



QUALITY OF LIFE, SELF ESTEEM AND ALCOHOLIC ABSTINENCE AMONG CLIENTS ATTENDING ALCOHOLICS ANONYMOUS MEETING REGULARLY AND NOT REGULARLY

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ABSTRACT

Alcoholics Anonymous (AA) group meeting plays a significant role in enhancing the welfare of individuals struggling with alcohol use disorders. The study was undertaken to assess quality of life (QoL), self-esteem and alcoholic abstinence among clients attending alcoholics anonymous group meeting regularly and not regularly. The objectives were to compare the quality of life (QoL), self-esteem and alcoholic abstinence among clients attending alcoholics anonymous group meeting regularly and not regularly and to find the relationship between quality of life (QoL), self-esteem, and alcoholic abstinence. Using convenience sampling technique, 148 clients attending and not attending alcoholics anonymous group meeting were included in this study. Socio demographic proforma, WHOQOL BREF scale, Rosenberg self-esteem scale, and self reported checklist to assess alcoholic abstinence were used to collect the data. Findings of the study showed that there was significant difference between quality of life ($t=11.56$, $p=0.001$), self-esteem ($t=06.57$, $p=0.001$) and alcoholic abstinence ($t=6.75$, $p=0.001$) among clients attending alcoholics anonymous group meeting regularly and not regularly. A positive correlation between quality of life and self-esteem

($r=0.78$, $p=0.033$), quality of life and alcoholic abstinence ($r=0.62$, $p=0.001$) and self esteem and alcoholic abstinence ($r=0.46$, $p=0.001$) among clients attending alcoholics anonymous meeting regularly.

Key Words: Quality of life (QoL), self-esteem, alcoholic abstinence, alcoholics anonymous meeting, alcoholic dependence syndrome.

INTRODUCTION

Alcoholism is the most common form of drug abuse in the society. The world health organization (WHO) reports harmful use of alcoholism causes behavioral disorders and socio personal losses to an individual [1]. Globally, every year about 5 million people are dying due to alcoholism. In India, alcohol consumption has increased alarmingly with an estimated number of alcohol users will be 160 million in the general population in 2020. There are 11% of people are binge drinkers with the highest prevalence of alcohol using states is Chhattisgarh, Tripura, Punjab, Arunachal Pradesh and Goa [2].

Alcoholics Anonymous (AA) is an international fellowship of people who have drinking problems. It is a nonprofit organization that



provides support for an individual in an anonymous environment. AA group is based on a set of 12 steps program designed to maintain sobriety for an alcohol dependence. The effectiveness of AA group program varies from each person depends on willingness to follow the steps of meetings. Alcoholics Anonymous (AA) is active in India that presence in various cities around the country. AA meetings are typically organized by local volunteers who are dedicated to help an individual to recover from alcoholism [3].

Quality of life (QoL) is an important parameter among alcohol users which explains physical, psychological, social, and environmental domains of QoL are accomplished. Alcohol consumption is responsible for medical issues with the involvement of many body organs that are liver damage, stroke and varies cancers. These destructive impacts of liquor may affect human wellbeing and quality of life (QoL). Alcohol abuse and dependence appear to have greater QoL impairments in role functioning of mental and physical health [4].

Self-esteem refers to the appraisal of ones self that associated with failure to cope up with family, social, occupational, financial, legal, and sexual issues. The mental health and counselling centre of university, Texas reported that low self-esteem may foster maladaptive personality such as higher emotional instability in adults [5]. Addiction cause prefrontal cortex to shrink that decreases self control and increase aggressive behaviour. Also, alcoholism can negatively impact on brain signals that induce risk of suicide. A therapist can use techniques like motivational interviewing to help an individual to boost their self-esteem [5].

Alcoholic abstinence refers to the practice of abstaining from the consumption of alcoholic beverages. It is often a critical component of treatment and recovery for individuals who struggle with alcohol use disorder (AUD). Alcoholic abstinence typically involves refraining from drinking alcohol completely and maintaining sobriety. Most important recommendations a clinician can make a patient to involve local services that provide psychosocial support to become alcohol free. Family members also need to be brought into the process [6].

By comparing the experiences of those who attend AA meetings regularly with those who do not, helps to provide valuable insights that can inform treatment approaches, support systems, and public health strategies. This research seeks to shed light on whether the consistent engagement with AA meetings contributes positively to these dimensions of recovery, ultimately enhancing the overall well-being and prospects for individuals on their path to sobriety. This process gives cognitive restructuring that change the way think about drinking [7].

Alcoholism treatment with AA group meeting is considered as very effective. Sixty percent of clients undergoing deaddiction treatment remain abstinent, while 40% experience relapses within the first 3 months after treatment. The ultimate aim of an AA group meeting is to maintain abstinence and improve quality of life and self-esteem. It is important for clients with alcoholic dependence syndrome to attend AA meetings regularly to improve the parameters of daily living. [8] So, the investigator felt the need to conduct a study to assess QoL, self-esteem and alcoholic abstinence among clients attending alcoholics anonymous meeting regularly and not regularly.

METHODOLOGY

The present study adopted a quantitative, non-experimental approach with a comparative correlational research design to examine differences and relationships among selected variables. The outcome variables included quality of life, self-esteem, and alcoholic abstinence, while the socio-demographic variables comprised age, type of family, religion, marital status, education, occupation, monthly income, family history of alcoholism, and duration of alcohol consumption. The study was conducted in selected deaddiction centers of Ernakulam District & Idukki District, Central Kerala. The target population consisted of clients attending Alcoholics Anonymous (AA) meetings regularly and not regularly in deaddiction centers of Central Kerala, while the accessible population included such clients from the selected study settings.

A total sample of 148 clients was selected using a non-probability convenience sampling technique. The sample comprised 74 clients who attended AA meetings regularly (n_1) and 74 clients who attended AA meetings not regularly (n_2). Regular attendance was defined as participation in six consecutive AA meetings, whereas non-regular attendance referred to those who attended fewer than six meetings or did not attend regularly. Inclusion criteria required participants to understand either English or Malayalam. Clients with intellectual disability, a history of multidrug dependence, or other psychiatric comorbidities were excluded from the study.

Data were collected using four tools: a socio-demographic proforma, the WHOQOL-BREF scale to assess quality of life, the Rosenberg Self-Esteem Scale, and a self-reported checklist to assess alcoholic abstinence. Content validity of the tools was established by five experts in nursing and medicine, and the Content Validity Index was 0.96 for the socio-demographic proforma and 0.94 for the abstinence checklist. The reliability of the WHOQOL-BREF, Rosenberg Self-Esteem Scale, and abstinence checklist was established using Cronbach's alpha, yielding values of 0.89, 0.88, and



0.83 respectively. All tools were translated into Malayalam and back-translated into English to ensure linguistic equivalence. A pilot study was conducted among 30 clients in each group to assess feasibility, following which minor modifications were made in the scoring of the tools.

Ethical clearance was obtained from the Institutional Ethics Committee, and administrative permission was secured from the deaddiction centers of Ernakulam District & Idukki District. Written informed consent was obtained from all participants, and confidentiality and anonymity were maintained using a coding system. After explaining the purpose of the study and obtaining consent, socio-demographic information was collected, followed by assessment of quality of life, self-esteem, and alcoholic abstinence using the tools. Each interview required approximately 25–30 minutes, and participants were thanked for their cooperation upon completion of data collection.

RESULTS

Section 1: Description of sample characteristics

In this section, an attempt was made to study socio demographic variables of clients attending alcoholics anonymous meeting regularly and not regularly. Sample characteristics include age, type of family, religion, marital status, educational status, occupation, monthly income of the family, family history of alcoholism and duration of alcohol consumption.

Table 2 revealed that among the study participants in the AA regular group, 56.80% had experienced a good quality of life, 41.80% had reported moderate quality of life, and only 01.40% had poor quality of life. For those participants who were not regular members of AA, 74.30% had reported a moderate quality of life, 21.60% had experienced a good quality of life, and 04.10% had poor quality of life. Good QoL was seen among clients who attended AA meeting regularly than who attended AA meeting not regularly.

Table 3 revealed that among the AA Not regular participants, 75.70% had low self-esteem, while 24.30% had high self-esteem. In contrast, among the AA regular participants, 33.80% had low self-esteem, while 66.20% had high self-esteem. High self-esteem was demonstrated by clients who attended AA meeting regularly than who attended AA meeting not regularly.

Table 4 indicated that within the group of AA regular participants, 70.30% had successfully

abstained from alcohol, whereas 29.60% had not abstained. Among those who were not regular AA participants, 78.40% had not achieved alcoholic abstinence, while 21.69% had successfully abstained from alcohol. Clients who attended AA meeting regularly successfully abstained from alcohol than clients who attended AA meeting not regularly.

Section 3: Compare quality of life (QoL), self-esteem and alcoholic abstinence among clients attending Alcoholics anonymous meeting regularly and not regularly

An independent t-test was conducted to assess the differences in quality of life (QoL), self-esteem, and alcoholic abstinence between two groups: those who attended Alcoholics Anonymous meetings regularly and not regularly, as the data follows normality.

Table 5 showed that there was significant difference between quality of life ($t=11.56, p=0.001$), self-esteem ($t=06.57, p=0.001$) and alcoholic abstinence ($t=6.75, p=0.001$) among clients attended alcoholics anonymous meeting regularly and not regularly. Compare with mean score QoL, self-esteem and alcoholic abstinence were high among clients attending alcoholics anonymous meeting regularly than clients attending AA meeting not regularly.

Section 4: Relationship between quality of life (QoL), self-esteem, and alcoholic abstinence between clients attending alcoholics anonymous meeting regularly and not regularly

Karl Pearson's correlation coefficient was estimated to determine the relationship between quality of life (QoL), self-esteem, and alcoholic abstinence among clients who attended Alcoholics Anonymous meetings regularly and not regularly, as the data followed normality.

Table 6 showed that a positive correlation between quality of life and self-esteem ($r=0.78, p=0.033$), quality of life and alcoholic abstinence ($r=0.62, p=0.001$) and self-esteem and alcoholic abstinence ($r=0.46, p=0.001$) among clients attended alcoholics anonymous meeting regularly.

Table 7 showed that a positive correlation between quality of life and self-esteem ($r=0.60, p=0.001$), quality of life and alcoholic abstinence ($r=0.49, p=0.001$) and self-esteem and alcoholic abstinence ($r=0.39, p=0.001$) among clients attended anonymous meetings not regularly.

Table 1: Frequency and percentage distribution of sample characteristics among clients attending alcoholics anonymous group meeting regularly and not regularly. (n1= 74, n2=74)

Sl No.	Socio demographic variables	AA Regular(n1)		AA Not Regular (n2)	
		Frequency (f)	Percentage (%)	Frequency (f)	Percentage (%)
1	Age in years				
	Below 20	01	01.40	00	00.00



	21-30	04	05.40	07	09.50
	31-40	21	28.40	30	40.50
	40 years and above	48	64.80	37	50.00
2	Type of family				
	Nuclear	61	82.40	52	70.30
	Joint	13	17.60	22	29.70
3	Religion				
	Hindu	34	45.90	41	55.40
	Muslim	05	06.80	06	08.10
	Christian	35	47.30	27	36.50
4	Marital status				
	Married	61	82.40	52	72.30
	Unmarried	11	14.80	14	18.40
	Divorced /Separated	01	01.40	03	04.10
	Widower	01	01.40	05	05.20
5	Educational status				
	No formal education	01	01.40	01	01.40
	Primary	09	12.20	04	04.30
	High school	13	17.50	17	23.00
	SSLC	16	21.60	15	21.30
	Plus two	29	39.20	29	39.20
	Diploma	06	08.10	08	10.80
6	Occupation				
	Coolie worker	14	18.90	12	16.20
	Self-employed	33	44.60	22	29.70
	Private	16	21.50	19	25.70
	Government	08	10.80	15	20.30
	Unemployed	03	04.20	06	08.10
7	Monthly income of the family (in Rupees)				
	<5000	07	09.50	10	13.50
	5000-10000	09	12.20	14	18.90
	10001-15000	13	17.60	09	12.20
	>15000	45	60.70	41	55.40
8	Family history of alcoholism				
	Yes	58	78.40	56	75.70
	No	16	21.60	18	24.30
9	Duration of consumption of alcohol (in years)				
	<5	10	13.50	13	17.60
	5-10	10	13.50	11	14.90
	11-15	10	13.50	19	25.70
	>15	44	59.50	31	41.80

Section 2: Assess the quality of life (QoL), self-esteem and alcoholic abstinence among clients attending alcoholics anonymous meeting regularly and not regularly.

Table 2: Frequency and percentage distribution of quality of life among clients attending alcoholics anonymous group meeting regularly and not regularly (n1= 74, n2=74).

Sl No.	Categories of quality of life	AA Regular(n ₁)		AA Not Regular (n ₂)	
		Frequency (f)	Percentage (%)	Frequency (f)	Percentage (%)
1	Poor (26-60)	01	01.40	16	21.60
2	Moderate (61-94)	31	41.80	55	74.30
3	Good (95-130)	42	56.80	03	04.10



Table 3: Frequency and percentage distribution of self-esteem among clients attending alcoholics anonymous group meeting regularly and not regularly (n1= 74, n2=74)

SI No.	Categories of Self-esteem	AA Regular(n ₁)		AA Not Regular (n ₂)	
		Frequency (f)	Percentage (%)	Frequency (f)	Percentage (%)
1	Low self -esteem (10-25)	25	33.80	56	75.70
2	High self -esteem (26-40)	49	66.20	18	24.30

Table 4: Frequency and percentage distribution of Alcoholic abstinence among clients attending alcoholics anonymous group meeting regularly and not regularly (n1= 74, n2=74).

Sl. No	Alcoholic abstinence	AA regular(n ₁)		AA not regular(n ₂)	
		Frequency (f)	Percentage (%)	Frequency (f)	Percentage (%)
1	Yes	52	70.30	16	21.60
2	No	22	29.70	58	78.40

Table No: 5 Comparisons of quality of life (QoL), self-esteem, and alcoholic abstinence between clients attending alcoholics anonymous meeting regularly and not regularly (n1= 74, n2= 74)

SI No	Variables	Group	Mean ± S D	t value	p value
1	Quality of life	AA Regular	96.46 ± 13.87	11.56	0.001*
		AA Not Regular	70.03 ± 13.91		
2	Self-esteem	AA Regular	26.92 ± 4.03	06.57	0.001*
		AA Not Regular	22.80 ± 3.58		
3	Alcoholic abstinence	AA Regular	00.70 ± 0.46	06.75	0.001*
		AA Not Regular	00.22 ± 0.41		

*Significant at p <0.005

Table 6: Correlation between quality of life (QoL), self-esteem, and alcoholic abstinence among clients attending alcoholics anonymous meeting regularly (n1=74).

SI No	Variables	Pearson correlation Coefficient (r)	p value
1	Quality of life and Self esteem	0.78	0.033*
2	Quality of life and Alcoholic Abstinence	0.62	0.001*
3	Self-esteem and Alcoholic Abstinence	0.46	0.001*

*Significant at p <0.005

Table 7: Correlation between quality of life (QoL), self-esteem, and alcoholic abstinence among clients attending alcoholics anonymous meeting not regularly (n2= 74).

SI No	Variables	Pearson correlation Coefficient (r)	p value
1	Quality of life and Self esteem	0.60	0.001*
2	Quality of life and Alcoholic abstinence	0.49	0.001*
3	Self-esteem and Alcoholic abstinence	0.39	0.001*

*Significant at p <0.005

DISCUSSION

The present study demonstrated clear differences in quality of life, self-esteem, and alcoholic abstinence between clients attending Alcoholics Anonymous (AA) meetings regularly and those attending not regularly. Clients who attended AA meetings regularly predominantly reported good to moderate quality of life, higher levels of self-esteem, and a greater proportion of successful alcoholic abstinence. In contrast, the majority of clients who attended AA meetings not regularly experienced moderate to poor quality of life, low self-esteem, and a markedly lower rate of abstinence. These findings suggest that regular participation in AA meetings plays a meaningful role in enhancing psychosocial wellbeing and

sustaining abstinence among individuals with alcohol dependence.

The observed findings are consistent with earlier research indicating the positive impact of regular AA participation on recovery outcomes. Studies by Michael Gossop and Harris J. reported significant improvements in drinking behavior, psychological problems, and quality of life among individuals who attended AA meetings regularly. Similarly, Raj and Arjunan identified that a substantial proportion of individuals with alcohol dependence experienced a moderate quality of life, supporting the present study's results. The significant differences noted between the two groups in quality of life, self-esteem, and abstinence further reinforce the effectiveness of structured peer-



support programs such as AA in long-term recovery [12].

The study also established statistically significant differences between regular and non-regular AA attendees in quality of life, self-esteem, and alcoholic abstinence, leading to the rejection of the null hypothesis. These findings align with evidence reported by Elif Aktan and Mutlu, who found longer abstinence duration among individuals who attended AA compared to those who did not [13]. Comparable results were reported by Priyadarshini and Williams, who observed significant differences in quality of life between individuals attending and not attending AA meetings. Collectively, these findings highlight AA participation as an important protective and rehabilitative factor in alcohol dependence management [14].

Furthermore, the present study revealed positive correlations among quality of life, self-esteem, and alcoholic abstinence in both regular and non-regular AA attendees, with stronger correlations observed among regular attendees. This indicates that improvements in self-esteem and sustained abstinence are closely linked with better quality of life. These results are in agreement with studies by Neumann and Wagner [15], as well as Shrikant Pawar and Kiran, which reported significant associations between self-esteem, substance use outcomes, and psychosocial support. From a nursing perspective, these findings emphasize the need for holistic, supportive, and psychosocially oriented interventions. Nursing practice, education, administration, and research can collectively utilize these insights to strengthen deaddiction services, promote regular AA participation, and design

evidence-based interventions aimed at enhancing self-esteem, sustaining abstinence, and ultimately improving the quality of life of clients with alcohol dependence syndrome [16].

The findings of the present study should be interpreted in light of certain limitations. The relatively small sample size and the use of a non-probability convenience sampling technique limit the generalizability of the results. Data were collected using self-reported questionnaires, which may be subject to recall and social desirability bias, and the availability of full-text literature for comparison was limited. Based on these limitations, it is recommended that future studies employ larger and more diverse samples, adopt longitudinal or qualitative designs to gain deeper insight into recovery experiences, and evaluate the effectiveness of structured intervention programs aimed at improving regular AA participation, self-esteem, quality of life, and sustained abstinence among clients with alcohol dependence syndrome.

The present study concludes that regular attendance at Alcoholics Anonymous meetings is significantly associated with better quality of life, higher self-esteem, and greater alcoholic abstinence among clients with alcohol dependence syndrome. The significant differences and positive correlations observed among these variables underscore the importance of continuous peer support and psychosocial interventions in recovery. These findings highlight the critical role of nurses and mental health professionals in promoting regular AA participation, early identification of psychosocial issues, and implementation of holistic, client-centered interventions to support long-term abstinence and overall wellbeing.

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