QUALITY OF LIFE AMONG THE FAMILIES OF ALCOHOL ADDICTION TRIBES STAYING IN SOUTH KARNATAKA

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ABSTRACT

Background: The quality of life among tribal members who care for people with alcohol addiction in their community sheds light on the unique challenges they encounter and potential sources of assistance. Caregivers in tribes impacted by dependency on alcohol often experience an array of obstacles that adversely affect their standard of life. The intergenerational trauma, cultural stigmas associated with alcoholism, and limited access to resources exacerbate the problems faced by these caregivers. Despite these challenges, caregivers show resiliency and dedication to their work, trying to assist and care for their loved ones in the face of hardship. **Methods & Materials:** Aim: The study aims to understand the quality of life among the caregivers of alcohol-addicted individuals in the tribal community of Karnataka. A descriptive research design, with a sample size of 150 Soliga tribal adults was conducted in the southern Karnataka state. A semi-structured interview schedule along with the Quality-of-Life Scale (WHOQOL) was used. **Results:** 45% of the tribal patients with ADS were illiterates. 87% of the caregivers were female, mostly spouses, 98% of the respondents had a Family History of ADS. The respondents were spending Rs 3776 per month on alcohol. The study show that the quality of life of caregivers, particularly elderly caregivers, is adversely impacted in the areas of physical, psychological, and social interactions, as well as the environment. **Conclusions:** Overall, the burden for caregivers of patients with ADS in the Mysore tribal region has a significant impact on their quality of life.

Keywords: ADS, Quality of life, Tribes, Caregivers/family, Mental Health

INTRODUCTION

According to the UN, it is estimated that there are more than 476 million indigenous population spread across 90 countries worldwide(Short & Lennox, 2013).These individuals possess distinctive social, cultural, economic and political traits, languages, knowledge, systems, beliefs, resource management techniques and hold diverse development concepts based on traditional values and priorities(Newcomb, 2011).

The term "indigenous people" in India has been used for a long time, but with the term "Adivasi" referring to the tribal population. According to the 2011 census, the tribal population constituted 8.6% of the country's population, up from 8.2% in 2001(Chandramouli & General, 2011).The tribal population in India is the poorest and

most vulnerable, with a significant decline in poverty due to their low starting point. Rajasthan has the largest tribal population, constituting over 12% of the state's population. In southern states, tribal's reside in rural and forest dwellings in Kerala, Karnataka, Andhra Pradesh, and Tamil Nadu(Pradesh & Andhra, 2020; Sudarshan & Seshadri, 2022).

Quality of life is an individual's perspective on life influenced by cultural and value frameworks. It measures improvement in various aspects, with a healthy life, knowledge acquisition, and dignified resources being crucial(S. K. Chaturvedi & Muliyala, 2016). However, the quality of life of tribes is unique because they have been socially marginalized. In India, the biggest problems faced by tribal communities range from land alienation to alcoholism and underemployment(Vidyarthi, 1972). The tribal community's well-being is at risk due to various diseases, malnutrition, mental illness, addictions, and poor health-seeking behaviour(Balgir, 2006).

Alcohol abuse in developing countries like India is worse than the developed countries despite equal amounts of drinking. Chronic alcohol dependence is characterized by excessive and compulsive drinking that produces disturbances in the mental or cognitive level of functioning that interfere with social and economic levels (Saxena, 1997).Alcohol dependence is a harmful drinking pattern causing distress or impairment, characterized by intense cravings, gradual increase in consumption, and withdrawal symptoms. Individuals often organize their day to obtain, consume, and enjoy alcohol (Skinner & Allen, 1982). It causes financial strain, mental and physical discomfort, workplace and social dysfunction, mainly impacting individuals life and their relationships (Vaishnavi, Karthik, Balakrishnan, & Sathianathan, 2017a).

In 2004, a study by the Ministry of Social Justice and Empowerment in India and the United Nations Office of Drugs and Crime revealed that 21% of adult males and 5% of adult females consume alcohol (Benegal, 2005). Similarly, a studying Rajasthan revealed that 36% of males and 13% of females consume liquor and locally produced toddy, with higher usage reported in tribal communities (Sundaram, Mohan, Advani, Sharma, & Bajaj, 1984).

The tribal population is significantly underrepresented in health indices, with women and children being the most vulnerable, and over 72% of tribal men over 15 use tobacco and drink alcohol(Debbarma, 2019). A 2017 survey in Arunachal Pradesh revealed that 49% of men and 28% of women in some indigenous tribal cultures regularly consume alcohol, indicating a higher prevalence of alcohol misuse and disease load (H. K. Chaturvedi, Bajpai, & Tiwari, 2019).

A National Family Health survey shows that 26% of indigenous people consume alcohol, compared to 9% for non-indigenous populations. This disparity is linked to socioeconomic marginalization, mistreatment, and limited access to health information, leading to poverty, severe health issues, violence, and high morbidity among native tribal populations. The rate of alcohol abuse is greater within native tribal populations, and the resulting health issues have become more prevalent(Sadath, Uthaman, & Kumar, 2018; Subramanian, Smith, & Subramanyam, 2006).

Karnataka was once part of several kingdoms, which is rich in its historic, cultural, and anthropological heritage and is home to 42,48,987 tribes of whom 50,870 belong to the primitive group (Chandramouli & General, 2011). Some of the known tribes in Karnataka are Soligas, Yeravas, Todas, and Siddhis who constitute 6.9% of the total population of Karnataka (Roy, Hegde, Bhattacharya, Upadhya, & Kholkute, 2015). This paper

details the quality of life of caregivers of Soliga tribal about alcohol dependence on habitats in forest regions in the state of Karnataka.

METHODS AND MATERIALS

Study design: It is a community-based cross-sectional study with a descriptive research design

Study setting: The population of the study consists of the male and female inhabitants of the Soliga tribes, who live in the forest regions of south Karnataka.

Sampling technique: A simple random sampling was used for the quantitative survey

Sample Size: 150 respondents were selected for the study.

Inclusion and exclusion criteria: People of all age groups who were using alcohol were considered as the population of the study. Tribes staying in forests, who were willing to participate in the study and were able to understand the Kannada language were included. Those tribes who were unwilling to give consent were excluded from the study.

Details on Tools

1. Semi-structured interview schedule for persons with ADS, and their caregivers: An interview schedule prepared for the assessment of personal and household details for both caregivers and persons with ADS, which includes personal and socio-demographic data.

2. Quality of Life: (World Health Organization Quality-of-Life Scale (WHOQOL): This scale is used to measure the quality of life of family members living with persons with ADS(Vahedi, 2010).

Statistical analysis: The data was entered and analyzed in SPSS 20. Categorical variables were summarized as percentages and quantitative variables were summarized as means with standard deviation (SD), with inter-quartile range (IQR) according to the distribution of the variables.

Ethical aspects: The participant's anonymity was maintained and all participant information was kept confidential. Written informed consent was obtained from all participants. The current study received ethical clearance from the Institute Ethics Committee, Mysore University. Ref: IHEC-UOM No.82/Res/2022-23. Dated: 24.11.2022.

RESULTS

Table 1: Socio-demographic details of patients with ADS

Variable		Frequency/ Mean	Percent /SD
Sex	Male	142	95
Age		37.46	10.7
Education	Illiterate	67	45
	UP to 10thstd	78	52
Marital status	Unmarried	27	18
	Married	112	75
Occupation	Unemployed	21	14
	Agriculture	112	75
Family type	Nuclear	142	95
Languages spoken	Kannada	95	63
	Soliga	29	19
	Jenukuruba	18	12
	Kaadu and BettaKuruba	8	5
Own house	Yes	143	95

Table 1 shows the caregiver's patients details. The majority of patients with ADS are males, with an average age of 37.46 (SD=10.7). They have limited education, with 45% being illiterate and 52% having up to the 10th standard. Most are married, with 75% working in agriculture and 14%is unemployed. They mainly belong to nuclear families residing in their own houses and speak Kannada, followed by other languages.

Table 2: Socio-demographic details of caregivers with ADS

Variable		Frequency/Mean	Percent/ SD
Sex	Female	130	86.7
Age		33.94	12.7
Education	Illiterate	68	45.3
	UP to 10th std	74	49.3
Marital status	Unmarried	14	9.3
	Married	129	86.0
Occupation	Self-employed	21	14.0
	Agriculture	98	65.3
Income (annual)	Up to one lakh	90	60.0
	Up to 5 lakhs	55	36.7
Relationship with Pt	Wife	86	57.3
	Siblings	8	5.3
	Children	21	14.0
	Others	12	8.0

Table 2 explains the caregiver's demographic details. The majority of caregivers for patients with ADS are women, with an average age of 33.94(SD=12.7). They are predominantly married and engaged in agriculture or self-employment, with an annual income of up to one lakh (60%) or up to 5 lakhs (36.7%). Wives (57.3%) are the primary caregivers.

Table 3: Quality of life among the caregivers of ADS tribes

Quality of life among the caregivers of ADS tribes		
Sub domains	**Mean**	**SD**
Physical health	13.27	2.100
Psychological health	12.68	2.500
Social relationships	14.36	3.550
Environment	13.49	3.234
Total Quality of life score	56.10	10.727

Table 3 shows caregivers' quality of life among ADS tribes, revealing average ratings in physical, psychological, social, and environmental health, resulting in an overall score of 56.10 (SD=10.727).

Table 4: Clinical details of caregivers with ADS

Variable		Frequency/mean	Percent /SD
Family History of ADS	Yes	147	98
Causes for ADS	Work stress	32	21
	Regular habit	63	42
	Family/financial	11	7.3
	No reason	39	26
Amount monthly spending on alcohol		3776 Rs	3511.5 Rs

Table 4 reveals the clinical details of caregivers with ADS. Majority have a family history of ADS (98%), with causes attributed to work stress (21%), regular habits (42%), family/financial issues (7.3%), and no specified reason (26%). The average monthly spending for alcohol is Rs. 3776.

Table 5: Correlations between quality of life and socio-demographic variables

Pearson Correlations between quality of life (QOL) and socio-demographic variables				
	Age of Patient	**Amount spent**	**Age of caregivers**	**QOL Total**
Age of patient	1	-0.075	0.091	-.288
Amount spent on alcohol	-0.075	1	0.024	-0.00
Age of caregivers	0.091	0.024	1	-0.09
QOL Total	-.288**	-0.006	-0.091	
**. Correlation is significant at the 0.01 level (2-tailed).				

Table 5 shows a significant negative correlation between patient age and the total quality of life score (r = -0.288**), but no significant correlation was found between alcohol expenditure, caregiver age, and the total quality of life score.

DISCUSSION

Alcoholism is a serious mental health condition that is often linked to challenges(Das, Balakrishnan, & Vasudevan, 2006). Not only does it impact the person dealing with addiction, but it also has a lasting impact on caregivers and family members(Shetty, Manikappa, Murthy, Anjanappa, & Rawat, 2022). This study is the first to explore the quality of life of alcohol-dependent caregivers in Karnataka tribes, revealing the profound impact of this syndrome on their lives, and highlighting the importance of understanding their experiences.

This research found that 95% of caregivers' partners with ADS were men, indicating a higher prevalence of alcohol dependence among tribal men(Sadath et al., 2022), with the incidence increasing in younger men(Mohindra, Narayana, Anushreedha, & Haddad, 2011), as per previous studies.

The study reveals that 87% of caregivers are women, with 98% having a family history of ASD. Habitual drinking accounts for 42% of alcohol dependence causes, with no specific explanation accounting for 26%. This highlights the inherited and early exposure to habitual drinking, leading to the normalization of alcoholism among abusers and caretakers. The findings align with a previous study on alcohol abuse among tribal men in Kerala's Wayanad district, which found individuals began drinking alcohol at a young age due to various economic, cultural, and social factors(Sadath et al., 2019).

A large amount of research suggests a link between abusing alcohol, unemployment, and

economic strain(Vaishnavi, Karthik, Balakrishnan, & Sathianathan, 2017b). The study reveals that over half of the participants work in the agricultural sector, with most earning up to 1 lakh and 38% earning up to 5 lakhs. However, the average alcohol spending is 3779 Rs, with significant variability. This expenditure is not justified, as most are in nuclear families with spouses, parents, children, and some siblings. The WHO alcohol impact study shows that excessive alcohol consumption harms families by increasing debt and reducing spending on food, necessities, and savings(Health & Abuse, 2004).

In a study on the issues of alcohol dependence among Kerala tribes, researchers discovered that the majority of people were exploited by outsiders on the wage for their work by providing substandard quality local alcohol instead of money and that these people spent their earnings on alcohol consumption(Shihab, 2020). Similarly, the Soliga tribes in this research face the same challenge; a significant portion of their revenue is spent on alcohol drinking, but there is no external exploitation of the people.

The study found no significant association between alcohol consumption and other variables like patient age, caregiver age, or total quality of life (Jyani, Prinja, Ambekar, Bahuguna, & Kumar, 2019; Mohindra, et al., 2011; Shetty, Janardhana, Math, Marimuthu, & Rajkumar, 2022). However, there was a significant negative correlation between patient age and caregiver quality of life, suggesting that as patient's age, caregivers' quality of life tends to decrease. This contradicts previous studies indicating a correlation between alcohol consumption and overall quality of life. This could be due to various reasons like an increase in the complexity of care like co-morbid issues due to prolonged alcohol intake(Sundaram, et al., 1984), financial strain due to medication and hospital visits(Olickal, Saya, Selvaraj, & Chinnakali, 2021), interpersonal issues(Sadath, et al., 2019) lack of time for necessary self-care can all lead to emotional strain and burnout impacting the overall quality of life.

Large-scale community interventions are crucial to address the complex relationship between cultural norms and individual coping mechanisms, especially for young people susceptible to unhealthy practices. By focusing on prevention and offering alternative coping mechanisms, we can reduce the prevalence of alcohol dependence syndrome among tribes. Additionally, stakeholders can develop targeted interventions that address the well-being of both caregivers and ADS patients, with a particular focus on supporting older individuals with ADS.

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