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Effect of Cognitive Behaviour Therapy on Quality of Life of Alcoholic Dependents

Dr. Priyanka[1]*

ABSTRACT

Alcoholism is a global phenomenon. The consequences of alcoholism remain the same everywhere with little variation in the magnitude. In the present study, an attempt has been made to study the effect of cognitive behaviour therapy on quality of life of alcoholic dependents. This is a field experimental study in which the alcoholic dependents were given Cognitive Behaviour Therapy before and after administration of Quality of Life Scale. In the present research, cognitive behavior therapy was taken as the independent variable and quality of life was taken as dependent variable. The incidental purposive sampling technique was used in the selection of the sample. 60 alcohol-dependent patients were taken as a sample whose age ranged between 25 – 38 years. Results revealed that cognitive behaviour therapy has no impact on the psyche of the subjects because when they were getting opportunities for acquiring new information & skills, they were not able to make use of their thinking, learning, memory & concentration. They were possessing faith in religion & were thinking that the almighty will be taking care of them. It also shows that the subjects were reluctant and do not want to change their lifestyle.

Keywords: *Cognitive Behaviour Therapy, Alcoholic, Quality of life*

Alcoholism is a global phenomenon. The consequences of alcoholism remain the same everywhere with little variation in the magnitude. It is apparent that alcoholism is not the problem of only a small segment of the population but it has far reaching consequences in almost all walks of life. It has affected the lives of young and old, men and women. It is apparent that the menace of alcoholism especially affects the youth, particularly in the age group of 21 to 30 years under different factors. The main cause of alcoholism is peer pressure, curiosity, frustration, depression, feel good, party sake, failure, family problems and poor quality of life (Tripathi, 2010).

CBT for alcoholic dependents captures a broad range of behavioural treatments including those targeting operant learning processes, motivational barriers to improvement and a traditional

[1] Assistant Professor of Psychology, Government College, Pali, Raj., India
*Responding Author

variety of other cognitive-behavioural interventions (McHugh et al. (2010). Overall, these interventions have demonstrated efficacy in controlled trials and may be combined with each other or with pharmacotherapy to provide more robust outcomes.

Srivastava and Bhatia (2013) found significant improvement in QoL of patients with alcohol dependence over three months' abstinence. The physical, psychological, social, and environment domains of QoL in alcohol dependence subjects were significantly lower before treatment initiation than the healthy controls. Alcoholic liver disease emerged as a predictor of improvement in psychological and social domains of QoL.

The study confirms the poor quality of life in patients with alcohol dependence before the intervention. The regular follow-up with the family members in out-patient setting enables the patients to achieve complete abstinence, thereby improving their quality of life.

To conclude, the present study found poor quality of life in alcohol-dependent Indian patients before treatment initiation. The regular follow-up in an outpatient setting along with the caregivers improve the compliance and enables the patients to pursue their work and take up other responsibilities. This enhances the self-esteem and achieves complete abstinence, thereby improving their quality of life.

Findings stress the need for public health officials to incorporate quality of life as an important measure to evaluate treatment outcome in alcohol dependence whose natural course consists of relapses. Treatment of alcohol dependence with a favorable outcome is possible with minimal financial resources, regular follow-up, and the involvement of caregivers. There is a need to create general awareness in public that alcohol dependence is a disorder that requires immediate attention.

Lahmek et al. (2009) revealed that QoL improvement after a residential treatment was related to low QoL scores at admission. Improvement in the physical component of QoL was related to baseline alcohol intake and good somatic status. Improvement in mental component of QoL was related to other drugs abuse/dependence.

Statement of Problem

Keeping the above views the following problem is taken - *Effect of Cognitive Behaviour Therapy on Quality of Life of Alcoholic Dependents*.

Objectives

1. To assess the quality of life among alcohol dependents.
2. To examine the effect of cognitive behaviour therapy on quality of life of alcohol dependents.

Hypotheses:

For the present research process, the following alternative hypotheses were formulated -

1.Alcohol dependents will be having a poor level of quality of life.

2.There will be an improvement in the perceived quality of life after cognitive behavior therapy.

The rationale behind these hypotheses is based on the studies of Chubon (1985), Chaturvedi et al. (1997).

Design:

This is a field experimental study in which the alcoholic dependents were given Cognitive Behaviour Therapy before and after administration of Quality of Life Scale. In the present research, cognitive behavior therapy was taken as the independent variable and quality of life was taken as dependent variable. The design of the research is as follows -

Group	Pre-Test	Treatment	Post Test
Alcohol Dependents	Administration of Quality of Life Scale	Cognitive Behaviour Therapy (3 times in a week for 40 min.)	Administration of Quality of Life Scale

Tool:

For the present research study quality of life scale was the main tool selected and used for collecting the data. A brief description of these is given below –

1. **WHOQOL-BREF Scale of Orley (1996):** This scale measures the quality of life that looks at domain level profiles – Physical Health, Psychological, Social Relationships and Environment.

a. Physical Health – Activities of daily living, Dependence on medicinal substances and medical aids, Energy and fatigue, Mobility, Pain and discomfort, Sleep and rest, Work Capacity.

b. Psychological – Bodily image and appearance, Negative feelings, Positive feelings, Self-esteem, Spirituality/Religion/Personal beliefs, Thinking, learning, memory and concentration.

c. Social Relationships – Personal relationships, Social support, Sexual activity.

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

Sample

The incidental purposive sampling technique was used in the selection of the sample. 60 alcohol-dependent patients were taken as a sample whose age ranged between 25–38 years. The educational level for all the subjects was metrics and above. Only those alcohol-dependent patients were selected, who have been diagnosed as alcohol dependent by Psychiatrist. The

sample was drawn from Psychiatry Department, MDM Hospital, Jodhpur and Centre for De-addiction, Manaklao. Before selection of the sample, permission was taken from the authorities.

Procedure:

Each subject was given the scale individually by the investigator. The scale was administered under proper and adequate testing conditions. All the instructions were strictly followed, which was given by the authors of the scale in the manual. Session of test ended with an expression of thanks to the subjects for their cooperation. All the subjects were given Cognitive Behaviour Therapy between Pre Test and Post Test Sessions. It was three times in a week and of 40 minutes for each session.

Scoring:

Scoring of the obtained data of the scale was done with the help of manual available for the scale used. After tabulating the scores, the data was statistically analyzed, for a significant difference.

RESULTS AND DISCUSSION

Table – 1: Showing Mean, SD and 't' scores on Physical Health dimension of Quality of Life.

Sessions	Measures	Values
Before (N=60)	M	17.80
	SD	3.38
After (N=60)	M	18.51
	SD	3.61
	t	1.12

**p<0.01, *p<0.05, NS=Not Significant.

Table – 2: Showing Mean, SD and 't' scores on the Psychological dimension of Quality of Life.

Sessions	Measures	Values
Before (N=60)	M	9.76
	SD	3.47
After (N=60)	M	9.58
	SD	3.69
	t	.28

**p<0.01, *p<0.05, NS=Not Significant.

Table – 3: Showing Mean, SD and 't' scores on Social Relationships dimension of Quality of Life.

Sessions	Measures	Values
Before (N=60)	M	6.78
	SD	2.16
After (N=60)	M	7.01
	SD	2.41
	t	.55

**p<0.01, *p<0.05, NS=Not Significant.

Table – 4: Showing Mean, SD and 't' scores on Environment dimension of Quality of Life.

Sessions	Measures	Values
Before (N=60)	M	20.71
	SD	3.93
After (N=60)	M	21.55
	SD	3.62
	t	1.20

**p<0.01, *p<0.05, NS=Not Significant.

Tables 1 to 4 indicates that on Quality of Life Scale the alcohol dependents have obtained higher mean scores in post-test session on PH. (M = 18.51, SD = 3.61), SR. (M = 7.01, SD = 2.41) and E. (M = 21.55, SD = 3.62) as compared to their pre-test sessions (M = 17.80, SD = 3.38), (M = 6.78, SD = 2.16), (M = 20.71, SD = 3.93) respectively. But no significant difference was found between both the sessions on PH. (t = 1.12), SR. (t = .55), E. (t = 1.20) which reveals that CBT has no effect in post-test session as the subjects were still dependent on medicinal substances & medical aids as in pre-session. After CBT, no significant change is reported among the subjects for their quality of life. Hence, the characteristics like experiencing pain & discomfort, often feeling fatigue & sleepy & their working efficiency were affecting. As far as personal relationship & sexual activity is concerned, it was also found to be similar in both the sessions. The home environment, financial resources & social support also did not improve as cognitive behaviour therapy had any impact on quality of life of the subjects. The quality of life as regard to health & social care was accessible as before. On dimension P. of Quality of Life Scale the alcohol dependents have obtained higher mean scores in pre-test session (M = 9.76, SD = 3.47) than in post-test session (M = 9.58, SD = 3.69). The insignificant difference was found between both the sessions on P. (t = .28). Here also, CBT has no impact on the psyche of the subjects because when they were getting opportunities for acquiring new information & skills, they were not able to make use of their thinking, learning, memory & concentration. They were possessing faith in religion & were thinking that the almighty will be taking care of them. It also shows that the subjects were reluctant and do not want to change their lifestyle.

The present findings seem to be in support with Srivastava & Bhatia (2013) which confirms the poor quality of life in patients of alcohol dependence before the intervention. The regular follow-up with the family members in out-patient setting enables the patients to achieve complete abstinence, thereby improving their quality of life. Bharadwaj and Sharma (1997) stated that emotional in competencies may disturb the emotional reactivity of an adolescent that may lead to serious consequences and desire to be more dependent on alcohol in coping with life, escape from boredom, relief from pain, stress and strain, just to maintain a high sense of self-esteem and to expand ones' consciousness. Thus, the problems in adjustment appear to be an altered state of the individual that arises as a consequence of adaptive failure and non-adaptive challenge. It can be classified as frustration, conflict and pressure, all of which are closely related. It is a necessary positive force leading to effective work and maintenance of good health.

CONCLUSION

Thus, it can be concluded that alcohol addicts, in particular are the sick people; they are a part of society and require special attention. The Indian approach fully recognizes that in a traditional society, social support is a vital input in bringing the erring individuals back to the mainstream. As alcohol addiction is not merely a medical problem, it has to be treated in the totality of the life situations of the addict.

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Conflict of Interests

The author declared no conflict of interests.

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