SOME PSYCHO-SOCIAL EFFECTS ON A
GROUP OF SUDANESE ALCOHOL ADDICTS

Prepared by : Lawahiz Taj Eldin Abdulrahman
Supervised by : Professor Othman Abdu

A thesis submitted for requirement of PhD in Psychology.

Nov. 2003
Dedication

TO MY FATHER
MY HUSBAND
MY SON "OSAMA"
MY DAUGHTER "ASMA"
ACKNOWLEDGEMENT

I would like to extend my appreciation and gratitude to Professor Othman Abdu, who saved no efforts in helping me during all stages of the preparation of this research.

I express my special thanks to Dr. Fatima Mohammed Sherif, Dr. Mohayyad Mohammed Al Mutawakkil, Akram Abdalmajeed, and Abdurrahman Hassan for their valued support.

I would also like to express my appreciation to senior officials and staff members of the following hospitals and institutions for their help:

1. El-Tijani El-Mahi Psychiatric Hospital in Omdurman.
2. Kober Institution.
3. Khartoum Teaching Hospital Psychiatric Unit.
4. Military Hospital Psychiatric ward.
ABSTRACT

The aim of this study is to identify some psychosocial effects of Alcohol addiction; the researcher adopted the experimental study. The sample was divided into two groups; (100) patients of average age (30) years in experimental group those patients are covering all patients admitted to four main psychiatrists in-patients hospitals in Khartoum state (EL Tijani EL Mahi Psychiatric Hospital in Omdurman, Kober Reformatory Institution, Khartoum Teaching Hospital Psychiatric Unit, Military Hospital Psychiatric Ward) .and (100) males of average age (30) years as a control group selected randomly from the visitors of the patients who come to visits the patients in the hospital.

The research tools used by the researcher were the questionnaire and two scales, depression scale and anxiety scale "taken from D.S.M.I". The questionnaires were subjected to three experts, whose views were taken in amending and changing some questions. The methods used for analyzing data were; Chi-square test, T-test, Z-test.

The most important result was that it is evident that alcoholism can exert along-lasting psychological and social impact. Alcoholics place themselves at high risk for various accidents and impair their capacities to function effectively in daily life and
perform their jobs. Furthermore, alcoholism threatens the welfare of families by destroying the relationships between loved ones. Marital separation and divorce are more common among alcoholic fathers. Worst of all, children who grow up in such dysfunctional environment learn a lot of bad customs like, stealing-lying. The most important results was that, depression and anxiety are more common among alcoholic patients and among their wives.

The results show that violence and sexual crimes are more common among alcoholic. Our results show that alcoholic patients are more often derived from alcoholic fathers. Our results show that there is significant personality pathology in alcoholics background also there is a significant family pathology.

The results show that socialization pathology is more common among alcoholic’s patients.
لا يمكنني قراءة النص العربي المكتوب في الصورة.
Introduction

Alcohol is a natural product of the breakdown of carbohydrates in plants. Its euphoriant and intoxication properties have been known from prehistoric times and almost all cultures have had some experience of its use. Fermentation with yeast can achieve alcohol concentration of approximately 10%.

Early Egyptian and Greek writings make several references to alcohol and distinguish between its beneficial effects in moderation and the problem of drunkenness for which severe penalties were often prescribed, particularly when it occurred amongst the young. Hypocrites recognized many of the medical complications of excessive drinking and hence introduced the idea of loss of control and habituation. (Harold I, Kaplan MD-Benjamin J- Sadoc MD, 1992).

Problems of hospitalized alcoholics in Sudanese treatment institutions have not been adequately studied (Baghir, 1979, Nadim 1980, Baasher 1981,) Reported low rates of alcohol-related problems in this culture are attributed to Islam. Application of Sharia law, since 1983, was paralleled by a reduction of hospital admission. rates of patients with alcohol-related problems in the Al Tigani El-Mahi Hospital from 186 patients in 1982 to 46 patients in 1991. It is difficult to tell
whether this reflected true drop in prevalence or that patients thought they were to be reported and whipped and so avoided coming to hospital (Sharia law, 1983, Appendix 1).

An important contribution of the epidemiologists has been to demonstrate that the problem drinker is not an individual irredeemably condemned but rather that people move into and out of problem drinkers.

Surveys record low rates of drinking problem after age 50. An Australian study examining ages of alcoholics known to agencies concluded that the prevalence of alcoholism in the population diminishes more rapidly with age than can be accounted for by mortality and successful treatment. One-half to one-third of respondents in two large US surveys who reported a given "Problem" no longer reported that problem when re-interviewed four years later. Though some of these had developed a different alcohol related problem instead, this was by no means inevitable. In a Swedish general population cohort, re-interviewed after a 15 year interval 40% of the 71 alcoholics identified originally and still alive, were completely free of drinking problems (Ojesjo 1981). Positive changes in social circumstances such as job and personal relationships are important in the history of these recovered individuals. \[R-E-KENDELL – A-K. ZEALLEY 1988\]
**Objectives of the Study**

**A) General objectives:**

1) To throw some light on the characteristics of hospitalized Sudanese alcohol drinkers.

2) To add more insight into this problem and therefore help organizers or the national mental health program in their efforts to deal with it.

**B) Specific objectives:**

1. In this population of hospitalized alcohol drinkers the study is expected:

   A. To describe drinking behaviors.

   B. To identify some psychosocial effects of drinking.
Hypotheses of the Study:

1. Alcoholics have a high rate of marital separation and divorce than the control group.
2. Alcoholic patients are more often derived from alcoholic fathers than non-alcoholic.
3. Depression is common among alcoholic patients than non-alcoholic.
4. Anxiety is common among alcoholic patients than non-alcoholic.
5. There are significant increases in violence and sexual crimes due to alcoholic than non-alcoholic.
6. Social difficulties are common among alcoholic patients than the control group.
7. Behavioral and psychological problems are common among alcoholics’ children than the control group.
8. Both (tension and anxiety) and (depression and sadness) are common among alcoholics’ wives than non-alcoholic wives.
9. a) There is a significant personality pathology in alcholics background.
9. b) There is a significant family pathology in alcoholic background.
9. c) There is significant socialization pathology in alcoholic background.
ALCOHOLISM

Definition:
The third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III) separated alcoholism into two types: alcohol abuse and alcohol dependence. The criteria for alcohol abuse included a pattern of pathological alcohol use and impairment in social and occupational functioning due to alcohol use. The diagnostic criteria for alcohol dependence were identical, with one addition. The patient must also demonstrate tolerance or withdrawal symptoms.

These definitions were widely considered inadequate and in the revision of (DSM-III) (DSM-III-R). The term "alcohol abuse" was modified and new criteria for alcohol dependence were introduced (or dependence on any drug). The person must demonstrate at least three of the following symptoms:

1. When not actually using the substance, the person spends a great deal of time looking forward to use of or arranging to get the substance.
2. The substance is often taken in larger amounts or over a longer period than the individual intended.
3. The person develops a tolerance; thus, there is a need for increased amounts of the substance in order to achieve intoxication or desired effect, or there will be a diminished effect with continued use of the same amount.
5. The substance is often taken to relieve or avoid withdrawal symptoms.
6. There is a persistence desire or repeated efforts to cut down or control substance use.
7. The person shows frequent intoxication or withdrawal symptoms when excepted to fulfill social or occupational obligations, or when substance use is hazardous (e.g., doesn’t go to work because hangover, drive when drunk)

8. Important social, occupational or recreational activity is given up or reduced because of its incompatibility with the use of substance.

9. Substance use continues, despite a persistent social occupational, psychological or physical problems that it causes or exacerbates.

For the diagnosis to be made, some symptoms of the disturbance must have persisted for at least 1 month or have occurred repeatedly over a longer period of time.

In addition, DSM-III-R introduced criteria for severity of dependence as follows. In full remission: During the past 6 months, either no use of the substance or use of the substance and no symptoms of dependence.

In partial remission: During the past 6 months, some use of the substance and one or two symptoms of dependence.

Mild: Few, if any, symptoms in excess of those required to make the diagnosis and the symptoms result in only mild impairment in occupational functioning or in usual social activities or relationships with others.

Moderate: Symptoms or functional impairment intermediate between mild and severe.

Severe: Many symptoms in excess of those required to make the diagnosis and the symptoms markedly interfere with occupational functioning or with usual social activities or relationships with others.

DSM-III-R defines alcohol abuse as a residual category for noting maladaptive patterns of alcohol use that have never met the criteria for dependence.
The criteria for alcohol abuse apply to abuse of all psychoactive substances - according to DSM-III-R. The category usually applies to people who have only recently started taking psychoactive substances and mainly involves substances, such as cannabis, cocaine and hallucinogens that are unlikely to produce severe withdrawal symptoms. The assumption was that only rarely would it be applied to alcohol problems. {Harold I, Kaplan MD-Benjamin J-Sadoc MD,1992}.

The diagnosis of alcohol addiction depends on the occurrence of the following symptoms:

1. Excessive desires for alcohol consumption, alcoholics lose their capacity to exercise self-control over their emotions and feelings.
2. Inner feeling of losing control of behaviour. Alcoholics lose their ability to control alcohol consumption in terms of start/finish drinking and consumption level.
3. Drinking for removing withdrawal symptoms and feel the usefulness of this act.
4. Occurrence of physiological withdrawal symptoms, such as psychosis and delirium
5. Occurrence of signs of tolerance, prominent of which increasing the doses to reach the same level of effect available with fewer doses.
6. Keeping pace with the daily alcohol consumption rate during the week and weekend, regardless the social restriction. Alcoholics appear unable to respond appropriately to social drinking rules.
7. Increasing ignorance of other entertainment activities and fully engage in alcohol-related activities.
8. Continuation of drinking despite the clear evidences of having medical diseases, such as liver problems. The inability for alcoholic addict to keep their jobs and their needs for medical treatment due to alcohol-related reasons certainly places tremendous stresses on the family. It could also be psychological reason, such as depression.
9. Relapse, following quitting, could lead to other dependence symptoms which could not be existed among normal people. (World
The prevalence of alcohol related disorder: In the past, much effort was extended to derive prevalence estimates of "Alcohol". Epidemiologists nowadays choose to study the components of this conglomerate concept alcohol dependence and the adverse health and social consequences of drinking. Dates on the prevalence of physical damage from alcohol are available in mortality records and hospital admission statistics. Mortality from cirrhosis is greatest in the grape-growing countries of central and southern Europe where consumption is high and is less in the northerly countries where consumption is lower. The increase in cirrhosis death in the UK has occurred since 1945 and is accounted for by an increase in alcoholic cirrhosis (Saunders et al; 1981).

The number of admissions to general hospitals in which alcohol was recorded as one of the diagnoses increased nearly fourfold from 1968 to 1978 in Scotland. In general hospital 20 to 30% of all male admissions and 5 to 10% of female admissions are deemed to be "Problem drinkers". The rate varying with the catchment area of the hospital and of course with the definition of "Problem drinker". [R-E-KENDELL – A-K. ZEALLEY 1988]

Official statistics also reveal a rise in adverse social and psychological consequences of drinking, such as public drunkenness. The rise in admissions for alcoholism took place against a fall in the first admissions for all diagnoses from 1966. To 1979 of 39% in England and Wales and as unchanged rate of first admissions for all diagnoses in Scotland. Social processes influence these figures. Drunkenness offences will, for example, reflect degrees of public intolerance as well as court and police practices. Allocation of special beds for alcoholics could also have contributed to the rise in admission to psychiatric hospitals for alcoholism, while greater out
patient and day patient facilities may diminish inpatient statistics. This has been shown to be a partial explanation for the greater rate of alcoholism admissions in Scotland than in England (Latcham et al 1984) "mentioned in the references at the foot of the paragraph" and a trend towards out patient treatment of alcohol withdrawal may have contributed to the fall in Scottish admissions figures in the 1980.

The general population survey permits a prevalence estimate that is not subject to the vagaries of hospital admission and referral polices or the defining processes of social agencies. However the door to door interviewer has difficulty in finding the heavy drinkers at home and when he is there, he tends to under report his consumption and his problems. The 1978 survey of England and Wales derive a prevalence figure of "Problem drinking" of 5-3% in men and 1-6% in women. Doorsteps comments by refusers suggested that at least a further O. 77% might have been classified as problem drinkers (Wilson, 1980). "mentioned in the references at the foot of the paragraph" however, such estimates are very sensitive to alterations in the definition of a case for example. Smaler number or severity of alcohol related symptoms required to reach the criterion for inclusion and whether or not past as well as present symptoms are counted.

The epidemiologist has given up looking at "Alcoholism" as either present or absent and instead thinks in terms of alcohol related problems which people move in to and out of and which may be of varying severity. (R-E-KENDELL-A.K. ZEALLEY, 1988).

The prevalence of alcohol related problems in population is linked to the alcohol consumption per person in that population. For example, when nations and regions are compared, there is a high correlation between consumption and cirrhosis mortality within countries. Fluctuations in consumption over time are positively correlated with fluctuation in
cirrhosis mortality (Skog, 1980). "mentioned in the references at the foot of the paragraph" since increases in overall consumption appear to lead to increases in alcohol related problems, it follows that changes which increase consumption, such as more advertising or sales outlets or greater social permissiveness, also contribute to rising problem rates. Of course overall consumption is not the only influence; style of drinking is also important. In cultures where people drink in very heavy sessions interspersed by comparative abstinence there is higher level of social harm than in cultures where heavy session drinking is rare, for example in Scotland where average consumption per occasion is slightly higher than in England, there are correspondingly more social problems (Crawford et al, 1985). [R-E-KENDELL – A-K. ZEALLEY 1988]

Alcohol Related Problems:

**Social complications of excessive drinking:** The idea of social complication implies a failure to fulfil adequately an expected social role. The failure may be in meeting expectations as, for example family member, employer or employee, good neighbor or law-abiding citizen. The result may be detrimental both to the individual and to those around them. A social complication may also mean tangible alcohol related loss or damage in the social dimension. The driving license forfeited for instance, the doctor’s loss of right to practice, the house gone, and so on. As for the alcohol mediated processes that lead to functional impairments, several factors usually interact. Excessive drinking can at an early stage result in hangover over which makes it difficult to get to work, while intoxication may impair ability to manage the complexities of the job and physical and mental impairment later make work impossible more subtly, The drink-centredness of the individual and the salience which depended drinking begins to acquire over other demands can mean that work ceases to matter
and this person moves into an alcoholic role which competes with any pre-existing roles.

Social complication will almost inevitably spread to involve the family and other people rather than ever affecting only the one individual. Such impacts on other people are in the economists language referred to as externalities. In the United States and for the year 1988 the total financial cost of alcohol related problems was estimated at US 85.8 billion [Rice et al, 1991] “coated by Richard et al, 1991”.

So much for general principles, the list of headings that follows attempts to deal with major areas of social problem experience:

- Problem at work
- Housing
- Financial difficulties
- Homelessness & vagrancy
- Crime, including violence and sexual crime
- Drink – driving
- Victimisation
- Impact on education and training

**Problems at work:**

The difficulty that a person with a drinking problem may encounter when seeking employment has just been instanced and this example shows how stigmatisation may compound the objective difficulties. The varieties of adverse influence that excessive drinking may have on work performance are many and costly [Jones et al, 1995, Romelsjo, 1995]. The impact is not limited to any one level of seniority in the employment hierarchy, and drinking problems are as linkly to be found in the board room as on the shop floor.
The drinking doctor (Brooke, 1996), “coated by Richard et al, 1991” provides an instance of a profession where alcohol induced impairment can set special kinds of problems, but occupations and alcohol can interact in many different ways and whatever the job, result in impaired efficiency or cause inconvenience, loss or danger to other people. In senior positions in industry or the armed services, in the diplomatic service or in the legal profession (Goodliffe 1994), “coated by Richard et al, 1991”, drunken indiscretion irascibility or bad judgement at a crucial meeting may be the major problems. For the bus or train driver, the aeroplane pilot (Holdener 1993), "mentioned in the references at the foot of the paragraph" or the ships officer drunk on the bridge intoxication carries enormous dangers for the public. In professions such as the church or teaching, the hint of scandal may be specially damaging, although it is surprising how tolerant or blind-eyed those in the individual’s environment often appear to be. The seriousness with which excessive drinking is officially viewed by the medical profession is evidenced by the disciplinary procedures which in many countries may be called in to action if a doctor’s drinking comes to official notice, although the story is often after one of the complicity and cover-up. The conclusion to be drawn from this paragraph must therefor be that, whoever the individual we are trying to assess and help, the analysis of their alcohol related social problems requires a job specific inquiry. (RICHARD R. BOORZIN-JOAN ROOSS ACOCELLA, 1991).

**Housing:**

Urban housing problems and urban drinking problems often go together (each exacerbating the other) and where there are great concentration of substandard housing and social deprivation, drinking is one of many endemic disorders contributing to, and deriving from the totality of social disorganisation.
However, cases are frequently encountered where drinking is leading directly to a housing problem. In this latter type of instance the patients claim that they are drinking because of their unsatisfactory surrounding’s has a hollow ring. Theirs is the only house in the street which is shabby and unpainted and with, perhaps, an old sofa lying in the front garden, Housing problems of this kinds will be more acute the more marginal the family’s income. Bad relationships with the neighbours, gross evidence of poor house maintenance, failure to meet the rent, services cut off, eviction, the sojourn in to temporary accommodation and multiple changes of address are familiar elements in the housing history as the drinking problem becomes more extreme [RICHARD R-BOOTZIN-JOAN ROOSS ACOCELLA, 1991]

**Financial Problems:**

An awareness of the possible financial complications of drinking problems and of the family’s financial position is necessary for any complete case assessment. To maintain a major drinking habit is expensive and large additional sums are often spent without the drinker knowing how the money has gone-drinks for the friends, or drinks grandly offered to strangers, meals out and taxis home, a massive cigarette consumption, gambling and so on. As with housing problems and many other social complications, the well-moneyed will be better protected for a longer time. [RICHARD R-BOOTZIN-JOAN ROOSS ACOCELLA 1991].

The financial balance is determined not only by the cost of the drinking and associated spending, but also by the inflow of cash-demotion sickness and devious strategies may be engaged in to maintain the cash flow. "Moonlighting" on the second job is common [often in a bar so as further to aid the drinker], loans are negotiated on preposterous terms, goods are pawned, houses re-mortgaged. The employee works a bit of a racket and a
local of bricks disappear from the builder’s yard, it becomes vital to evade income tax and to defraud social security. The rent is not paid and hire purchase payments fall behind. [RICHARD R-BOOTZIN-JOAN ROOSS ACOCELLA 1991].

The family may have reached the stage where financial chaos has become the central and pressing pain from the social work angle. Sorting out that chaos may be the necessary first-aid, but it will be very temporary aid if the drinker problem is not radically met.

**Homelessness and Vagrancy:**

The vagrant way of life offers many pressures towards drinking and at the same time the man or women with a serious drinking problem may move towards vagrancy (Braumohl, 1989, Fishcher 1991). “coated by Richard etal, 1991” professionals with special interest in alcohol do well also to remember that the homeless single person may be homeless for many other reasons than their drinking. Economic hardship and unemployment vary in the contribution they make to vagrancy from decade to decade while mental illness, physical incapacity, epilepsy and personality disorders contribute continually to the genesis of a city problem which in many countries still seems intractable. Come boom or slump with those provisos noted, it is still true that the vagrant who is sleeping under the railway area may be manifesting the end-result of a drinking career a "social complication" of highly visible and dramatic nature and the concern of the social reformer from the nineteenth century on wards (Mc Dermott, 1994). “coated by Richard etal, 1991” the element of this complication constitutes a complex system of related problems, the homelessness itself, the difficulty in getting a wash, the lack of clothes, the lack of fixed employment, the breakdown in family contacts and lack of any kinship of friendship supports, the petty criminal involvement the poor nutrition, and
the risks of illness and accident. Drinking is what particularly contributes to
the ultimate core characteristic of this situation its seeming inescapable
ness, the sense of the treadmill it is easier to find a way in to that
degradation than a way out on leaving hospital or the detoxification center
the only friendship or support readily available may be that offered by a
return to the company of the drinkers in the park. [RICHARD R-
BOOTZIN-JOAN ROOSS ACOCELLA, 1991].
What is the likely background of the man or woman who is begging at the
street corner and hoping to raise funds for the next bottle of cheap wine?
There are many routes in to that situation but with the need to avoid
constructing a picture in terms of any stereotype again noted, the average
story is as follows. That individual is more frequently a man than a woman,
although women do reach this plight. The parents are often themselves
holding onto socio-economic survival tenuously, the father an unskilled
worker living in poor urban conditions or rural poverty and the childhood
family often large and lacking in care. Gross disruption of the childhood
home is a frequent finding; education is likely to have been meagre and job
training nil. The picture is therefore typically of someone who has started
with few advantages and many handicaps. The vagrant drinkers with
overwhelming frequency a casualty with origins in the underprivileged
working class; the shop-keeper or skilled tradesman who becomes involved
in drink and falls in hard times seldom goes in that direction. The
geographical origins may be well known and typical in a particular country
in London the casualties will usually not be London based, but have come
from Scotland or Ireland. After leaving school the story tends to be of a few
short-term job in the hometown. A period perhaps in the armed forces on
the merchant navy, a short-lived marriage and an unsuccessful attempt to
settle down and then probably the mobility and rootless ness of the casual
labourer who move from town to town and who follows the construction work and the big wages. Contact with family and friends are lost as the drinking becomes more incapacitating there is a drift towards low grade work such as kitchen portering and with periods of unemployment, spells in prison and psychiatric hospital and the final arrival at that disorganised way of life which is often referred to as skid row. That term was originally used in the United States to indicate the downtown tract of rooming houses, cheap hotels, blood banks, rescue missions, wines and bottle gangs found in many North American cities. In the UK and other European countries clearly segmented patches of social disorganisation generally do not exist. Skid row refers more to a way of life that to particular streets. [RICHARD R-BOOTZIN-JOAN ROOSS ACOCELLA, 1991]

As for the involvement of drinking in this unfolding story, excessive drinking often started at an early age and then followed an accelerated course soon after the age of 30, drinks has become a dominantly destructive influence and this man is now beginning to stand apart ever from other heavy drinking members of the casual work force is beginning to be picked up for drunkenness with alarming frequency, is violently shaky every morning and is finally drawn in to companionship with the bottle-gang and to sharing their cider, wine or industrial spirits. [RICHARD R-BOOTZIN-JOAN ROOSS ACOCELLA, 1991]

The skid row way of life may appear to be chaos and disorder but it has its own social organisation and sub-culture; it becomes the individual’s only support system and gives them values and expectations as well as drinks. The pathways through which women move toward a life of alcohol and vagrancy may overlap with the typical male routing but can often involve more evidently individual negative life experience with a history of spousal violence a common feature.
Accurate and sympathetic understanding of this extreme social complication of drinking is needed if we are to be able to cope with such problems. Too often the person in this condition tends to be even further alienated and his or her pessimism further reinforced by responses which indicate that we do indeed regard them as alien, hopeless and beyond the pale—one of the lesson of close experience is in fact that this condition is recoverable and that there are pathways off skid row, however difficult to find (Cook, 1975), [RICHARD R-BOOTZIN-JOAN ROOSS ACOCELLA, 1991]

Crime:
The relationship between crime and drinking is as complex as with any other social complications of alcohol. Simple, direct and one way causality is seldom a sufficient analysis and various models of understanding have been proposed (Collins, 1981). Personality, background, and social circumstances which predispose to crime may as such and independently predispose to drinking. Genetic influences may need to be considered. Alcohol and criminality are both then symptoms of an underlying nexus of disorders. A drinking problem may also in passing affect a dedicated and professional criminal, perhaps at a later stage of their career. Sometimes the person is seen who suddenly shifts from a circulation around the prisons to a hospital and voluntary agency circuit. Their drinking remains much the same, but they have learnt to present themselves and their problems differently. The offence may by definition involve the actual intoxication itself for instance, the drunkenness offender (Green Field and Weisner, 1995), and the drink driver (National institute on alcohol abuse and alcoholism 1996). The drunkenness offender overlaps with the vagrant drinking population.
The variations on the alcohol crime connection are legion. There is no type of offence that will not sometimes be related to drinking and many types of offence will often be so related. The problems load at the "petty" end of the spectrum petty: theft, minor assault, travelling on public transport without a ticket failing to pay for the meal in the cheap café, urinating in the subway begging. The persons with drinking problems may know that when they are drunk (and only when they are drunk), they are apt to engage in their own particular offence. For example, taking cars and driving them away, "going burgling" in a clumsy sort of fashion or passing dud cheques. Drinking may be the story behind embezzlement (Natural Institute on Alcohol Abuse and Alcoholism, 1996).

**Alcohol, Violence and Sexual Crime:**
To the judge or the magistrate the relationship between drinking and violence may appear to be evident and to make a repeated contribution to the offences coming before the courts.

All too often drinking seems to be responsible for disinhibition and release of violent or sexual violent behaviour: skid row drinker hits a fellow member of a bottle gang on the head with an iron bar; a man comes out of a pub and follows a women down an alleyway and rapes and murders her; three drunken youth brutally assault and rob the owner of an off licence. [RICHARD R-BOOTZIN-JOAN ROOSS ACOCELLA 1991]

Although to the courts and the ordinary citizen it may appear evident that alcohol causes or considerably contributes to the genesis of these kinds of serious crime, researchers have repeatedly pointed out the dangers in assuming an identity between correlation and causality in this arena (Collins 1991, Shepherd, 1994), "mentioned in the references at the foot of the paragraph" many case series have shown a high frequency of
intoxication among violent offenders at the time of the criminal act (Roslund & Larson 1979), "mentioned in the references at the foot of the paragraph" but that does not prove that the drinking caused the crime. People bent on violence may coincidentally choose to drink, drinking can be a mere adjunct to intrinsically dangerous situations and confrontation and alcohol may be used for excuse.

Several different research approaches have been used to examine the validity of the assumption that alcohol can contribute to the genesis of these types of offence and the inherent difficulties in the interpretation of simple cross-sectional studies has been referred to above. One approach has come from anthropological research which has suggested that the degree to which people behave violently or sexually, when drunk is not so much determined by their drinking, but the way in which society and culture believes or propose that people will behave when intoxicated (Mac Andrew 8, Edgerton, 1969), “coated by Richard etal, 1991” psychologists have explored the influence of alcohol on aggression within experimental paradigm (Gustafson 1993), “coated by Richard etal, 1991”, from the various types of work mentioned above it is reasonable to infer that culture and set setting will influence the individual’s response to alcohol, but these studies still leave unanswered the question of whether alcohol is likely significantly and directly to contribute to violence in an industrial society.

Further light has however been thrown on an issue where everyday experience and rational analysis have previously sometimes seemed to be at odds, by research which explores the correlation over time in national per capita alcohol consumption and rates for assault or homicide (Lenke 1990, Edwards et al, 1994), for some but not all countries the correlations are positive. Other recent research has looked specifically at the relationship between drinking and offending among juveniles and has
shown that with correction for shared risk factors there is, in this age group, a significant association between drinking and violent offending (Fergusson et al, 1996), despite the intrinsic complexity of the question being asked it is thus more possible to give answers than was earlier the case. The relationships are indeed multiple and varied, but alcohol consumption plays a direct part in the cause of violent crime. Whether this conclusion can be extended to sexual crime is still unclear. [RICHARD R-BOOTZIN-JOAN ROOSS ACOCELLA 1991].

A rather similar literature has been developing on the relationship between drinking, self-harm and suicide (Murphy 8, Wetzel 1990, Rossow, 1996). That a true causal link exists here of some significance is becoming increasingly evident. [RICHARD R-BOOTZIN-JOAN ROOSS ACOCELLA 1991]

**Drink-driving offenders:**
The bulk of drink-driving offences are committed by the generality of the drinking population. It is to that broad target that counter measures should predominantly be directed (Edwards et al, 1994), "mentioned in the references at the foot of the paragraph" the factors which predict involvement in these kinds of offence include not only drinking behaviour (Quantity and frequency of drinking) but also other groups of variables such as socio-demographic factors, drinking behaviour, and psychological characteristics (National Institute on Alcohol Abuse and Alcoholism, 1996).

Estimates for the proportion of subjects among drink-driving offenders as "alcohol" or problem drinkers have varied from 4% to 87% across jurisdictions, with incidence rates influenced by the operational definition and tending to be lower when definition are more tightly drawn. Alcohol dependence is likely to have a stronger association with drink driving, the
higher the Blood Alcohol Concentration (BAC) at the time of offence and among repeat offenders, and a research literature attempts to identify the differential characteristics of drinkers in treatment who are likely to offend (Macdonald & Pederson 1990), “coated by Richard et al, 1991”, multiple offenders are not only likely to be more alcohol involved but to show wider personality and background disturbance.

From the clinical angle the conclusion must be that enquiry into driving behaviour and drink-driving offences should be an integral part of any assessment. By no means everyone who has been convicted of driving while intoxicated will have an otherwise manifest drinking problem (Gruenewald et al, 1990), “coated by Richard et al, 1991”, but among clinical populations there will be a significant proportion of individuals whose driving poses a threat to themselves and other people, with that fact putting distinct responsibility on the clinician. [RICHARD R-BOOTZIN-JOAN ROOSS ACOCELLA 1991]

**The individuals’ drinking and their risk of being a victim of crime:**

There is a positive relationship in the general population between the quantity an individual drinks and the likelihood of being assaulted (Room, 1983; Edwards et al, 1994), a grossly intoxicated person will easily fall prey to having their pockets turned out, or be deprived of capacity to resist violence or rape. Thus, victimisation is a common social complication of heavy drinking. [RICHARD R-BOOTZIN-JOAN ROOSS ACOCELLA 1991]

**Impact on education and training:**

An aspect of social complication that deserves greater note is the long-term handicap which results when an educational or training opportunity is partly wasted or totally lost. Being sent down from university, failing to complete apprenticeship because of drinking problem, may all have serious
long term consequences.[RICHARD R-BOOTZIN-JOAN ROOSS ACOCELLA 1991]

The essential themes:
It is useful finally to re-emphasise certain essential themes. Drinking can impair many aspects of social adjustment and lead to many types of social loss or damage, but is usually element which contributes to causality. The social impact of excessive drinking can seldom be understood in uni-causal and single directional terms. Impairment of social well-being is as real and important as the physical and mental impairment with which it may interact and concern for this dimension is therefore fundamental both to the initial assessment and the work of recovery. [RICHARD R-BOOTZIN-JOAN ROOSS 1991 ]
Social and community factors:
The problem of alcoholism has sociocultural as well as psychological dimensions. The values and norms of the community influence attitudes towards drinking. Alcoholism tends to be extremely high among certain ethnic groups, such as the Irish and the French, while it is still relatively low among Jews, although the number of alcoholics who are Jewish is in creasing. Since groups with different alcoholism rates often do not differ in times of the age at which children are first exposed to the taste of alcoholic beverages, some other factor must be involved. [Richard R-Bootzin-Joan Rooss Acocella 1991 ].

There does appear to be a definite relationship between culturally accepted drinking patterns and the incidence of alcoholism in a given ethnic group. The more the average person in a society drinks, the greater is the incidence of alcoholism in that society. Why is the alcoholism rate five times greater in France than in Italy? One explanation is that Italians drink mostly wine and they do so mostly with their meals. Frenchmen drink more distilled spirits, they frequently drink without meals. The simultaneous in take of food with alcohol physiologically reduces the likelihood of severe behavioral manifestations.

It seems unlikely that genetics can account for the many ethnic differences in alcoholism. Alcohol drinking, people who expected alcohol drank more this finding supports a cognitive interpretation of drinking. [Richard R-Bootzin-Joan Rooss Acocella 1991 ].
**The Islamic Norms and Rules**

The Islamic belief has a crucial role in preventing the society from alcohol addiction.

It also helps prevents relapse among addicts subject to treatment, as those who can not resist alcohol influence find themselves compelled to practice the habit secretly and later under severe social pressure (Badri 1996).

According to the Islamic norms and rules, alcohol trade and drinking is prohibited and religious scholars have played an important role in convincing huge number of alcohol addicts to abandon the habit (Badri 1996).

The mass prayers performed everyday in mosques, the concept of fraternity and social support have strong impact on solving alcohol problems in Muslim societies, as the addicts find themselves neglected in their society and surrounded by accusation of shame they cause to their families (Badri, 1996).

(After the revelation of Surat (verse) Al Maeda, in the Holy Qur'an; “Ye who believe! Intoxicants and gambling, dedication of stones and divination by arrows are an abomination of Satan’s (devil) handwork: Eschew such abomination, That ye may prosper”, the Almighty God creator of all the things, who is All-Knowing, All-Wise, has pulled out all its benefits, so it does not contain any medical benefits at all.

Using alcohol as remedy for any disease is an idea of those having no scientific background, according to well known scholars; Al Rabee and Al Dhahak, The Prophet Mohammed (Peace and Blessing of Allah be upon him) said: “Almighty God has prohibited alcohol drinking and has pulled out its benefits).(Al Barr/2004).
Moral harm: There is a diversion in the alcoholic drinker's moral and conduct, as obscenity, vulgarity and indecency, which are prohibited under Islamic Sharia, are continuously observed from his/her behaviours. The alcohol drinker will carelessly behave with insolence, intransigence and dares to misbehave and insult others using repugnant and improper words. Therefore, their general state of mind is moody and hostile, leading to increased chances of aggressive behaviour at the slightest provocation. Such acts obscene the public behaviour and contravenes morals and traditions, then anger, assaults, and selfishness will prevail in the society. Deprived of their ability to think clearly and deeply, alcoholics, under the influence of alcohol, do not realize that they can behave in an alternative way. What is even more dangerous is that drunken people can develop a sense of grandiosity and believe that they are more powerful than they actually are. Thus, they may deliberate provoke others or misinterpret others’ behaviour as a challenge to their supremacy (Al Sagheer/1997)
**PSYCHOLOGICAL COMPLICATIONS**

**Perception and Self-awareness:** At low levels of intoxication there actually may be a slight increase in auditory acuity. Pleasant feelings, such as warmth may dominate perception of the body. At higher level of intoxication, sensory impairment occurs, such that a drunk person may not be able to read or otherwise perform fine visual discriminations. At very high level the intoxicated person begins to see double. Nausea and vomiting also may occur at very high levels, with a hangover the following day.

The primary effect of alcohol on self-awareness is extremely unfortunate; it tends to produce feelings of increased competence and ability rather than a realistic perception of the impairments of mental and motor functioning that occur, such an effect is responsible for the difficulty one has in convincing a drunk that he or she in incapable of driving and for the death and destruction that the drunk driver produces. (John Donnelly MD-Eand S. Living Stone LTD EDTUBURCH-1969)

**Emotions:** Alcohol intoxication has long been known for its effects on emotions. The relaxation and lowering of inhibitions that accompany drinking have often been cited as a plus for successful parties, allowing people to feel sociable and interact more freely. It has been found that reduction of existing anxiety does not occur until rather high levels of intoxication are reached and that a major effect of alcohol is to induce fantasies of power in users. At lower levels of intoxication these tend to be feeling of "Socialized Power" that is, being able to do things to save the world and the like, but at higher levels they become fantasies of purely power. Thus a good deal of the aggressiveness that can result from drunkenness is understandable.
Alcohol is also widely counted as reducing sexual inhibitions, but there is some question as to how much of this (as well as other behaviors characteristic of alcohol intoxication) is actually a direct effect or simply a culturally mediated effect, that is, looser standards of conduct are applied to people defined as "drunk" and they are allowed to do things that normally they would be censured for (Lyle, E-Bourne Jr. Bruce R. Erstrand 1932).

**Delirium Tremens:** Although often taken as the hallmark of alcoholism it is not a common condition, with only about 5% of alcoholics attending clinics having experienced it. It occurs when the alcoholic stops or reduces his drinking. The full syndrome is characterised by marked tremor of the limbs, body and tongue, restlessness, loss of contact with reality, disorientation and illusions progressing to terrifying hallucinations which are most commonly visual, but may be auditory or tactile. Delusions, often of a paranoid kind, may arise out of the hallucination, fever, sweating and tachcardia are pronounced. The disturbance usually develops out of milder withdrawal symptoms one day after cessation of drinking and rarely persists for more than four days. Symptoms are often worse at night. There is a significant mortality in this condition (Approximately 10%), partly because it often complicates other medical emergencies like appendicitis, infections or injuries. The development of fever, dehydration and signs of shock are ominous prognostic signs. It is important to remember that concomitant infection, wernick’s encephalopathy, metabolic disturbance, hypoglycemia or head injury may complicate the clinical features and prognosis withdrawal fits may occur at any time from the first to the 14th day (Isbell et al, 1955).
**Alcoholic Hallucinosis:**

As well as in delirium tremens, hallucination in alcoholics may occur in clear consciousness. Sometimes this is a continuation of hallucinations first experienced during withdrawal from alcohol. However, hallucinations may also commence de novo in a patient who is still drinking. Usually these experiences begin as fragmentary sounds. [R. E. Kendll-A-K-Zeally, 1988]

In such cases the sounds gradually becomes formed and voices are heard, often making unpleasant remarks: "She ought to be ashamed of herself," "He’s a queer" etc. The voice may give commands to do things against the subject’s will and delusions of imagined persecutions may develop. The experiences may be very compelling and distressing, occasionally resulting in violent suicide. Visual hallucinations may also occur in this syndrome, but rather in frequently. [R. E. Kendll-A-K-Zeally, 1988]

In the two large published series of cases (Benedetti, 1952, victor & Hope, 1958) only a few cases (5-10%) continued to have symptoms for six months or more if abstinence was maintained. Renewed drinking; however tends to bring about a return of the hallucinations.

Despite the close resemblance of the hallucinations to those of acute schizophrenia, only a few go on to show typical schizophrenic deterioration (4 out of 76 in Victor & Hope’s series 1952 and 13 out of 113 in Benedetti’s series 1932). Further more, in the initial presentation there is no disturbance of volition or experience of interference with thinking. Premorbid adjustment in the social and sexual spheres tends to be normal. A family history of schizophrenia is usually absent (Benedetti, 1952) except in the cases where hallucinations persist and schizophrenia personality deterioration’s occurs. There is no close relationship with gross cognitive impairment though both may be present in some patients [R. E. Kendll-A-K-Zeally, 1988].
**Pathological Jealousy:** Firmly held delusions of infidelity are not uncommon in alcoholism. They may be precipitated by the patient’s feeling of inadequacy stemming from alcohol-induced impotence and further aggravated by the spouse’s growing indifference towards her drunken partner. The patient’s accusations become repetitive and aggressive demands for proof are reinforced by violence. No amount of contrary credence will dispel the delusion and cases sometimes end in tragic assault or murder. Alcoholism is not the only cause of this syndrome. [R.E.KENDLL-A-K-ZEALLEY 1988].

Mood Disorders: About 30 or 40 percent people with an alcohol-related disorder meet the diagnostic criteria for major depressive disorder sometime during their lifetimes. Depression is more common in women than in men with these disorders. Several studies reported that depression is likely to occur in patients with alcohol-related disorders who have a high daily consumption of alcohol and who have a family history of alcohol abuse. People with alcohol-related disorders and major depressive disorders are at great risk for attempting suicide and are likely to have other substance-related disorder diagnoses. Some clinicians recommend that depressive symptoms that remain after 2 to 3 weeks of sobriety be treated with antidepressant drugs. Patient with bipolar I disorder are thought to be at risk for developing an alcohol-related disorder; they may use alcohol to self-medicate their manic episodes. Some studies have shown that people with both alcohol-related disorder and depressive disorders diagnoses have low cerebrospinal fluid (CSF) concentration of dopamine metabolites (homovanillic acid) and y-aminobutyric acid (GABA).
**Anxiety Disorders:** Many people use alcohol for its efficacy in alleviating anxiety. Although the co-morbidity between alcohol-related disorders and mood disorders is fairly widely recognized, it is less well known that perhaps 25 to 50 percent of all people with alcohol-related disorders also meet the diagnostic criteria for an anxiety disorder. Phobias and panic disorder are particularly frequent co-morbid diagnoses in these patients. Some data indicate that alcohol may be used in an attempt to self-medicate symptoms of agoraphobia or social phobia, but an alcohol-related disorder is likely to precede the development of panic disorder or generalized anxiety disorder. [Harold I-Kaplan, Benjamin J-Sadock, 1997]

**Cognitive Impairment and Brain Damage:** Some 50 to 60% of alcoholics presenting to psychiatrists perform worse on cognitive testing than would be predicted from their verbal intelligence, educational level and age. There is impairment of memory, visual more than verbal narrowing and rigidity of thought processes i.e difficulty changing from one way construing and categorising to other; difficulty learning new material; and impairment of visuospatial and visuoperceptive skills. Heavy alcohol consumption on single occasions is the main cause, though malnutrition and folate and vitamin deficiency play apart (Cuthrie 8 Elliot, 1980), that some of these deficits might predate the heavy drinking has support from cognitive research in sons of their patterns of behaviour when they were children.

Air encephalography and computerised tomography show cerebral atrophy in about 60% of alcoholics, though there is only limited correlation between atrophy so demonstrated and cognitive impairment (Lishman et al, 1980).

Cognitive functioning improves most in the first few days after detoxification and in many cases continues to improve for at least a year, if
further drinking is avoided. It is prudent to give thiamine-containing vitamin supplements for at least four-month. Small bowel malabsorption, in addition to poor intake and excessive utilisation, contributes to vitamin deficiency in alcoholics. Since this may take some weeks to recover, parenteral vitamins are necessary initially [R.E.KENDELL-A-K-ZEALLEY 1988].

**Alcohol Suicide and Attempted Suicide:** Alcohol problems may mean a higher risk of attempted suicide. One study found that 20% of those diagnosed as having serious alcohol problems had attempted suicide and 80% went on to kill themselves. Alcohol is implicated in suicide in two ways.

1. Because of its disinhibitory effects on behaviour leading to rash acts while intoxicated.
2. Though a more prolonged build up of depression and self-incriminatory ideas.

*[Alcohol concern factsheet-Alcohol and mental health-October 1996]*.
**Physical Complications of Alcohol Abuse:** In the community men who admit to drinking 6 or more units per day have triple their expected mortality. This is not all accounted for by their tendency to drink heavily (Dyer et al, 1980), in an unselected population of Swedish city-dwelling men aged about 50, followed up for one to four years; alcohol was the most important single factor accounting for death in the study period. Cancer (gastric and oropharyngeal, cardiovascular disease, cirrhosis, pancreatic and gastrointestinal disease), accidental death and suicide all contribute to this raised mortality. Amongst alcoholics known to hospitals, mortality from lung disease (bronchitis, tuberculosis) is also raised, but this is probably contributed to by smoking and by the "skid row" lifestyle of some of this group. [R.E.KENDELL-A-K-ZEALLEY 1988]

Gastrointestinal Complications: Gastritis, presenting as upper abdominal pain and haematemesis, perhaps accompanied with acute gastric erosions, is unequivocally related to alcohol. However failure may also result from alcoholic hepatitis in the absence of cirrhosis. [Harold I-Kaplan, Benjamin J, Sadock, 1997]

**Sexual Impairment:** High blood alcohol level impairs penile erection by a direct pharmacological effect. Heavy drinkers who repeatedly fail to maintain an erection become anxious about their sexual performance, which itself leads to further failure. Alcohol also has direct toxic effects on the leydig cells of the testis, resulting in reduced testosterone production and eventually in testicular atrophy. [R.E KENDELL-A-K-ZEALLEY 1988]

**Neurological Complications:** Wemicke’s encephalopathy. The triad of confusion ataxia and ocular palsy was described by wernicke in 1881. Patients dying of this condition show hemorrhages in the brain stem and hypothalamus. Identical lesions have been produced in thiamine deficient
animals. The condition responds to urgent treatment with intravenous thiamine and withdrawal of alcohol but even with such measures there is often a residual dementia of korsakoff psychosis (Victor 1992), disturbance of consciousness in the alcoholic must also raise the suspicion of traumatic subdural haematoma, though unilateral signs will then probably be present. Occasionally dementia is marked and accompanied initially by incontinence, generalised weakness, tremor persisting long after withdrawal from alcohol, slurred speech and ataxia, the patient resembling a case of general paresis of syphilitif origin. Alcohol cerebellar degeneration presents as ataxia of stance and gait. [R.E.Kendll-A-K-Zeally 1988].

Polyneuropathy, contributed to by vitamin deficiency, is common in alcoholics in at least a mild form, with absence of the ankle jerks and calf tenderness. In the established condition the patient complains of muscular cramps and unpleasant paraesthesiae in the feet and calves and unsteadiness of gait. All forms of sensation are impaired in a stocking distribution. Flaccid weakness in the limbs may progress to wrist drop. The cranial nerves are spared (and due to nerve damage but to intoxication to the point of stupor).

Alcohol myopathy presents as chronic weakness with wasting, punctuated by exacerbation during bouts of drinking. [R.E KENDELL-A-K-ZEALLEY 1988]

Alcoholic liver disease: The major adverse effects of alcohol use are related to liver damage. Alcohol use, even as short as weel-long episode of increased drinking, can result in an accumulation of fats and proteins, which produce the appearance of a fatty liver. The association between fatty infiltration of the liver and serious liver damage remains unclear. Alcohol use, however, is associated with the development of alcoholic
hepatitis and hepatic cirrhosis. [Harold I. Kaplan, Benjamin I. Sadock, 1997].
TREATMENT

Medical Aspects of Treatment:
Medication to minimize withdrawal symptoms makes stopping drinking easier, but is only essential when delirium threatens or there is a history of fits.
In view of the frequency of cognitive impairment in heavy drinkers and its probable relation to vitamin depletion, vitamin supplements should be given in most patients, and in cases in which cognitive impairment of neuropathy is clinically demonstrable, for several months. [R.E.KENDELL, A-K ZEALLEY 1988]

Social Skills Training:
Many heavy drinkers are influenced by social cues. Many report that they feel deficient in social skills. Refusing drinks, buying non-alcoholic drink, applying for jobs, being firm with subordinates, expressing affection to loved ones and expressing annoyance without being insulting are some of the items of interpersonal behavior that alcoholics find useful to role-play in social skills training groups. Identifying triggers to drinking and learning new methods to cope with such triggers is a common part of these behavior-based programs. [R.E.KENDELL, A-K ZEALLEY 1988]

Group Therapy:
The comradeship of others who have similar difficulties greatly enhances the self-esteem of some alcoholics. Participating in treatment in a group carries other advantages. Fellow alcoholics are quick to expose the rationalizations and self-deception of their peers, but often do so most sympathetically and with great tolerance. If a member recommences drinking, it can be difficult to retain him in the group; but others will be able to empathize with his once again turning to alcohol as a response to,
for example rejection or disappointment. [R.E.KENDELL, A-K ZEALLEY, 1988]

**Conjoint and Family Therapy:**

Cohesiveness of marriage and family life is a predictor of recovery [Orford 8, Edwards, 1977; Moos et al, 1979], "mentioned in the references at the foot of the paragraph".

Bitterness, mistrust and fear in the spouse and children may take many months to subside even when the patient has achieved abstinence. Family interviews enable members to have their views heard, without the discussion spiraling into denials, accusation, and counteraccusation. The patient can be helped to see that members of his family are bound to feel hesitant at first but that this need not imply that they do not care about him or appreciate his efforts. The man who has opted out of married and family life, or who has gradually been extruded because of his drinking, may suddenly want to resume his roles of husband and father, ignoring the fact that others in the family now have their own way of doing things [Chick and Chick, 1984].

Other members of the family sometimes fear that the therapist is going to blame them for the patient’s drinking and so refuse to be involved in discussions. The psychiatrist’s invitation to them might be "To hear their views of how things have been, and to have their opinions on how X can best be helped. [R.E.KENDELL, A-K ZEALLEY 1988]

**Specialist Services:**

Units for the treatment of alcohol problems, offer a specialized service in most regions of Britain. They have a responsibility for treatment, training and research and facilities of a similar kind are to be found in many parts of the industrialized world. Traditionally they have offered inpatient treatment of six to eight week’s duration with an emphasis on group psychotherapy.
In recent years there has been a shift away from this devotion to inpatient treatment toward offering outpatient therapy combined with brief inpatient or day-patient treatment. In response to evaluation studies, which have cast doubts on the importance of very intensive forms of therapy, these units have become more experimental, offering a range of approaches, including behavior therapy, marital and family therapy as well as more familiar group and individual psychotherapy. [R.E.KENDELL, A-K ZEALLEY 1988]

Glaser (1980) has criticized the tendency for specialist services to act as if the alcoholic population were homogeneous and to offer a single form of treatment for all. He has proposed a "care-shell program" containing a care service concerned with careful assessment of each patient’s needs and matching these to a range of treatment options which from the "shell" of the program. [R.E.KENDELL, A-K ZEALLEY, 1988]

**Councils on Alcoholism and Alcohol Advice Centers:**

Many developed countries now have counseling services separate from psychiatric or medical clinics. Problem drinkers or their families may initiate the contact and referrals will be accepted from doctors. In some countries drink-driving offenders will be directed by the court to seek help from these or other agencies. [R.E.KENDELL, A-K ZEALLEY 1988]

**Employment Policies:**

Employers who are prepared to face the issue of drinking problems amongst their workforce may arrange with their employees and trade union for affected employees to be encouraged to seek help at an early stage. Such firms usually realize the cost to the industry of absenteeism, accidents and inefficiency due to alcohol. When drinking has led to a breach of work regulations, the employee may be offered the opportunity of attending a treatment service rather than facing dismissal. The outcome of problem
drinkers identified and treated in the work context tends to be good.  
[R.E.KENDELL, A-K ZEALLEY, 1988]

**Service for the Homeless Alcoholic:**

The homeless alcoholic usually finds abstinence unattainable unless he or she can be helped out of the "skid row" environment of lodging houses or sleeping in the open. Hostels are an important part of rehabilitation. Most hostels for alcoholics require abstinence as a condition of residence, and they usually provide a therapeutic program in which the residents help each other to find a new lifestyle. After a residence of up to one year, many patients find the transition to independent life extremely difficult and some areas provide halfway houses and supported accommodation as the next stage.

Hostels need not be the exclusive domain of the homeless. They are often valuable for alcoholics who live in unsatisfactory accommodation, or in a domestic setting which is so tense that a period of separation is a necessary prelude to a return to the family. Most hostels are managed by church or other voluntary organizations. In some cities they are also provided by the social work department. [R.E.KENDELL, A-K ZEALLEY, 1988]

**Tolerance:**

In general, people feel better becoming intoxicated than they do becoming sober that is, as the blood alcohol level climbs from A to B to C, a person may feel euphoric at B and C. As the blood level falls from C to B, the person feels discomfort, presaging the hangover to come at A. This slope effect is closely related to and hard to separate from the duration effect. As people drink more alcohol over days, months, and years, they gradually need to drink even more to obtain the same effect. The importance of tolerance however is often exaggerated. Seasoned alcoholics, at the prime of their drinking capacity, may be able to drink, at most, twice more than a
teetotaler of similar age and health compared with tolerance for morphine. which may be manifold. Tolerance for alcohol is modest. [R-E-KENDELL A.K. ZALLEY 1988]

Nevertheless, the importance of tolerance in the addictive process seems established. Recent studies indicate that tolerance may result from changes in cell membranes. A cell membrane consists of a bilayer of phospholipids arranged with the "head" of the molecule facing the extracellular space and the "tail" dangling toward the interior of the cell. The former attracts water and the latter repels water. The result is a strong and resistant sheath for the cell that is also easily perturbed by external and internal changes. Alcohol among other external influences (such as temperature) makes the membranes more flexible on fluid after chronic exposure to alcohol, the membranes become stiff again, and this condition is interpreted as tolerance at the cellular level. The so-called disordering effect of alcohol on membranes corresponds to an increase in lipid solubility of alcohol. [R-E-KENDELL A.K. ZALLEY 1988]
**EPIDEMIOLOGY**

**Consumption Data:**
Currently, the annual consumption of alcohol (pure alcohol) in the United States is about 3 gallons per person over 14 years of age. This figure is based on tax data. Untaxed sales, such as these at military installations, are not included. So per capita consumption estimates are based on the population of each state. When residents of one state cross into another state to purchase lower-priced alcoholic beverages, the result is a higher per capita consumption figure for the state where sales occur. Washington DC, and state with high rates of tourism and business travel have higher reported consumption rates because sales to transients are calculated as consumption by the resident population. [R-E-Kendell A.K. Zalley 1988]

There was a modest increase in taxed alcohol sales in the United States from 1950 to 1980, perhaps because of the decreased availability of untaxed alcohol, moonshine is no longer a booming industry in some backwoods areas. Making moonshine alcohol mainly was a small family business, and the small family business in the United States have declined. Since 1980, alcohol sales have declined.

Reasons often cited are increased health consciousness, use of other recreational drug (especially marijuana) and the current fanatical devotion to slimness. [R-E-Kendell A.K. Zalley 1988]

There has been interesting change in preference within beverage category in the diet conscious United States.

People drink more light beer that is beer with fewer calories than regular beer. They also drink more white spirits, such as vodka or gin, than brown spirits (whiskey). There is no clear explanation for the color preference, unless people have the notion that white spirits are healthier than brown, which is probably not true. So-called California coolers have recently
become popular. Consisting of white wine and fruit juice these drinks contain about 5 percent alcohol, the equivalent of strong beer. The fruit juice masks the wine taste and the drinker may be deceived about the strength of the potion. International comparisons are difficult at best it. Appears, however, that wine countries, such as France and Italy, consume more than countries where distilled spirits are favored. Israel has the lowest per capita consumption Ireland, contrary to its popular image, has a lower consumption rate than the United Kingdom. The United States ranks in the middle with regard to alcohol consumption. Soviets are notoriously heavy drinkers, but consumption figure are hard to come by. [R-E-KENDELL A.K. ZALLEY 1988]

**Drinking Patterns:**

More is known about patterns of normal drinking than about the prevalence of alcoholism, at least in the United States. Nationwide surveys of drinking practices reveal that about 70 percent of adults in America drink alcohol on occasion and that 12 percent are heavy drinkers. A heavy drinker is defined as a person who drinks almost every day and becomes intoxicated several times a month. Moderate drinking is defined by some authors as an intake that does not exceed 0.8g. per kg of body weight of ethanol per day. Up to a limit of 80g, or an average of 0.7g per kg. For 3 successive days. Generally, drinkers tend to be young, relatively prosperous, and well educated. More drinkers live in cities and suburbs than in rural regions and small towns. To some extent, religion determines whether a person is drinker or a teetotaler. Almost all urban Jews and Episcopalians drink on occasion, whereas fewer than half of rural Baptists drink. [R-E-KENDELL A.K. ZALLEY 1988]

More men than women are heavy drinkers – 20 percent of men verses 9 percent of women. Heavy drinkers more often come from the lower classes
and are less well educated than moderate drinkers. Drinking patterns appear to be highly changeable. It is common for individuals to be heavy drinkers for long periods and then to become moderate drinkers or teetotalers.

**Prevention of Alcohol Abuse:**
For alcohol-related problems prevention should be better than cure because the efficacy of treatment is uncertain and the problem is endemic in most industrialized countries. Unfortunately, prevention is often seen to imply prohibition and interference with the liberty of the individual.

Primary prevention of alcohol abuse relies on three strategies: control of availability, education about sensible use, and providing alternative pursuits. These are not alternatives but approaches, which are interdependent. For instance, it would be politically unwise to introduce controls, which did not enjoy a measure of public acceptance, an aim that would have to be pursued first by an active public education program. [*R. E. KENDELL A. K. ZEALLEY 1988, Fourth Edition.*]

**Controls:**
Legislation restricting times of sale and the number, type and location of premises probably influences consumption, but such legislation is usually introduced at times when other attitudes are changing, making it difficult to pinpoint its effectiveness. The major restrictions on permitted hours in Britain were introduced by Lloyd George in 1915 in an effort to ensure that the workforce was sufficiently sober to meet the demands imposed by the war effort. Consumption certainly dropped at that time and remained low for more than a decade.

Most countries impose a minimum age at which young people are allowed to drink in public. Most will drink in a clandestine way before that age, but there is some evidence that the real age at which drinking commences is further reduced by lowering the permitted age. In the USA and Canada
experience has shown that states or provinces which lowered the permitted age experienced a rise in motor accidents and drink–driving offences amongst the young.

In Britain there is now pressure from the health lobby to restrict alcohol advertising. There is already a voluntary code of practice governing the ethics of alcohol-advertising and breaches of this agreement should be referred to the Advertising Standards Authority.

Price, Over the past 300 years, alcohol consumption in Britain has shown marked fluctuations. Every time the price of alcohol relative to disposable income has fallen, as it has almost continuously since 1945, consumption has risen. In 1981 an increase in the excise duty on beer and spirits caused their price to rise faster than the retail price index and average disposable incomes. These economic changes were associated in Edinburgh with a decline in alcohol consumption of 18% and a reduction in alcohol-related harm of 16%. Contrary to predictions, heavy drinkers and even dependent drinkers reported a disproportionate reduction in their consumption (Kendell et al 1983)

The health lobby is but one competing interest group in the debate about controlling the availability and consumption of alcohol. Other groups argue in favor of continuing growth in the alcohol market. There is, for instance, the employment argument (the drink trade in Britain employs 750 000); the desire to expand over seas trade (a viewpoint which ignores the probably harmful effect on health in developing countries); and the needs of the tourism and advertising industries.\[R. E. KENDELL A. K. ZEALLEY, 1988\]

**Education:**
Public education can have a number of objectives. It can be concerned with informing the public about alcohol problems along with specific advice about where to seek help. Campaigns of this kind have not influenced
drinking habits but have often produced an increase in utilization of treatment and counseling facilities. More recently public education has focused on groups who are known to be heavy drinkers, such as young males in social class V, or on those whose habits are changing rapidly, such as women.

Other campaigns may be directed towards very specific high-risk groups, for instance, education for employees in the brewing trade, or towards populations who are unusually vulnerable to alcohol, such as pregnant women. Television advertising can, for example, highlight the immediate consequences of drinking too much, such as fights or embarrassment, and illustrate alternative models of moderate problem-free drinking. Recently information has been disseminated about sensible drinking, along with booklets describing self-help strategies for limiting consumption. [R-E-KENDELL A.K. ZALLEY 1988]

Provision of alternative:
Many communities are heavily dependent on drinking places as a principal source of entertainment. Clearly the pub has a significant social role in its neighborhood but (those concerned with planning should ensure that other leisure pursuits are encouraged and that other nonalcoholic beverages are readily available. Alternative choice for relieving tension and facilitating social contacts can be taught, for instance, relaxation training, meditation and social skills training. These alternative styles of living could be explored within schools, if the curriculum were thoughtfully redrawn).

Secondary prevention
(Secondary prevention aims to prevent the further progression of a condition by identifying and treating cases at an early state. The symptom-free excessive drinker sees little reason to change his habits. However a primary care worker, consulted perhaps for some other reason, might
educate and persuade him or her to cut down. The general practitioner, industrial medical officer, social worker, nurse or health visitor are in a position to do this, provided they understand alcohol problems sufficiently). Russell et al (1979) showed that general practitioners who advised smokers attending their surgeries to stop smoking and provided a leaflet describing some useful strategies increased the rate of stopping smoking amongst their patients from 0.3 to 5.1% per annum. Though this 17-fold increase may seem trivial, if every general practitioner did likewise the number of smokers in the UK who gave up each year reach half a million. [R-E-KENDELL A.K. ZALLEY 1988]

Young men with heavy alcohol consumption had an increased risk of developing alcoholism if they later worked in an environment characterized by low control. This finding was not due to selection of heavy drinkers into low control jobs. Similar results were obtained when data from blue-collar workers were analyzed separately. [Hemmingsson – T, Lundberg – 2001]

Reduction in alcohol intake is associated with lowering of blood pressure in randomized clinical trials. Each drink per day reduction in intake lowers systolic and diastolic blood pressure by approximately 1mm. Hg.

Excessive alcohol intake increases the risk of many medical and psychosocial problems. (Cushman, W–C, 2001). Men benefit more than women from citalopram in the treatment of alcohol dependence. These findings highlight the importance of examining sex as a significant variable in evaluating response to pharmacotherapy.[Naranjo-C-A; Knoke-D-M; Bremner-K-E, 2000]

Ancovs (2000) found significant effect of drinking status on general health, physical functioning, physical role functioning, bodily pain, vitality, mental health, emotional role and social functioning controlling for age and gender, with low-risk drinkers scoring significantly better than abstainers.
At-risk drinkers had significantly poorer mental health functioning than low-risk drinkers. Few significant gender differences were found on sf-36 scales. [Blow, F-C; Walton-M-A; Barry-K-L; Coyne-J-C; Mudd-S-A; Copeland-L-A, 2000]

Alcohol abuse and alcoholism are common but under recognized problems among older adults. One third of older of alcoholic persons develop a problem with alcohol in later life, while the other two thirds grow older with the medical and psychosocial sequelae of early-onset alcoholism. The common definitions of alcohol abuse and dependence may not apply as readily to older persons who have retracted or have few social contacts. The effects of alcohol may be increased in elderly patients because of pharmacologic change associated with aging interactions between alcohol and drugs, prescription and over-the-counter, may also be more serious in elderly persons. Physiologic changes related to aging can alter the presentation of medical complications of alcoholism. Management of alcohol withdrawal in elderly persons should be closely supervised by a health care professional alcohol treatment programs with an elder-specific focus may improve outcomes in some patients. [Rigler,-S-K, 2000]

Thus, alcohol’s role in stimulating men’s sexual responding cannot be construed as occurring through a strictly pharmacological. [George-W-H; Stoner, S-A; Norris,-J, Lopez,-P-A; Lerman,-G-L, 2000]

Equal numbers of married fathers, married mothers, and single mothers from each of these groups received either alcoholic or non-alcoholic beverages prior to videotaped interactions with male child confederates who, depending on condition, enacted behaviors characteristic of either normal boys or boys with attention deficit hyperactivity conduct oppositional defiant disorder (ADHD/CD/ODD). Results indicated that intoxicated parents rated their ADHD/CD/ODD child partners as less
deviant than did sober parents. Alcohol intoxication caused all participant groups to exhibit less attention and productive work and more commands, indulgences, and off-task talk in the interaction. Implications for better understanding of the rate of psychosocial factors in the correlation between adult drinking problems and childhood behavior disorders are discussed [Lang, A-R, Pelham, W-E, Atkeson, B-M, Murphy, D-A, 1999].

In addition to previously reported cognitive impairments heavy prenatal alcohol exposure is related to significant impairments in psychosocial functioning [Roebuck, T-M, Mattson, S-N, Riley, E-P, 2000]

Cognitive functioning was examined 69 mildly to moderately alcohol-dependent outpatients without comorbid psychiatric, neurologic, or systemic medical illness. Circumscribed decrements in reaction time and verbal memory were associated with higher amounts of alcohol consumption in the go days prior to enrollment in the study, and amount of recent consumption was correlated with scores on numerous cognitive tests. In contrast, longer drinking history was not associated with poorer performance on any neuropsychological measures, thus, in this group of high-functioning mildly to moderately alcohol-dependent outpatients, mild cognitive deficits were related to the amount of recent, but not lifetime, alcohol consumption [Horner, M-D, Waid, L-R; Johnson, D-E, Iatham, P-K; Anton, R-F, 2000]
Methodology

The researcher adopted the experimental approach because it is the most suitable for such types of studies.

Area of the Study:

Data for this study were collected from Eltigani Elmahi Psychiatric Hospital in Omdurman town were most of the Sudanese Senior Psychiatrist, Psychologist and Social Workers work.

Eltigani Elmahi Psychiatric Hospital is a training hospital for both psychiatry and parapsychiatric profession in the Sudan.

The second human resource for data collection was Khartoum Teaching Hospital and thirdly Omdurman Military Hospital, fourthly Kober Institution. All patients admitted for alcohol abuse were seen by consultant psychiatrists.

Sample:

The sample was divided into two groups:

1) "100" male patients their average age is (30) years (Range 20-55 years) as experimental group. Those patients are covering all patients admitted to four main psychiatric in-patients hospitals in Khartoum state. These hospitals contains many wards, which furnished with hundreds of beds, the patients may spend more than (40) days in these wards. The biggest hospital of all is El-Tigani El-Mahi. All patients were diagnosed by psychiatrist.

2) '100' male of average age (30) years range 20-55 years as control group selected randomly from the visitors of non alcoholic patients.
Tools of the Study:

Questionnaire:
The demographic questionnaire was designed by the researcher to know the psychological and social effects of alcohol. The questionnaire covers two areas; psychological and social effects. It consists of 17 questions which include sub-questions.
The questionnaire subjected to three experts, whose views were taken in amending and changing some questions. The researcher trained two psychologists to help in the data collection so the questions were asked by the same way. The verbalizations of the questions are the same for all questions. All answers of the questions were recorded by the researcher.
The questionnaire was implemented on pilot study included 20 samples. It encompassed two scales; depression and anxiety, and was translated into Arabic Language.
For the purpose of the realization of validity, the researcher used the statistical partial division; reliability is the square root of the validity.
Scales:
The researcher used two scales, depression scale and anxiety scale for their suitability to the present study taken from the (D.S.M₄).

Depression Scale:
To know the reliability and validity of depression scale in the population of this study, the researcher use analysis of variance method, and this procedure shows that or indicate a high validity and reliability, the researcher noted that all correlation coefficients are positive and having high values.
Pilot Study (For Depression Scale)

1/Internal Consistency:
Table No. (1) show the Person correlation coefficients between each item and scale total score.

<table>
<thead>
<tr>
<th>Item No.</th>
<th>Correlation coefficient</th>
<th>Item No.</th>
<th>Correlation coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.915</td>
<td>6</td>
<td>.800</td>
</tr>
<tr>
<td>2</td>
<td>.895</td>
<td>7</td>
<td>.561</td>
</tr>
<tr>
<td>3</td>
<td>.879</td>
<td>8</td>
<td>.646</td>
</tr>
<tr>
<td>4</td>
<td>.829</td>
<td>9</td>
<td>.702</td>
</tr>
<tr>
<td>5</td>
<td>.604</td>
<td>10</td>
<td>.000</td>
</tr>
</tbody>
</table>

From previous table, the researcher noted that the correlation coefficient of item No. (10) equal zero, so she decided to deal it away from the scale.

2/Scale reliability:

To know the reliability coefficient of depression scale in the population of this study, the researcher use analysis of variance method (Alpha Equation), and this procedure show that, the reliability coefficient is equal (.934) which indicate a high reliability.

Anxiety Scale:

To know the reliability and validity of anxiety scale in the population of this study, the researcher use analysis of variance method, and this procedure shows that or indicate a high validity and reliability, the researcher noted that all correlation coefficients are positive and having high values.

Pilot Study (For Anxiety Scale)

1/Internal Consistency:

Table No. (2) show the Person correlation coefficients between each item and scale total score.
<table>
<thead>
<tr>
<th>Item No.</th>
<th>Correlation coefficient</th>
<th>Item No.</th>
<th>Correlation coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>.906</td>
<td>4</td>
<td>.958</td>
</tr>
<tr>
<td>2</td>
<td>.891</td>
<td>5</td>
<td>.932</td>
</tr>
<tr>
<td>3</td>
<td>.852</td>
<td>6</td>
<td>.935</td>
</tr>
</tbody>
</table>

From previous table, the researcher noted that the all correlation coefficient are positive and having high values, so she decided to dealt nothing from the scale.

2/Scale reliability:
To know the reliability coefficient of depression scale in the population of this study, the researcher use analysis of variance method (Alpha Equation), and this procedure show that, the reliability coefficient is equal (.932) which indicate a high reliability.

Statistical Techniques:
The researcher use different method to calculate frequencies:-
   a. Chi-square test, to know the significance of relationship between two groups.
   b. T-test for independent groups to explore the significance of differences.
   c. Z-test, for one proportion to know the significance.

Procedure of the Study:
To carry out this study the researcher applied the following steps:
1. Identifying alcohol drinker patients in the mentioned hospitals.
2. Time spent in data collection is about (8) months.
3. The researcher trained two psychologists to help her in data collection.
1. Time vary for collecting data from each alcoholic drinker patients.
2. After completing data collection from each patient, the researcher makes sure that every question has an answer.

**Difficulties of the Study:**

1. The difficulty of patient’s cooperation in my filling the tools of data collection.
2. The unavailability of previous Sudanese studies in the same field.
### Tables and Results

This chapter intends to show the results of the information collected by procedure mentioned in chapter three.

**Results of Hypothesis (1):**

Alcoholics have a high rate of marital separation & divorce than the control group.

Table No. 1 shows relationship between alcoholic and marital separation.

<table>
<thead>
<tr>
<th>Marital Separation without divorce</th>
<th>Chi square Value</th>
<th>df</th>
<th>Sig.(P)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Compr</td>
<td>47.414**</td>
<td>3</td>
<td>.001</td>
</tr>
<tr>
<td>Not happened</td>
<td>10</td>
<td>40</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sometimes</td>
<td>16</td>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most of times</td>
<td>17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Always</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(*) Means that the value is significant at (.05) (1-tailed)

(**) Means that the value is significant at (.01) (1-tailed)

Table No. (2) shows differences between alcoholic and non alcoholic concerning marital divorce.

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Chi square Value</th>
<th>df</th>
<th>Sig. (P)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Compr</td>
<td>47</td>
<td>46</td>
<td>5.298*</td>
</tr>
<tr>
<td>Married</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Divorce</td>
<td></td>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(*) Means that the value is significant at (.05) (1-tailed).

(**) Means that the value is significant at (.01) (1-tailed)
**Results of Hypothesis (2):**

Alcoholic patients are more often derived from alcoholic fathers than the control group.

Table No. (3) Shows relationship between alcoholic and father drinking.

<table>
<thead>
<tr>
<th>Father drinking alcohol</th>
<th>Frequency</th>
<th></th>
<th>Chi square Value</th>
<th></th>
<th>Sig. (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Observed</td>
<td>Expected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No</td>
<td>37</td>
<td>50</td>
<td>6.760**</td>
<td>1</td>
<td>.009</td>
</tr>
<tr>
<td>Yes</td>
<td>63</td>
<td>50</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(*) Means that the value is significant at (.05) (1-tailed)

(**) Means that the value is significant at (.01) (1-tailed)

**Results of Hypothesis (3):**

Depression is common among alcoholic patients than non alcoholic.

Table No. (4) Shows differences between alcoholism and depression

<table>
<thead>
<tr>
<th>Depression</th>
<th>Alcohol</th>
<th>Compr</th>
<th>Chi value</th>
<th>df</th>
<th>Sig. (P)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-clinical</td>
<td>94</td>
<td></td>
<td>188.255**</td>
<td>1</td>
<td>.001</td>
<td>There is a sig. differences</td>
</tr>
<tr>
<td>Clinical</td>
<td>100</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(*) Means that the value is significant at (.05) (1-tailed)

(**) Means that the value is significant at (.01) (1-tailed)
**Result of Hypothesis (4):**

Anxiety is common among alcoholic patients than non alcoholic.

Table No. (5) Shows differences between alcoholic and anxiety.

<table>
<thead>
<tr>
<th>Anxiety</th>
<th>Alcohol</th>
<th>Compr</th>
<th>Chi value</th>
<th>df</th>
<th>Sig. (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub-clinical</td>
<td>2</td>
<td>100</td>
<td>188.255**</td>
<td>1</td>
<td>.001</td>
</tr>
<tr>
<td>Clinical</td>
<td>98</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(*) Means that the value is significant at (.05) (1-tailed)

(**) Means that the value is significant at (.01) (1-tailed)
**Result of Hypothesis (5):**

There are significant differences in violence due to alcoholic than non alcoholic.

Table No. (6) Shows the results of T-test for independent group to explain the significance of differences in violence & sexual crimes due to alcoholic.

<table>
<thead>
<tr>
<th>Violence &amp; sexual crimes</th>
<th>Study groups</th>
<th>Mean</th>
<th>S.D</th>
<th>(t) value</th>
<th>Df</th>
<th>Sig. (P)</th>
<th>Induction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical aggression towards his children</td>
<td>Alcoholics</td>
<td>1.27</td>
<td>.85</td>
<td>2.195</td>
<td>127</td>
<td>.030</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.07</td>
<td>.33</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical aggression towards his family</td>
<td>Alcoholics</td>
<td>1.80</td>
<td>1.33</td>
<td>5.851</td>
<td>101</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.02</td>
<td>.14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical aggression towards others</td>
<td>Alcoholics</td>
<td>1.78</td>
<td>1.23</td>
<td>5.591</td>
<td>113</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.07</td>
<td>.33</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal aggression towards his children</td>
<td>Alcoholics</td>
<td>1.60</td>
<td>1.11</td>
<td>4.480</td>
<td>117</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.08</td>
<td>.34</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal aggression with his family</td>
<td>Alcoholics</td>
<td>2.81</td>
<td>1.52</td>
<td>11.10</td>
<td>108</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.09</td>
<td>.32</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal aggression with others</td>
<td>Alcoholics</td>
<td>2.92</td>
<td>1.55</td>
<td>11.36</td>
<td>110</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.11</td>
<td>.37</td>
<td>4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Destroy things</td>
<td>Alcoholics</td>
<td>2.38</td>
<td>1.38</td>
<td>8.861</td>
<td>113</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.11</td>
<td>.37</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practice sex without marriage</td>
<td>Alcoholics</td>
<td>2.58</td>
<td>1.29</td>
<td>10.93</td>
<td>119</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.10</td>
<td>.41</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Result of Hypothesis (6):**

Social difficulties are common among alcoholic patients than the control group.

Table No. (7) shows social difficulties due to alcoholic.

<table>
<thead>
<tr>
<th>Social difficulties</th>
<th>Study groups</th>
<th>Mean</th>
<th>S.D</th>
<th>(t) value</th>
<th>df</th>
<th>Sig. (P)</th>
<th>Induction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Careless about his children</td>
<td>Alcoholics</td>
<td>1.58</td>
<td>1.08</td>
<td>4.436</td>
<td>123</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.07</td>
<td>.38</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Absence from work</td>
<td>Alcoholics</td>
<td>2.31</td>
<td>1.43</td>
<td>6.386</td>
<td>138</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.31</td>
<td>.64</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Changing jobs</td>
<td>Alcoholics</td>
<td>4.40</td>
<td>.93</td>
<td>25.109</td>
<td>198</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.43</td>
<td>.73</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social isolation</td>
<td>Alcoholics</td>
<td>4.44</td>
<td>.87</td>
<td>26.253</td>
<td>198</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.44</td>
<td>.74</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not feeling home</td>
<td>Alcoholics</td>
<td>1.22</td>
<td>.75</td>
<td>2.947</td>
<td>99</td>
<td>.004</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.00</td>
<td>.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**Result of Hypothesis (7):**

Behavioral & psychological problems are common among alcoholic’s children than the control group.

Table No. (8) Shows in children’s behavioral & psychological problems due to alcoholism.

<table>
<thead>
<tr>
<th>Children’s behavioral &amp; psychological problems</th>
<th>Study groups</th>
<th>Mean</th>
<th>S.D</th>
<th>(t) value</th>
<th>df</th>
<th>Sig. (P)</th>
<th>Induction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Alcoholics</td>
<td>1.15</td>
<td>.78</td>
<td>1.428</td>
<td>51</td>
<td>.080</td>
<td>There isn’t sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.00</td>
<td>.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression &amp; sadness</td>
<td>Alcoholics</td>
<td>1.54</td>
<td>1.29</td>
<td>2.866</td>
<td>53</td>
<td>.003</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.02</td>
<td>.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enuresis</td>
<td>Alcoholics</td>
<td>2.00</td>
<td>1.46</td>
<td>4.820</td>
<td>52</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.02</td>
<td>.15</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not going for school</td>
<td>Alcoholics</td>
<td>1.65</td>
<td>1.28</td>
<td>3.385</td>
<td>54</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.04</td>
<td>.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>School trawancy</td>
<td>Alcoholics</td>
<td>1.73</td>
<td>1.36</td>
<td>3.877</td>
<td>51</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.00</td>
<td>.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lies</td>
<td>Alcoholics</td>
<td>1.25</td>
<td>.88</td>
<td>.966</td>
<td>96</td>
<td>.169</td>
<td>There isn’t sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.11</td>
<td>.48</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stealing</td>
<td>Alcoholics</td>
<td>1.21</td>
<td>.87</td>
<td>.868</td>
<td>96</td>
<td>.194</td>
<td>There isn’t sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.09</td>
<td>.46</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jealousy</td>
<td>Alcoholics</td>
<td>1.25</td>
<td>.88</td>
<td>1.640</td>
<td>57</td>
<td>.050</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.04</td>
<td>.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Verbal Aggression</td>
<td>Alcoholics</td>
<td>1.42</td>
<td>1.09</td>
<td>2.460</td>
<td>55</td>
<td>.009</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.04</td>
<td>.21</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Aggression</td>
<td>Alcoholics</td>
<td>1.19</td>
<td>.72</td>
<td>1.939</td>
<td>51</td>
<td>.029</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.00</td>
<td>.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There is a significant different between the two groups regarding all the items of the question except for steeling ad lying, anxiety.
**Result of Hypothesis (8):**

Both (Tension & Anxiety) & (Depression & Sadness) are common among alcoholics wives than non alcoholic.

Table No. (9) Shows (Tension & Anxiety) & (Depression & Sadness) alcoholisms’ wives

<table>
<thead>
<tr>
<th>Wives psychologic al problems</th>
<th>Study groups</th>
<th>Mean</th>
<th>S.D</th>
<th>(t) value</th>
<th>df</th>
<th>Sig. (P)</th>
<th>Induction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tension &amp; Anxiety</td>
<td>Alcoholics</td>
<td>2.52</td>
<td>2.22</td>
<td>3.958</td>
<td>55</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>1.20</td>
<td>.65</td>
<td></td>
<td>52</td>
<td>.001</td>
<td></td>
</tr>
<tr>
<td>Depression &amp; Sadness</td>
<td>Alcoholics</td>
<td>3.36</td>
<td>1.61</td>
<td>10.548</td>
<td>52</td>
<td>.001</td>
<td>There is a sig. difference</td>
</tr>
<tr>
<td></td>
<td>Comparison</td>
<td>.91</td>
<td>.28</td>
<td></td>
<td>55</td>
<td>.001</td>
<td></td>
</tr>
</tbody>
</table>
**Result of Hypothesis (9/a):**

There is significant personality (pre-morbid personality) pathology in alcoholics.

Table No. (10) shows personality pathology in alcoholics.

<table>
<thead>
<tr>
<th>Patients personality before disease</th>
<th>Mean</th>
<th>S.D</th>
<th>Tested value</th>
<th>(t)  value</th>
<th>df</th>
<th>Sig. (P)</th>
<th>Induction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introvert</td>
<td>2.06</td>
<td>1.92</td>
<td>2.00</td>
<td>.370</td>
<td>99</td>
<td>.356</td>
<td>Very small</td>
</tr>
<tr>
<td>Paranoid</td>
<td>1.31</td>
<td>.83</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>Not exited</td>
</tr>
<tr>
<td>Sociable</td>
<td>3.63</td>
<td>1.76</td>
<td>3.50</td>
<td>.740</td>
<td>99</td>
<td>.231</td>
<td>Above average</td>
</tr>
<tr>
<td>Religious</td>
<td>2.39</td>
<td>1.31</td>
<td>2.00</td>
<td>2.978</td>
<td>99</td>
<td>.002</td>
<td>Small</td>
</tr>
<tr>
<td>Aggressive</td>
<td>1.78</td>
<td>1.07</td>
<td>1.50</td>
<td>2.619</td>
<td>99</td>
<td>.005</td>
<td>Very small</td>
</tr>
<tr>
<td>Shay</td>
<td>2.24</td>
<td>1.42</td>
<td>2.00</td>
<td>1.696</td>
<td>99</td>
<td>.047</td>
<td>Small</td>
</tr>
<tr>
<td>Anxious</td>
<td>2.51</td>
<td>1.18</td>
<td>2.50</td>
<td>.084</td>
<td>99</td>
<td>.467</td>
<td>Small</td>
</tr>
<tr>
<td>Dependent</td>
<td>2.18</td>
<td>1.47</td>
<td>2.00</td>
<td>1.222</td>
<td>99</td>
<td>.113</td>
<td>Very small</td>
</tr>
<tr>
<td>Independent</td>
<td>3.55</td>
<td>1.56</td>
<td>3.5</td>
<td>.321</td>
<td>99</td>
<td>.374</td>
<td>Above average</td>
</tr>
<tr>
<td>Responsible</td>
<td>3.40</td>
<td>1.63</td>
<td>3.00</td>
<td>2.449</td>
<td>99</td>
<td>.008</td>
<td>Above average</td>
</tr>
<tr>
<td>Stubborn</td>
<td>2.45</td>
<td>1.27</td>
<td>2.00</td>
<td>3.554</td>
<td>99</td>
<td>.001</td>
<td>Small</td>
</tr>
</tbody>
</table>
Result of Hypothesis (9/b):

There is a significant early family pathology in alcoholics background.

Table No. (11) shows family pathology in alcoholics background.

<table>
<thead>
<tr>
<th>Family pathology elements</th>
<th>Frequency</th>
<th>Proportion</th>
<th>Z-value</th>
<th>Sig. (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father drinking</td>
<td>63</td>
<td>.63</td>
<td>13.049</td>
<td>.001</td>
</tr>
<tr>
<td>Father psycho-disease</td>
<td>12</td>
<td>.12</td>
<td>3.693</td>
<td>.001</td>
</tr>
<tr>
<td>Father Psycho-pathic</td>
<td>1</td>
<td>.01</td>
<td>1.005</td>
<td>.159</td>
</tr>
<tr>
<td>Mother psycho-disease</td>
<td>9</td>
<td>.09</td>
<td>3.145</td>
<td>.001</td>
</tr>
<tr>
<td>Brothers drinking</td>
<td>16</td>
<td>.16</td>
<td>4.364</td>
<td>.001</td>
</tr>
<tr>
<td>Brothers psycho-disease</td>
<td>5</td>
<td>.05</td>
<td>2.294</td>
<td>.011</td>
</tr>
<tr>
<td>Brothers psycho-pathic</td>
<td>5</td>
<td>.05</td>
<td>2.294</td>
<td>.011</td>
</tr>
</tbody>
</table>
**Result of Hypothesis (9/c):**

There is significant socialization (early development) pathology in alcoholics’ background.

Table No. (12) Shows differences between alcoholic and socialization pathology.

<table>
<thead>
<tr>
<th>Socialization (9/c)</th>
<th>Groups</th>
<th>Chi value</th>
<th>Df</th>
<th>Sig. (P)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sucking</td>
<td>Normal</td>
<td>83</td>
<td>96</td>
<td>8.992**</td>
</tr>
<tr>
<td></td>
<td>Not</td>
<td>17</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Breasting feeding period (Per month)</td>
<td>12</td>
<td>34</td>
<td>17</td>
<td>8.418**</td>
</tr>
<tr>
<td></td>
<td>18</td>
<td>6</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td></td>
<td>24</td>
<td>58</td>
<td>76</td>
<td></td>
</tr>
<tr>
<td></td>
<td>36</td>
<td>2</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>The weaning</td>
<td>Gradually</td>
<td>13</td>
<td>34</td>
<td>12.265**</td>
</tr>
<tr>
<td></td>
<td>Suddenly</td>
<td>87</td>
<td>66</td>
<td></td>
</tr>
<tr>
<td>Adolescent Smoking</td>
<td>No</td>
<td>3</td>
<td>36</td>
<td>34.687**</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>97</td>
<td>64</td>
<td></td>
</tr>
<tr>
<td>Adolescent drugs</td>
<td>No</td>
<td>47</td>
<td>85</td>
<td>32.175**</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>53</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Adolescent verbal Aggressive</td>
<td>No</td>
<td>83</td>
<td>94</td>
<td>5.944*</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>17</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Adolescent physical aggressive</td>
<td>No</td>
<td>84</td>
<td>94</td>
<td>5.107*</td>
</tr>
<tr>
<td></td>
<td>Yes</td>
<td>16</td>
<td>6</td>
<td></td>
</tr>
</tbody>
</table>

(*) Means that the value is significant at (.05) (1-tailed)

(**) Means that the value is significant at (.01) (1-tailed)
RESULTS

Relationships between Alcohol and Marital Separation:
There is significant difference between alcohol and control groups regarding marital separations. Marital separation without divorce are more common among alcoholic paints, show table No. (1)

Relationship between Alcohol and Marital Divorce:
There is a significant difference between alcohol and control group regarding marital divorce. Divorce is more common among alcoholic paints, show table No. (2)

Relationship between Alcoholic and Father Drinking Alcohol:
There is significant relationship between alcoholic and father drinking alcohol 63% are derived from alcoholic fathers, show table No. (3)

Relationship between Alcoholic and Depression:
There is significant relationship between alcoholism and depression. Depression is more common 100% among alcoholic, show table No. (4)

Relationship between Alcoholic and Anxiety:
There is significant relationship between alcohol and anxiety. It is common 98% common among alcoholic patients, show table No. (6)

Violence and Sexual Crimes Due to Alcohol:
There is significance difference between alcoholic and control group regarding violence and sexual crimes. Violence and sexual crime are more common among alcoholic paints, show table No. (7)

Differences in Social Difficulties:
There is a significant difference between alcoholics and the control group regarding the social difficulties, show table No. (8)
Children’s Behavioral and Psychological Problems Due to Alcoholic:
There is a significant difference between the two group regarding all the items of the questioner expect for steeling and lying, show table No. (9)

(Tension & anxiety) and Depression and Sadness in wives:
There is significant relationship in wives tension, anxiety and depression due to alcohol, show table No. (10)

Personality Pathology in Alcohols:
There is significant personality pathology concerning. Religious personality aggressive personality, sociable personality, shy personality, responsible personality and there is no significance personality pathology concerning introvert personality and paranoid personality, dependant and independent personality anxious personality show table No. (11)

Significant of Family Pathology in Alcohols:
There is significant family pathology in alcoholics’ background, show table No. (12)

Socialization Pathology in Alcohols Background:
There is significant difference between the two group regarding socialization pathology. Socialization pathology is more common among alcoholics paints, show table No. (13)
Discussion

This chapter deals with the information collected according to the procedure described in chapter three, and analyzed in chapter four, according to what was mentioned in the theoretical background and the hypotheses of the present study.

Our results show that significant relationships exist between alcoholics and their fathers drinking alcohol, and this idea is supported by (Windle, 1996) who claims that, parents who drink heavily serve as negative role models for their children who are likely to take on their alcoholic behavior at a young age, without adequate supervision and control. It is likely that these children will become alcoholics and engaged in alcohol-related activities. By their actions, alcoholic parents teach their children to drink as a way of coping with their lives.

Harold I Kaplan, Benjamin Sadock (1998) indicated that, children who grow up in such a dysfunctional environment grow up to become like their parents and impose their ways on their children thus triggering a never-ending cycle of alcohol abuse. These ideas support our results, that there is significant of relationship between alcohol and socialization pathology. The authors claim that, many researchers have identified several factors in the childhood histories of people with later alcohol-related disorders and in children at high risk for having an alcohol-related disorder because one or both of their parents are affected. In experimental studies children at high risk for alcohol-related disorders have been found to possess, an average, a range of deficits on neurocognitive testing and a variety of abnormalities on electroencephalogram (EEG) recordings. Studies of high-risk of offspring have also shown a generally blunted effect of alcohol compared with the effect seen in people whose parents have not been diagnosed with alcohol-related disorders. These findings suggest that a heritable biological brain
function may predispose a person to an alcohol-related disorder. (this is not accepted in the Islamic culture). Also many studies have shown that persons with first degree relatives affected with an alcohol-related disorder are three to four times more likely to have an alcohol-related disorder than are people without affected first degree relatives and patients with alcohol-related disorders with family histories of alcohol are likely to have sever forms of the disorder and to have higher rates of alcohol intake and more alcohol-related problems than do patients without such family histories. This finding is supported by studies of monozygotic and dizygotic twins which consistently show a much higher concordance rate among monozygotic than among dizygotic twins, who are more likely to be concordant for alcohol related disorder than are siblings who are not twins.

Results indicate that, behavioral and psychological problems are more common among alcoholics children and this ideas supported by (Lang, Pelham, Atkeson and Murphy, 1999). Saying that, alcoholic parents have a negative effect on their children because the effects of alcohol under mines their capacity to use their parenting skills in a number of ways, first, excessive drinking by the parents can lead to inconsistent parenting behavior, when the child misbehaves in certain way, the parents may over react by screaming the child on one occasion; on another occasion, the parents may act indulgently towards the child. Consequently, the child receives mixed signals about inappropriate behavior; in addition the inconsistency in parenting behaviors creates an unpredictable and unstable environment that can undermine the child’s mental and emotional growth.

"In study conducted on the effects of alcohol on parents’ interactions with children, it was found that parents are unable to respond appropriately to a child’s improper behavior. Although the child is acting improperly, the group of intoxicated parent not only fails to discipline the child, but engage
in parental indulgences that are inappropriate for the occasion." Second, parents who are frequently abusing alcohol can not monitor their children appropriately. An integral dimension of parental monitoring involves setting limits on proper and improper behavior along with a consistent enforcement of sanctions against violations of these rules. Without the establishment of these rules and their consistent enforcement, the child cannot learn about limits and proper behavior. Third, alcoholic parents are not nurturing parents who can provide quality time for their children because they constantly suffer from hangovers of mood changes from excessive alcohol consumption. These parents fail to behave in an emotionally supportive fashion towards their children. Thus they push their children to seek emotional support in the outside world, a situation that can have adverse consequences (Windle, 1996). Fourth, parents who abuse alcohol are also known to exercise harsh discipline. As alcoholics are easily provoked at the slightest offense. Therefore, they can be excessively harsh and arbitrary in their use of discipline. These forms of discipline can result in the growing alienation of the children from their parents. Harold I, Kaplan, Benjamin, Sadock, (1998) claim that, high in school students, alcohol-related problems are correlated with a history of school difficulties. High school dropouts and a record of frequent truancy and delinquency and stealing, telling lies appear to be at particularly high risk for alcohol abuse. Results show that, alcoholics have a high rate of marital separation and divorce. Social difficulties are common among alcoholic patients, Windle, (1996) agrees with our results, he says that families with alcoholic parents are characterized by frequent marital disorders and therefore, their children grow up in an unhealthy emotional environment that is threatened by
potential disintegration. Children are afraid that they are going to lose their parents and their lives will be disrupted.

Spousal and child abuse are also common part of the picture of a household affected by alcoholism. The inability of alcoholic parents to keep their jobs and their needs for medical treatment due to alcohol-related reasons certainly places tremendous stresses on the family. Financial stress is a common reason of disputes between spouses. However, coupled with the extra expenditure of alcohol purchase, medical treatment and the lack of income, alcoholism can destroy the welfare of the family.

Mullahy and Sindelar (1992) indicated that, alcoholics are incapable of performing well in their work and personal relationship. Most studies that attempt to analyze the relationship between alcohol use and income indicate that households with alcoholics have lower incomes than households with no alcoholic drinkers. The disparity of incomes ranges from zero to 32% reduction in the incomes of these studies. Alcoholics are incapable of holding a full-time job. The people in the prime age working group are most affected by alcohol abuse even though some studies show that with young adults, employment rate is higher among alcoholics than non-alcoholics; the main cause being attributed to the fact that young adult drop out of school and start working at an earlier age. Even when they work, alcoholics are likely to miss work frequently because of their drinking problems. One study indicates that absenteeism caused by alcoholism can exceed that of non-alcoholics by 40% (Mullahy 8 Sindelar 1992) in addition, because the alcoholics capacity to work is impaired by alcohol abuse, they can not work in important occupations that demand reliability and high competence. From the above discussion, it is evident that alcoholism can exert a long-lasting social impact. Alcoholics place
themselves at high risk for various accidents and impair their capacities to function effectively in daily life and perform their jobs.

Our results show that violence and sexual crimes are more due to alcoholic Graham, Wells and West (1997) agree with our assumption. They claim that excessive consumption of alcohol can exert a severe impact on the brain, both on the short-term and long-term basis. The reason why alcoholics exhibit aggressive behavior can be attributed to the effects of alcohol on various parts of the brain. First alcohol can affect the gamma-aminobutyric acid receptor (GABA-A) complex in the brain that inhibits aggressive behavior and create anxiety over socially inappropriate behavior. Second, the effect of alcohol on the dopaminergic system that controls the psychomotor stimulation can lead to an increase in the intensity and level of aggression. The lower blood sugar in the brain can also contribute to a heightened level of aggression; consequently, alcoholics tend to overreact to unpleasant situations by using aggression. Furthermore, with excessive alcohol consumption, alcoholics lose their capacity to exercise self-control over their emotions and feelings very often. Alcohol consumption becomes a means for them to unleash pent-up negative feelings of anger, guilt and depression, therefore, their general state of mind is moody and hostile, leading to increased chances of aggressive behavior at the slightest provocation (Graham, Wells and west 1997).

Graham, Wells, 8 West, (1997) agree with our assumption that violence and sexual crimes can be due to alcohol by saying that, alcoholics, under the influence of alcohol, do not realize that they can behave in an alternative way. What is even more dangerous is that drunken people can develop a sense of grandiosity and believe that they are more powerful than they actually are. Thus, they may deliberately provoke others or misinterpret others behavior as a challenge to their supremacy.
Our results show that, depression and anxiety are more common among alcoholic patients and this assumption is supported by (Harold 1, Kaplan, Benjamin J, Sadock, 1998). They claim that, about 30 to 40 percent of people with an alcohol-related disorder meet the diagnostic criteria for major depressive disorder sometime during their lifetime. Several studies reported that depression is likely to occur in patients with alcohol-related disorders who have a high daily consumption of alcohol and who have a family history of alcohol abuse. People with alcohol-related disorders and major depressive disorder are at great risk for attempting suicide. Some studies have shown that people with both alcohol-related disorder and depressive disorder diagnoses have low cerebro-spinal fluid (CSF) concentrations of dopamine metabolites Harold 1, Kaplan, Benjamin J, Sadock, 1998 indicate that, it is less well known that perhaps 25 to 50 percent of all people with alcohol-related disorders also meet the diagnostic criteria for an anxiety disorder. Phobias and panic disorder are particularly frequent comorbid diagnoses in these patients. Some data indicate that alcohol may be used in an attempt to self-medicate symptoms of agoraphobia or social phobia but an alcohol-related disorder is likely to precede the development of panic disorder or generalized anxiety disorder. Our results show that in wives of alcoholics’ depression and anxiety predominate. This is because alcoholic creates an unpredictable and unstable environment. Alcoholics are likely to miss work frequently because of their drinking problem, alcoholics lack the ability to function in an appropriate manner, it is evident that alcoholics are incapable of performing well in their work and personal relationship. According to the world health organization (1996), the problem of an addict in a family is a problem for the whole family as the addict becomes difficult to live with, irritable, changeable in mood, unreasonable, or
withdrawn from social contact. His health and psychological problems also affect the family. Tension and arguments within the family are also frequent. As the whole family is in trouble not only the drug addict, they are all in need of help, so wives becomes depressed and anxious.

Our results indicated that, there is a significant personality and family pathology in alcoholic background. *Harold I, Kaplan, Benjamin J, Sadock 1998* claim that, a relation between antisocial personality disorder and alcohol-related disorders has frequently been reported. Some studies have suggested that antisocial personality disorder is particularly common in men with an alcohol-related disorder and can precede the development of the alcohol-related disorder. In experimental studies, children at high risk for alcohol-related disorders have been found to possess, on average, a range of deficits on neurocognitive testing, decreased amplitude of the P300 wave on evoked potential testing and a variety of abnormalities on electroencephalogram (EEG) recording. Studies of high-risk offspring in their zos have also shown a generally blunted effect of alcohol compared with the effect seen in people whose parents have not been diagnosed with alcohol-related disorder. These findings suggest that a heritable biological brain function may predispose a person to an alcohol-related disorder. A childhood history of attention-deficit, hyperactivity disorder or conduct disorder or both increases a child’s risk for alcohol-related disorder as an adult. Personality disorders especially antisocial personality disorder, as earlier noted, also predispose a person to an alcohol-related disorder. *(Harold I, Kaplan, Benjamin J, Sadock 1998)*. Some psychodynamic psychiatrists describe the general personality of a person with an alcohol related disorder as shy, isolated, impatient, irritable anxious, hypersensitive and sexually repressed.
**Conclusion**

Our results show that significant differences exist between alcoholics and their fathers drinking alcohol. Parents who drink heavily serve as negative hole models for their children, alcoholic parents’ teach their children to drink as away of coping with their lives.

The result show that marital separation and divorce are more common among alcoholics patients.

Our results indicate that there is a significant differences between alcohol and socialization pathology. Researchers have identified several factors in the childhood histories of people with later alcohol related disorders and in children at high risk for having an alcohol related disorder because one or both of their parents are affected. Results indicate that, behavioral and psychological problems are more common among alcoholics’ children.

Social difficulties are common among alcoholic patients.

A result shows that violence and sexual crimes are more due to alcoholics.

Our results show that depression and anxiety are more common among alcoholics’ patients.

Our results show that in wives of alcoholic depression and anxiety predominate. This is because alcoholic creates an unpredictable and unstable environment.

Our results indicated that there is a significant personality and family pathology in alcoholic background.

Results show that socialization pathology is more common among alcoholic patients.

**RECOMMENDATIONS:**

1. More studies required to explain the psycho-social factors behind alcohol complications.
2. The data of the present study can help in promoting further studies.
REFERENCES


2. Blow,-F-C; Walton,-M-A; Barry,-K-L; Coyne,-J-C; Mudd,-S-A; Copeland,-I-A
   (The relationship between alcohol problems and health functioning of older adults in primary care setting, /2000 ).

3. Costello R

4. Cushman,–W.C
   Alcohol consumption and hypertension/ 2001

5. George-W-H; Stoner,-S-A; Norris,-J; Lopez,-P-A; Lerman,-G-L
   Alcohol expectancies and sexuality = a self-fulfilling prophecy analysis of dyadic perception and behavior/ 2000

6. Graham, K, Wells, S, and West-P
   A frame work for applying explanations of alcohol-related aggression to naturally occurring aggressive behavior/1997.

7. HAROLD 1, KAPLAN, MD-BENJAMIN J, SADOCK-MD,
   Comprehensive Text Book of Psychiatry- fifth edition – volume one

8. Hemmingsson,–T; Lundberg,–1
   Development of alcoholism between heavy adolescent drinking and later low sense of control over work /2001.

9. Horner,-M-D; Waid,-L-R; Johnson, D-E; Latham,-P-K; Anton, R-F
   The relationship of cognitive functioning to amount of recent and lifetime alcohol consumption in out patient alcoholics/ 1999..


12. KENDELL R-E- A.K. ZEALLEY

13. Lang-A-R; Pelham-W-E; Atkeson, B-M; Murphy; D-A
    Effects of alcohol intoxication on parenting behavior in interaction
    with child confederates exhibiting normal or deviant behavior/1999.

14. Lyle E-Bourne JR. Bruce R-Erstrand

15. Mullahy, J, and Sindelar
    Effects of alcohol on labour market success = income, earnings,
    labor supply and occupation /1992

16. RICHARD R. BOOTZIN-JOAN ROSS ACOCELLA
    Abnormal-psychology current perspectives/1991

17. Rigler,-S-K
    AM-Fam-Physician, 61 (6) = 1710 - 6, 1883-4-1887-8 passim

18. Roebuck,-T-M; Mattson, S-N; Riley, E-P
    Behavioral and psychosocial profiles of alcohol-exposed children

19. Windle, M
    Effect of parental drinking on adolescent, alcohol health and
    research world/1996.


Reports:

1. Alcohol concern fact sheet-Alcohol and mental health-
   October/1996.

2. Alcohol health and research world, 16 (2), 134 - 140.
Periodicals:
2. Baghir, 0. (1979) Alcoholism in Khartoum province. MD Thesis university of Khartoum

Thesis:
Appendixes
١-
٢-
٣-
٤-
٥-
٦-
٧-
٨-
٩-
١٠-
<table>
<thead>
<tr>
<th>رقم</th>
<th>نمط الصيانة</th>
<th>الكمية</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>طبيعة ولادة</td>
<td>2</td>
</tr>
<tr>
<td>11</td>
<td>طبيعة غمرة</td>
<td>2</td>
</tr>
<tr>
<td>12</td>
<td>صناعية الرضاعة</td>
<td>4</td>
</tr>
<tr>
<td>13</td>
<td>الأسماء الرضاعة</td>
<td>2</td>
</tr>
<tr>
<td>14</td>
<td>فلسطين</td>
<td>5</td>
</tr>
<tr>
<td>15</td>
<td>أنثى واپل</td>
<td>3</td>
</tr>
</tbody>
</table>
المرض قبل الشخصية:
1. انطوي
2. ظني
3. اجتماعي
4. متدين
5. عنيف
6. خجل
7. قلق
8. عليه
9. التأثير السهل ومن
10. مستقل
11. مسؤول
12. عنيد
13. الحالية
الشراب طريقة:
1. الشراب من بعُد العمر:
2. يشرب أين:
أ - البيت في ب.
ب - البيت عن بعيداً.
ج - كلما في.
3. يشرب مع:
أ - وحدته يشرب ب.
ب - الأسرة أفراد أحده مع يشرب ج.
ج - الأصدقاء مع يشرب
4. الشراب مرات عدّ:
5. الشراب أوقات:
6. يتناوَّل الأمل الكحول كمية:
7. الشراب نوع:
8. أخرى لا دوارة.
9. استعمال آخر.
لله ومكنصل سعيد بـ.

لا ولكنه يعاني تركه في يرغب.

الحالة الاجتماعية

1/ الزوجة خارجية،

2/ سن صغير،

3/ متأخر 16

4/ ألزمان

5/ وظيفة بدون حالة العمل

6/ حالة عدم

7/ مسيرة حالة حياة

8/ رأى مع مقطع علاقات

9/ الآخرين

10/ دعامة جهات

11/ زكاة

12/ انتحاري

13/ أطفال

14/ الأخرى

15/ شديد

16/ تملأ

17/ الشيء

18/ القمر

19/ الصغر

20/ التاج

21/ جينج

22/ وجوه

23/ الأقدام

24/ وجو

25/ آخر
الزوجة: أ. القلق ب. المكتبة

الأطفال: أ. القلق ب. الحزن ج. أردنيان

لمدرسة إلى الذهاب رفض. لمدرسة من الهراب و. الكذب

السرقة ح. الغرفة

اللفظي العدوان ي. البدين العدوان

الأكتتابات: 1. الوقت ومعظم بالحزن تشعر هلى نعملا

2. بعدين تشعر اليوميةهل نشاطتك في الرغبة م. نعملا

3. رجيم عمل بدون وزنك زاد أو وزنك فقدت هلى نعملا

4. تقرباً يوم كل بالإرقام تشعر هلى نعملا

5. تقرباً يوم كل والكلب بالانتماء تشعر هلى نعملا
اذّن حقّاً وعذوبةً

٦.

٧.

٨.

٩.

١٠.

١١.

١٢.

١٣.

١٤.

١٥.

١٦.

١٧.

١٨.

١٩.

٢٠.

٢١.

٢٢.

٢٣.

٢٤.

٢٥.

٢٦.

٢٧.

٢٨.

٢٩.

٣٠.

٣١.
(2) 5əp đ
f əli FullScreen
2. ﻲﻼﺣﻆ ﻋﻠﻰ ﺍﳌﺮﻳﺾ ﺗﻀﺎﺅﻝ ﺍﺣﺴﺎﺱ ﺑﺎﻟسعادة، أو ﻋﺪﻡ ﺍﻟﺸﻌﻮﺭ ﻋﻦ ﻣﻄﻠﻘﺎً، ﺧﻼﻝ ﻷﻛﺎﻓﺔ ﺍﻻﻧﺸﻄﺔ ﰲ ﻣﻌﻈﻢ ﻓﺘﺮﺍﺕ ﺍﻟﻴﻮﻡ ﺗﻘﺮﻳﺒﺎً، ﻭ ﻲﻐﻠﺐ ﺫﻝﻚ ﻋﻠﻰ ﺳﻠﻮﻙ ﺍﳌﺮﻳﺾ ﰲ ﻷﻛﻞ ﻳﻮﻡ ﻳﻮﻡ ﻳو) ﻭ ﺫﻝﻚ ﻋﻦ ﺍﻟﺘﻘﺮﻳﺮ ﺍﳌﺮﺿﻲ ﻋﻦ ﻷﺣﺎﻟﺘﻪ أو ﻣﺎ ﻲﻼﺣﻈﻪ ﺍﳌﻘﺮﺑﻮﻥ ﻣﻨﻪ.

3. ﺍﲣﻔﺎﺽ ﻋﺎد ﰲ ﻭﺯﻥ ﺍﳌﺮﻳﺾ ﺟِّﻩ ﻋﻨﺪ ﱐﻼ ﻲﻜﻮﻥ ﺍﳌﺮﻳﺾ ﻣﺘﺒﻌﺎً ﻟﱪﻧﺎمﺞ ﺛﻲ ﻋﺬﺍﺋﻴﺔ ﺛﺎﺣﺎ ﻛﻮ ﺍﻟﻮﺯﻥ ﺍﳉﺴﻢ ﻭﺯﻥ ﰲ ﺗﺰﺍﺩﺓ أو ( ﻋﻠﻰ ﻳﺒﻞ ﺍﳌﺜﺎﻝ: ﻲﻄﺮﺍ ﺗﻐﻴﲑ ﻭﺍﺿﺢ ﻋﻠﻰ ﺑﻨﻴﺔ ﺍﳉﺴﻢ ﺳﻴﺚ ﻲﻔﻘﺪ ﺍﳌﺮﻳﺾ ＃ﺴﺔ ﺑﺎﳌﺎﺋﺔ ﻣﻦ ﺍﻟﻮﺯﻥ ﰲ ﺷﻬﺮ ﻭﺍﺣﺪ ( ﺑﺎﻹﺿﺎﻓﺔ إﱃ ﺍﲣﻔﺎﺽ أو ﺗﺰﺍﺩﺓ ﺍﻟﺸﻬﻴﺔ ﺖﻮﻡﻴﺎً ﺗﻘﺮﻳﺒﺎً.

4. ﻣﻼﺣﻈﺔ: ﺑﺎﻟﻨﺴﺒﺔ ﰻﻠﻸﻃﻔﺎﻝ ﻣﻼﺣﻈﺔ ﻓﺸﻞ ﰲ ﺍﺳﺘﻌﺎﺩﺓ ﺍﻟﻮﺯﻥ.

5. ﺍﻹﺣﺴﺎﺱ ﺑﺎﻷﺭﻕ ﰲ ﻷﻛﻞ ﻳﻮﻡ ﺗﻘﺮﻳﺒﺎً.

6. ﺗﺞ ﺗﻮ ﺍﳉﻬﺎﺯ ﺍﻟﻌﺼﻴBitmap Not Supported

7. ﺍﻹﺣﺴﺎﺱ ﺑﻔﻘﺪﺍﻥ ﺍﻟﻘﻴﻤﺔ ﻭ ﺗﻔﺎﻫﺔ ﺍﻟﺸﺄﻥ أو ﺍﻟﺸﻌﻮﺭ ﺍﳌﺘﺰﺍﻳﺪ ﻭ ﻣﻐﲑ ﺍﳌﱪﺭ ﺑﺎﻟﺬﻧﺐ ( ﻟذي) ﺗﻜﻮﻥ ﻧﺎﲡﺎً ﻋﻦ ﻷﺟﺮﺩ ﺍﳌﻮﻫﻢ، و ﺫﻝﻚ ﰲ ﻷﻛﻞ ﻳﻮﻡ ﺗﻘﺮﻳﺒﺎً) ﻻ ﻷﺟﺮﺩ ﺗﺼﺮﻑﺍً ﺗﺍﺗﻴﺎً أو ﺍﺳﻼﺱ ﺑﺎﻟﺬﻧﺐ ﺑﺴﺒﺐ ﺑﻜﻮﻧﻪ ﻣﺮﻳﺾ (.

8. ﺍﻹﺣﺴﺎﺱ ﺑﻔﻘﺪﺍﻥ ﺍﻟﻘﻴﻤﺔ ﻭ ﺗﻔﺎﻫﺔ ﺍﻟﺸﺄﻥ أو ﺍﻟﺸﻌﻮﺭ ﺍﳌﺘﺰﺍﻳﺪ ﻭ ﻣﻐﲑ ﺍﳌﱪﺭ ﺑﺎﻟﺬﻧﺐ ( ﻟذي) ﺗﻜﻮﻥ ﻧﺎ RouteServiceProvider organisation=1

9. ﺗﻀﺎﺅﻝ ﻓﺪﺭﺍﺕ ﺍﻟﺘﻔﻜﲑ أو ﻣﻌﺎﺽ ﺍﻟﺘﺮﻛﻴﺰ أو ﻋﺪﻡ ﺍﻟﻘﺪﺭﺓ ﻋﻠﻰ ﺍﺳﻤﺎﺀ، و ﺫﻝﻚ ﰲ ﻷﻛﻞ ﻳﻮﻡ ﺗﻘﺮﻳﺒﺎً) ﺍﻹمﺎ ﻣأ ﺑﻤﺎ ﻲﻼﺣﻈﻪ ﺍﳌﻘﺮﺏﻮﻥ ﻣﻨﻪ.
10.

السيرة الفكرية

الموت بشكل متكرر على مدار

التفكير المتكرر في الانتحار دون وضع خطماً لتنفيذ ذلكل أو الامام.

أ. لا يتبناي التطبيق السابق على المعايير الخاصة بالظاهرة المتلاصقة.

ب. يتسبب الأعراض في حدوث حالة ضيقة حادة للمرحاض يتطلب تدخل جياع أو ضعف في العلاقات الاجتماعية أو ضعف وظيفي أو ضعف في مستلزمات الأكياس ACA (ب.)

ج. لا يحدث الأعراض بسبب الأثار الجسدية مباشرة أو المادية أو نتيجة لأسباب طبية عامة) حالة مرضية ناجمة عن إفرارات الطريقة الداكنة مثل (. د.

د. لا يحدث الأعراض عادلة بسبب فقد أحد الأطراف، وتشمل هذه الأعراض المدة الأطول من شهرين وتتم تحديد هذه الأعراض من خلال وجود عجز أو 

ؤ.

ؤ.

ؤ.
Appendixes (2)

Depression Scale

Criteria for Major Depressive Episode:
1. Five (or more) of the following symptoms have been present during the same 2-week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood or (2) loss of interest of pleasure.

Note: Do not include symptoms that are clearly due to a general medical condition, or mood-incongruent delusions or hallucinations.

(1) depressed mood most of the day, nearly every day, as indicated by either subjective report (e.g., feels sad or empty) or observation made
by others (e.g., appears tearful). **Note:** In children and adolescents, can be irritable mood.

(2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day (as indicated by either subjective account or observation made by others)

(3) significant weight loss when do not dieting or weight gain (e.g., a change of more than 5% of body weight in a month), or decrease or increase in appetite nearly every day. **Note:** In children, consider failure to make expected weight gains.

(4) insomnia or hypersomnia nearly every day.

(5) psychomotor agitation or retardation nearly every day (observable by others, not merely subjective feelings of restlessness or being slowed down)

(6) fatigue or loss of energy nearly every day.

(7) feelings worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day (not merely self-reproach or guilt about being sick)

(8) diminished ability to think or concentrate, or indecisiveness, nearly every day (either by subjective account or as observed by others)

(9) recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

A. The symptoms do not meet criteria for a Mixed Episode (see P. 343).

B. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).
D. The symptoms are not better accounted for by Bereavement, i.e., after the loss of a loved one, the symptoms persist for longer than 2 months or are characterized by marked functional impairment, morbid preoccupation with worthlessness, suicidal ideation, psychotic symptoms, or psychomotor retardation.
ضعف التركيز و سيطرة حالة من الشرود الذهن.

الهياج.

التوتر العصبي.

اضطرابات النوم ( حدوث صعوبة في النوم أو الاستمرار فيه، أو عدم تحقيق حالة الاستمرار في النوم بصورة مرتبة).
Appendixes (3)

Anxiety Scale

Diagnostic criteria for F41.1 Generalized Anxiety Disorder

A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).

B. The person finds it difficult to control the worry.

C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more
days than not for the past 6 months). **Note:** Only one item is required in children.

(1) restlessness or feeling up or on edge
(2) being easily fatigued
(3) difficulty concentrating or mind going blank
(4) irritability
(5) muscle tension
(6) sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)

**D.** The focus of the anxiety and worry is not confined to features of an axis I disorder, e.g., the anxiety or worry is not about having a Panic attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.

**E.** The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

**F.** The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a mood disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.