than anybody else.

1 I am critical of myself for my weaknesses or mistakes.

2 I blame myself all the time for my faults.

3 I blame myself for everything bad that happens.

9. Suicide thoughts

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 any more than usual.

1 I cry more now than I used to.

2 I cry all the time now.

3 I used to be able to cry, but now I can't cry even though I want to.

11. Agitation

0 I am no more irritated by things than I ever was.

1 I am slightly more irritated now than usual.

2 I am quite annoyed or irritated a good deal of the time.

3 I feel irritated all the time.

12. Loss of interest

0 I have not lost interest in other people.

1 I am less interested in other people than I used to be.

2 I have lost most of my interest in other people.

3 I have lost all of my interest in other people.

13. Indecisiveness

0 I make decisions about as well as I ever could.

1 I put off making decisions more than I used to.

2 I have greater difficulty in making decisions more than I used to.

3 I can't make decisions at all anymore.

14. Worthlessness

0 I don't feel that I look any worse than I used to.

1 I am worried that I am looking old or unattractive.

2 I feel there are permanent changes in my appearance that make me look unattractive

3 I believe that I look ugly.

15. Loss of energy

0 I can work about as well as before.

1 It takes an extra effort to get started at doing something.

2 I have to push myself very hard to do anything.

3 I can't do any work at all.

16. Changes in sleep

0 I can sleep as well as usual.

1 I don't sleep as well as I used to.

2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.

3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. Irritability

0 I don't get more tired than usual.

1 I get tired more easily than I used to.

2 I get tired from doing almost anything.

3 I am too tired to do anything.

18. Chances in appetite

0 My appetite is no worse than usual.

1 My appetite is not as good as it used to be.

2 My appetite is much worse now.

3 I have no appetite at all anymore.

19. Concentration difficulty

0 I haven't lost much weight, if any, lately.

1 I have lost more than five pounds.

2 I have lost more than ten pounds.

3 I have lost more than fifteen pounds.

20. Tiredness or fatigue

0 I am no more worried about my health than usual.

1 I am worried about physical problems like aches, pains, upset stomach, or constipation.

2 I am very worried about physical problems and it's hard to think of much else.

3 I am so worried about my physical problems that I cannot think of anything else.

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 have almost no interest in sex.

3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression over
40	Extreme depression

APPENDIX – VI
SOCIO DEMOGRAPHIC DATA – TAMIL

பகுதி - அ

தன்னிலை விபரக்குறிப்பு

மாதிரி எண்:

1. வயது

அ) 20 - 30 ஆண்டுகள்

ஆ) 31 - 40 ஆண்டுகள்

இ) 41 - 50 ஆண்டுகள்

ஈ) 51 - 55 ஆண்டுகள்

2. மதம்

அ) இந்து மதம்

ஆ) கிறிஸ்தவர்

இ) முஸ்லிம்

ஈ) இதர

3. திருமண நிலை

அ) ஒற்றை

ஆ) திருமணம்

இ) பிரிக்கப்பட்டது

ஈ) விதவை

4. கல்வி நிலை

அ) முறையான கல்வி இல்லை

ஆ) ஆரம்ப கல்வி

இ) உயர்நிலைப் பள்ளி கல்வி

ஈ) இரண்டாம் நிலை கல்வி

உ) பட்டதாரி / முதுநிலை பட்டதாரி

5. குடும்ப வகை

அ) அணு குடும்பம்

ஆ) கூட்டு குடும்பம்

இ) விரிவாக்கப்பட்ட குடும்பம்

ஈ) உடைந்த குடும்பம்

6. மாதாந்திர குடும்ப வருமானம்

அ) ரூ .3000

ஆ) ரூ .3001-5000

இ) ரூ .5001-10000.

ஈ) ரூ .10000 மற்றும் அதற்கு மேல்

7. குடியிருப்பு பகுதி

அ) சேரிப்புறம்

ஆ) கிராமப்புறம்

இ) நகர்ப்புறம்

8. தொழில்

அ) கூலி

ஆ) தனியார் ஊழியர்

இ) அரசாங்க ஊழியர்

ஈ) வணிகம்

உ) வேலையில்லாதவர்கள்

9. பொழுதுபோக்கு

அ) படித்தல்

ஆ) டிவி பார்த்தல்

இ) இசை கேட்பது

ஈ) விளையாடுவது

ஈ) தோட்டவேலை

10. நாள் ஒன்றுக்கு ஆல்கஹால் எடுக்கப்பட்ட அளவு

அ) 100 மில்லிக்கு குறைவாக

ஆ) 100 மில்லி – 200 மில்லி

இ) 200 மில்லி – 300 மில்லி

ஈ) 300 மில்லிக்கும் அதிகமாக

11. எத்தனை வருடங்களாக மது அருந்துகிறீர்கள்?

அ) 5 வருடங்கள்

ஆ) 6 – 10 வருடங்கள்

இ) 11 – 16 வருடங்கள்

ஈ) 16 வருடங்களுக்கு மேலாக

12. நீங்கள் எப்பொழுதெல்லாம் மது அருந்துவீர்கள்?

அ) தினந்தோறும்

ஆ) வாரத்தில் இரண்டு நாள்

இ) காசு இருக்கும் போது

ஈ) மாதத்தில் இரண்டு நாள்

APPENDIX – VII

RESEARCH TOOL - TAMIL

பெக் டெப்ரஸின் ஸ்கேல்

1. வருத்தம்

0 நான் சோகமாக உணரவில்லை.

1 வருத்தமாக உணர்கிறேன்.

2 நான் எல்லா நேரத்திலும் சோகமாக இருக்கிறேன், என்னால் அதிலிருந்து வெளிவர இயலாது.

3 நான் மிகவும் சோகமாகவும் மகிழ்ச்சியுற்றும் இருக்கிறேன், என்னால் இப்படியே இருக்க முடியாது.

2. அவநம்பிக்கை

0 எதிர்காலத்தைப் பற்றி நான் குறைவாக மதிப்பிடுவதில்லை.

1 வருங்காலத்தைப் பற்றி எண்ணி நான் சோர்வடைகிறேன்.

2 நான் எதிர்நோக்குவதற்கு எதுவும் எனக்கு இல்லை என்று நினைக்கிறேன்.

3 நான் எதிர்காலம் நம்பிக்கையற்றது என்று உணர்கிறேன், அதனால் எந்த முன்னேற்றமும் வராது என்று கருதுகிறேன்.

3. கடந்த தோல்வி

0 நான் தோல்வி அடைந்தவனாய் உணர்கிறேன்.

1 நான் சராசரி நபர் விட தோற்றுவிட்டேன் என்று நினைக்கிறேன்.

2 என் வாழ்க்கையில் நான் திரும்பிப் பார்க்கையில், என்னால் பார்க்க முடிந்த எல்லாத் தோல்விகளும் நிறைய இருக்கின்றன.

3 நான் ஒரு நபர் ஒரு முழுமையான தோல்வி உணர்கிறேன்.

4. மகிழ்ச்சி இழப்பு

0 நான் பயன்படுத்தியதைப் போலவே எனக்கு மிகவும் திருப்தி கிடைத்தது.

1 நான் பயன்படுத்தும் வழிகளை நான் அனுபவிப்பதில்லை.

2 இனி நான் எதையும் திருப்தி செய்ய மாட்டேன்.

3 நான் அதிருப்தி அடைகிறேன்.

5. குற்றவாளி உணர்வுகள்

0 நான் குறிப்பாக குற்றவாளி இல்லை

1 நேரம் நான் குற்றவாளி ஒரு நல்ல பகுதியாக உணர்கிறேன்.

2 பெரும்பாலான நேரம் நான் மிகவும் குற்றவாளி என்று நினைக்கிறேன்.

3 நான் எல்லா நேரத்திலும் குற்றவாளியாக உணர்கிறேன்.

6. தண்டனை உணர்வுகள்

0 நான் தண்டிக்கப்படுகிறேன் என்று நான் நினைக்கவில்லை.

1 நான் தண்டிக்கப்படலாம் என நினைக்கிறேன்.

2 நான் தண்டிக்கப்படுவேன் என்று எதிர்பார்க்கிறேன்.

3 நான் தண்டிக்கப்படுகிறேன் என்று நினைக்கிறேன்.

7. சுய விருப்பம்

0 என்னை நானே ஏமாற்றிக்கொள்ளவில்லை.

1 என்னை நானே ஏமாற்றிக்கொண்டிருக்கிறேன்.

2 நான் என்மேல் வெறுப்பாயிருக்கிறேன்;

3 நான் என்னை வெறுக்கிறேன்.

8. சுயமரியாதை

0 வேறு யாரை விட மோசமாக நான் உணர்கிறேன்.

1 என் பலவீனங்கள் அல்லது தவறுகளுக்கு என்னை நானே விமர்சிக்கிறேன்.

2 என் தவறுகளுக்கு எல்லா நேரங்களிலும் நான் குற்றம் சாட்டுகிறேன்.

3 மோசமான எல்லாவற்றிற்கும் என்னை நானே குற்றம் சொல்கிறேன்.

9. தற்கொலை எண்ணங்கள்

0 என்னை கொலை செய்வதற்கான எந்த எண்ணமும் எனக்கு இல்லை.

1 என்னைக் கொன்றுபோட எண்ணங்கள் எனக்குண்டு; அவைகளை நான் சுமக்கமாட்டேன்.

2 என்னை கொல்ல விரும்புகிறேன்.

3 எனக்கு வாய்ப்பு கிடைத்திருந்தால் நான் கொல்லுவேன்.

10. அழுகை

0 நான் வழக்கத்தை விட அதிகமாக அழுவதில்லை.

1 நான் இப்போது அதிகமாகக் கூப்பிடுகிறேன்.

2 இப்போது நான் எப்பொழுதும் அழுகிறேன்.

3 நான் கூப்பிடுவேன், ஆனால் நான் விரும்பினாலும் இப்போது அழுகிறேன்.

11. ஆர்ப்பாட்டம்

0 நான் இதுவரை இருந்ததைவிட எரிச்சலடைந்தேன்.

1 நான் வழக்கத்தைவிட சற்றே எரிச்சலடைகிறேன்.

2 நான் மிகவும் எரிச்சலடைந்திருக்கிறேன் அல்லது நேரம் ஒரு நல்ல ஒப்பந்தம் எரிச்சல்.

3 நான் எப்போதாவது எரிச்சலூட்டும் உணர்கிறேன்.

12. எதிலும் ஆர்வமின்மை

0 நான் மற்றவர்களிடம் ஆர்வத்தை இழக்கவில்லை.

1 நான் இருந்ததை விட மற்றவர்களிடம் நான் மிகவும் ஆர்வம் காட்டவில்லை.

2 நான் மற்றவர்களிடம் என் ஆர்வத்தை மிக அதிகமாக இழந்துவிட்டேன்.

3 மற்றவர்களிடம் என் ஆர்வம் அனைத்தையும் நான் இழந்துவிட்டேன்.

13. சந்தேகம்

0 நான் முடிவெடுக்கும் முடிவை எடுப்பேன்.

1 நான் பயன்படுத்துவதை விட அதிகமான தீர்மானங்களை எடுத்தேன்.

2 நான் பயன்படுத்தியதை விட அதிகமான தீர்மானங்களை எடுப்பதில் எனக்கு அதிக சிரமம் உள்ளது.

3 நான் இனிமேல் முடிவெடுக்க முடியாது.

14. மதிப்புமிக்கது

0 நான் பயன்படுத்தியதை விட மோசமானதை நான் உணர்கிறேன்.

1 நான் பழைய அல்லது கடின உழைப்பாளி என்று நான் கவலைப்படுகிறேன்.

2 என் தோற்றத்தில் நிரந்தர மாற்றங்கள் உள்ளன என்று எனக்கு தோன்றுகிறது

3 நான் அசிங்கமாக இருக்கிறேன் என்று நான் நம்புகிறேன்.

15. ஆற்றல் இழப்பு

0 நான் முன்பும் அதே போல் வேலை செய்ய முடியும்.

1 ஏதேனும் ஒன்றைச் செய்யத் துவங்குவதற்கு கூடுதல் முயற்சி எடுக்கிறது.

2 நான் எதையும் செய்ய மிகவும் கடினமாக தள்ள வேண்டும்.

3 நான் எந்த வேலையும் செய்ய முடியாது.

16. தூக்கத்தில் மாற்றங்கள்

0 நான் அதே போல் வழக்கமான தூங்க முடியும்.

1 நான் அதே போல் தூங்கவில்லை.

2 1-2 மணிநேரங்களுக்கு முன்னர் நான் சாதாரணமாக எழுந்திருக்கிறேன், தூங்குவதற்கு கடினமாகக் கண்டேன்.

3 நான் பயன்படுத்தியதை விட பல மணி நேரங்களுக்கு முன்னால் எழுந்திருக்கிறேன், மீண்டும் தூங்க முடியாது.

17. எரிச்சல்

0 நான் வழக்கமான விட சோர்வாக இல்லை.

1 நான் மிகவும் எளிதாக சோர்வடைந்தேன்.

2 கிட்டத்தட்ட எதையும் செய்ய எனக்கு சோர்வடையவில்லை.

3 நான் எதையும் செய்ய சோர்வாக இருக்கிறேன்.

18. பசியின்மை வாய்ப்புகள்

0 என் விருப்பம் வழக்கமான விட மோசமாக உள்ளது.

1 என் பசியின்மை அது போலவே நல்லது அல்ல.

2 பசி இப்போது மோசமாக உள்ளது.

3 இனிமேல் எனக்கு பசியும் இல்லை.

19. செறிவு சிரமம்

0 நான் நிறைய எடை இழக்கவில்லை, ஏதாவது இருந்தால், சமீபத்தில்.

1 நான் ஐந்து பவுண்டுகள் இழந்துவிட்டேன்.

2 நான் பத்து பவுண்டுகள் இழந்துவிட்டேன்.

3 நான் பதினைந்து பவுண்டுகள் இழந்தேன்.

20. சோர்வு அல்லது சோர்வு

0 நான் வழக்கமாக விட என் உடல்நிலை பற்றி கவலை இல்லை.

1 வலிகள், வலி, வயிற்றுப்போக்கு, அல்லது மலச்சிக்கல் போன்ற உடல் பிரச்சினைகள் பற்றி கவலைப்படுகிறேன்.

2 நான் உடல் பிரச்சினைகள் பற்றி மிகவும் கவலைப்படுகிறேன் மற்றும் வேறு எதையும் யோசிக்க கடினமாக உள்ளது.

3 என் உடல் பிரச்சினைகள் பற்றி நான் மிகவும் கவலைப்படுகிறேன், வேறு எதையும் நான் சிந்திக்க முடியாது.

21. பாலியல் ஆர்வம் இழப்பு

0 பாலியல் குறித்த எனது ஆர்வத்தில் சமீபத்திய மாற்றங்களை நான் கவனித்திருக்கவில்லை.

1 நான் இருந்ததை விட பாலியல் ஆர்வம் எனக்கு இல்லை.

2 செக்ஸ் பற்றி எனக்கு எந்த ஆர்வமும் இல்லை.

3 பாலியல் ஆர்வத்தை முழுமையாக இழந்துவிட்டேன்.

மொத்த மதிப்பெண்__________________ மன அழுத்தம் நிலை.

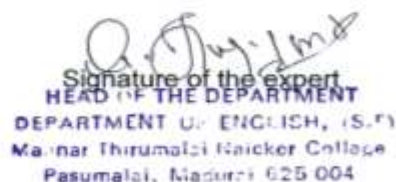
APPENDIX – VIII

ENGLISH EDITING CERTIFICATE

CERTIFICATE OF ENGLISH EDITING

TO WHOM SO EVER IT MAY CONCERN

This is to certify that the dissertation **"A Study to evaluate the effectiveness of group therapy on depression among alcoholics at a selected De-addiction Centre in Madurai"** by Mrs. G. Thulasi M.Sc (N) II year student, Jainee College of Nursing Dindigul has been edited for English Language appropriateness.



Name: Dr. G. Jeya Jeevakani

Designation: Head, Assistant Professor of English.

Institution: Mannar Thirumalai Naicker College.

APPENDIX – IX

TAMIL EDITING CERTIFICATE

CERTIFICATE OF TAMIL EDITING

TO WHOM SO EVER IT MAY CONCERN

This is to certify that the dissertation **"A Study to evaluate the effectiveness of group therapy on depression among alcoholics at a selected De-addiction Centre in Madurai"** by Mrs. G. Thulasi M.Sc (N) II year student, Jainee College of Nursing Dindigul has been edited for Tamil Language appropriateness.

Name: Dr. T. PARIMALA

Signature of the expert

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Designation: Assestant Professor of Tamil

Institution: Mannar Thirumalai Naicker College

APPENDIX – X

PROTOCOL FOR GROUP THERAPY

ALCOHOL WITH DEPRESSION

STEP I : ALCOHOL

INTRODUCTION

Many of us drink alcohol to enjoy, but drinking some can become a serious problem. In fact, alcohol is more harmful than cannabis and heroin. Wine is a calm, addictive, cause of many hospital admissions by accident and health disorders.

The problems caused by alcohol

Drinking too much, drinking in the wrong place or at times causes many problems. Since alcohol affects your valuation, you will do things that you do not even think naturally. Because you are less likely to feel the dangers of alcohol, you will be easy. You will most often engage in sexual activities in the fight, arguments, money, family, or momentum. Alcohol housing, road, water, and sports are caused by accidents.

Health disorders caused by alcohol

Excessive alcohol consumption may cause hangovers, abdominal pain, blood vomiting, anesthesia and death. Lots of long-term drinking can increase the risk of liver disease and some forms of cancer. Women over 40 years old and men with moderate intake can reduce the risk of cardiovascular disease.

Cognitive disorders of alcohol

Even if we think of drinking alcohol for the sake of drinking, you may have too much drinking depression. Many people who commit suicide have alcoholism. Alcohol reminiscent and brain damage. It will hear the voice and sounds - this is very sweet and tough to get rid of.

Warning signs

Below are some of the warning signs that addictive addiction is addictive.

- Do not be able to start a day without being able to drink or drink without it
- Drying, trembling and anxiety in few hours of drinking
- Being overly drunk and not eating
- More and more drinks to get the same effect
- Failure to stop the settlement
- Your drinking will continue if you are affected by work, family and relationships
- You will have to remember "Memory Blanks" so that you do not remember what happened for a few hours or days

Handling the problems of alcohol

If you are worried about your or your friend's drinking, you should make immediate changes. Before the health is affected, it is easy to reduce the strain, and drinking alcohol can be difficult.

First step

Mark your drinks in a diary - you will be surprised by the size of your dwelling and it will encourage you to reduce your stay. Talking about your plans will be helpful to friends or relatives. Do not be shy to talk to others. Most true friends will be happy to help you - and they will feel some time worrying about you.

Getting Help

If you find it hard to change your alcohol, try to talk to the doctor or get advice from the local alcohol. If your doctor is trying to reduce the strain, your doctor can help you with some medicines for a short period of time. If you have difficulty altering alcohol then you will need special help.

Change habit

We all struggle to change a habit. Especially when it is a big part of our lives. There are three ways to solve this problem

- Realizing and accepting the problem
- Getting help to change habits
- Once you have made changes once you are done

Being alcohol can be your way of dealing with your stress and anxiety. A psychiatrist or psychologist may be able to help with the non-drinking methods to deal with concerns.

It is very useful to meet others in groups with the same problem. Group-based therapies are taking place in self-help groups such as "alkalikic anonymous" and alcohol treatment units.

Most people do not have to go to the hospital to deal with drinking. Some people need to get rid of places and drinking people. It is important for them to be treated for a short time in the alcohol treatment unit. Drugs can only be used to repair the alcohol disorders (Withdrawal symptoms). It is important to avoid relieving peacekeepers as an alternative medicine

Whatever the drinker can have alcohol problems - some lose everything - a major cause of alcohol homelessness. Some people just need support and talk, but others may need long-term assistance to live in something and start living relationships.

Whether it's hard work to monitor alcohol, eventually it's all aspects of your life

STEP 2: DEPRESSION

Introduction

Depression is very common - one in five people become depressed at some point in their lives. Anyone can get low, but someone is said to be suffering from depression when these feelings don't go away quickly or become so bad they interfere with their everyday life.

Depression can last for a few months. You can get better, only for the depression return again. It is usual to recover from depression, but it is also common for the depression to return. Episodes can last several months (or even longer in some instances).

Why do people get depressed?

Sometimes there may be an obvious reason for becoming depressed, sometimes not. The reason may seem obvious – a relationship breakdown or a bereavement or even the birth of a child – sometimes it is not clear. Either way, these feelings can become so bad that you need help.

What does it feel like to be depressed?

The feeling of depression is deeper, longer and more unpleasant than the short episodes of unhappiness that everyone experiences occasionally.

You will notice:

- Persistent sadness or low mood
- Not being able to enjoy things
- Losing interest in life
- Finding it harder to make decisions
- Not coping with things that used to be easy

- Feeling exhausted
- Feeling restless and agitated;
- Loss of appetite and weight
- Difficulties getting to sleep
- Loss of sex drive
- Thoughts of self-harm or suicide.

Doctors grade depression as mild, moderate and severe to help them decide which treatment to choose.

How do I know if I am depressed?

You may not realise how depressed you are because it has come on so gradually. You may try to struggle on and cope by keeping busy. This can make you even more stressed and exhausted. Physical pains, such as constant headaches or sleeplessness, then start. Sometimes these physical symptoms can be the first sign of a depression.

What help and treatment is available?

- **Self-help**: there are now a number of self-help books and computer programmes based on Cognitive Behavioural Therapy (CBT) for depression.
- **Talking treatments:** there are several different types of talking treatments. Counselling enables you to talk about your feelings to a professional. Your GP may have a counsellor at the surgery who you can talk to.
- **Cognitive Behavioural Therapy** helps people overcome the negative thoughts that can sometimes be the cause of depression.
- If you have become depressed while suffering from a disability or caring for a relative, then a self-help group may give you the support you need.

- **Medication**: Antidepressants can help if your depression is severe or goes on for a long time. They can help you to feel less anxious and cope better so that you can start to enjoy life and deal with problems effectively again. It is important to remember that you won't feel the effect of antidepressants straight away. People often don't notice any improvement in their mood for 2 or 3 weeks.
- As well as tablets, there is an **alternative remedy** called St John's Wort available from chemists. This can help in mild to moderate depression. It seems to work in much the same way as an antidepressant, but some people find that it has fewer side-effects. If you are taking other medication, it's important to tell your doctor before taking St John’s Wort.

Which is right for me – self-help. talking treatments or tablets?

It depends on how your depression has developed and how severe it is. On the whole, self-help and talking treatments are best for mild depression. They are equally helpful for moderate depression. If you depression is severe, you are more likely to need antidepressants.

What will happen if I don’t get treatment?

Many depressions will go away eventually, but it may take many months. A small number of people with depression will take their own lives.

What can I do to help myself?

- Tell someone how you feel.
- Try to keep active. Even just going for a walk regularly can help your mood and sleep pattern. Doing things can help to take you mind off thoughts that make you depressed.
- Make sure you eat well.
- Be careful with alcohol as it makes depression worse.

- Try not to get worried if you can’t sleep, but do something relaxing in bed such as reading, watching TV or listening to the radio.
- If you think you know what is causing your depression, it can help to write down the problem and then think of the things you could do to tackle it. Pick the best actions and see if they work.
- Also try to keep hopeful. This is a very common experience and you will come through it, probably stronger and more able to cope than before.

How can I help someone who is depressed?

- Listen to them, but try not to judge them.
- Don’t offer advice unless they ask for it, but if you can see the problem that is behind the depression, you could work with the person to find a solution.
- Spending time with them, listening over and over to their problems, and encouraging them to keep going with activities in their routine, is all helpful.

STEP 3: SIMPLE WAY OF OVERCOME DEPRESSION (REHABITATION)

Irengbam Jenny

Depression is a pervasive feeling or a state of mood which affects a person's thoughts, behaviour. If one is depressed they lose interest in activities once they considered pleasurable.

Sometimes depression can be deliberating and different from feeling of being sad or unhappy. It results from a combination of recent events and other long-term or personal factors. Though, it cannot be cured with medication but there are simple ways which can be done to overcome depression.

Here are some simple ways to overcome depression:

Be mindful: Depressed mind thinks over all the wrong and unnecessary worries. This negative thought is not helpful to the person who is depressed. It can be overcome with the practice of mindfulness. Mindfulness means practice engaging your senses i.e focus, touch, sight,sound, taste, in the present moment and it is a skill that needs to be practiced. Engaging yourself will leave you with less time to worry.

Listen to music: Listening to music is also one of the ways to overcome depression. One should listen to the upbeat or happy music to change the atmosphere instantly and to create a positive vibe. Happy music changes the mood and helps you to overcome depression.

Stop negative talk: Depressed people tend to see and talk negatively of everything in the world. They also reinforce self doubt and feelings of worthlessness because if things go wrong they blame themselves and if things go right they put down to luck. One should not take seriously of the negative thought if you feeling low. A perspective should be kept to avoid the negative talks and overcome depression.

Distraction: One should distract oneself from the thoughts of all the useless things and over thinking. Your thought is the enemy and makes way for you to set in depression. Reading a book or finishing a puzzle are the best ways to distract yourself from thinking while depressed. Make yourself busy as it is an effective way to overcome depression.

Get enough sleep: Lack of sleep can cause you irritability and stress, while healthy sleep can enhance well-being. Sleep and mood swings are closely connected. It is proved that sleep deprivation has a significant effect on mood. One should get adequate amount of sleep to avoid stress and mood swings which leads to depression.

Exercise: Exercise regularly as it helps in overcoming depression. Exercise releases endorphins which improves the mood. Besides improving the mood, exercising also benefits our health, protect us from many diseases and boosts our self esteem. One should exercise at least for half an hour to an hour everyday as advised by experts for a healthy mind and body.

Stay connected: If you are depressed then sitting idle at home alone or isolating from others is the worst thing to do. You may not like to go out and do recreational activities but one should force oneself to go out as these activities are one of the ways to overcome the feeling of depression. Connect with your friends and hang out with them, as it will have huge positive effect on your mood.

APPENDIX – XI

PROTOCOL FOR GROUP THERAPY

மதுபானம் மற்றும் மனச்சோர்வு நோய்

படி 1 **சாராயமதுபானம்**

முன்னுரை:

நம்மில் பலர் இன்பம் அனுபவிக்க மதுபானம் அருந்துவோம் ஆனால் சிலருக்கோ குடிப்பது தீவிர பிரச்னையாக மாறலாம். உண்மையில் சாராயமதுபானம், கஞ்சா மற்றும் ஹெராயினை விட அதிக தீங்கு விளைவிக்கும். மது ஒரு அமைதியூட்டி, அடிமைப்படுத்தும் தன்மையுடையது, விபத்து மற்றும் உடல்நலக் கோளாறுகளால் பல மருத்துவமனை சேர்க்கைகளுக்கு காரணமாகும்.

மதுவினால் உண்டாகும் பிரச்னைகள்:

அளவுக்கு அதிகமாக குடிப்பது, தவறான இடத்தில் அல்லது நேரத்தில் குடிப்பது பல பிரச்னைகளுக்கு காரணமாகும். மது உங்களின் மதிப்பீடும் தன்மையை பாதிக்கும் ஆதலால் நீங்கள் இயல்பாக சிந்தனைகூட செய்யாத விசயங்களை செய்வீர்கள். மதுவினால் ஆபத்துகளை குறைவாக உணர்வீர்கள் ஆதலால் நீங்கள் எளிய இலக்காவீர்கள். நீங்கள் பெரும்பாலான சமயங்களில் சண்டை, வாதங்கள், பணப்பிரச்னைகள், குடும்பதுன்பங்கள் அல்லது அக்கணத்தில் உந்தப்பட்டு பாலியல் நடவடிக்கைகளில் ஈடுபடுவீர்கள். மது வீடு, சாலை, நீர்நிலைகள் மற்றும் விளையாட்டு களங்களில் ஏற்படும் விபத்துகளுக்கு காரணமாகும்.

மதுவினால் உண்டாகும் உடல்நலக்கோளாறுகள்:

அளவுக்கு அதிகமாக மது அருந்துவதால் தீவிர நீட்டிப்பு (Hangovers), வயிற்று வலி, இரத்த வாந்தி, மயக்கமடைதல் மற்றும் மரணம் நேரிடலாம். மிகவும் அதிகமாக நீண்ட காலம் குடிப்பதால்

கல்லீரல் நோய் மற்றும் சில வகையான புற்றுநோய் ஏற்படும் ஆபத்து அதிகரிக்கும். 40 வயதிற்கு மேற்பட்ட ஆண்கள் மற்றும் மாதவிடாய் அடைந்த பெண்கள் மிதமாக மது அருந்துவதால் இதய நோய் உண்டாகும் அபாயத்தை குறைக்க இயலும்.

மதுவினால் உண்டாகும் மனநலக்கோளாறுகள்:

நாம் மதுபானத்தை சந்தோஷமாக இருப்பதற்காக குடிக்கிறோம் என்று நினைத்தாலும் மிகையான குடி மனச்சோர்வை கொண்டுவரக்கூடும். தற்கொலை செய்துகொள்ளும் பலருக்கு குடிப்பழக்கம் இருப்பதுண்டு. மது ஞாபகமறதி மற்றும் மூளை பாதிப்பை உண்டாக்கும். அது குரல் மற்றும் சத்தங்களை கேட்க வைக்கும் - இவ்வனுபவம் மிகவும் இனிமையற்றதாகவும் விடுபட கடினமானதாகவும் இருக்கும்.

எச்சரிக்கை அறிகுறிகள்:

கீழே குறிப்பிட்டுள்ளவை போதை பழக்கத்திற்கு அடிமையாக்கும் சில எச்சரிக்கை அறிகுறிகளாகும்.

- குடிக்காமல் இயல்பாக இருக்க இயலாதது அல்லது குடிக்காமல் ஒரு நாளை தொடங்க முடியாமல் இருத்தல்
- குடித்து முடித்த சில மணி நேரத்தில் வேர்வை, நடுக்கம் மற்றும் மனப்பதட்டம் ஏற்படுதல்
- அதிகமாக குடித்தாலும் போதை இல்லாமல் இருப்பது
- அதே விளைவைப்பெற மேலும் மேலும் குடிக்க நேரிடும்
- குடியை நிறுத்த முயன்றாலும் முடியாமல் போதல்
- வேலை, குடும்பம் மற்றும் உறவுகள் குடியினால் பாதிக்கப்பட்டாலும் உங்கள் குடிப்பழக்கம் தொடரும்
- உங்களுக்கு “நினைவக வெற்றிடங்கள்” (Memory blanks) ஏற்படும் அதனால் சில மணி நேரங்களுக்கு அல்லது நாட்களுக்கு என்ன நடந்தது என்று நினைவில் இருக்காது

மதுவினால் வரும் பிரச்னைகளை கையாள்வது:

நீங்கள் உங்களுடைய அல்லது உங்கள் நண்பரின் குடிப்பழக்கத்தைப் பற்றி கவலைப்பட்டால் உடனடியாக மாற்றங்களை செய்யவேண்டும். உடல்நலத்தை பாதிப்பதற்கு முன் மிக எளிதாக குடியை குறைத்து கொள்ளலாம், குடிப்பழக்கம் கைமீறிவிட்டால் சிரமமாகிவிடும்.

முதல் படி:

உங்கள் குடிப்பழக்கத்தை ஒரு நாட்குறிப்பில் குறியிடுங்கள் - நீங்களே உங்கள் குடியின் அளவைக் கண்டு வியந்து போவீர்கள் மற்றும் இது உங்கள் குடியை குறைக்க ஊக்குவிக்கும். நண்பரிடமோ அல்லது உறவினரிடமோ உங்கள் திட்டங்களைப்பற்றி பேசுவது உதவி செய்யும். பிறரிடம் பேசுவதற்கு வெட்கப்படாதீர்கள். மிகவும் உண்மையான நண்பர்கள் உதவ சந்தோஷப்படுவார்கள் - அவர்களும் சில நேரம் உங்களைப்பற்றி கவலை கொண்டிருப்பதை உணர்வீர்கள்.

உதவி பெறுவது:

உங்கள் குடிப்பழக்கத்தை மாற்றுவது கடினமாக இருந்தால் மருத்துவரிடம் பேச முயற்சி செய்யலாம் அல்லது உள்ளூர் மது அமைப்பிடமிருந்து ஆலோசனை பெறலாம். குடியை குறைக்க முயல்கையில் மிதமிஞ்சிய நடுக்கமோ, அமைதியற்ற நிலையோ குடிப்பழக்கத்தை நிறுத்த தடையானால் உங்கள் மருத்துவர் குறுகிய காலத்திற்கு சில மருந்தளித்து உதவமுடியும். இதற்கு பின்னும் குடிப்பழக்கத்தை மாற்றுவது சிரமமாக இருந்தால் உங்களுக்கு சிறப்பு உதவி தேவைப்படும்.

பழக்கத்தை மாற்றுதல்

நாம் அனைவரும் ஒரு பழக்கத்தை மாற்ற சிரமப்படுவோம். குறிப்பாக அப்பழக்கம் நம் வாழ்வின் ஒரு பெரும்பகுதியாய் இருக்கும் பொழுது. இந்த பிரச்னை தீர மூன்று வழிகள் உண்டு

- பிரச்னை உள்ளது என்பதை உணர்தல் மற்றும் ஏற்றுக்கொள்ளுதல்
- பழக்கத்தை மாற்ற உதவி பெறுதல்
- ஒருமுறை மாற்றங்கள் செய்ய தொடங்கியபின் அவற்றை தொடர்ந்து செய்தல்

நீங்கள் மது அருந்துவது உங்கள் மன அழுத்தம் மற்றும் கவலையை கையாளும் வழியாக இருக்கலாம். ஒரு மனநல மருத்துவரோ அல்லது உளவியல் வல்லுநரோ கவலைகளை சமாளிப்பதற்கு குடி சாராத வழிமுறைகள் மூலமாக உதவமுடியும்.

இதே பிரச்னை உள்ள மற்றவர்களை குழுக்களில் சந்திப்பது மிகவும் பயனளிக்கும். சுய உதவி குழுக்களான "ஆல்ககாலிக் அனானிமஸ்" மற்றும் மது சிகிச்சை பிரிவுகளில் குழு சார்ந்த சிகிச்சைகள் நடைபெறுகின்றன.

பெரும்பாலானவர்களுக்கு குடிப்பழக்கத்தை சமாளிக்க மருத்துவமனை செல்ல வேண்டிய அவசியம் இல்லை. சிலருக்கு குடிக்கும் இடங்கள் மற்றும் உடன் குடிக்கும் நபர்களிடம் இருந்து விடுபடுதல் அவசியம். இவர்களுக்கு, மது சிகிச்சை பிரிவில் குறுகிய காலத்திற்கு சிகிச்சை பெறுவது இன்றியமையாதது. மது விலகல் நோய் அறிகுறிகளை (Withdrawal symptoms)சரிசெய்ய மட்டுமே மருந்துகள் பயன்படும். முக்கியமாக அமைதியூட்டிகளை மாற்று மருந்தாக சார்ந்திருப்பதை தவிர்க்க வேண்டும்

குடிப்பவர் எவராயினும் அவருக்கு மது சார்ந்த பிரச்னைகள் உண்டாகலாம் - சிலர் எல்லாவற்றையும் இழக்க நேரிடும் - மது வீடற்ற நிலைக்கு முக்கிய காரணமாகும். சிலருக்கு வெறும் ஆதரவு மற்றும் பேசுவது மட்டுமே போதுமானாலும் மற்றவருக்கோ வேலைக்கு செல்ல, ஏதோ ஓரிடத்தில் வாழ மற்றும் உறவு முறைகளை தொடங்க நீண்ட கால உதவி தேவைப்படும்.

குடிப்பழக்கத்தை கண்காணிப்பது மிகவும் கடின உழைப்பாயினும் இறுதியில் அது உங்கள் வாழ்வின் அனைத்து அம்சங்களிலும் மாற்றங்களை உண்டு பண்ணி பலனளிக்கும்.

எவ்வளவு மதுபானம் அருந்துவது மிக அதிகமானது?

சில மதுபானங்கள் மற்றவைகளவிட வலிமையானவை. நாம் அருந்தும் மதுவின் அளவை "அலகுகள்"(Units) மூலமாக கணக்கிடுவது, எவ்வளவு மதுபானம் அருந்துகிறோம் என்பதை சுலபமாக அறிந்துகொள்ளும் வழியாகும். ஒரு அலகு 10 மில்லி சாரயத்துக்கு சமமானதாகும் - மதுக்கடையில் கிடைக்கும் நிலையான சாரய அளவு (Standard pub measure), அரை திரவளவு (Half pint) சாதரண பீர் அல்லது லாஹர், ஒரு சிறிய கண்ணாடிக்குடுவை (glass) திராட்சைபழச்சாறு (Wine) ஆகியவற்றில் உள்ள சாரயத்தின் அளவு ஒரு அலகாகும்.

ஒரே எடையுடைய ஆணும் பெண்ணும் சமமான அளவு மதுபானம் பருகினாலும் மதுவின் அளவு ஆண்களைவிட பெண்களின் உடம்பில் அதிக அளவில் காணப்படும். ஆதலால், நியாயமற்றதாகத் தோன்றினாலும், பெண்களின் பாதுகாப்பான (Safe limit) மது அளவு (ஒரு வாரத்திற்கு14 அலகுகள்) ஆண்களைவிட (ஒரு வாரத்திற்கு 21 அலகுகள்) குறைவானதாகும்.

மது அலகு குறித்த கூடுதல் விபரங்களுக்கு "டிரிங் அவேர் "(Drink Aware) ஐ அணுகவும்.

அதிகப்படியான குடி (Binge Drinking):

ஒரு சமயத்தில் நீங்கள் எவ்வளவு குடிக்கிறீர்கள் என்பது மிக முக்கியம். மேற்குறிப்பிட்ட "பாதுகாப்பான குடியளவு" (Safe limits) என்பது உங்கள் குடி, வாரம் முழுவதும் பரவியிருக்கும் என்ற ஊகத்தில் அமைந்ததாகும்.

எந்த ஒரு நாளிலும் ஆண்கள் 4 அலகுகளுக்கு மேலும் பெண்கள் 3 அலகுகளுக்கு மேலும் குடிக்காமலிருப்பது மிகச்

சிறந்தது. ஒரே நாளில் ஆண்கள் 8 அலகுகளுக்கு அதிகமாகவும் பெண்கள் 6 அலகுகளுக்கு மேலும் குடிப்பதே “அதிகப்படியான குடி”யாகும்.

ஒரே இரவில் பாதுகாப்பான குடி அளவிற்கு மேல் குடித்தாலும் அந்த வாரம் முழுவதும் நீங்கள் பாதுகாப்பான குடியளவு எல்லைக்குள்ளேயே இருக்ககூடும். இரண்டு நாட்கள் அதிகப்படியாக குடித்தல் (Binge drinking) மூளையின் உயிரணுக்களை கொல்லத் தொடங்கும் என சில ஆய்வுகள் கூறுகின்றன. இது தொடர்ந்து நீண்ட நாட்கள் குடிப்பவர்களுக்கு மட்டுமே நிகழும் என முன்னர் கருதப்பட்டது. அதிகப்படியான குடி (Binge Drinking) நடுத்தரவயதுடைய ஆடவருக்கு மரணம் விரைவில் சம்பவிக்கும் ஆபத்தை அதிகப்படுத்தும்.

படி 2

மனச்சோர்வு நோய் பற்றிய விளக்கம்

மனச்சோர்வு நோயுள்ளவர்கள், அவர் சார்ந்த உறவினர்கள் மற்றும் நண்பர்களுக்காக இந்த தாள் தயாரிக்கப்பட்டு உள்ளது.

இதை படித்தவுடன் மனச்சோர்வு நோய் பற்றி தெளிவு பெற்று அதுவும் ஒரு வகையான நோய் என்று நீங்கள் அறிவீர்கள் என்று நம்புகிறோம்.

நம்மில் பலருக்கும் அவ்வப்பொழுது மனச்சோர்வு ஏற்படுவது இயற்கையே. இது சில மணி நேரமோ அல்லது சில தினங்களோ இருந்து விட்டு நம்மை அறியாமலே நீங்கி விடும்.

ஆனால் மனச்சோர்வு நோய் உள்ளவர்களுக்கு இத்தகைய உணர்வு பல வாரங்கள் மற்றும் மாதங்கள் நீடிக்கும்.

இதனால் அவர்களின் தினசரி வாழ்க்கை, குடும்ப வாழ்க்கை மற்றும் அலுவலக வேலை எல்லாமே பாதிப்படையும்.

மனச்சோர்வு நோய்க்கான அறிகுறிகள்

1. எப்பொழுதும் சோகமாக இருத்தல் (மதியம் மற்றும் சாயந்திர வேளைகளில் இது சற்றே மாறலாம்)
2. வாழ்க்கை மேல் பிடிப்பு இல்லாமை. எதிலும் நாட்டம் மற்றும் மகிழ்ச்சி இல்லாமை.
3. சிறு விசயங்களில் கூட முடிவு எடுக்க முடியாத நிலை.
4. முன்பு எளிதாக செய்த வேலைகளை கூட செய்ய முடியாத நிலை.
5. எப்பொழுதும் உடல் சோர்வாக இருத்தல்
6. மனம் அமைதி இல்லாமல் சஞ்சலத்துடன் இருத்தல்
7. பசியின்மை. அதனால் உடல் எடை குறைதல். (மிக சிலருக்கு அதிகமான பசி மற்றும் உடல் எடை கூடுதல் இருக்கலாம்)
8. தூக்கமின்மை. (தூக்கம் வருவதிற்கு அதிக நேரம் பிடிப்பது, முழு தூக்கம் கிடைக்காமல் அதிகாலை வேளைகளில் விழித்தல், முழு திருப்தி தராத தூக்கம்)
9. தாம்பத்திய உறவில் நாட்டமின்மை.
10. தன்னம்பிக்கை இல்லாமை,
11. தாழ்வு மனப்பான்மை, எதிர்காலத்தை பற்றிய வெறுமையான உணர்வு,
12. எளிதில் எரிச்சல் அடைதல்,
13. நண்பர்கள் மற்றும் உறவினர்களை சந்திக்கும் ஆர்வம் குறைந்து தனிமையை நாடுதல்.
14. வாழ்வதில் நாட்டமில்லாமல் தற்கொலை எண்ணம் மிகுதல், அதற்குரிய முயற்சிகளை செய்தல்.
15. அடிக்கடி தலைவலி மற்றும் உடம்பு முழுவதும் வலி, குடைச்சல் -- இவை கூட மனச்சோர்வு நோய்க்கான அறிகுறிகளாக இருக்கலாம்.

உங்களுக்கு மனச்சோர்வு நோய் உள்ளது என்பதை அறியவே பல வாரங்களோ அல்லது மாதங்களோ ஆகலாம். நிறைய நேரங்களில் நீங்கள் அறிவதற்கு முன்பே,

உங்கள் நெருங்கிய உறவினர்கள் மற்றும் நண்பர்கள், (உங்கள் நடத்தையில் உள்ள மாற்றங்களை அறிந்து கொண்டு) இதனை உங்களிடம் தெரிவிக்கும் நிலை வரலாம்.

மனச்சோர்வு நோய் எதனால் ஏற்படுகிறது?

பெரும்பான்மையான நேரங்களில் நம்மை மனதளவில் பாதிக்கும் நிகழ்ச்சிகள் மற்றும் மன உளைச்சல் உருவாக்கும் விஷயங்கள் தான் மனச்சோர்வு நோய் உருவாவதற்கு காரணமாகிறது.

சில வகையான உடல் உபாதைகள் கூட மனச்சோர்வு நோயை உண்டாக்கும்.

சில நேரங்களில் எந்த விதமான மன உளைச்சலோ அல்லது உடல் உபாதைகளோ இல்லாத நேரத்திலும் மன சோர்வு நோய் உருவாகலாம்.

மனச்சோர்வுநோய் ஏற்படுவதற்கான காரணங்கள்

- குடும்ப சூழ்நிலைகளினால் ஏற்படும் பாதிப்பு. (குடும்ப உறவில் சச்சரவு, மணவாழ்க்கையில் பிரச்னை, பணபிரச்ச னை அலுவலகம் மற்றும் நண்பர்களுடன் பிரச்னை இவையாவும் இதில் அடங்கலாம்)
- சிலவகையான உடல்நலகேடுகள் (தை ராய்ட் நோய் பாதிப்பு, சில வகையான வைரஸ் நோய்கள் தாக்குதலக்கு பின், சில வகையான புற்று நோய் பாதிப்புக்கு பின்னால், மாரடைப்புக்கு பிறகு, மூளை பாதிப்புகளுக்கு பின்னால்), மனச்சோர்வு நோய் ஏற்படலாம் .
- மேலே குறிப்பிட்டவை சில உதாரணங்களே .
- மரபு வழியாகவும் மனச்சோர்வு நோய் வரலாம் . இதனால் சில குடும்பங்களில் அதிக பேருக்கு மனச்சோர்வு நோய் இருப்பதை காணலாம்.
- குடிபழக்கம் அல்லது போதை பழக்கம் உள்ளவர்களுக்கு மனச்சோர்வு நோய் அதிகமாக வரலாம்.

- மனச்சோர்வு நோய் உள்ளவர்கள் அதனை வெளியில் யாரிடமும் சொல்ல முடியாத நிலையில் மது பழக்கத்துக்கும் போதை பொருள் உபயோகத்திற்கும் அடிமை ஆவதற்கு நிறைய வாய்ப்புக்கள் உள்ளன.
- ஆண்களை விட பெண்களை இந்த நோய் அதிகமாக பாதிக்கும்.

உங்களுக்கு மனச்சோர்வு நோய் உள்ளதா?
நீங்கள் செய்ய வேண்டியது இதோ:

உங்கள் நோய்க்கு உரிய அறிகுறிகளை உங்கள் நெருங்கிய உறவினர்களோ அல்லது நண்பர்களிடமோ மனம் திறந்து கூறுங்கள்.

இதன் மூலம் அவர்களுக்கு உங்கள் செயல் மற்றும் நடவடிக்கைகளில் உள்ள மாறுதல்கள் மனச்சோர்வு நோயினால் ஏற்பட்டது என்று புரியும்.

நீங்கள் தினசரி செய்ய வேண்டிய வேலைகளை (மனம் மற்றும் உடல் சோர்வினால்) பிறகு செய்து கொள்ளலாம் என்று ஒதுக்காமல் முடிந்த வரை அப்பொழுதே செய்யப்பாருங்கள். (அதிக நேரம் எடுத்தாலும்).

பசியுணர்ச்சி இல்லாவிட்டாலும் அந்தந்த வேளைகளில் நல்ல சத்தான உணவு வகைகளை உட்கொள்ளுங்கள்.

நாள்தோறும் சரியான நேரத்தில் படுக்கைக்கு சென்று, சரியான நேரத்தில் எழுந்து விடுங்கள்.

தூக்கம் வராவிட்டாலும் படுக்கையில் படுத்துக் கொண்டே புத்தகம் படித்துகொண்டோ, தொலைகாட்சி பார்த்துகொண்டோ இருங்கள்.

தூக்கம் வரவில்லை என்பதற்காக படுக்கையை விட்டு எழுந்து செல்லாதீர்கள்)

காலையில் விழித்தவுடன் உடனே எழுந்து விடுங்கள்.

உடல் மற்றும் மன அசதியினால், தூக்கத்தில் திருப்தி இல்லாத நிலை இருந்தாலும் கூட மேலும் படுக்கையில் படுக்காமல் உடனே எழுந்து விடுங்கள்.

இப்படி செய்தால் சில மணி நேரங்களில் நீங்கள் ஒருவாரான மனமலர்ச்சி அடைவீர்கள்.

அப்படி செய்யாமல் படுக்கையில், உறங்கினால், தூக்கமும் வராமல் மேலும் உடல் மற்றும் மனச்சோர்வை அடைவீர்கள்.

மனச்சோர்வு நோயினால், உருவாகும் தாம்பத்திய உறவின் மீதான நாட்டமின்மை, அந்நோய் குணமானவுடன் சரியாகி விடும். அதனால் இதை பற்றி மிகவும் கவலை கொள்ள வேண்டாம்.

தாங்களாகவே மனச்சோர்வுக்கு மருந்தாக மது அருந்த வேண்டாம்.

அது மனச்சோர்வை மேலும் அதிகப்படுத்தும் .

உங்கள் மனச்சோர்வுக்கு காரணம் ஆக உள்ள குடும்ப பிரச்னைகள், பணபிரச்னைகளை தீர்க்க முயற்சி செய்யுங்கள்.

ஒரு நாளில் அரை மணியோ அல்லது ஒரு மணியோ உடல் பயிற்சி செய்யுங்கள். இது நடை பயிற்சியோ அல்லது உங்களுக்கு பிடித்த விளையாட்டாகவோ இருக்கலாம்.

மேலும் செய்ய வேண்டியது:

- **உங்கள் மருத்துவரிடம் சென்று, உங்கள் நோய் அறிகுறிகளை கூறினால், அவர் உங்களுக்கு மனச்சோர்வு நோய் உள்ளதா, அப்படி இருந்தால் எத்தகைய தீவிரத்தில் உள்ளது என்பதை கண்டறிந்து உடனே மருத்துவம் செய்வார்.**
- **தற்காலத்தில் இந்த நோயை குணமாக்க சிறந்த மருந்துகள் உள்ளன.**
- **அவை உங்கள் நோயை போக்கி உங்களை பழைய மனிதர் ஆக்கும்.**

உங்கள் மருத்துவர் சில சமயங்களில் உங்களை மன நல மருத்துவரிடம் கலந்து ஆலோசிக்க பரிந்து உரைப்பார்.

இந்த நோயை குணமாக்க மனப்பயிற்சியும் உதவும்.

இத்தகைய மன பயிற்சியை அதற்குரிய பயிற்சி பெற்ற செவிலியர்கலோ அல்லது மன நல வல்லுனர்களோ வழங்குவர்.

- **மனச்சோர்வு நோயை, நீங்கள் செய்த ஏதோ தவறினால் வந்தது என்று அணுகாமல், ஒரு வகையான நோய் என்றும், அது குணமாக்க வல்லது என்றும் புரிந்து கொண்டால் நீங்கள் விரைவிலேயே குணமடைவீர்கள்.**

படி 3

நோயை தவிர்க்கும் மன அழுத்தத்தை கட்டுபடுத்தும் முறை

“வெள்ளம் வரும் முன் அணை போட்டு தடுக்க வேண்டும் நோய் வரும் முன் காக்க வேண்டும்" என்பது முன்னோர்கள் கருத்து. இது மன அழுத்தத்தை கட்டுப்படுத்துவதற்கும் பொருந்தும். சிறு குழந்தைகள் முதல் வயதானவர்கள் வரை அனைவரையும் பாதிக்கிறது மனஅழுத்தம். கண்ணுக்குத் தெரியாமல் தொடங்கும் இந்த மன அழுத்தத்தினால் ஒற்றைத்தலைவலி முதல் மாரடைப்பு வரையிலான நோய்கள் மனிதர்களை தாக்குகின்றன. மன அழுத்தத்தை போக்கி கட்டுப்படுத்தவே பல்வேறு நிறுவனங்கள் உளவியல் வல்லுநர்களின் உதவியோடு மன அழுத்த மேலாண்மையை உருவாக்கியுள்ளனர். இன்றைய சூழலில் அனைத்துத் துறைகளிலும் எல்லா பணி நிலைகளிலும் அனைவரும் ஒருவிதமான மன இறுக்கத்துடனேயே உழன்று கொண்டிருக்கிறார்கள். இதுவே மன அழுத்தத்தைக் கையாள்வதன் தேவையை நமக்கு எடுத்துக் கூறுகிறது.

அனைவரையும் பாதிக்கும் மன அழுத்தத்திற்கான காரணத்தைக் கண்டறிந்து அதனை ஆரம்பத்திலேயே தீர்க்க

வேண்டும். அதற்கான தீர்வு நம்மிடம்தான் இருக்கிறது. மன அழுத்தமானது உடலையும், உள்ளத்தையும் பாதிக்கின்றது. மனிதனுக்கு வரும் நோய்களில் 75 சதவிகிதம் முதல் 90 சதவிகிதம் வரை நோய்கள் அழுத்தமான சூழல் காரணமாக வருபவையே என சமீபத்திய ஆராய்ச்சி ஒன்று அதிர்ச்சித் தகவல் சொல்லியிருக்கிறது. எதிர்பார்ப்பும் ஏமாற்றமும் எதிர்பார்ப்புகள் அதிகமாகி அவை நிறைவேறாத போதும், எதிர்பாராத சூழலுக்கு தள்ளப்படும் போதும் மனிதர்கள் அதிக மன அழுத்தத்துக்கு உள்ளாகின்றனர் என்கின்றனர் மருத்துவர்கள். எதிர்பார்ப்புகளைக் குறைக்கும் போது மன அழுத்தம் பெருமளவில் குறைந்து போவதாகவும் அவர்கள் தெரிவிக்கின்றனர்.

ஏமாற்றம், பயம், நிராகரிப்பு, எரிச்சல், அதிக வேலை, அதிக சிரத்தை, குழப்பம் இவையெல்லாம் மன அழுத்தத்தைத் தோற்றுவிக்கும் சில காரணிகள். சிலருக்கு அதிக வெளிச்சம், அதிக சத்தம் இவை கூட மன அழுத்தத்தை அதிகரிக்கும் என்கிறார்கள் மருத்துவர்கள். விவாக ரத்துகள், நோய்கள், பதவி இழப்பு, கடன், வறுமை, தேர்வு, போக்குவரத்து நெரிசல், வேலை அழுத்தம், கோபம், நட்பு முறிவு, உறவு விரிசல், என நம்மைச் சுற்றி நிகழும் எல்லா விதமான காரணிகளும் மன அழுத்தத்திற்குள் நம்மை இட்டுச் செல்ல முடியும். பண அழுத்தம் பணமானது மன அழுத்தத்தை உருவாக்கும் முழு முதற் காரணியாக உள்ளது. அனைத்து சூழ்நிலைகளிலும் பணமானது முக்கிய பங்கு வகிக்கிறது. தேவையான நேரத்தில் தேவையான அளவு பணம் கிடைக்காத பொழுது ஒருவித அழுத்தம் ஏற்படுகிறது.

எனவே பண அழுத்தமானது மன அழுத்தத்தை உருவாக்கும் காரணிகளில் முதன்மையிடத்தை வகிக்கிறது. பணிச்சூழல் மன அழுத்தத்திற்கு மற்றொரு முக்கிய காரணியாக உள்ளது. சில நேரங்களில் உறவுகளும், வாழ்க்கைத்துணையும், குழந்தைகளுமே மன அழுத்தத்தை தோற்றுவிப்பவர்களாக உள்ளனர். மது போதை பழக்கம் புகை பிடித்தல், சரியான உணவுப் பழக்கம் இல்லாமை,

போதை மருத்து பழக்கம், குடிப்பழக்கம், சரியான தூக்கம் இல்லாமை இவையெல்லாம் மன அழுத்தத்தை நாம் விலை கொடுத்து வாங்கும் செயல்கள். புகை பிடிக்கும்போது உடலில் கலக்கும் நிக்கோட்டினுக்கு மன அழுத்தத்தை அதிகரிக்கும் சக்தி இருப்பதாக ஆராய்ச்சிகள் நிரூபித்திருக்கின்றன. முதுமை நிலையை அடைபவர்களிடமும், மாதவிடாய் காலத்தில் பெண்களிடமும் இந்த மன அழுத்தம் அதிகமாய் இருக்கும் என்றும் அத்தகையவர்களிடம் அன்புடன் உரையாடி மன இறுக்கத்தைத் தணிக்க வேண்டும் என்றும் மருத்துவர்கள் அறிவுறுத்துகின்றனர்.

சுகமான சுமைகள் மன அழுத்தம் நல்ல செயல்களில் கூட வரும் என்கிறது ஒரு ஆய்வு. திருமணம் போன்ற நிகழ்வுகள், பதவி உயர்வு, இவையெல்லாம் ஒருவகையில் மன அழுத்தத்தை அதிகரிக்கும் என்றும் அதை சரியான விதத்தில் கையாள்வதில் நம்முடைய கவனத்தைச் செலுத்தவேண்டும் என்கிறது அதே ஆய்வறிக்கை. மன அழுத்தத்தினால் உடல்நலமானது அதிக அளவில் பாதிக்கப்படுகிறது. இதயநோய்கள், ஹைபர்டென்சன், கண்நோய்கள் போன்ற மிகப்பெரிய நோய்களும் மனிதர்களுக்கு ஏற்படுகின்றன. மன அழுத்தத்தை கட்டுப்படுத்தினால் நோய்களை தவிர்க்கலாம் என்கின்றனர் மருத்துவர்கள். மனஅழுத்தத்தை தவிர்க்க சில ஆலோசனைகளையும் அவர்கள் கூறியுள்ளனர். உற்சாக ரசாயனம் உடற்பயிற்சி என்பது மன அழுத்தத்தை போக்கும் மிக முக்கிய வழிமுறையாகும். தினசரி அரைமணிநேரம் உடற்பயிற்சி மேற்கொள்வதன் மூலம் மன அழுத்தத்தை ஏற்படுத்தும் ஹார்மோன்கள் சுரப்பது குறைகிறது.

உடலும் உள்ளமும் புத்துணர்ச்சியடைகிறது. எண்டோர்பின்ஸ் உள்ளிட்ட நல்ல ரசாயனங்கள் உடலில் சுரக்கின்றன. பாக்ஸிங் எனப்படும் விளையாட்டுகளில் ஈடுபடுபவர்களுக்கு மன அழுத்தம் ஏற்படுவது குறைவு என்கின்றனர் மருத்துவர்கள். மனசே ரிலாக்ஸ் தினமும் ரிலாக்ஸ் செய்ய சில மணிநேரம் ஒதுக்கவேண்டும். ஏனெனில் அரக்க பரக்க அலுவலகம் சென்று பணிச்சூழலில் உழன்று திரியும் உள்ளம் அமைதியை எதிர்பார்ப்பது இயற்கை.

ஆவேசம், கோபம் இவை மன அழுத்தத்தின் வெளிப்பாடுகள், தெளிவான அமைதியான மனம், ஞானம் இவற்றைக் கொண்டு அவற்றை அடக்க வேண்டும்.

தியானம், யோகா போன்றவற்றில் மனதை ஈடுபடுத்துவதும், ஆழமாக மூச்சை இழுத்து விடும் மூச்சுப் பயிற்சியைச் செய்வதும் மன அழுத்தத்தைக் குறைக்கும் வழிமுறைகளில் சில என்கின்றனர் பயிற்சியாளர்கள். மனதை ஒருமுகப் படுத்தும் பயிற்சிகளும் நல்ல பலனைத் தருகின்றன. அமைதியே வழி கட்டுப்பாடான உணவுப்பழக்கம் மன அழுத்தத்தை மாற்றும் என்கின்றனர் மருத்துவர்கள். பழங்கள், காய்கறிகள், அதிகமாக உணவில் சேர்த்துக்கொள்வதன் மூலம் மன அழுத்தத்திற்கு எதிரான சூழலை மாற்றி ஆரோக்கிய வாழ்க்கைக்கு அடிகோலுகிறது. தேவையற்ற வீண் விவாதங்களை தவிர்க்கவேண்டும். இதுவே மன அழுத்தத்தை தவிர்ப்பதற்கான வழிமுறை.

எத்தகைய சூழ்நிலையிலும் அமைதியை கடைபிடிப்பதே மன அழுத்தம் நேராமல் தடுக்கும் என்பது அவர்களின் அறிவுரை. ஆழ்ந்த உறக்கம் அவசியம் தினமும் 7 முதல் 8 மணி நேரம் நன்றாக உறங்கவேண்டும். எந்த வித இடைஞ்சலும் ஏற்படாத வகையில் தூங்குவதன் மூலம் மூளை அமைதியடையும் என்கின்றனர் மருத்துவர்கள்.

உறங்குவதில் ஏதேனும் பிரச்சினைகள் ஏற்படும் பட்சத்தில் நல்ல புத்தகங்களை படித்து ரிலாக்ஸ் செய்துகொள்ளவேண்டும். இனிய இசையை கேட்கலாம் என்றும் மருத்துவர்கள் ஆலேசனையில் தங்கள் கூறியுள்ளனர். இயல்பான வாழ்க்கையைப் பறித்து நிம்மதியற்ற பொழுதுகளையும், நோய்களையும் தந்து செல்லும் மன அழுத்தம் மிகவும் கொடுமையானது. மருத்துவர்கள் மற்றும் உளவியல் வல்லுநர்கள் கூறியுள்ள ஆலோசனைகளை பின்பற்றி மன அழுத்தத்தை களைய வேண்டும்.

APPENDIX – XII

PHOTOGRAPHS