

Effectiveness of Health Promotional Strategies on Quality of Life among Spouse of Alcoholics in Selected Communities of Dakshina Kannada District, India

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ABSTRACT

Introduction: Alcoholism is a major problem in developing countries like India. Alcoholism affects not only the individual but also his family and the society. Spouses of alcoholics are among those who suffer the maximum consequences of alcoholism and its effects.

Aim: To find the effect of health promotional strategies (Yoga and Health education) on Quality of Life (QOL) of the spouse of alcoholics.

Materials and Methods: Quasi experimental pre-test post-test control design was adopted. A total of 330 men were administered the Alcohol Use Disorders Identification Test (AUDIT) tool to screen for alcoholics through house to house survey, of which 279 men who scored in the range of 8-15 AUDIT score were considered as alcoholics. Their spouses were selected as study participants (who met the sampling criteria) and subjects were randomly allocated to intervention group (132) and control group (147) through simple randomised sampling. The data was gathered by using WHOQOL-BREF tool to assess the QOL; initially pre-test QOL was assessed, followed by individual health education (45 minutes) and yoga (15 minutes) once a week for 3 consecutive weeks and post-test was done during fourth week for intervention (127) and control groups

(142). There were five dropouts in post-test from each group due to health problems, migration and no cooperation from the family for the intervention. Independent t-test was performed by using SPSS version 18.0 to determine effectiveness of health promotion strategies on QOL scores between the intervention and control group and chi-square test was used to find the association between post-intervention QOL scores and selected demographic variable at $p < 0.05$ level of significance.

Results: QOL scores in all four domains in the intervention group showed that there was an increase before and after the interventions. On comparing the mean differences between QOL scores post-test in intervention and control group, calculated t-value was (34.04) and the difference was highly statistically significant at $p < 0.001^{**}$ showing that health promotional strategies were effective in improving QOL among spouse of alcoholics. There was a significant association between post-test intervention QOL scores of subjects and selected variables such as primary decision maker ($p = 0.002^*$) of the family and history of domestic violence ($p = 0.030^*$).

Conclusion: The study findings suggest that adopting health promotional strategies such as yoga can help the spouses of alcoholics to improve their QOL.

Keywords: Alcohol, Perceived quality of life, Quasi experiment, Wives of alcoholics, Yoga

INTRODUCTION

Alcoholism is a global health concern and India is one of the largest producers of alcohol in the world. There has been a steady increase in its production over the last 15 years [1]. The consumption of alcohol by Indians was 2.4 liters in 2005, but in 2010 it increased to 4.3 liters and further scaled up to 5.7 litres in 2016, according to the global status report on alcohol and health 2018 released by the World Health Organisation (WHO) [2].

Alcoholism affects each and every member of the family including young or grown up children, spouse of an alcoholic, siblings and other relatives [3]. Mostly, spouse of an alcoholic face lot of problems like arguments, role changes, conflicts, quarrels, physical violence, marital discord, divorce and even suicide [4].

Alcoholism also has negative psychological effects on family members of an alcoholic. The spouses of the alcoholics may have the feeling of hatred, social contact avoidance, self pity and may become physically and mentally sick [5]. Mostly, the spouse has to shoulder the roles of both parents which lead to painful chaos in managing family alone [6].

A community-based cross-sectional study was carried out to measure the prevalence and determinants of alcohol consumption among adults in Pondicherry [7]. Results showed that prevalence of alcohol consumption was found to be 59.6%. Determinants

like lower literacy level, family history of alcohol consumption, and cigarette smoking were positively associated with alcohol consumption [7].

Alcoholism also leads to disharmony in the family and studies proved that the spouses are undergo various psychosocial problems in their life [8].

Hence, the present study envisaged identifying the QOL of spouses of alcoholics and based on that researcher set a plan to prevent this serious threat by adopting various health promotional strategies like yoga and health education to promote the QOL among spouses of alcoholics.

Research hypothesis: The health promotional strategies (Yoga and Health education) affect the Quality of Life (QOL) of the spouse of alcoholics. Also, there was a significant association between the post-test QOL scores and selected demographic variables.

Null hypothesis: The health promotional strategies (Yoga and Health education) do not affect the Quality of Life (QOL) of the spouse of alcoholics. Also, there was no significant association between the post-test QOL scores and selected demographic variables.

MATERIALS AND METHODS

To meet the objectives of the study a quantitative approach with quasi experimental pre-test post-test control design was adapted

and the study was carried out during July 2017 to April 2019. The project was examined and approved by the Father Muller Institutional Ethics Committee (FMMC/FMIEC/2907/2016). The study was conducted in two villages of Mangalore and Bantwal taluks of Dakshina Kannada District. Investigator did house to house survey with the help of social workers, Anganwadi workers, ASHA (Accredited Social Health Activist) workers, ANMs (Auxiliary Nurse Midwife), Mahila mandal representatives to identify the houses of alcoholics after obtaining permission from the concerned authority.

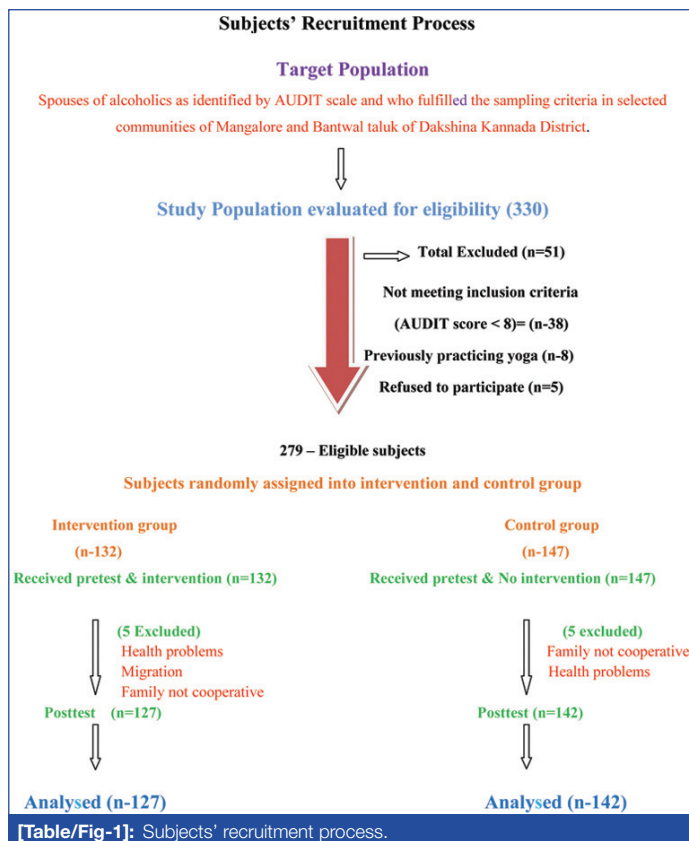
AUDIT [9] is a standardised, valid and reliable free to use instrument consisting of 10 items with five options scored (0-4) to identify the alcoholics. Maximum score can be 40 and scores in the range of 8-15 represented individuals with medium level of alcohol problems/alcoholics. AUDIT was translated in the local language by the investigator herself and its reliability was measured. The Cronbach's Alpha value obtained was 0.85. Tool was administered to 330 men by the investigator through house to house visit; of which 279 men were identified as alcoholics. The study included the spouse of these alcoholic men who were residing with the husband and not consuming alcohol. The spouses of alcoholics who were diagnosed as having psychological problems, separated from husband and already practicing yoga were excluded from the study. The sample size was found to be adequate, based on an earlier work in 2013-2014 [10]. These identified 279 spouses of alcoholics were allotted to intervention and control group by simple randomisation technique using coin toss method. Heads were assigned to intervention group and tails to the control group. Since more tails were observed while tossing the coin there was difference in sample size in both the groups. The nature and purpose of the study was explained by participant information sheet and informed consent was obtained.

The subjects were administered demographic proforma and WHOQOL-BREF scale. Demographic proforma included age, religion, education status, type of family as per income, occupation, monthly income, type of family, place of residence, family support, social support, duration of marital life, number of children, primary decision maker, years of husband drinking alcohol and history of domestic violence. World Health Organisation QOL (WHOQOL-BREF) [11] tool is a standardised, valid and reliable tool. It consists of 26 items with five options scoring (1-5) in 4 Domains: Physical (Domain 1), Psychological (Domain 2), Social (Domain 3) and Environmental (Domain 4). Scores of all four domains denote an individual's perception of QOL. WHOQOL-BREF is a pre validated with high intra-rater reliability for the total WHOQOL-BREF [12] and its subscales (ICC or Intraclass correlation coefficient range: 0.84-0.930). Inter-rater reliability was moderate for the total WHOQOL-BREF and its sub scales (ICC range: 0.56-0.95) Kannada version [13] and internal consistency was measured by using Cronbach's alpha (0.94). QOL mean scores of all four domains were calculated based on the raw scores. Higher domain scores denote higher QOL.

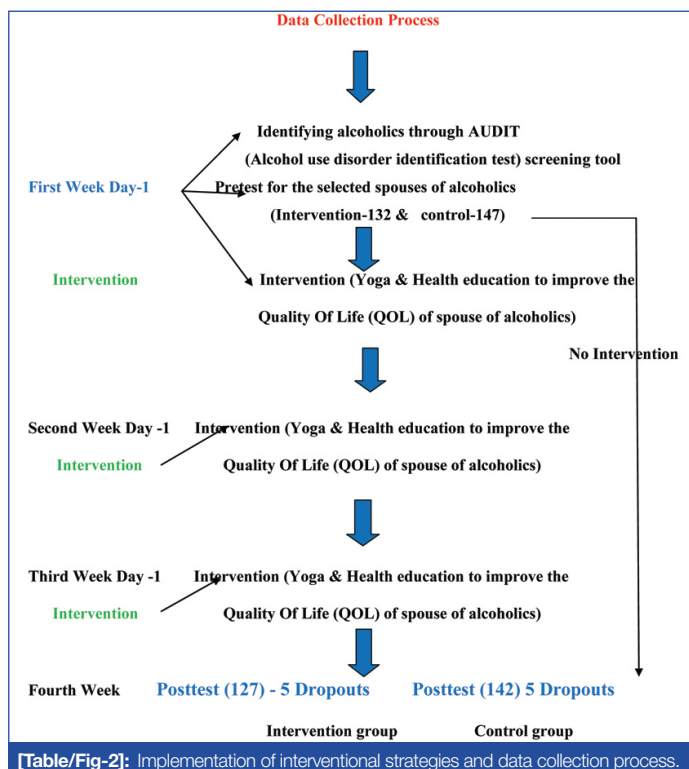
The investigator had undergone yoga training and Health promotion training by National Institute of Health and Family Welfare (NIHFW), New Delhi prior to the study. Hence the investigator herself was competent to demonstrate yoga for 15 minutes, health teaching regarding stress management, marital harmony, lifestyle balancing, behavioural modification and health problems faced by spouses of alcoholics and different coping strategies such as yoga, breathing exercises, good nutrition, spiritual aspects in physical, psychological, social and environmental areas for about 45 minutes to the subjects, once in a week for three consecutive weeks followed by post-test on 4th week. The recruitment of subjects, duration and implementation of interventional strategies is depicted in the flow chart given in [Table/Fig-1,2].

STATISTICAL ANALYSIS

The collected data was analysed using descriptive and inferential statistics. The data were analysed through SPSS version 18.0. Independent t-test was performed to determine the effectiveness



[Table/Fig-1]: Subjects' recruitment process.



[Table/Fig-2]: Implementation of interventional strategies and data collection process.

of health promotion strategies on QOL scores between intervention and control group at p-value 0.05 level of significance and chi-square test was computed to find the association between post-intervention QOL scores and selected demographic variables at 0.05 level of significance.

RESULTS

Description of Sample Characteristics

Majority 73 (55.3%) of the subjects belonged to the age group of 36 years and above in the intervention group and 89 (60.5%) in control group. Most of the subjects 114 (86.4%) of them belonged to Hindu religion in intervention group and 124 subjects (84.4%) in control group.

With regard to educational status, majority 73 (55.3%) had primary education in intervention group and 91 (61.9%) in control group . Most 104 (78.8%) of the family belonged to BPL family in intervention group whereas in control group 110 (74.8%). About 97 (73.5%) were daily wagers in intervention group and 110 (74.8%) in control group. Around 47 (35.6%) had income of Rs.10,001 to 15,000 in intervention group and in control group 67 (45.6%) had income of Rs. 10, 001 to 15,000 per month. Also, 55 (41.7%) subjects had a nuclear family in intervention group and 59 (40.1%) in control group. Place of residence of 61 (46.2%) subjects was rural in intervention group and 58 (39.5%) in control group. About 56 (42.4%) of the subjects had moderately adequate family support in intervention and whereas in control group it was 53 subjects (36.1%). Majority of them, 87 (65.9%) had social support from social organisations in intervention group whereas 107 (72.8%) has social support in control group. Duration of marital life of subjects was more than 10 years in 87 (65.9%) subjects in intervention group and 100 (68%) in control group. Number of children in 57 (43.2%) individuals were two in intervention group and 63 (42.9%) in control group. Primary decision maker in the family, in both the groups majority had both partners as decision makers by mutual consent in intervention group 92 (69.7%) and in control group 86 (58.5%), respectively. For about 50 (37.9%) subjects, duration of alcohol intake by spouse was about 6-10 years in intervention. History of domestic violence was present in 25 (18.9%) subjects' households in intervention group and 30 (20.4%) in control group [Table/Fig-3].

S. No.	Variables	Experimental group (n=132)		Control group (n=147)		p-value
		f	%	f	%	
1	Age (in years)					0.093
	<20	0	0	0	0	
	20-25	3	2.3	1	0.7	
	26-30	21	15.9	11	7.5	
	31-35	35	26.5	46	31.3	
	36 and above	73	55.3	89	60.5	
2	Religion					0.832
	Hindu	114	86.4	124	84.4	
	Muslim	6	4.5	9	6.1	
	Christian	12	9.1	14	9.5	
3	Educational status					0.122
	No formal education	35	26.5	25	17.0	
	Primary school	73	55.3	91	61.9	
	Secondary school	12	9.1	16	10.9	
	High school	8	6.1	14	9.5	
	PUC	3	2.3	0	0.0	
	Graduation	1	0.8	0	0.0	
	Postgraduate and above	0	0	1	0.7	
4	Type of family as per income [14]					0.435
	APL	28	21.2	37	25.2	
	BPL	104	78.8	110	74.8	
5	Occupation					0.938
	Home maker	29	22.0	29	19.7	
	Daily wages	97	73.5	110	74.8	
	Business	4	3.0	6	4.1	
	Technical	2	1.5	2	1.4	
	Professional	0	0	0	0	
6	Monthly income of the family (in rupees)					0.186
	Less than 5000	2	1.5	0	0.0	
	5000-10000	46	34.8	43	29.3	
	10001-15000	47	35.6	67	45.6	
	>15000	37	28.0	37	25.2	

7	Type of family					0.138
	Nuclear	55	41.7	59	40.1	
	Joint	40	30.3	59	40.1	
	Extended	37	28.0	29	19.8	
8	Place of residence					0.035*
	Rural	61	46.2	58	39.5	
	Semi urban	60	45.5	61	41.5	
	Urban	11	8.3	28	19.0	
9	Family support					0.660
	Not at all	9	6.8	12	8.2	
	A little	48	36.4	59	40.1	
	Moderately adequate	56	42.4	53	36.1	
	Good support	19	14.4	23	15.6	
10	Social support					0.142
	Family members	5	3.8	12	8.2	
	Relatives	33	25.0	25	17.0	
	Friends	5	3.8	2	1.4	
	Social organisations	87	65.9	107	72.8	
	Neighbours	2	1.5	1	0.7	
11	Duration of marital life (in years)					0.455
	<5	10	7.6	6	4.1	
	5-10	35	26.5	41	27.9	
	>10	87	65.9	100	68.0	
12	Number of children					0.764
	None	9	6.8	11	7.5	
	One	33	25.0	43	29.3	
	Two	57	43.2	63	42.9	
	3 and above	33	25.0	30	20.4	
13	Primary decision maker in the family					0.110
	Husband	40	30.3	60	40.8	
	Wife	0	0.0	1	0.7	
	Mutual consent	92	69.7	86	58.5	
14	Since how many years your husband is drinking alcohol					0.926
	<1	2	1.5	1	0.7	
	1-5	37	28.0	41	27.9	
	6-10	50	37.9	57	38.8	
	>10	43	32.6	48	32.7	
15	History of domestic violence					0.758
	Present	25	18.9	30	20.4	
	Absent	107	81.1	117	79.6	

[Table/Fig-3]: Frequency and percentage distribution of subjects according to their demographic characteristics. P-value to check the homogeneity with respect to demographic characters. chi-square *p<0.05 significant; *p<0.001 statistically highly significant APL: Above poverty line; BPL: Below poverty line; PUC:Pre university course

Assessment of Quality of Life (QOL) of Subjects in Intervention and Control Group

The data presented in [Table/Fig-4] depicts that mean % QOL scores in intervention and control groups pre-test and post-test for all QOL domains i.e., Physical, Psychological, Social and Environmental. It showed that there was an increase in mean percentage of QOL scores before and after the intervention.

Effectiveness of Health Promotional Strategies on Quality of Life (QOL) of Subjects

In order to find out the effectiveness of Health promotional strategies on QOL of subjects, independent t-test was used. The data presented in [Table/Fig-5] shows that there was a significant difference in the change from pre to post-test score between

Domains of QOL		Intervention group			Control group		
		Mean	SD	Mean %	Mean	SD	Mean %
Pre-test n=279 Intervention group-132 Control-147	Physical	11.73	2.029	33.53	11.43	1.943	32.67
	Psychological	9.43	1.786	31.42	9.36	1.438	31.20
	Social	5.04	1.206	33.60	4.91	1.363	32.75
	Environmental	13.10	2.529	32.74	13.04	2.393	32.59
Post-test n=269 Intervention Group-127 Control-142	Physical	19.27	3.439	55.07	11.29	1.866	32.27
	Psychological	16.69	2.620	55.65	9.40	1.593	31.32
	Social	8.54	1.845	56.94	4.68	1.257	31.23
	Environmental	23.64	3.413	59.09	12.46	2.485	31.14

[Table/Fig-4]: Mean, Standard deviation and Mean % of domain wise QOL of subjects in pre and post-test.

Group	Mean±SD	Mean difference±SD difference	t-value	df	p-value	Comparison of difference between the groups (post-test scores)	
						t-value	p-value
Intervention	Pre-test	-28.847±4.921	18.45	131	3.357 <0.001 HS	34.04	<0.001
	Post-test						
Control	Pre-test	0.912±0.55	3.74	146	3.357 <0.001	34.04	<0.001
	Post-test						

[Table/Fig-5]: Mean±Standard deviation and t-value to determine effectiveness of health promotion strategies on Quality of Life (QOL) scores between in experimental and Control group.

Independent t-test conducted to find the effectiveness
p-value <0.001

intervention (-28.847±4.92) and control group (0.912±0.55). In the intervention group, there was improvement in the QOL scores, however in the control group, there was slight deterioration in the QOL scores. Calculated t-value of (34.04) with p<0.001** inferred that Health promotional strategies improved the QOL of subjects in intervention group compared to control group.

Association of post-test QOL Scores with Selected Demographic Variables

Chi-square test was computed to determine the association between the post-test scores of QOL with selected demographic variables [Table/Fig-6]. The study findings showed that there was a significant association between post-test QOL scores of subjects and selected variables such as primary decision maker of the family (p=0.002*) and history of domestic violence (p=0.030*). Hence, the null hypothesis which stated that there was no significant association of post-test QOL scores of spouses of alcoholics with selected demographic variables was rejected and research hypothesis was accepted.

There was no significant association between post-test QOL scores of subjects and rest of the variables such as age, religion, education status, type of family as per income, monthly income, occupation, type of family, place of residence, family support, social support, duration of marital life, number of children, years of husband drinking alcohol. Hence, the null hypothesis was accepted, and research hypothesis was rejected.

DISCUSSION

The present study focussed on adopting various health promotional measures to improve the QOL of spouses of alcoholics. The study findings revealed that mean post-test QOL scores of all the domains were increased compared to mean pre-test QOL scores in the intervention group. This suggested that most of the spouse of alcoholics had poor QOL and they had various physical, psychological and social problems.

A study was conducted on perceived QOL among wives of alcoholic and non alcoholics. The study findings revealed that majority (66.7%) of the wives of the alcoholics reported that they had low level perceived QOL compared to wives of non alcoholics [15].

Another similar study was conducted to assess the QOL of wives of alcoholics in Perambalur district. The study results showed that Overall QOL of the respondents (52%) was low level with regard to various dimensions of QOL [16].

The present study also showed that there was a significant difference in mean scores of pre-test and post-test in intervention group compared to control group. Hence, it can be inferred that health promotional strategies were effective in improving QOL of subjects.

A study was conducted to assess the community based nursing intervention strategies on alcohol dependence and QOL among alcoholics by using WHOQOL-BREF. The study findings revealed that mean differences between pre-test and post-test overall QOL, was 23.93 with t-value 32.99. These scores were highly significant at p<0.001 suggesting that community based nursing intervention strategies such alcohol education was effective in reducing alcohol dependence [17].

A similar study was conducted to evaluate the effectiveness of pranayama on reduction of anxiety level among alcoholics A quasi-experimental pre-test, post-test design was used. A total of 60 subjects were selected for the study using probability purposive sampling technique, of which 30 samples each assigned to both experimental group and control group. Fifteen minutes of Pranayama was administered for the experimental group. Results of the study showed effectiveness of pranayama on level of anxiety among alcoholics. The obtained t-value was 23.69 (p<0.001), which suggested that pranayama helps in decreasing the level of anxiety among alcoholics [18].

A pilot randomised controlled trial was undertaken to investigate the effect of a yoga intervention on alcohol and drug abuse behaviours in women with Post-traumatic Stress Disorder (PTSD). Subjects were selected by using AUDIT and Drug Use Disorder Identification Test (DUDIT). Twelve-session yoga intervention was given, followed by 1-month follow-up. Linear mixed models were used to test the significance of the change in AUDIT and DUDIT scores over time. Results of the study revealed that while there was a decrease in the mean AUDIT and DUDIT scores in the yoga group, in the control group, mean AUDIT scores were increased, while no difference was noted for mean DUDIT scores. Most yoga group participants reported a reduction in symptoms and showed improved symptom management. Hence, it was inferred that yoga may play a role in attenuating the symptoms of PTSD and reducing risk of alcohol and drug use [19].

The present study findings also showed that there was a significant association between post-test QOL scores of subjects and selected

Sl. No.	Variables	Observed values		Chi Square	df	p-value
		<Median (66)	≥Median (66)			
1	Age in (years)			0.044	1	0.834 NS
	20-35	25	32			
	36 and above	32	38			
2	Religion			0.109	1	0.741 NS
	Hindu	50	60			
	Others	7	10			
3	Educational status			4.735	2	0.094 NS
	No formal education	10	23			
	Primary school	33	37			
	Secondary to professionals	14	10			
4	Type of family as per income			2.356	1	0.125 NS
	APL	09	19			
	BPL	48	51			
5	Occupation			0.711	1	0.399 NS
	Homemaker	15	14			
	Others	42	56			
6	Monthly income of the family (in rupees)			2.012	2	0.366 NS
	<5000-10000	16	27			
	10001-15000	24	22			
	Above 15000	17	21			
7	Type of family			0.164	2	0.921 NS
	Nuclear	24	27			
	Joint	17	22			
	Extended	16	21			
8	Place of residence			0.578	2	0.749 NS
	Rural	26	31			
	Semi urban	25	34			
	Urban	06	05			
9	Family support			5.258	2	0.072 NS
	Not at all and little	23	34			
	Moderately adequate	22	31			
	Good support	12	05			
10	Social support			1.517	2	0.468 NS
	Family members, relatives and friends	18	16			
	Social organisations	36	48			
	Others	03	06			
11	Duration of marital life (in years)			0.090	1	0.765 NS
	<5-10	21	24			
	>10	36	46			
12	Number of children			0.217	2	0.897 NS
	None and one	20	22			
	Two	23	29			
	Three and above	14	19			
13	Primary decision maker in the family			9.849	1	0.002 S*
	Husband	09	29			
	Mutual consent	48	41			
14	Years of husband drinking alcohol			0.644	2	0.725 NS
	<1-5 years	15	23			
	6-10 years	23	26			
	>10 years	19	21			
15	History of domestic violence			4.729	1	0.030 S*
	Present	06	18			
	Absent	51	52			

[Table/Fig-6]: Association between the post-test quality of life of wives of alcoholics and selected demographic variables. Chi-square test conducted to find association; p=0.05 level of significance; *significant; S: Statistically significant; NS: Not significant

variables such as primary decision maker of the family ($p=0.002$) and history of domestic violence ($p=0.030$).

An exploratory study was conducted to assess the psychosocial problems of wives of alcoholic dependents of selected community. Subjects were selected purposively and assessed using rating scale on psychosocial problems. Results revealed that there was a significant association of psychosocial problems with duration of marriage (p -value= 0.006), number of children (p -value= 0.002), duration of alcohol consumption (p -value= 0.0001) and history of domestic violence (p -value= 0.0001). Study concluded that wives were suffering from one or other problems due to alcoholic husband in their life [4].

Limitation(s)

The yoga practiced by the spouse of alcoholics at home could not be monitored and the control group could not be taught yoga because of the nature of the study.

CONCLUSION(S)

Alcoholism is a major familial and social problem in India. The present study highlighted the problems faced by the family members specially the spouses of alcoholics in terms of their QOL. With this aim, the investigator adopted various health promotional measures such as yoga and health education for the spouse alcoholics there by to improve the QOL among spouses of alcoholics. This study suggested that practicing yoga and health awareness can help in improving the QOL.

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