The terms ‘alcoholic’ and ‘alcoholism’ have been the subject of some controversy in the past. The term alcoholic is often used to refer to a person with a serious drinking problem whose drinking impairs his or her life adjustment in terms of personal relationship and occupational functioning. Likewise, the term alcoholism refers to a dependence on alcohol that seriously interferes with life adjustment.

As stated by Babor & Boca (2003), variety of treatment approaches exists for patients with alcohol dependence syndrome, each of them appropriate for particular individuals and less so for others. These include behavioural modifications, support groups, as well as pharmacological treatment. Some treatment has as its goal abstinence from alcohol, while other approaches seek to change the pattern of drinking to one that is moderate and compatible with a healthy and balanced lifestyle.

Alcohol Anonymous (AA) meetings are run worldwide to achieve sobriety. Currently there are 3000 groups in United Kingdom and 8800 groups worldwide associated with Al-Anon (for relatives of problem drinkers), Al-Ateen (for the teenage children of the problem drinkers). AA views alcoholism as a lifelong problem, an incurable disease the symptoms of which can be arrested by lifelong abstinence (AA World Series, 1972)

An AA meeting will generally follow a standard routine: there will be 10-20 people in each group, only first names are used; a rotating chairman will introduce himself with ‘my name is X’ and I am an alcoholic; then will read the preamble; a number of speakers from the floor will give an account of their stories and recovery if possible, leading to general discussion; the discussion then ends with the prayer and is followed by an informal discussion, a contact between the new members and sponsors who may offer emotional support & ex-

change of phone numbers. It involves one full day. The obsession or urge to drink can be dealt by staying in close proximity with the AA sponsors who help and motivate them to stay abstinent.

Background and need for the Study
The harmful use of alcohol is a serious health burden, and it affects virtually all individuals on an international scale. Health problems from dangerous alcohol use arise in the form of acute and chronic conditions, and adverse social consequences are common when they are associated with alcohol consumption. Every year, the harmful use of alcohol kills 2.5 million people, including 320,000 young people between 15 and 29 years of age. It is the third leading risk factor for poor health globally, and harmful use of alcohol was responsible for almost 4 percent of all deaths in the world (UN Document, 2001).

Many people who attend AA meetings are able to stop the use of alcohol. Alcoholic Anonymous has helped millions of people worldwide to stay away from alcohol. 'Emotional sobriety', rather than mere physical sobriety is the goal. In fact the 12 steps are directed towards such a spiritual transformation rather than towards alcohol abstinence directly. Also working through the 12-step approach triggers cognitive processes previously uninformed, un-recognised or unfocussed and may encapsulate powerful dynamics capable of having impact on craving, conditioning and character. AA offers a non-judgemental setting, with unconditional acceptance of the alcoholic, without inducing guilt on him.

Nurses, being frontline providers of care in hospital can give initial counselling and provide education about alcohol, its ill effects and effectiveness of Alcoholic Anonymous group meetings referring them to self-help groups by giving them relevant telephone numbers, addresses or introducing them to any appropriate resource person.
Objectives

A comparative study was conducted in a selected areas of Delhi with the following objectives:

1. To assess the quality of life of patients with ADS, attending AA meetings and those not attending AA meetings.

2. To compare the quality of life of patients with ADS attending AA group meetings with those not attending AA meetings.

3. To find the association between quality of life and selected variables like age, monthly income and duration of alcoholism.

Methods and Materials

Conceptual framework-Stuart's stress adaptation model based on substance abuse using quantitative research approach was adopted. The setting of the study was: AA meeting selected church of South Delhi and non-AA meeting selected de-addiction centre.

Population under study - 30 ADS clients attending AA groups and 30 ADS patients attending AA meetings were included. Total sample size was 60 using purposive sampling.

Data collection technique and tools consisted of paper & pencil method. Background proforma contained eight items. Structured questionnaire on quality of life had 45 questions under the domains viz. physical (8), psychological (9), social relationship (7), environment (12), spiritual (7) and quality of life (2). Total score for 45 questions were 225. The interpretation of scores was done as:

- 1-75 : Poor qol
- 76-150 : Average qol
- 151-225 : Good qol

Results

For clients attending AA meetings, it was found (Tables 1 and 2) that 10 (33.33%) clients were equally in the age group of 45 years and above and 36 to 45 years, 21 (70%) were married, 19 (63.33%) were had been graduated or acquired a higher degree, 11 (36.66%) were professionals, 24 (80%) were Hindu, 13 (43.33%) had earned a monthly income of Rs 25,000 and more, 21 (70%) were taking alcohol for the past 11 years and more, 17 (56.66%) were never hospitalised for the treatment of alcoholism.

As for clients with ADS not attending AA meeting, it was found that 8 (26.66%) belonged to the age group of 15-25 years, 17 (56.66%) were married, 13 (43.33%) had secondary education, 5 (16.66%) were equally unemployed and unskilled, 22 (73.33%) were Hindu, 13 (43.33%) were having a monthly income of Rs 5000 and less, 12 (40%) were taking alcohol for the past 11 years and more, 17 (56.66%) were never hospitalised for the treatment of alcoholism (Tables 1 and 2).
Figure 1 reveals that majority of the sample subjects in non-AA groups that is, 16 (53.33%) subjects had average qol, low qol was seen in 1 (3.33%) sample subjects and high qol was seen in 13 (43.33%) of the sample subjects. Whereas, majority of the sample subjects in the AA groups, that is, 24 (80%) had high qol, 6 (20%) had average qol and surprisingly none of the sample subjects had low quality of life.

The mean scores of each of the six domains of quality of life were calculated (Table 3) and it was found that mean scores in all the six domains were higher in AA group as compared to non-AA group, suggesting better quality of life of clients with ADS attending AA meetings. Further, the rank order of quality of life scores showed that the highest modified mean scores was found in the ‘quality of life’ domain in both AA group (2.16) and non-AA group (1.7) whereas least modified mean scores was found in the ‘environment domain’ in AA group (0.40) and non AA group (0.30). The descending order of the quality of life domain-wise rank order of clients attending AA meetings was: qol domain (2.16), spiritual domain (0.76), social domain (0.58), psychological domain (0.50), physical domain (0.49) and environment domain in AA group (0.40). The descending order of the quality of life rank order of clients not attending AA meetings was: qol domain (1.7) in spiritual domain (0.59), social domain (0.50), physical domain (0.41) psychological domain (0.40) and environment domain (0.30).

There was no association between quality of life scores and selected demographic variables.

**Discussions**

The present study revealed that there was a significant difference in the quality of life of the clients with ADS attending AA meetings and those not attending AA meetings. AA members had high mean scores on all the domains of a structured questionnaire compared to clients with ADS not attending AA meetings. These findings are congruent with the findings of the study by Savitha, who reported that there was a significant difference in the quality of life of clients with ADS attending AA meetings and those not attending AA meetings (‘t’ value =7.323 and p-value=0.01).

The present study also revealed that the quality of life was higher in quality of life domain in both the groups that is AA group and non-AA group whereas clients in both groups scored the least in the environment domain. Savitha found in her study that the mean scores were higher in environment domain in both the groups that is AA group and non AA group. Also the lowest mean scores were obtained in the social domain in both the groups.

Newyork in a study revealed that AA may help patients to accept treatment and keep patients in treatment more than alternative treatments. In the present study clients with ADS attending AA meetings showed enhanced quality of life in comparison to those not attending AA meetings, which substantiates the effectiveness of AA.

The present study revealed better quality of life
of clients with ADS attending AA meetings in comparison to those not attending AA meetings. The findings are consistent with the study done by Tonigan et al who reported that AA members stayed sober more if they (1) had an AA sponsor, (2) worked the “twelfth step” programme, (3) led a meeting, (4) increased their degree of participation over time, or (5) sponsored other AA members. The study also found that professionally treated alcoholic patients who attended AA during or after treatment were somewhat more likely to reduce drinking than were those who do not attend AA. Membership in AA was also found to reduce physical symptoms and to improve psychological adjustment.

Conclusion

Based on the findings it is evident that regularly attending AA group meetings had an enhanced quality of life. They could enable them to approach AA, which if communicated to clients would lead a recovered life from the captivity & bondage of alcoholism as they find it difficult to break the cobwebs of obsessions related to opening the bottle and having their first drink.

A comparative study which supports the present study findings was conducted in North India by Singh. Total quality of life scores on all the four domains of WHO-QOL-BREF were significantly lower for the patients with psychosocial treatment when compared with twelve-step programmes.

The abstinence rates are more among AA attenders. For example, as reported by Pisani the more days the patient attended Alcoholics Anonymous self-help meetings, the longer their abstinence lasted. AA meeting attendance improved abstinence considerably more than did adherence to prescribed medication. In the present study also quality of life was found to be higher in clients with ADS attending AA meetings with those not attending AA meetings.

Implications

Since the study findings indicated that AA is one of the effective psycho-social interventions for improving the quality of life of clients with ADS, therefore, nurses have to proactively do advocacy and endorsement of self-help groups like AA guide and educate patients and family members about these so that they can make informed choices about joining such groups.

Student nurses and nurse professionals in general should organise educational programmes in community, drug deaddiction and rehabilitation centres, psychiatric OPDs, day-care centres etc. in order to educate the clients with alcohol dependency and their caregivers about the ill effects of alcoholism, its consequences, relapse prevention and de-addiction and rehabilitation facilities available in the community.

The nurse administrators play a key role in formulation and implementation of the policies and the protocols to emphasise the care given to the alcoholics and other addicts. Also she can keep links with AA so that the patients can be referred to them. They can organise some conferences with the AA sponsors or recovered addicts. The administrator can transmit the knowledge about AA to other subordinate staffs so that this knowledge can reach the patients and they can avail appropriate AA services.

Recommendations

♦ Since the present study was conducted on a small sample, a more extensive study covering both male and female clients can be conducted on a wider sample to arrive at some generalisations.

♦ A qualitative study can be conducted on quality of life and lived experiences of clients with ADS attending AA group meetings with those not attending AA.

♦ A study can be conducted to assess and compare the quality of life and social support of clients with ADS with those having other mental illnesses

References

4. Savita. A comparative study to determine the quality of life and social support of clients with ADS attending AA group meetings in selected hospitals and AA centers of Uduppi District of Karnataka [M.N Thesis]. MCON; Manipal University, 2010
7. Robert G, John W. Effectiveness of AA or TSF programs compared to other psychosocial interventions. Research Advances in Alcohol and Drug Problem. New York