Hospitalised Saudi Problem Drinkers: A psychosocial profile

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Declaration

I declare that this thesis embodies the result of my own special work, that is has been composed by my self and that it does not include work forming a part of a thesis presented successfully for a degree in this or another University.

Abstract

Many characteristics of those entering alcohol treatment in Saudi Arabia remain unknown. Above all, their psychosocial characteristics and their patterns of drinking. In order to provide adequate and effective treatment and prevention intervention, it is necessary, before anything else, to elicit the facts about those with alcohol problems. As part of solving the mystery of alcohol problems in Saudi Arabia, the main objective of this research is to draw a general profile and investigate the patterns of drinking of hospitalised problem drinkers in Saudi Arabia.

To achieve this goal, 136 hospitalised patients and 11 therapists were interviewed. The interviewed patients consisted almost entirely of male patients who, at the time of data collection, were hospitalised for having an alcohol problem in four of Saudi Arabia's treatment hospitals (Al-Amal hospitals in Riyadh, Jeddah, Dammam, and Qaseem). Two instruments were implemented for use with the patients. The first was a comprehensive instrument devised by the researcher to elicit information regarding the psychosocial profile of hospitalised problem drinkers. The second was the Alcohol Use Disorders Identification Test (AUDIT), which was used to identify problem drinking as well the frequency and the quantity of drinking. The therapists, however, were selected from Al-Amal hospital in Riyadh. Unlike the patients' interviews, the therapists' interviews were semi-structured and were aimed at eliciting more information regarding problem drinking and its treatment from the therapist's point of view.

The results showed that a typical profile of a hospitalised Saudi problem drinker is that he is most likely to be of younger age (20–35 years old), married, of little education (high school or less), on a low income (less than 3000SR), and unemployed. In addition, if currently or previously employed, the hospitalised Saudi problem drinker is likely to hold an administrative post, live in a city, occupy a house which is owned by others and shared with seven people or more.

The parents of a typical hospitalised Saudi problem drinker are most likely not living together, as a result of either separation, divorce or the death of one or both of them. The parents are most likely to be illiterate, and have a history of remarriage. Furthermore, if married or previously married, the hospitalised Saudi problem drinker is most likely to have an uneducated housewife and more than three children.

Contrary to the drinking practices in many countries where alcohol is allowed, araq and cologne are the most common types of alcohol consumed by hospitalised problem drinkers. Although it is forbidden, alcohol is easily accessible, especially in the form of cologne. Alcohol drinking mostly takes place in hidden places, at home, in private resorts or outside the city. Many hospitalised problem drinkers restrict the time of their drinking to weekends. Another finding of this research shows that about a quarter of the patients are not really alcohol dependants. Most hospitalised problem drinkers, including those with high alcohol dependence, abstain during the holy month of Ramadan. The majority of hospitalised problem drinkers are smokers (cigarettes and shisha), and users of illegal drugs (hashish is the commonest).

The interviews with therapists confirmed many of the research findings produced by investigations of the patients. Also, they provided many suggestions regarding the improvement of treatment and prevention of alcohol problems in Saudi Arabia. The implications of the research findings are discussed in depth in the last chapter.

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To the memory of my brother Salem, to my mother, to my wife, and to my children I dedicate this work

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Introduction

In Saudi Arabia, the consumption of alcohol has unique characteristics. Unlike in many other countries, drinking alcohol is socially unacceptable, and religiously and legally prohibited. Individuals who drink alcohol or unlawfully use drugs or other substances are subject to imprisonment and social stigmatisation. Surprisingly to many, even with such stiff punishment, alcohol consumption is increasing (Al-Rwaibikh, 2000; Al-Baz, 1999; Ministry of Interior Statistical Books, 1985-1995). Many interrelated factors have led to this situation.

The first factor is the decrease in religious affiliation among some people, especially youngsters (Al-Khalidi, 1983). The second is the fast economic growth that the country is witnessing, which in turn has led to dramatic changes in many aspects of people's lives (Al-Baz, 1999). Al-Khudiri & Al-Suaidan (1994) have indicated that having more money has made some people look for more leisure activities such as drinking alcohol. The relative absence of parents' guidance and supervision is the third factor, as some parents are busy either doing extra work or entertaining themselves (Al-Aubaidi, 1990; Al-Khalidi, 1983).

The fourth factor is the increasing number of people who travel to countries where alcohol is legally sold and its consumption is acceptable. Such exposure serves as an introduction to alcohol consumption and an encouragement to use it in Saudi Arabia. Some studies indicate that some Saudis travel abroad mainly to drink (Al-Bar, 1986; Al-Khudiri & Al-Suaidan, 1994).

The foreign media, especially as a result of the communication revolution that the world is experiencing, have had an impact on various aspects of the lives of young Saudis, including their alcohol consumption (International Islamic Conference for the Prevention of Intoxicants and Drugs, 1982). A movie star who drinks while having a good time, and the advertising of alcohol on satellite television (Al-Dossari, 1983) are examples of such influence.

The sixth factor is the presence in Saudi Arabia of a non-Saudi labour force and various foreign political organisations, which together constitute more than a quarter of the population (Ministry of Information, 21 July 2001). Some of these expatriates come from

societies where alcohol is consumed, and therefore bring the habit of alcohol use along with them (Al-Baz, 1999). Through the process of mutual cultural influence a situation arises in which alcohol consumption for some Saudis becomes the basis of friendship with non-Saudis (Al-Dossari, 1983). The last but not least factor is the influence of drinkers on non-drinking friends through the process of imitation. Many problem drinkers have mentioned that they have been introduced to alcohol by a friend (Al-Anazi, 1999). Individual personality, lack of constructive leisure places and activities (Al-Aubaidi, 1990), curiosity, family problems, life stress (Al-Qahtani, 1990), economic status, and adventurousness (International Islamic Conference for the Prevention of Intoxicants and Drugs, 1982) are all additional factors that may contribute to the use and abuse of alcohol and drugs.

The growing number of alcohol drinkers has resulted in a large increase in alcohol-related problems, including problem drinking (Al-Mutairi, 1996). The government has adopted several approaches to deal with the problem. One of these approaches was to provide treatment for those troubled by alcohol or other illicit drugs (Sidi, March,1987). So, about fifteen years ago, the government began to provide services for such people within the context of the healthcare system.

Since the royal decree to establish organised services for such patients was issued, four treatment facilities (hospitals located in western, central and eastern province of Saudi Arabia) have been developed and are now operational (Al-Munief, 1992). Services are provided for adult Saudi males, both inpatients and outpatients. Unfortunately, services for adolescent and female problem drinkers are not provided. It is falsely assumed that these sections of the population do not have drinking problems; or, because of the social stigma associated with alcohol and other drugs, providing services for them means admitting the wide prevalence of the problem. However, female problem drinkers have a better chance of getting treatment than adolescents, for while they can receive treatment in mental health hospitals under a socially acceptable diagnosis, adolescent problem drinkers are still completely deprived of treatment. Clearly, there are still some gaps in services.

A variety of treatment approaches and modalities have been utilised since the inception of these services. The treatment outcome, however, has been limited. Provision of additional services, and modifications and adaptations of existing ones are needed in the present system. However, alcohol and drugs use and abuse cannot be clearly understood aside

from its social and cultural context (Gomberg, White, & Carpenter, 1985) and without identifying who are the users and abusers (Weiss & Moore, 1994). To be most effective, clinical staff and treatment programmes must draw heavily upon social and cultural aspects of Saudi society. To assist in this, a scientific study and analysis of the recipients of treatment services are urgently needed.

With regard to alcohol in Saudi Arabia, very few studies have been conducted. Even fewer studies have been devoted to alcohol alone, since most of the existing studies combine alcohol with other drugs. By doing so, they lack depth and detail in their findings.

While occasional or moderate consumption of alcohol is not viewed as a problem in western and other cultures, it is in Saudi Arabia. The consumption of alcohol is part of religious practice in some cultures (Akel, July, 1976), but not in Saudi Arabia. Alcohol has long been viewed as a part of people's life in many cultures. In Mexico and Central and South America, for example, it may be acceptable and even "macho" to drink heavily (Avis, 1993). However, alcohol consumption remains one of the most serious legal, religious, and social offences in the Kingdom of Saudi Arabia (Al-Muateq, 1985).

It is important to consider a society's understanding of its problems. How a society views alcohol and the individuals that drink it has a direct bearing on how it deals with related issues. Its attitude to alcohol is reflected in the policies that regulate drinking, the kinds of prevention and treatment approaches that are undertaken to deal with it, and the extent of alcohol's availability and accessibility.

The collection of data on problem drinking is one of many requirements for a comprehensive understanding of alcohol-related problems in their broader social context. Identifying the demographic characteristics as well as the drinking-related problems of hospitalised Saudi problem drinkers is essential for the development of effective treatment and prevention programmes. Such information would provide greater insight into the design, development and implementation of more socially and culturally adapted prevention and treatment programmes.

Definition of terms:

Some of the terms used in this study are widely used. However, for the purpose of this study, a more specific definition is given to each of the following terms:

Problem drinker:

Fitzgerald & Mulford (1981) defined problem drinkers as those "persons who repeatedly drink beverage alcohol to the extent it adversely effects their life, their health, domestic relations, job performance or relations with the law". Similarly, the Royal College of Physicians (1991) defined the problem drinker as "an individual whose physical, mental, or social well-being has been harmed as a consequence of their drinking". Further, Rush & Brennan (1990) indicate that problem drinking occurs "if the use of alcohol interferes with the person's physical, psychological or social well-being or achievement of need satisfaction, or that of significant others, to the extent that it is identified by the person, his health care attendant or others as a problem." In simpler terms, McNeill (1998) defines problem drinking as "any drinking which causes problems to the drinker or others".

However, Booth, Ross, & Rost (1999) adopt more concrete terminology to define problem drinkers as "currently drinking individuals meeting DSM-IV criteria for 1-year alcohol misuse or dependence (recent alcohol disorder), as well as currently drinking individuals who were at risk for meeting diagnostic criteria in the next year."

The reliance on adverse consequences of drinking to define problem drinkers has been challenged by some researchers. DeCourville & Sadava (1997) argue that the definition of problem drinking should include criteria that refer to both consumption and consequences. Donovan, Jessor, & Jessor (1983) define young adult problem drinkers as "drinkers who, in 1979, had been drunk 6 or more times in the past 6 months, or who had experienced 3 or more of 9 negative consequences due to drinking in the past 6 months." Negative consequences include interpersonal problems (criticism from friends, family concerned about the individual's drinking), job-related problems (missing work, calling in sick, or being told one's drinking was creating problems at work), trouble with police, financial problems, accidents at home or at work, problems with one's spouse or the person one is living with, and driving under the influence of alcohol.

Using a relatively modest measure, Chick & Chick (1992) suggest that having a drinking problem means that the unpleasant side to one's drinking is beginning in some way to effect his/her life; or that the person is becoming dependent on alcohol. They argue that an individual can be alcohol-dependent without having any other problems.

However, Velleman (1992) mentions that "if someone's drinking causes problems for him or her, or for someone else, in any area of their lives, then that drinking is problematic". The author argues that whether or not someone has a drinking problem is not determined by fixed quantities of alcohol, or fixed timings, but instead is a matter of negotiation by the individual with him or herself, family, friends, the workplace, and society as a whole.

By distinguishing problem drinking from dependency, Payne, Hahn, & Pinger (1991) define problem drinking as "any drinking pattern that produces problems in a person's life." Problem drinking may be for some a precursor to the development of alcoholism. The authors add that problem drinkers are not so dependent on alcohol that they suffer withdrawal if they are deprived of alcohol. While a problem drinker may drink occasionally, alcoholics must consume alcohol to maintain homeostasis and to avoid toxic withdrawal effects.

Moreover, Payne et al. (1991) attempt to identify a problem drinker as anyone who has one or more of the following characteristics:

- Must drink in order to function or cope with life.
- Frequently drinks to a state of intoxication, by his/her definition or that of another.
- Goes to work intoxicated.
- Is intoxicated and drives a car.
- Sustains bodily injury requiring medical attention as a consequence of an intoxicated state.
- Does something under the influence of alcohol he/she contends he/she would never do without alcohol.

- May experience one of the following signs: the need to drink before facing certain situations, frequent drinking sprees, a steady increase in intake, early morning drinking, and the occurrence of blackout.

For the purpose of this research, problem drinkers are individuals who have developed some kind of life troubles as a consequence of their drinking and who as a result seek some kind of alcohol treatment/rehabilitation. Treatment may be sought voluntarily (self-referral), or through referral by the legal system or significant others, e.g. family members and friends.

Alcohol:

Generally, alcohol is "the name for a whole class of chemicals that have an oxygen atom and a hydrogen atom connected together at one or more locations on the molecule" (*Columbia Electronic Encyclopaedia*, 17 July 2001). Moreover, Payne et al. (1991) define alcohol as "any substance that contains the clear fluid of ethyl, grain, or ethanol that can be produced through the process of fermentation and/or distillation of yeast cells."

Kinney & Leaton (1991) indicated that alcohol is a term used to refer to a family of substances that contain ethanol alcohol, ethyl alcohol, or grain alcohol. All types of alcohol have a grouping of carbon, hydrogen, and oxygen atoms. However, they differ only in the number of carbon atoms and associated hydrogen atoms. Each alcohol is named according to the number of carbon atoms it has. Ethanol has two.

Further, Kinney & Leaton (1991) mention that there are other kinds of alcohol: wood alcohol (methyl alcohol), with one carbon atom, and rubbing alcohol (isopropyl), with three carbon atoms. The authors claim that with their chemical make-up, these other "alcohols" cause big problems if taken into the body.

Moreover, according to the *Columbia Electronic Encyclopaedia* (17 July 2001) methanol, or methyl alcohol, or wood alcohol, CH_3OH, a colourless, flammable liquid that is miscible with water in all proportions is a monohydric alcohol. It melts at –97.8°C and boils at 67°C. It reacts with certain acids to form methyl esters. Methanol is a fatal poison. Small internal doses, continued inhalation of the vapor, or prolonged exposure of the skin to the liquid may cause blindness. As a result, commercial use of methanol has sometimes been prohibited. Methanol is used as a solvent for varnishes and lacquers, as an antifreeze,

and as a gasoline extender in the production of gasohol. Large amounts of it are used in the synthesis of formaldehyde. Because of its poisonous properties, methanol is also used as a denaturant for ethanol. Methanol is often called wood alcohol because it was once produced chiefly as a by-product of the destructive distillation of wood.

In this research the term alcohol refers to any substance that contains any type of alcohol (i.e. ethyl, isopropyl, methyl), of which a large amount, if consumed, causes intoxication, whether or not it is produced for the purpose of human consumption.

Chapter 1. Alcohol in Islam

Introduction

The Arabic word *khamar* is used to name any material that causes intoxication regardless of its type and source. During the pre-Islamic age people of the Arabic Peninsula used to love drinking alcohol. They almost worshiped alcohol. There were more than a hundred Arabic names for it. Even the word *alcohol* is Arabic in origin (Crawford, 1985). However, when Islam came into existence fourteen centuries ago, drastic and profound changes occurred in all aspects of people's lives. One of these dramatic changes concerned the use of alcohol. In accordance with the teaching of Islam and its prohibition of alcohol, new Muslims immediately gave up alcoholic drinking. The process by which Islam was able to change people's behaviour in relation to alcohol is similar to one of the successful approaches to the treatment of alcoholism used in the present time. This chapter tells the story of alcohol use in Islam.

Sources of Islamic Law

Muslims derive their laws from two major sources: the Holy Quraan and the Sunna. The Holy Quraan is defined as 'the book containing the speech of God revealed to Prophet Muhammad in Arabic and transmitted to us by continuous testimony' (Kamali, 1991). It provides information and instructions which Muslims are obliged to follow. The Sunna, the second source of law, is defined as 'all that is narrated about the Prophet Muhammad, his acts, his sayings and whatever he has tacitly approved, plus all the reports which describe his physical attributes and character' (Kamali, 1991). In addition to providing new instructions and laws, much of the Sunna provides clarification and interpretation of what the Quraan has revealed. Neither the Quraan nor Sunna is limited to merely providing instructions and laws for they also provide meaningful stories (Maher, 1975) about previous Prophets and nations, and give explanations for various phenomena.

The Quraan and Sunna are not the only sources of laws for Muslims. There are also *ijma* (the consensus of the population regarding a regulation) and *qias* (the analogy of a subject to a regulation that has been revealed by the Quraan or Sunna) (Lampton, 1991).

Alcohol in the pre-Islamic period

Before the emergence of Islam, the life patterns of the people of the Arabian Peninsula were completely different. The age in which they were living is called *Jahiliah,* which means the age of ignorance. People of that time used to lead a life that was full of hardships and wrong-doings, at least from a human rights point of view. For example, women were given little respect, and were not allowed to inherit after the death of their husbands or relatives. Some tribes even used to bury their new-born babies if they were girls (Badri, 1976). It was the belief that girls only brought shame and stigma to the family (Al-Bar, 1986). One would expect that mothers of those buried babies would have suffered a great deal for the loss of their children, and that their suffering would have impacted heavily on family relations. In addition, people of that era would always have suffered from a lack of all forms of security. Wars among tribes were the norm. Some wars lasted for forty years for no plausible reason (Al-Bar, 1986). Revenge, tribal honour and self-esteem were the ideals for which a pre-Islamic Arab would do anything (Badri, 1976). The fear of being killed injured or captured in one of those wars was constant for men and women, adults and children.

The lack of religious belief for some and the worship of idols for others contributed to the lack of inner security those people felt (Badri, 1976). Caliph Omar used to make fun of himself by saying, 'During *Jahiliah* I would make an idol out of dates, then worship it for days. When I felt hungry I ate an arm or a head of that idol.'

In regard to alcohol, no people loved the consumption of alcohol like the Arabs (Hazri, 1993). Owing to the quality of their life and their lack of security, their tendency to consume alcohol was very strong (Kamali, 1991). Badri (1976) has indicated that alcohol probably served a much greater psychological necessity for the Arabs than it did for any other people. During the pre-Islamic period, Arabs were in love with alcohol. This can be seen in their language, which had more than a hundred names for alcohol, in their poetry, and in the records of their drinking parties (Badri, 1976; Mansoor, 1986).

Alcohol drinking was associated with machismo, courage and leisure (Hazri, 1993). It was even associated with generosity. Hosts had to present alcohol along with food as an expression of warm feelings towards their guests (Al-Bar, 1986). Furthermore, alcohol was strongly believed to be healthy, and on many occasions was prescribed as a medicine (Hazri, 1993). Al-Muateq (1985) indicated that in the time of the Prophet Muhammad

there was a woman who made wine as a cure for her ill daughter just as she had done before Islam. But Prophet Muhammad forbade her from doing so, saying:

> Allah does not put your cure in anything that is *haram* [forbidden].

Alcohol drinking used to take place almost everywhere: at home, at poetry clubs, and inside bars that were open most of the time. Red flags, called *Ghaia* (goal), were hung to distinguish bars from other places (Al-Bar, 1986). Alcohol used to be made out of dates, grapes, corn, honey, yeast or wheat (Al-Muateq, 1985).

The association of alcohol drinking with many social, personal and cultural situations often resulted in heavy drinking. As (Al-Bar, 1986) puts it:

> Being alcoholic was not strange, given the hardship and social conditions at that time. However, what was strange (even a miracle) was how Islam managed to change people's drinking habits along with their other behaviour.

Even in the early stages of Islam, people continued the practice of drinking alcohol. It was not until later, when Islam gradually began applying restrictive measures on alcohol consumption, that the practice stopped.

Prohibition of alcohol (treatment approach)

For people who are used to consuming alcohol, it is quite hard to give up the habit of drinking. It is even harder for those who are alcohol dependent. When Islam prohibited alcohol consumption, the practice did not end at once. Taking into consideration the people's craving for drink, and the situations that were associated with drinking, the prohibition of alcohol had to be gradually enforced (Kamali, 1991).

Some Islamic scholars have explained why in the case of alcohol consumption Islam took a gradualist approach, which it did not apply to other commands, like that relating to prayer, for example. Since alcohol had its social and cultural roots in people's lives it was very hard simply to ask them to stop drinking straightaway. Iisha, wife of Prophet Muhammad, said on this matter:

> In the beginning of Islam, the first thing to be revealed concerned belief, and heaven and hell. When people began to comprehend Islam, what was *halal* (lawful) and *haram* (prohibited) was gradually revealed. If Islam had started by

> asking people not to drink or not to commit adultery, people would have refused (Al-Bar, 1986).

Islamic scholar Syad Khotp points out (Hazri, 1993) that if prohibitions or commands concerned a matter of belief, Islam asked people to follow at once. However, when the matter related to traditions, social values, or complex social situations, Islam prepared the ground gradually to make change easier. So, as the consumption of alcohol was socially and culturally rooted in people's lives, successful modification of this behaviour needed a gradualist strategy. Such a strategy was implemented as follows:

Stage one

Islam began by attracting people's attention towards alcohol with this Quraanic verse:

> And of the fruits of the palms and the grapes – you obtain from them intoxication and goodly provision; most surely there is a sign in this for a people who ponder (Quraan: 16:76).*

Stage two

The Quraan began to adopt a more direct approach to the issue of alcohol by raising people's awareness of its benefits and harms. The following Quraanic passage gives this moral advice (Kamali, 1991):

> They ask you about intoxicants and games of chance. Say: In both of them there is a great sin and means of profit for men, and their sin is greater than their profit. And they ask you as to what they should spend. Say: What you can spare. Thus does Allah make clear to you the communications, that you may ponder (Quraan: 2:219).

As a result of this verse people began seriously to question alcohol. Some Muslims began discussing the benefits of alcohol: was it good for health, was there any virtue in the state of being drunk, or did alcohol only benefit those earning money from trading it (Ibn Tymmiah, 1985). Some traders changed from alcohol to another kind of merchandise. Others stopped drinking it even though it had not been banned yet (Al-Bar, 1986).

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* All the Quraanic verse translations are taken from the Shaker translation of the Holy Quraan.

Stage three

This stage began by breaking up the habit of drinking. The Quraan instructed people in the following verse not to come to prayers while intoxicated:

> O you who believe! do not go near prayer when you are intoxicated until you know (well) what you say (Quraan: 4:43).

In the above verse, the Quraan restricted alcohol consumption to certain times. Given that Muslims should pray five times a day, and that prayer for Muslims is a must, there was no chance to drink except in the evening when they had only eight hours maximum (there are between two and eight hours between each prayer in 24 hours). So, even if they were to drink, they had to do so in a way that allowed them to become sober before prayer time. In other words, they had to consume alcohol in smaller quantities and in a shorter time. While some people stopped drinking others began to control their drinking behaviour. However, alcohol had not yet been banned (Zahrani, 1989).

Stage four

This stage saw the total prohibition of alcohol consumption according to the Quraanic verses which read:

> O you who believe! Intoxicants and games of chance and (sacrificing to) stones set up and (dividing by) arrows are only an uncleanness, the Shaitan's (Devil's) work; shun it therefore that you may be successful. The Shaitan only desires to cause enmity and hatred to spring in your midst by means of intoxicants and games of chance, and to keep you off from the remembrance of Allah and from prayer. Will you then desist? (Quraan: 5:90–91).

Badri (1976) has related that when some Muslims heard the above verses, they replied: 'We have desisted, O Lord! We have desisted'. At the same time some Muslims who were drinking, as soon as they heard someone announcing, '*khmar* has indeed been prohibited,' poured the remaining drinks upon the ground and broke the big clay pots in which other drinks were being fermented (Badri, 1976). Although it is not well documented, some scholars believe that the took around twenty three years between the first stage and the final one (Al-Bar, 1986).

Punishment

When alcohol drinking became unlawful, there had to be some sort of punishment for violating the prohibition. Before discussing such punishment, it should be mentioned that one of the main objectives of Islamic laws is to protect five values, which are called the five principles (Eied, 1984; Kamali, 1991):

1. Religion
2. The life of individuals
3. The mind
4. Lineage
5. Property

One of the Islamic laws meant to protect the mind was the banning of alcohol. It is not only the consumption of alcohol that is prohibited, but all activities that are involved with or lead to alcohol consumption (Eied, 1984; Maher, 1975). A detailed discussion about what is forbidden in Islam with regard to alcohol will follow later.

In Islamic law there are two kinds of punishment for drinking alcohol. First, by drinking alcohol the individual is committing the sin of violating Allah's commands, which would result in facing punishment in the hereafter. Allah promises such punishment only for those who disobey him and continue drinking alcohol until they die. Such punishment would include but is not limited to the deprivation of alcohol in the hereafter (Al-Muateq, 1985).

However, forgiveness is available for renouncing and repenting the drinking of alcohol before death, in which case punishment in the hereafter is avoided. If an individual is caught and punished by a temporal authority during his life, punishment in the hereafter is likewise avoided (Eied, 1984). It is reported that while a man was being sentenced for drinking, another cursed him for his persistent behaviour. Prophet Muhammad, then, said:

> Do not curse him because God and his Prophet love him' (Al-Muateq, 1985).

The second kind of punishment is delivered during a person's lifetime and takes the form of physical punishment. According to Islamic law, an individual who is caught drinking alcohol should be flogged with 40–80 lashes (Eied, 1984; Imam, 1984; Kamali, 1991; Maher, 1975). The number of lashes depends on the individual's repetition of the offence and the opinion of the Islamic judge. During the time of the Prophet Muhammad, alcohol drinkers were punished with only 40 lashes (Eied, 1984; Maher, 1975).

Punishment applied to alcohol drinkers is called *hadd* (Kamali, 1991; Lampton, 1991). For *hadd* to be executed, the following conditions should be met (Al-Shazili, 1984):

1. At the time of the violation, the alcohol drinker should be adult and known to be sane. So if a child or an insane adult drinks alcohol, no punishment is applied.

2. Drinking should be intentional. This means that if an individual is forced to drink, or does not know that he/she is drinking alcohol, punishment is not applied.

3. Drinking should not be as the result of necessity. For example, in a case of severe thirst where there is nothing to drink but alcohol, punishment is excluded. The Quraanic verse reads: 'But whoever is driven to necessity, not desiring nor exceeding the limit, then surely your Lord is Forgiving, Merciful' (Quraan: 6:145).

4. Drinkers should be aware of the prohibition against alcohol drinking. However, some Muslim scholars have excluded this condition for the punishment of alcohol drinkers (Imam, 1984).

5. One last thing concerning the punishment of alcohol consumption relates to the committing of another crime while intoxicated. If an individual commits a crime while intoxicated, say homicide for example, he/she will be dealt with as if not intoxicated at the time of the act. This means an individual would get the deserved punishment regardless of any consideration of being under the influence of alcohol. However, if the individual is forced to drink or does not know the nature of what has been consumed, exemption from punishment may be granted (Al-Shazili, 1984).

What is prohibited?

As mentioned earlier, prohibition applies not only to the act of drinking alcohol but also to any kind of behaviour that has to do with alcohol consumption. All activities pertaining to alcoholic beverages are forbidden in Islam. Such activities include drinking, selling, producing, serving, carrying, receiving or buying it. The Prophet cursed ten categories of people in relation to alcohol by saying:

> Truly, Allah has cursed *khamr* [alcohol] and has cursed the one who brews it, the one for whom it is brewed, the one who drinks it, the one who serves it, the one who carries it, the one for whom it is carried, the one who sells it, the one who earns from the sale of it, the one who buys it, and the one for whom it is bought (Al-Shazili, 1984).

Prohibition of alcohol applies to any pattern of consumption, regardless of the quantity or quality of alcohol being consumed. A small amount of alcohol is treated the same as a large amount. Some Islamic scholars like Al-Bar (1986) point out that, given the nature of alcohol and its effects on the body, a small amount may lead to a large one and so on, and at worst it may cause addiction. When asked about the prohibition of drinking a small amount of alcohol, the Prophet Muhammad replied:

> Of that which intoxicates in a large amount, a small amount is *haram* [forbidden] (Al-Shazili, 1984).

And on another occasion he said:

> If a bucketful intoxicates, a sip of it is *haram* [forbidden] (Eied, 1984).

In addition, all types of beverages that contain alcohol are forbidden (Khater, 1984). The definition of *khamr* includes not only wine but any substance which intoxicates, in whatever form or under whatever name it may appear. Thus, for example, beer and similar drinks are prohibited. Prophet Muhammad was once asked about certain drinks made from honey, corn, or barley by the process of fermenting them until they became alcoholic. The Prophet replied succinctly:

> All intoxicants are *khamr,* and all types of *khamr* are *haram* [forbidden] (Al-Muateq, 1985).

Prohibition includes giving or receiving alcohol as a gift. It is reported (Khater, 1984) that a man brought a cask of wine to the Prophet Muhammad as a gift. The Prophet informed him that Allah had prohibited it:

> Shall I not sell it?' asked the man. 'The One Who prohibited drinking it has also prohibited selling it,' replied the Prophet. 'Shall I not give it to a Jew as a gift?' asked the man. 'The One who has prohibited it has also prohibited that it be given as a gift to the Jew,' said the Prophet. 'Then what shall I do with it?' asked the man. 'Pour it on the ground,' the Prophet replied (Khater, 1984).

However, alcohol usage for purposes other than consumption is not prohibited (Hazri, 1993). The use of alcohol for cleaning or as a deterrent is lawful, for example. It can even be consumed if it is used as a medication. Some Muslim scholars have denied this as a result of the Prophet Muhammad saying, when asked about the use of alcohol as a medication:

> It is not a medicine but a disease' (Shwkani, 1973).

He also said:

> Allah has sent down the disease and the cure, and for every disease there is a cure. So take medicine but do not use anything that is prohibited as medicine' (Al-Muateq, 1985).

Advocates of the use of alcohol as a medication base their arguments on an Islamic principle according to which 'necessity permits prohibitions' (Al-Shazili, 1984). Therefore, if an individual is very ill or at risk and there is nothing that can rescue him/her but alcohol, prohibition does not apply in this case. The Quraanic verse supporting this reads:

> But whoever is driven to necessity, not desiring nor exceeding the limit, then surely your Lord is Forgiving, Merciful' (Quraan: 6:145).

Why the consumption of alcohol is prohibited in Islam

Although Muslims should not search into the wisdom behind God's commands, especially if such search takes the form of questioning God, many Islamic scholars have considered the effects of alcohol drinking. As mentioned earlier, one of Islam's objectives is the protection of life, mind, property, lineage and religion. These five elements are called the

five necessities, and it is believed that drinking alcohol leads to the violation of all of them (Al-Shazili, 1984; Khater, 1984; Maher, 1975).

Caliph Ali Ibn Abi Talib, one of the companions of the Prophet Muhammad, said once, 'When a person gets drunk, he raves, and when he raves, he accuses falsely' (Al-Muateq, 1985). Drinking alcohol may result in being drunk. Drunkenness then may lead to homicide, suicide, adultery, rape, stealing, neglecting religious practices, and/or committing other unlawful behaviour (Al-Shazili, 1984; Eied, 1984).

When God prohibited the consumption of alcohol, he stated in the Quraan why he did so:

> O you who believe! Truly, intoxicants and gambling and divination by arrows are an abomination of Satan's doing: avoid it in order that you may be successful. Assuredly Satan desires to sow enmity and hatred among you with intoxicants and gambling, and to hinder you from the remembrance of Allah (God) and from *salat* (prayer). Will you not then desist? (Quraan: 5:90–91).

In these two verses God advises people that one of the ways of making a success of life is to avoid alcohol. The negative effects of alcohol at individual, family and societal levels has recently been confirmed by many studies on alcohol (Hazri, 1993).

In addition, alcohol may stand in the way of a person's success not only in life but also in the hereafter, for alcohol leads to a neglect of religious obligations and remembrance of God.

Discussion

The remainder of this chapter will be devoted to discussing whether the Islamic laws pertaining to alcohol consumption were effective during the early stages of Islam? Although there are few records on this subject, some have argued that alcohol consumption was reduced to a minimal level (Khater, 1984; Maher, 1975). Al-Bar (1986) believes that the Muslims' response to the alcohol prohibition was genuine and rapid, and that the whole of Islamic society was soon freed from its slavery to alcohol. Further, he states that the reason behind such a response 'was the strong belief Muslims of early stages were holding. Belief makes miracles' (Al-Bar, 1986).

Many factors have contributed to such success. First, Islam paved the way for an alcohol-free society through changing people's beliefs, attitudes, norms and views in many aspects

of their lives. Badri (1976) has indicated that instead of attacking alcohol consumption, Islam first attacked the deep-rooted false beliefs and values upon which they were really based. Idolatry, tribalism, and the ancient Arab morality were the real sources of the illness of which gambling, adultery, and alcoholism were simply symptoms (Badri, 1976).

Secondly, after spending thirteen years establishing the new faith (Badri, 1976), Islam adopted a gradual approach to changing people's attitudes towards alcohol consumption. This approach took three additional years to be effective.

A third factor was the elimination of the means by which alcohol could be obtained. This included a prohibition of drinking, selling, producing and serving any beverages that contained alcohol.

Strong personal and social attitudes towards alcohol were a fourth factor. People at that time are believed to have had negative attitudes towards alcohol as a result of the strong belief they held. Since the consumption of alcohol was in conflict with their faith, believers chose to demonise alcohol for the sake of their faith. The strong faith of early Muslims enabled them to do whatever was necessary to please God and his Prophet. Quitting alcohol was not the only thing early Muslims achieved, for they also performed many harder things only for the sake of God (Al-Bar, 1986).

Social attitudes affected the way people behaved towards individuals who consumed alcohol. Such individuals were less respected by others and subject to social disapproval. For example, many court cases have been reported in which Muslim judges rejected an alcohol drinker as a reliable witness. Some scholars like Ibn Tyammiah (1985) states that greeting people who drank in public was forbidden.

Fifthly, laws were enacted to punish those who drank alcohol. In addition to the promised punishment in the hereafter, physical punishment in the form of flogging was prescribed for the drinker of alcohol. Knowing of such punishment made people think twice before breaking the law.

The sixth factor was the enforcement of laws. During the early stages of Islam, enforcing as well as enacting laws in relation to alcohol contributed to minimising alcohol drinking and its associated problems. It has been reported that, after the death of the Prophet

Muhammad, Caliph Omar bin Al-Khattab raised the punishment for drinking alcohol to its maximum and used to flog alcohol drinkers with 80 strokes instead of 40 (Maher, 1975).

From the preceding discussion we can see that various interrelated factors including laws formed a package for dealing with the problem of alcohol. Having said that, it should be noted that, in spite of all the measures that were taken, alcohol drinking and its related problems continued to exist in the early Islamic stages. Yet, they were maintained at a minimum level. Total elimination of the problem is practically impossible to achieve even in societies where consumption of alcohol is considered to be a deviant behaviour. Alcohol consumption existed in the past and exists in the present and will continue as long as there are living human beings. All a society can do is alleviate the problem by keeping the consumption of alcohol to a minimum level.

Contemporary Islamic world

Given the above discussion about the early stages of Islam, one needs to think about the laws relating to alcohol in the Islamic world of today. There are more than one billion Muslims who constitute today's Islamic population. They are divided among countries with different types of governments. Some countries are ruled by Islamic governments and others by non-Islamic governments. These differences affect the laws and attitudes regarding alcohol. Even among Islamic states, laws and views in relation to alcohol vary from one country to another.

While some Islamic countries, like Saudi Arabia and Pakistan, continue applying Islamic laws concerning the drinking of alcohol, others have made slight changes to these laws (for example, by imposing imprisonment instead of physical punishment). Other Islamic countries, like Libya and Iran, have adopted very drastic laws. In Libya punishments for the consumption of alcohol are prescribed as follows (Cortan & Mallat, 1996):

> One. . . .
>
> Two. If a person who is not a Muslim consumes alcoholic drinks in a public or open place or is found apparently drunk in such a place, he shall be punished by life imprisonment.
>
> Three. Drinking, possession, serving and offering alcoholic drinks is punishable by imprisonment for a period exceeding three years up to fifteen years and a fine of between LD 1,000 and LD 5,000.

Other Islamic governments, like those of Egypt, Bahrain and the United Arab Emirates, permit drinking and all associated activities with alcohol. In 1979 Egypt enacted a law restricting alcohol consumption to non-Egyptians. A week later, this law was modified to permit Egyptians to drink (Hazri, 1993). In addition to allowing alcohol consumption, countries like Tunisia, Iraq, and Morocco produce alcoholic drinks for use both at home and abroad.

Some countries have returned to applying Islamic laws, including those which deal with alcohol. Sudan for example began applying Islamic alcohol laws during the rule of President Numari in 1984 (Al-Bar, 1986). On the other hand, although claiming Islamic laws, in 1980 Yemen opened its first brewery for the production of beer for local consumption.

So we can see variations between Muslim countries in enacting and enforcing Islamic laws relating to alcohol. An assessment of the prevalence of alcohol-related problems would have to be made in each of these countries individually. However, the increasing use and abuse of alcohol along with other drugs is receiving more attention from the authorities, institutions and people of the Islamic world as a whole.

Owing to its sensitivity, work on alcohol epidemiology has not yet been published in most of the Islamic countries. However, although much research has been conducted into the effects of alcohol, few have addressed the extent of the problem. Politicians, health doctors, sociologists, social workers, columnists and many others discuss and warn about the problem but never discuss its extent.

Conclusion

The subject of alcohol has continued to draw the attention of various parties. Public health practitioners, politicians, researchers, preventionists, alcohol producers, sellers, consumers, alcohol dependents and their families, and even ordinary people are all interested in one way or another with alcohol. The more the subject of alcohol is addressed the more controversial it becomes. In addition, the interests of different parties are sometimes strongly opposed.

Governments all over the world are devoting much effort, time and money to studying, planning, and issuing laws and policies in an attempt to solve or at least to alleviate the

problems generated by alcohol (Hazri, 1993; Subhi, 1979). These laws and policies range from regulating alcohol consumption to designing prevention and treatment programmes and service. It seems that most societies are now adopting a control drinking approach, which aims to apply on the macro level of laws and policies a method that is used to treat alcohol dependency.

Alcohol-related problems are far beyond expectations. They are of all sorts and intensities and affect people in various different ways. Alcohol consumption is a primary or secondary factor in many work-related accidents, suicides, homicides, violent crimes and motor vehicle accidents (Watkins, Eisele, & Matthews, 2000). Expenditure incurred in dealing with alcohol-involved problems also far exceeds expectations. The United Kingdom loses nearly £3 billion a year as a result of alcohol-related problems, while the profits of alcohol industry is only £1.7 billion (Hazri, 1993).

According to Glucksman (1994), alcohol is thought to contribute to 50,000 deaths per year and up to 500,000 hospital admissions annually in the UK. Thus, up to 40 percent of all hospitalisation relates directly or indirectly to alcohol. Moreover, in 1995, a total of 6,507 deaths and 82,014 admissions to hospital were attributed to alcohol in Canada (Single, Rehm, Robson, & Truong, 2000). In Taiwan, drinking has been found to be one of the main causes of unnatural deaths (Wang & Chou, 1997). Two of five unnatural deaths are associated with alcohol in Sweden (Sjogren, Eriksson, & Ahlm, 2000).

Alcohol is also associated with crimes and violence. In China, for example, Zhang, Welte, Wieczorek, & Messner (2000) have found that alcohol is more likely to be involved with violent crime than with property crime. Violent crimes include assaults to strangers and domestic violence. In a study conducted to explore facial injuries in the UK, Hutchison, Magennis, Shepherd, & Brown (1998) have found that eleven percent of all falls were associated with alcohol consumption, and that 24 percent of facial injuries were caused by assaults which took place in the streets outside public drinking establishments.

Ernst, Weiss, Nick, Casalletto, & Garza (2000) have pointed out that alcohol use is strongly correlated with domestic violence. Incidents of physical violence between partners are more likely to happen when alcohol is involved (Leadley, Clark, & Caetano, 2000). Hutchison et al. (1998) point out that more women than men are assaulted at home.

As far as the problem of drinking and driving is concerned, about 40 percent of all fatal traffic accidents in Canada and the US in 1986–1987 were alcohol-related (Naranjo & Bremner, 1993). The authors have pointed out that similar statistics have been reported in the UK and Europe (e.g. Sweden). According to Margolis, Foss, & Tolbert (2000), between 1991 and 1996 a total of 3310 child deaths involved alcohol-related crashes in the US. Furthermore, in 1988–1996, an estimated 149,000 child passengers were non-fatally injured in crashes involving a drinking driver (Quinlan, Brewer, Sleet, & Dellinger, 2000).

Aside from domestic violence, alcohol is also a contributing factor in family problems. Studying 147 teenagers, Cavanaugh & Henneberger (1996) found that 22 percent believed that a family member had a problem with alcohol or other drugs. Also it has been found that divorce and separation are associated with increased anxiety and depression, and increased risk of alcohol abuse (Richards, Hardy, & Wadsworth, 1997).

With regard to alcohol and productivity, the absentee rate in alcoholics is 3.8 to 8.3 times greater than that for non-alcoholic workers (Watkins et al., 2000). Naranjo & Bremner (1993) have pointed out that at least 22 percent of work-related accidents may have involved alcohol use.

Rutherford (1997) has pointed out that in the UK around one in five male patients admitted to general medical wards have an alcohol problem and each year over one thousand children are admitted to hospital for acute intoxication. In the United States, $120 billion hospital admissions were linked to the abuse of alcohol in Hazri (1993). The social costs are uncountable. Grief, anxiety, depression, and emotional distress that result from alcohol-related events, such as deaths, violence, crime, family disputes, rape, and child abuse, cannot be estimated in terms of money. In Great Britain an estimated £33 million are spent on alcoholic drinks per day. Moreover, there are 40,000 alcohol-related deaths each year in the UK (Rutherford, 1997).

Having given such facts, one would ask about the benefits of alcohol. Is it worth it? If alcohol is believed to have some benefits (such as relaxation, pleasure and release of tensions), is it worth taking the risks for such benefits? The answer to this question is debatable and depends upon how the costs and benefits are viewed and weighed. Analysing these is beyond the scope of this chapter. For some societies, the consumption of alcohol is a question of 'to be or not to be'. It is part of their lives and rooted in their cultures. Elimination of alcohol consumption in such societies would be hard to achieve

and would cost a lot of effort, time and money. The failure of the United States during the period 1920–1933 is an example of such experience (Mansoor, 1989). Instead of a total prohibition, therefore, prevention and treatment measures may be more effective in reducing the risks associated with alcohol consumption.

However, given the tremendous problems associated with alcohol as compared to its benefits, continuity of prohibition might be appropriate in societies where alcohol is already banned, although some small problems may arise as a result of such a prohibition. Efforts should be concentrated on the enforcement of banning laws and on the design of prevention and treatment programmes and services for those who disobey these laws and become problem drinkers.

Summary

This chapter has been devoted to a discussion of alcohol in Islam. As one might expect, the chapter has been primarily descriptive, though it has included some analysis. In addressing this subject, a brief background about the sources of Islamic law has been provided; Islamic laws in relation to alcohol have been detailed; the reasons for and nature of the Islamic prohibition have been discussed; and the prevalence of alcohol-related problems during the early stages of Islam have been presented. Finally, a discussion regarding Islam and alcohol has been provided in the conclusion of this chapter. As alcohol in Islam is discussed in this chapter, alcohol in Saudi Arabia is the subject of the next chapter.

Chapter 2. Alcohol in Saudi Arabia

Introduction

> Before Islam, a very prestigious and beautiful lady invited a priest to her palace in order to help her with a problem that she was facing. The priest came to the house, but as soon as he had entered the door the servants locked it behind him. When he came face to face with the woman, she told him that she had lied to him and that she wanted him for a different reason. Issuing a threat, she told him that he had to choose one of three things: drink alcohol, sleep with her, or kill a man who was standing nearby. The priest, after great hesitation, chose to drink, thinking that drinking was the lightest of the three sins. He became drunk. She then asked him to sleep with her, and he did. Then she asked him to kill the man, and he did that too. (Al-Bar, 1986)

This story (narrated from Prophet Mohammed) along with other stories of the same kind are told to almost every child in Saudi Arabia. Families, teachers and religious men repeatedly teach children how alcohol is evil and therefore should be avoided. In spite of strong policies and laws and the stigma attached to alcohol, the consumption of alcohol continues, and the problems resulting from it are increasing.

Like most other countries in the world, Saudi Arabia is experiencing rapid changes in various aspects of its people's lives. One of these changes, despite the conservative nature of Saudi society, is an increasing exposure to alcohol and drugs. In this chapter, the problem of alcohol in Saudi Arabia is discussed; some statistics relating to the prevalence of alcohol are summarized; the policies and laws pertaining to the manufacture and consumption of alcohol are explained; and some official and non-official views regarding alcohol are reported. Finally, efforts made by the government to tackle alcohol problems, and the actions needed in future, are also discussed.

The prevalence of alcohol in Saudi Arabia

It is worthwhile to mention that in Saudi Arabia, alcohol is viewed and treated in many ways like any other illegal drug. It is therefore no surprise that Saudi Arabia is one of few countries where the drinking, selling, dealing and manufacturing of alcohol is prohibited and where offenders are subjected to legal punishment and social stigma.

Religious and social values in Saudi Arabia, along with the legal system, would seem to have an effect on the level of alcohol consumption, which is much lower than in countries

where alcohol is allowed (Al-Damigh, 1997). However, no society is completely protected from alcohol and drugs and their related problems (Al-Taweel, 1996), even in countries such as Saudi Arabia where alcohol and other drugs are prohibited.

Obtaining accurate and systematic statistics about alcohol and drugs is hard to achieve anywhere (Ismaeal, 1984) but particularly so in Saudi Arabia. It is hard to gauge even the extent of the alcohol problem in Saudi Arabia. Part of the problem is that the statistics are simply not there. In Arab countries there is a general lack of accurate information systems. As Hajar (1991) put it, "unfortunately, the base line (epidemiological studies) for planning and proceedings with relation to addiction is not well developed in the Arab world". Another problem is that, even if the statistical figures exist, they may not be available to anyone who wants to see them, owing to the sensitivity of the subject matter, and a fear of public criticism (Al-Najar, 1998).

It is worth mentioning that no single epidemiological study into alcohol use has been conducted in Saudi Arabia. This is hardly surprising, given that epidemiological studies into subjects of much less sensitivity and importance have not yet been undertaken. In consequence, researchers, writers and health professionals have to rely on their own observations in discussing issues relating to alcohol (e.g. Al-Baz, 1999; Al-Dossari, 1983).

Alcohol-related studies in Saudi Arabia consequently suffer from a lack of statistical data that are necessary for an understanding of the dimension of the problem. With no reliable database about the prevalence of alcohol and drug use and abuse, it is impossible to plan effectively for the prevention and treatment of addiction (Hajar, 1991). Furthermore, of the few alcohol-related studies that have been accomplished, no single study has provided data on the size of the alcohol problem in Saudi Arabia. Instead, most researchers rely on non-Saudi, even non-Arab, statistical figures as a basis for their research. Al-Bar (1986), for example, devotes a complete chapter of his book to discussing the prevalence of alcohol in Europe and the United States, while Al-Taweel (1996), Al-Khudiri & Al-Suaidan (1994) and Al-Najar (1998) all use statistics on alcoholics in the United States to show how risky alcohol consumption can be.

Some (e.g. Yousef, 1997) have indicated the growing problem of alcohol and drugs abuse by reference to the numbers of people charged by the police with drinking, selling, or manufacturing alcohol. Other researchers (e.g. Farook, 1983; Mahmood, 1993) describe the extent of alcohol problems in Saudi Arabia by means of general statements rather than

statistical figures. Hence they merely state that alcohol consumption and the consequences of drinking in Saudi Arabia have reached dangerous levels.

Briefly, the lack of alcohol epidemiological studies in Saudi Arabia can be accounted for as follows:

1. Epidemiological studies in almost every social aspect, not only that of alcohol consumption, have not yet been developed.
2. Alcohol is one of many topics that are very sensitive in Saudi society.
3. Alcohol problems have not received as much attention by the media as other illegal drugs have (Al-Damigh, 1997).
4. The use of alcohol is a new phenomenon in the Islamic world, and especially in Saudi Arabia. Consequently, a well-developed research foundation on alcohol has not been established yet (Al-Khalidi, 1983).

Conducting research on the epidemiology of alcohol is a very large task that involves money, time, effort and approvals. Such a task cannot be carried out by an individual researcher.

Given the problematic issue of alcohol consumption in Saudi Arabia, the size and seriousness of the problem are addressed here using two methods. First, I present some statistical figures indicative of the extent of the problem, even though these cannot give an accurate picture. Second, I examine what has already been said or written on the subject by others.

One indicator is the growing number of admissions in three of Al-Amal hospitals of individuals receiving treatment for substance abuse (Table 1, Ministry of Interior Statistical Books, 1990–1994). Although such figures do not show the number of admissions by the type of abused substance, alcohol abuse is known to be the primary form of abuse that is treated in Al-Amal hospitals (Al-Bawardy, 1998; Al-Nahedh, 1999).

Table 1. Number of admitted patients in three of Al-Amal hospitals between 1989-1993.

	Number of admissions					
Year / Hospital	1989	1990	1991	1992	1993	Total
Riyadh	3728	4024	5638	6290	6281	25961
Dammam	2563	3036	3147	3415	2394	14555
Jeddah*	-	-	3972	8212	12229	24413
Total	6291	7060	12757	17917	20904	64929

Table 1 shows that the number of admissions in Al-Amal hospitals, with the possible exception of Dammam, increased dramatically between 1989 and 1993. It also shows that Jeddah has the highest number of admissions for all years except for the year 1991. In 1993 for example, Jeddah had twice as many as Riyadh, and four times as many as Dammam.

Al-Riyadh Daily Newspaper (13 August 2000) reported that Al-Amal Hospital in Riyadh was witnessing increasing numbers of patients seeking treatment. The newspaper indicated that the demand for treatment was so high that many patients had to be put on a waiting list. The report added that many patients on the waiting list had complained to the newspaper, expressing their desperate need for treatment. It was the first time that so sensitive a report had been publicised in the country, and was perhaps an indication of a growing trend towards the public discussion of sensitive social and health issues.

It should be borne in mind, however, that an increasing number of patients seeking treatment is not necessarily an indication of an increase of the percentage of substance dependence. There could be other reasons to account for it, including the following:

1. Since it was established 15 years ago, Al-Amal hospital in Riyadh has had a full capacity of 280 beds. The population of Riyadh city back then was around 1.5 million but by 1999 had increased to 3.5 million (Ministry of Information, 21 July 2001). It is therefore not surprising that the pressure on the hospital has increased to the point where it cannot serve the number of patients.
2. It is possible that the number of patients who voluntarily seek treatment has increased as a result of their growing awareness of the need for treatment and or the availability of treatment.

*** Number of admissions for Jeddah for 1989 and 1990 were not available since the hospital started only in 1990.**

3. When the authorities intensify their efforts to fight alcohol and drugs, the dealers in alcohol and drugs decrease their activities, causing a shortage in supplies. When there is such a shortage, a demand for treatment increases.

According to the Ministry of Interior Statistical Books (1985, 1990, 1995, 1999), the number of alcohol-related crimes (Table 2) revealed a tendency of growing numbers of people to be involved with alcohol. Such involvement ranges from drinking to manufacturing, possessing and selling alcohol. Comparing the figures for the years 1995 to 1999, Table 3 shows that although the number of incidents decreased for the manufacture, possession and sale of alcohol in 1999, the number of individuals involved in those incidents increased. In addition, the figures indicate that the numbers of both alcohol-related crime incidents and individuals involved in those incidents had increased considerably by 1999.

Table 2. Number of alcohol-related incidents discovered by police In selected years Number of alcohol-related incidents discovered by police in selected years

Year	Number of incidents
1983	3023
1988	4627
1990	5063
1995	4999
1999	5309

Table 3. Numbers of alcohol-related incidents and individuals convicted in such incidents presented by the type of crime in the years 1995 and 1999

	1995		1999	
	Incidents	People involved	Incidents	People involved
Drinking	4318	5093	4786	5611
Manufacturing	232	551	127	278
Possessing and selling	449	698	396	653
Total	4999	6342	5309	6542

Moreover, according to the General Presidency of Religious Enforcement Council's Statistical Report (1999), the numbers of incidents involving alcohol discovered by the Religious Enforcement officers almost doubled between 1991 and 1999 (Table 4). It is worth mentioning, however, that the function of the Religious Enforcement is to ensure the compliance of people with the instructions of Islam, and report non-compliant behavior to

the police. The police, in turn, according to the criminal evidence, would reject the case or proceed with conviction procedures. The numbers presented by the Statistical Report of the General Presidency Religious Enforcement Council might therefore be different from the numbers presented by the Statistical Book of the Ministry of Interior.

Table 4. Number of alcohol-related incidents discovered by the Religious Enforcement Council, 1991–1999

Year	Number of incidents
1991	1890
1992	1120
1993	2411
1994	2562
1995	2939
1996	1312
1997	2112
1998	2898
1999	2901

As to other indications of alcohol use in Saudi Arabia, Al-Turki (1989) reported that in 1985- in the Riyadh region alone, police confiscated 1271 bottles of Araq (a Middle Eastern alcoholic beverage) and Cologne, 56 barrels of alcohol and twelve alcohol-manufacturing kits. In addition, two local alcohol factories were discovered by the authorities in late July and the beginning of August 2000. The Saudi daily newspaper *Economics* (23 July 2000) reported that the Saudi Security Authorities had found a secret factory for processing and bottling alcohol in Jeddah. The paper explained that the factory had been erected in a villa and that the police had received complaints from neighbours about the bad smell from the place.

When the policemen broke in they arrested one Saudi man and three Ethiopians (one man and two women) who were manufacturing alcohol. The policemen found 1,750 Araq bottles and 7,920 litres of Araq in barrels. The suspects admitted manufacturing and distributing of these alcoholic beverages.

The second factory, according to *Al Riyadh Daily Newspaper* (11 August 2000), was discovered in a flat in Al-Baha City, in the south region of Saudi Arabia. The factory was totally managed by non-Saudis who were occupying the flat. The authorities found 1,068 litres of fermented substance in plastic barrels ready to be distilled and 134 litres of Araq ready for marketing.

The Saudi Bureau of Drug Prevention and Control reported that they discovered 5,173 kg of illegal drugs in 1983. This amount increased two years later to reach 6,083 kg (Taleb, 1994). Although, the amount of confiscated alcoholic beverages was not mentioned, it would be assumed that the amount of alcohol was even larger since the punishment for dealing in or smuggling alcohol is less than for any other drugs (Al-Khudiri & Al-Suaidan, 1994).

Further evidence of the increasing alcohol and drugs problem in Saudi Arabia is to be found in the concerns that have been expressed by religious and political leaders, health professionals, researchers and journalists. The Presidency of the Council of Ministers (1982) recognised the increasing problem of addiction, and issued a bill requiring an assessment of the need for addiction treatment facilities. The King of Saudi Arabia, Fahd bin Abdulaziz, at the Second Islamic Conference in Islamabad (1–3 June 1989), indicated that "all kinds of drugs, of whatever type, class or name, have become a very dangerous disease that the world has to face" (Al-Khudiri & Al-Suaidan, 1994). Prince Naif bin Abdulaziz, the Minister of Interior, has described addiction as a "devil affecting every Saudi family" (*Al-Amal Magazine*, November 1995), where clearly he is referring to the extended family or the family in its larger context.

In the preface of a book about alcohol addiction, Farook (1983) suggests that "in our Islamic and Arab countries, we have reached the situation where drinking has to some extent become socially acceptable" P. 3. Mahmood (1993) believes that alcohol and drugs are one of the most serious problems that the Arab world, including Saudi Arabia, has to face. Al-Bar (1986) mentions a report in the Saudi newspaper *Al-Maddina* that nearly 50,000 Arabs come to London every year to get treatment for liver disease which is largely the result of heavy drinking, especially of hard liquor such as whiskey. Another Saudi newspaper, *Al-Sharq Al-Awsat*, reported that nearly one million Arab tourists visited London in 1979, and most of those tourists don't mind drinking alcohol (Al-Bar, 1986).

In an interview Dr. Al-Awaji, the former Deputy Minister of the Ministry of Interior, and the current president of the International Council on Alcohol and Addictions (ICAA), described alcohol and drug addiction as one of the nation's main problems (*Al-Amal Magazine*, August 1993). Al-Awaji strongly supported the initial establishment of Alcoholics Anonymous (AA) in Saudi Arabia.

The Ministry of Interior Statistical Book (1992) indicated that crimes involving alcohol (alcohol drinking, manufacturing and selling) composed 22 percent (5,063) of all reported crimes (22,952) in 1990. This percentage increased to 27 percent (6,401 out of 23,488) in 1991. But it decreased again to 21.5 percent (5,294 out of 24,716) in 1992. Furthermore, alcohol drinking, selling and manufacturing were at the top of the crime list, along with theft, between 1980 and 1990 (Yousef, 1997). Also, it has been indicated that the highest association be crimes is that between theft and alcohol drinking. In a study conducted on employees of the Bureau of Drug Prevention and Control, 57 percent of the subjects reported that there was a strong link between drinking and theft (Yousef, 1997).

With regard to the characteristics of alcohol users, Al-Bar (1986) points out that western studies have indicated that addicts tend to be from the lower class, to be unemployed, and to have mental and psychological problems. He alleges that in the Arab world, on the other hand, most addicts received their education in the west, and are frequently politicians, governors (leaders) or belong to the rich élite. Al-Bar does not mention on what basis he arrives at such conclusion, however.

After studying the characteristics of alcohol and drug addicts in Riyadh Al-Amal, Al-Anazi (1999) found that "alcoholics" constituted 38 percent of the subjects studied. The author also found that alcoholic patients were most likely to be single, unemployed, poorly educated, and with low incomes. Al-Damigh's (1997) study supported such findings. As far as the age of alcohol users is concerned, studies reveal that alcohol drinking is prevalent among young to middle aged men. Al-Damigh (1997) found that 47.2 percent of alcoholics were between the ages of 26 and 33 years old. In opposition to this finding, Al-Anazi (1999) found that 27.7 percent of alcoholics in the sample he studied were between 18 and 24 years old.

Furthermore, while the age of drug abusers in a study by Al-Anazi (1999) fell mainly between 18 and 30 years old, alcoholics cover a much wider age range according to Al-Damigh (1997). However, both studies were carried out in Saudi addiction treatment settings and therefore do not necessarily reflect the actual use of drugs and alcohol in Saudi Arabia. Another study reveals that 83 percent of drug users are between 10 and 30 years old (Mahmood, 1993).

As far as the socio-demographic data of those convicted of alcohol crimes is concerned, data for the year 1995 and 1999 (Ministry of Interior Statistical Book, 1995 & 1999)

showed that the numbers of Saudis convicted of alcohol drinking were higher than non-Saudis in both years (Table 5). However, whereas the number of Saudis convicted increased, the number of non-Saudis decreased in 1999. The figures also showed that alcohol manufacturing and dealing were dominated by non-Saudis.

Table 5. Numbers of people convicted of alcohol crimes by nationality, gender, and age in 1995 and 1999

		Saudis	Non-Saudis	Males	Females	Adults	Minors	Total
Drinking	1995	4146	947	5074	19	5090	3	5093
	1999	4762	849	5603	8	2272	3339	5611
Manufacturing	1995	108	443	510	41	550	1	551
	1999	34	244	254	24	184	94	278
Possessing & selling	1995	251	447	678	20	695	3	698
	1999	209	444	639	14	343	310	653

In addition, although the numbers of females was extremely low in all types of alcohol-related crimes in 1995, it was even lower in 1999. With regard to the age, only three teenagers were convicted of drinking in 1995. Surprisingly, the number of teenagers convicted of drinking has increased very sharply to a figure that exceeded the numbers of convicted adults in 1999. Such an increase is a worrying sign of potential drinking problems among teenagers, especially when we discover that Cologne is their preferred drink. Al-Turki (1989) gathered data on juvenile teenagers who had been convicted of drinking and detained in the Juvenile Correction Center in Riyadh (Table 6). The data showed that Cologne was the preferred drink in all the years presented. Moreover, alcohol was the most prevalent drug among teenagers convicted of alcohol or drug taking in all the years presented in Table 7.

Table 6. Number of teenagers' drinking incidents as reported by the Juvenile Correction Centre in the city of Riyadh, 1980–1984

Year	Normal alcohol drinking	Cologne drinking	Total
1980	86	119	205
1981	57	98	155
1982	52	84	136
1983	25	54	79
1984	35	72	107

Table 7. Number of teenagers convicted of alcohol, solvent, and drug taking as reported by Juvenile Correction Centre in the city of Riyadh, 1980–1984

Year	Drinking	Drugs	Solvents sniffing	Total
1980	205	23	10	238
1981	155	10	10	175
1982	136	15	17	168
1983	79	17	12	108
1984	107	12	12	131

With regard to the regional distribution of alcohol crimes, the Ministry of Interior Statistical Book (1995) shows that overall the highest numbers of alcohol-related convictions were in Riyadh, Makkah and the Eastern provinces (Table 8). The regional distribution also revealed that the highest number of drinking convictions was in Riyadh province. The highest number of cases of alcohol manufacturing was in Makkah province, and the highest number of cases of alcohol possession and selling was in the Eastern province.

Table 8. Number of alcohol crimes by the region and type of crime

Province	Drinking	Manufacturing	Possessing & selling	Total
Riyadh	1568	53	86	1707
Eastern	1019	37	164	1220
Makkah	1095	77	161	1333
Aseer	85	7	0	92
Madinah	113	2	21	136
Qaseem	119	14	16	149
Jezan	58	4	0	62
Tubook	40	7	1	48
Northern	48	9	0	57
Najran	29	9	0	38
Hail	85	10	0	95
Bahah	20	0	0	20
Joaf	39	3	0	42
Total	4318	232	449	499

To conclude this section, the factors contributing to the use and abuse of alcohol and drugs in Saudi Arabia, according to Al-Najar (1998), Al-Taweel (1996), Al-Nahedh (1999), and Al-Khudiri & Al-Suaidan (1994) can be summarised as follows:

1. The economic crises during the 1980s have affected the economic and social status of almost everyone in Saudi Arabia. As a result of these crises, some people tried to escape of financial problems by drinking and using drugs.

2. There is a lack of leisure places, in terms of both quantity and quality, where young people can spend their spare time enjoyably in a constructive way. This may led some people to spend their spare time destructively such as alcohol and drugs.

3. Because of limited educational, vocational and employment opportunities, many find themselves with no job, or with low-income employment.

4. Due to the sudden economic, social and technological changes, society has become more vulnerable to the use of alcohol and drugs.

5. For some people, large and quickly acquired incomes have facilitated their experience of new things such as drugs and alcohol.

6. The shortage of appropriate and effective approaches to raising the awareness among youth about drugs and alcohol.

7. With the increase of income, many have developed the habit of travelling abroad where more freedom can be enjoyed, and new things can be experienced.

8. Some Saudis, who travel abroad to study and may have stayed for many years, have brought home the habit using alcohol or drugs.

9. About 25 percent of the population are non-Saudis who have come either to work, or to perform Haj or Umra. These populations represent different social and cultural backgrounds, and some have brought with them their habits of drinking or drug using. Some Saudi nationals must have been affected by these habits.

10. One of the most important factors is the weakening of religious beliefs and practices, especially among youth.

11. Exposure of people, especially the youth, to all forms of the mass media, such as television, the internet magazines in which alcohol and drugs could be presented as something good.

Alcohol policies and laws: consuming, selling, dealing, smuggling, and manufacturing

The judicial system in Saudi Arabia is based on Islamic Shari'a (law), and most laws and policies relating to alcohol are derived from this. Islamic laws are applied to alcohol consumption, selling, dealing, manufacturing and smuggling.

Mr Al-Herish (1999), an official employee of the Ministry of Interior, in a personal interview about alcohol criminal procedures, pointed out that different security departments (i.e. the police, the National Guard, and Religious Enforcement) had the power of arrest for any alcohol-related crime. Then, the suspect has to be referred to a police station immediately.

Al-Herish also mentioned that the suspect has to be questioned during the first 24 hours after the arrest. The suspect may be kept in police custody no more than three days. During that period a decision as to whether or not to press charges must be made. If a confession or forensic evidence or both are obtained and recorded in the police station, the suspect is referred to an Islamic court of law to verify the confession, or to present the forensic evidence by the District Attorney, then returned to the police.

When asked if the suspect can be released on bail (Kafala), Al-Herish responded that only in the case of drinking could this be granted. In this case close relatives must guarantee the presence of the suspect whenever called by the judge or the police. The criminal charges are then referred to the governor, who in turn refers them to the court.

However, Al-Herish maintained that the procedures would be the same for those arrested on suspicion of alcohol manufacturing and dealing, except that suspects cannot be released under any circumstances until a sentence is issued by the court and executed by the police.

In the case of alcohol smuggling, more government departments are involved, such as Customs and the Border and Coastal Guards. Thus smuggling cases involve more complicated criminal procedures.

With regard to alcohol addiction, Al-Herish explained that if an individual is caught for drinking, and claims that he/she is an alcoholic, the suspect would then be referred to one

of Al-Amal hospitals for a laboratory test and interview. An assessment report must be issued by the hospital and sent to the police.

The court usually takes the state of addiction into consideration when sentencing the suspect. Nevertheless, the suspect must be punished according to Islamic law. In some cases, the court may ask for the suspect to be placed in one of Al-Amal hospitals prior to sentencing, Al-Herish concluded.

Forensic evidence required in cases involving alcohol-related offences

With relation to conviction evidence, it is enough for the judge to convict a drinker if the following evidence exists: 1) report of a smell of alcohol, or a smell of vomited alcohol, 2) two witnesses who can swear that they saw the person drinking, or a self-confession (The Presidency of Council of Ministers, 25 July 1977).

However, since the smell of alcohol might be confused with the smell of other substances such as a medication, the law in Saudi Arabia has asked the judge to rely on a laboratory blood test in order to convict the suspect (Ministry of Interior, 1989). Others have argued that this evidence should not be sufficient alone and that there should be additional evidence to support it (Zufair, 1995).

Due to recent technological developments in alcohol testing, alcohol criminal procedures in Saudi Arabia have been modified to include the forensic evidence of blood testing. Al-Ajrafi (1999) summarised the latest version of alcohol-conviction procedures as follows:

1. Report of alcohol smell, which must be prepared by the investigator, a member of the religious authority, and the physician on duty.

2. Referral to the laboratory for a blood sample analysis.

3. Search of the suspect's criminal record.

4. Interrogation of the suspect, and obtaining a confession.

5. Verification of the confession in front of the court.

6. Referral of the case to the court.

Types of punishments for alcohol-related offences

Many alcohol laws have been passed by the Office of the Head of Judges (Zufair, 1995) after having been recommended by the Council of Senior Ulema (a higher council which discuss any aspect of life and provides recommendations based on Islamic laws). Although the Islamic punishment (*had*) for alcohol is 40–80 lashes, other types of punishments have been introduced by the judicial system in Saudi Arabia. Imprisonment or increasing the number of lashes are examples of such punishments. However, it has been argued that these punishments are Islamic as well, and that they go under a type of punishment called *tasser* (a type of punishment that is left to the court to decide, and can range from lashing to execution).

The type and level of punishments for alcohol drinking varies according to the drinker's age (child or adult), mental status, intention, criminal record, repetition of drinking convictions, and other circumstances, including the judge's personality. However, a regular punishment for alcohol drinking, as recommended by the Council of Senior Ulema, is 40–80 of lashes, "as prescribed by the Islamic law" (Ministry of Justice, 1976; Zufair, 1995). With regard to the number of lashes, Saudi law allows a maximum of 80 to be prescribed (The Presidency of Council of Ministers, 25 July 1977), though this sentence is reserved for those who drink for the first time (Ministry of Justice, 1976). Furthermore, the Presidency of Religious Research (1977) has recommended that the 80 lashes must be applied in a single session.

In cases of repeated drinking, the convicted drinker might be sentenced to imprisonment, more lashes, or both, as well as the drinking punishment (*had*) (Ministry of Justice, 1976). It is left to the judge to decide whether to impose a sentence of lashing or imprisonment upon those who are repeatedly caught drinking (Presidency of Religious Research, 1977). Under what is called *tasser*, the upper limit of the number of lashes or imprisonment is not specified. For the individual repeatedly convicted of drinking, the level of punishment is increased every time he/she gets caught. Although some Islamic scholars demand that a drinker caught for the fourth time should be sentenced to death, this type of punishment has not been applied in Saudi Arabia (Zufair, 1995).

Punishment is prescribed for alcohol use regardless of the amount taken. Zufair (1995) claims to have witnessed many law cases concerned with alcohol drinking, in none of which the judge asked about the amount of alcohol consumed. Furthermore, punishment for drinking alcohol is not restricted to alcohol *per se*, but is extended to any drink or any substance leading to intoxication,regardless of its shape, form, or the way it is used. For example, in 1965 the punishment was applied to someone charged with drinking Cologne (Zufair, 1995).

In addition, an alcohol drinker is held liable for any other wrongdoings he/she commits while intoxicated. Consequently, the punishment for alcohol drinking is applied in addition to the punishment that a drinker may earn for an offence committed while intoxicated, whether a traffic offence or a criminal act (The Presidency of Council of Ministers, 25 July 1977).

With regard to the punishment of alcohol manufacturers and dealers, the Ministry of Justice (3 March 1980) indicated that the punishment for such people is left for the judge to decide under *tasser had.* This means the punishment may vary from one case to another according to the drinker's circumstances, the judge, and the circumstances of the crime itself. With alcohol smuggling, the punishment is similar to that of dealing and manufacturing (Ministry of Justice, 3 March 1980).

People's attitudes towards alcohol

According to the Ministry of Information (21 July 2001), the total population of Saudi Arabia is 21.4 millions. About 25 percent of this population are non-Saudis (Al-Seriani, 1992). Although Islam is the only religion among Saudis (Ministry of Information, 21 July 2001), religious commitments or affiliations vary from one region to another, from one family to another, and from one individual to another.

Saudi society is religious for many reasons. First, Saudi Arabia is the place where the Prophet Mohammed was born, and where Islam was founded. Second, Saudi Arabia is the place where the two most important Holy Mosques for all Moslems are located. For both these reasons the country is considered a role model for all other Moslem countries. Thirdly, in addition to encouraging people to follow the instructions of Islam, on which the Saudi governing system is based, the government directly or indirectly enforces their compliance as well. Consequently, Islamic beliefs and instructions have a strong effect in

shaping almost all aspects of people's lives. One of these aspects is their attitude to drinking alcohol . Hay, Kohli, & McKeganey (2001) have shown that attitudes towards drinking are influenced by the strength of an individual's religious or cultural beliefs.

That is not to say that nobody drinks in Saudi Arabia, rather that drinking alcohol, is unacceptable on religious, cultural and legal grounds. In fact, owing to various factors discussed earlier in this chapter, alcohol and drugs use and abuse are a problem that is getting larger and larger (Al-Damigh, 1997). Even those who drink or use illegal drugs know that what they are doing is prohibited by their religion, and that they should not do it (Al-Turki, 1989).

Although no research has been conducted into Saudis' thinking, beliefs and attitudes with regard to alcohol, it can be confidently stated at the start of this discussion, that the Islamic prohibition of alcohol is widely adopted by the majority of people. Indeed, the prohibition of other drugs is based on the Islamic principle which outlaws alcohol and which says, "every intoxicant is *haram* (prohibited)" (Zufair, 1995). This prohibition of alcohol is rooted in the soul and mind of the people through a long process of socialisation.

In accordance with the Islamic view, Saudis tend to see alcohol as evil, and often associate it with sin and criminal acts. Children are taught through family, school, religious scholars and the mass media that alcohol is forbidden. Thus, for a typical Saudi family alcohol is not a topic that can be discussed except with the assumption that it is forbidden. Even for those families who have a drinking member, a father or son for example, the subject of his/her drinking is hard to discuss openly. Also, a father who drinks usually tries not to drink in front of his family. A son would try his best to keep his drinking secret from the family. The secrecy, stigmatisation, and sensitivity of the subject of alcohol make discussion of it difficult and the problem of addiction even harder to treat.

Almost all people who drink tend to conceal their drinking even from their close relatives. It is enough for a wife, if she wants to get a divorce from her husband, to prove that he is a drinker. Such a divorce plea would be strongly supported by the court (Al-Muateq, 1985). A wife may spend many years with her husband not knowing of his drinking because he may drink outside the house and stay the whole day out, or he may only practise his drinking when he is abroad. Also, a drinking husband might find any excuse to conceal his drinking from his wife, especially if she is ignorant about the signs of drinking. In some cases, even if the wife knows about her husband's drinking, she does not dare to discuss

the problem with him for many reasons, such as the fear of stigma, family problems, divorce, or because she does not want to believe it.

The parents or custodians of a girl usually investigate any man who wants to marry their daughter. One of the very important things that parents usually investigate is whether the person seeking their daughter's hand is an alcohol or drug user. Consequently it is very hard for a drinker to find a family that will allow him to marry their daughter. From my own personal experience, I have known many fathers to come to Al-Amal hospitals in order to find out whether the person seeking to marry their daughter has a history of alcohol or drugs taking.

In general, people think of drinking as something that a good person would never do. A drinker is also regarded as someone who cannot be trusted. In court, for example, the judge rejects the testimony of a witness who happens to be a drinker (Al-Muateq, 1985).

While it is not acceptable for men to drink in Saudi Arabia, the stigma attached to women who drink is even greater. Women with an alcohol problem often have painful experiences as a result of the widespread disapproval of their drinking. Although alcohol problems among Saudi women are not too apparent, they do exist (*Al-Amal Magazine*, August 1999), and the stigma and disapproval associated with them have a profound effect in complicating them further. These problems range from concealing an alcohol problem to finding the appropriate facility for treatment, and getting access to and accepting treatment.

For the first time, in February 2000, Al-Amal hospital in Riyadh started a treatment programme for women with alcohol and drugs problems (*Al-Amal Magazine*, March 2000). The Minister of Interior commented that the launching of this programme did not mean that we had a dangerous problem with women's addiction, but rather that the facility should be ready to provide a service for whoever needed it (*Al-Amal Magazine*, March 2000). The initiation of this programme was considered a major step forwards in the treatment of a condition of such social sensitivity.

The use of alcohol by teenagers and young adults in Saudi Arabia represents a special problem. More than half (60%) of those convicted of drinking alcohol in 1999 were minors (Ministry of Interior Statistical Book, 1999). Although the young do not talk about the subject publicly, among their peers they seem proud of the fact that they drink. Many of them associate drinking with pleasure and having a good time. For some, drinking is often

linked with travelling abroad (Al-Khudiri & Al-Suaidan, 1994). Others travel abroad mainly for the sake of drinking (Al-Bar, 1986). However, many have been introduced to drinking inside the country. Some youngsters who do not drink nevertheless do not mind going with friends to places where alcohol is consumed. Such acceptance may have an impact on their own and their children's attitude towards alcohol in the future, especially in view of the fact that people under eighteen years old constitute more than 50 percent of the country's total population (Ministry of Information, 21 July 2001).

With regard to the types of alcoholic drinks consumed in Saudi Arabia, Araq, a locally made alcohol, and Cologne are the most prevalent. Other types of alcoholic beverages are of low use because they are hard to get and expensive to buy. Although Cologne drinking is believed to be very harmful for the health (Kinney & Leaton, 1991), since it contains a very high percentage of methyl alcohol, many use it as their drink of choice (Zufair, 1995). This type of alcohol is consumed by teenagers especially (Al-Turki, 1989). Others may only use it as a substitute for Araq.

Tackling alcohol problems

In order to address its alcohol problems, Saudi Arabia has implemented various strategic plans in the area of protection, prevention and treatment. These plans, according Al-Khudiri & Al-Suaidan (1994), aim to be:

1. *Comprehensive*: most government and non-government agencies, directly or indirectly, give some kind of effort to dealing with the problem of alcohol and drugs.

2. *Integrated*: every agency has a role to play in the war against alcohol and drugs.

3. *Balanced*: protection, prevention and treatment are given equal emphasis.

In the area of protection, the government has totally banned the consumption, selling, dealing, manufacturing and smuggling of all types of drink that contain alcohol. In addition, laws and policies relating to alcohol have been issued to enforce the ban. Severe punishments await anyone who consumes, sells, deals, makes or smuggles alcohol. A major effort is made to foil attempts to smuggle alcohol and drugs into the country. There are also valuable rewards for any person or group which helps in discovering any selling,

dealing or manufacturing of alcohol (The Presidency of Council of Ministers, 25 July 1977).

In pursuing a preventative approach, both government and non-government agencies are paying much attention to increasing people's awareness of the ethical, religious, and health implications of taking alcohol and drugs. Politicians, health professionals, social workers, religious leaders, teachers and others are playing an important role in such awareness raising. The mass media are also being used. Moreover, professional and academic seminars, workshops and conferences on the subject of alcohol risks are encouraged and supported by all agencies.

With relation to treatment, the government has established four facilities that provide treatment services to people with drinking problems (Al-Khudiri & Al-Suaidan, 1994). They are located in the largest provinces in the country. The treatment of alcohol and drugs is provided by those government facilities only, for no private health agency is allowed to offer addiction treatment. This policy gives the government total control of the facilities, but it unfortunately has two negative side effects. First, many treatment seekers may dislike the services or approaches provided by Al-Amal hospitals. As a result some may avoid seeking treatment, and others may undergo treatment but against their will, which can have a negative impact on the treatment outcome. Second, because the hospitals are public, certain people – the rich or famous, for example – may avoid seeking treatment either because they do not want to be mixed with ordinary people, or because they do not want to be seen as having a drinking problem.

More facilities are needed in the area of treatment as well as in extended care. Also, although Al-Amal hospital in Riyadh has just started a treatment programme for women with alcohol problems (Al-Amal Magazine, March 2000), more facilities are urgently needed to provide services to women and children with alcohol problems. Allowing the health private sector to provide addiction treatment is needed as well.

Future needs

As discussed earlier in this chapter, alcohol consumption as well as its related problems are increasing. In order to tackle these problems effectively, further steps need to be taken. These steps are summarised as follows:

1. Facilitating and funding alcohol epidemiological studies.

2. Establishing more effective laws and policies to prevent driving while drinking.

3. More effective laws and policies against Cologne drinking, owing to the serious harm resulting from this.

4. Appropriate strategies for increasing people's awareness of alcohol-related problems, such as choosing the right target, place, and time.

5. Dispelling the ambiguity surrounding certain aspects of alcohol consumption, such as whether an alcohol drinker should be considered a criminal or a patient.

6. Increasing treatment facilities.

7. Providing treatment services for women and children.

8. Allowing the private sector to provide alcohol treatment services.

Discussion

In Saudi Arabia, the subject of alcohol and its related problems receive less publicity than the problems associated with other illegal drugs. One reason for this is that the media continually discuss the dangers of drugs but give less attention to alcohol (Al-Damigh, 1997). Unlike other illegal drugs, alcohol is specifically prohibited in Islam. Although other drugs are not mentioned by name in Islamic scripture, they are included in the prohibition since Islam forbids the use or abuse of alcohol or any other intoxicating substance, no matter what the name of that substance is. Because most illegal drugs have been newly introduced to the country, they receive more attention from the media, the government and researchers. In addition, the subject of illegal drugs is receiving more attention from world governments, and national and international organizations. This global attention has had an impact on the Saudi view of illegal drugs, but at the expense of alcohol.

The legal, social and religious attitudes towards alcohol in Saudi Arabia (and in some other countries where alcohol is prohibited) make it necessary to understand many aspects

relating to alcohol consumption in such an environment. Yet, in spite of countless research studies on alcohol internationally, almost all of these studies have been carried out in countries where alcohol is allowed, with the result that none has focused on the implications of alcohol as an illegal substance.

While the studies of illegal drugs take into consideration the legal as well as the social, religious and family implications of drug use, alcohol studies tend to concentrate on the various types of alcohol consumption and the impact of excessive drinking on health, family, jobs or the economy, rather than on any criminal aspects of drinking. For example, a respondent might be asked if he/she had ever taken any kind of drug, or if he/she had ever been convicted for drug taking, but this respondent would never be asked if he/she ever been convicted of using alcohol.

It is the researcher's contention that alcohol use in a country where it is illegal has a different cultural and social meaning as well as a different effect on the body and mind than in a country where alcohol is allowed. After studying Mormon and Fundamentalist Christian populations, Linsky, Colby & Straus (1986) noticed that some alcohol-related problems appeared to be a response to the strong cultural disapproval of drinking. It has been noticed that when they drink abroad many Saudis get drunk fast, and lose control of their drinking, although no research has been carried out to support this observation. When drinking takes place inside the country, on the other hand, alcohol users drink responsibly and behave carefully. It seems that fear of getting caught and its consequences, such as severe punishment and loss of job and reputation, impacts on the behaviour of drinkers.

Another of the researcher's assumptions is that, because drinkers are afraid of being caught, they take extra precautions, such as drinking in private or remote places, or staying away for a whole night. Moreover, it is believed that the impact of alcohol on the drinker is affected by many variables, such as the person's weight, sex, fullness of stomach, the amount of alcohol consumed, pattern of drinking, type of drink, drinking history, and the state of mind at the time of drinking (Pandina & Schuele, 1983). Therefore, it would be no surprise to find that alcohol functioned differently in Saudis who at the time of drinking were afraid of being caught than it did on others who can drink at any time, in any place, without fear of being seen or caught.

The various aspects of alcohol consumption in Saudi Arabia needs to be given more attention by both professionals and researchers. The areas that still need to be studied

include alcohol epidemiology, vulnerable groups, the impact of alcohol on the mind, people's attitudes towards alcohol, the effects of alcohol, social, economic, and health problems resulting from alcohol, and the treatment of problem drinkers.

More effort and more effective approaches need to be applied to the areas of prevention and treatment. The use of appropriate strategies and the provision of accurate information to specific groups are essential to successful prevention. Effective utilization of the media, local leaders, and famous sportsmen should be achieved. Moreover, since Cologne drinking is very dangerous to health, it should be given special consideration.

Treatment facilities for all categories of patients, especially women and children, should be established and developed. There is a need to expand the existing treatment facilities to increase the number of beds and to give easy access. Allowing the private sector to participate in the provision of treatment would make treatment more accessible as well as providing alternative approaches to treatment.

Now as alcohol in Saudi Arabia is discussed in this chapter, in the next chapter the literature regarding alcohol use in Saudi Arabia, the Arabian Gulf, the Arabic world, and globally will be reviewed.

Chapter 3. Studying Alcohol Use

Introduction

Demographic and psychosocial characteristics of populations in relation to alcohol use have been the subject of many clinical and theoretical research studies. Data in this area have been established and documented for many nations, and are very useful to various parties (such as health professionals, policy makers and researchers) who have an interest in reducing the harms that result from alcohol consumption. Treatment plans and programmes to reduce such harms would not be effective if they were not based on a sound understanding of alcohol consumers themselves.

Furthermore, although the demographic and psychosocial characteristics are useful in looking at alcohol problems on a macro level, they are even more useful in focusing attention on certain groups (such as religious, social, ethnic, economic, working or educational). After studying demographic characteristics among college students, Weschler, Dowdall, Davenport, & Castillo (1995) suggested the need for early intervention among high-school students as a way to prevent drinking problems in adulthood. Adams, Yuan, Barboriak, & Rimm (1993) and others have studied alcohol-related hospitalisations among elderly people using prior demographic data.

In this chapter, the literature related to the demographic and social characteristics, patterns of drinking, health and risk behaviours of drinkers are reviewed. The chapter is divided into three sections. The first is devoted to reviewing alcohol studies in Saudi Arabia. The second is a literature review of alcohol studies in the Arabian Gulf States and some other Arab countries. The third is a general review of studies of alcohol world-wide. This last section is divided into sub-sections: alcohol public surveys, alcohol in ethnic groups, alcohol in treatment, alcohol health risks, drunken driving, alcohol-related crime, and alcohol and smoking. It should be noted, however, that throughout this literature review a great emphasis is placed on demographic and social characteristics wherever applicable.

Alcohol studies in Saudi Arabia

Very few behavioural researches have been conducted with regard to alcohol use in Saudi Arabia. Some studies, of a largely theoretical kind, have concentrated on alcohol and Islam. Other studies have been of a purely medical and experimental nature involving

alcohol. The reasons for the lack of field behavioural alcohol studies are discussed in Chapter [No.3], 'Alcohol in Saudi Arabia'.

One of the first alcohol studies was that of Al-Angari (1988), which was carried out in two Al-Amal hospitals. The author attempts to investigate the relationship between the Minnesota Multiphasic Personality Inventory (MMPI) profile of alcoholic patients and the Michigan Alcohol Screening Test (MAST), and the interactions between the MMPI and personal characteristics (age, marital status, educational level and occupation).

A comparison is also made between the MMPI profile of alcoholic patients in Al-Amal hospitals in Saudi Arabia and the MMPI profile of alcoholics in the United States. 83 alcoholic patients in two addiction hospitals in Saudi Arabia participated in this study, and three questionnaires were used to collect the data. Key findings of this study were that Saudi alcoholics receiving treatment were most likely to be 34 years old or younger (85%), unmarried (>65%), and poorly educated (62% had reached intermediate level or lower), and about fifth of the subjects were unemployed. The researcher also found that overall there was no significant correlation between the MMPI profile and the personal characteristics (age, marital status, educational level and occupation) of hospitalised Saudi alcoholics. Although one of the main hypotheses of the study was to test personal characteristics against the MMPI, the researcher did not include enough personal characteristics to be tested. Characteristics such as level of income, living style, type of accommodation, number of people living with the subjects would have been very beneficial in providing more reliable results.

In order to explore the social factors related to the relapse of drugs users and abusers after receiving treatment, Al-Ryias (1995) surveyed 399 relapsed subjects in three Al-Amal hospitals in Saudi Arabia. He also, surveyed 100 patients who stayed sober for three months or more as a control group. 49 treatment members were included in the study.

When comparing the demographic characteristics of relapsed and unrelapsed alcoholics, the author found that relapsed alcoholics were most likely to be younger, unmarried, unemployed, living in urban areas, and with fewer years in education, and a lower monthly income. He also found that the death of one or both parents was higher among relapsed alcoholics. Having an alcohol user/abuser as a relative was higher among relapsed subjects. Although the study provided more insights into the demographic characteristics of alcohol

and drug users and abusers, it is not known how the control group (unrelapsed subjects) was selected. It would have been more useful if the author had drawn an overall picture of the demographic characteristics of both groups.

The demographic characteristics of 72 Saudi alcoholics in three alcohol treatment facilities (Al-Amal hospitals) have also been described by Al-Damigh (1997). The author attempts to explore the types of alcoholics in Saudi Arabia, using Jellinek's (1976) alcoholism classifications. An attempt is also made to compare the results of the study with 92 American alcoholics. The author found most of the subjects to be in middle age or younger (>50%) and unemployed (56.9%). Given the fact that the aim of the study was to classify the subjects according to Jellinek's typology of alcoholics, it would have been more useful had the researcher included more social characteristics and tested their relationship with each of the classifications.

In a more recent study of 122 addicts in Riyadh Al-Amal Hospital, Al-Anazi (1999) attempted to identify three dimensions of the alcoholic's and drug addict's personality (social, religious, and moral). The author uses the casework approach to achieve the aim of the study. The study concludes by summing up the characteristics of the addict. Of the 122 subjects, 47 were alcoholics. By focusing on the alcoholics' demographic characteristics, the researcher found that a large proportion of alcoholic subjects were in the age group 18–31 (49%), living in urban areas (78.3%), unmarried (53.2%), poorly educated (more than 70% were below the intermediate level), living with one or both parents (53.2%), and living with 4 people or more (90%). He also indicated that 40.4 percent of alcoholic subjects were unemployed and that more than half were earning an income lower than SR3000 (around £ 600).

It is clear that the results of all these four Saudi studies (Table 9) of the characteristics of drinkers are very similar, except as regards work status. Being young, unmarried, poorly educated, unemployed, and urban resident were the most common characteristics of hospitalised Saudi alcoholics.

However, several points are worth mentioning about these four studies. Two of them relate mainly to the subject of alcohol, whereas in the other two alcohol is included as one among other drugs being studied. In addition, none of the four studies provided sufficiently detailed information regarding the drinking problem of the hospitalised Saudi patients. Information should have included a comprehensive profile of the drinker, patterns of

drinking, details about the onset of the problem, the drinker's health status, harmful practices and the consequences of the drinking problem. Finally, in none of the four studies was the study population taken from all the treatment hospitals in Saudi Arabia. Therefore, the generalisability of the findings to all Saudi problem drinkers is questionable. The present study is carried out to provide a clearer picture of hospitalised Saudi problem drinkers, and to overcome the shortcomings of the previous studies.

Table 9. A comparison of four Saudi studies on the characteristics of hospitalised male alcoholics*

	Al-Angari	Al-Ryias	Al-Damigh	Al-Anazi
Year of the study	1988	1995	1997	1999
No. of hospitals	2	3	3	1
No. of subjects**	83	?	72	47
Age	Less than 34	Young	Less than 34	18–31
Marital status	Unmarried	Unmarried	--	Unmarried
Education	Low	Low	--	Low
Working status	Employed	Unemployed	Unemployed	Unemployed
Income	--	Low	--	Low
Residential situation	--	--	--	With parents
Residential area	--	Urban	--	Urban
No. of people with the subject	--	--	--	4

Alcohol studies in Arabian Gulf States and some Arab countries

The demographic characteristics of alcoholics in the neighbouring Gulf States, which have a similar religious, economic, social, and cultural background to Saudi Arabia, are worthy to be mentioned. In spite the fact that alcohol drinking is legally permitted in Bahrain, the demographic characteristics are to some extent similar to those of Saudi alcoholics. According to Musaiger (1985), alcoholics in Bahrain are most likely to be Bahraini nationals, male, single, and 30– 39 years old. Most fall in the category of blue-collar workers and a small percentage of them are unemployed. Comparing the characteristics of Bahraini alcoholics to those of Saudi Arabia, it is noticeable that alcoholics in Bahrain are older and are more likely to be married.

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* The comparison presented here is showing the most occurrence of the variables among the subjects.
** Only subjects with alcohol problem presented here.

Exploring alcohol use in Qatar, where the consumption of alcohol is not allowed, Al-Eisa (1983) found that most alcohol drinkers were aged 25–29, and that they started drinking at an early stage in their life. Since alcohol is not allowed, many of them consume cologne. It should be noted that the sample selection might be biased since it was not a random sample.

In Kuwait, 10-year records (1961–1970) of patients with alcohol problems who had received alcohol treatment in mental health hospitals revealed that most of them were 40 years old or younger, were civil employees, and consumed hard liquor (The Arabic International Office for Crime Prevention, 1975). This study did not reflect the actual number of people in need of alcohol treatment, since the records were taken from mental health hospitals, and at that time no treatment facility was developed specifically to treat alcoholism.

As in Saudi Arabia and Kuwait, alcohol consumption in Oman is not allowed. In studying the use of alcohol in Oman, Al-Kindi (1996) based his study on data taken from criminal records. The author indicated that 1166 individuals had been incriminated for the possession and/or use of alcohol in 1987. Of those, 976 were Omani nationals, only one was female, and they belonged to the age group 25–30 years of age.

In Iraq, however, where alcohol is permitted, a study was conducted on 577 alcoholics (Kamar, 1985). The study indicated that alcoholics in Iraq were most likely to be in the age group 30–39, male, single, middle class, with a close alcoholic relative, and living in urban areas. About 19 percent had psychiatric problems of some sort.

Although a long time ago, a study was carried out on 126 hospitalised alcoholics in Egypt (The Arabic International Office for Crime Prevention, 1975). The study revealed that of all patients only one female had received treatment. The study also indicated that most of the subjects were between the age of 30 and 49, self employed, married, and had higher incomes.

It is noticeable that almost all of the studies in Arabic with regard to alcohol have been undertaken in treatment settings. No single study on the prevalence of alcohol use in any Arab country is available, in spite the fact that the consumption of alcohol is permitted in most Arab countries, namely Bahrain, the United Arab Emirates, Egypt, Iraq, Syria, Jordan, and the Arab countries in North Africa (except Libya). Although officials in some

Arab countries claim that alcohol-related problems are not serious, and that alcohol consumption is not yet considered a problem , such claims are very old, and hard to believe unless proven through scientific studies. The reality that alcohol-related problems do exist, no matter where, is well known. Of course these problems vary in their level and intensity from one society to another but they are there. In fact, being a drinker is a problem per se in Arab countries, where most people, on religious and social (not to mention legal) grounds, do not accept alcohol drinking. Whatever the reasons for not conducting studies on alcohol use, the need for such studies in all of the Arab countries remains reasonable.

Alcohol studies world-wide

In many other countries, in contrast to those of the Arab world, studies on the use of alcohol have periodically been conducted. In the remainder of this chapter, some of the relevant studies on alcohol consumption in the rest of the world are reviewed. It should be noted, however, that the selection of such studies is based on their relevance to the topic of this study and its particular research questions, and that this review aims only to exemplify the wide range of studies on alcohol around the world. The rest of the literature review is divided into sub-sections each of which addresses a specific aspect of the subject.

Population surveys

In order to have a holistic understanding of alcohol use and abuse, and to track present trends, national surveys to measure the prevalence of alcohol are periodically carried out by epidemiologists in many countries. Such studies help governments, policy makers, health professionals, researchers, and other interested parties to plan preventive and treatment measures or programmes to overcome problems related to alcohol consumption. Demographic characteristics of alcohol users and abusers are normally included in such studies.

For example, a national study to explore patterns of drinking has been conducted in Bulgaria (Balabanova, 1999). The study indicates that 50.7 percent of men and 13.6 percent of women drink at least weekly. Normal drinking mostly occurs among young people with good education and high incomes who live in urban areas. According to the authors, Muslims are less likely to drink than are orthodox Christians. Furthermore, heavy drinking is most common among men, those living in Sofia, and those with higher incomes.

Using different sources of information, including national public surveys, a report on alcohol consumption in the United Kingdom has been issued by the British Department of Health (June 2001). According to this report, the mean weekly alcohol consumption in Great Britain in 1996 is 16.0 units (a unit is four pints of beer or equivalent) for men and 6.3 units for women, compared to 16.3 and 5.3 units respectively in 1986. In 1998, nearly 39 percent of men drank more than four units of alcohol on one day in the previous week and around 21 percent of women drank more than 3 units of alcohol on one day in the previous week. The proportion of those reported drinking more than four units of alcohol on one day in the previous week varied sharply with age, ranging from around half of men aged 16–24 to around one in seven of men aged 65 and over. However, 34 percent of women aged 16–24 and one in twenty of those aged 65 and over reported drinking more than three units of alcohol.

The report also indicated that in 1996 women in non-manual socio-economic groups were more likely than those in manual groups to drink over fourteen units a week. Although men were not significantly different, 28 percent of those in non-manual groups drank over 21 units, compared to 26 percent of those in manual groups.

With regard to alcohol dependency, as defined by the ICD-10 (1992), the report estimates that the annual prevalence rate of alcohol dependence in Great Britain is 75 per thousand population among men aged 16–64 years and 21 per thousand population among women in the same age group. Alcohol dependence is more prevalent in younger age groups. For both men, and women, the prevalence is highest among those aged 16–29.

The prevalence of alcohol in the United States has been surveyed by the National Household Survey on Drug Abuse NHSDA in 1997 (Office of Applied Studies, June 2001). According to this survey, approximately 177 million (82%) of the 216 million people aged 12 or older in 1997 reported alcohol use in their lifetime; an estimated 139 million persons (64%) reported use in the past year; and 111 million persons (51%) reported current use (in the past month).

The survey also found that among all of the adult age groups, whites were more likely than blacks and Hispanics to report life-time, past year, and past month alcohol use. White adolescents were more likely than black and Hispanic youths to report past month use, and past year alcohol use among adolescents was less likely among blacks than among whites or Hispanics. Moreover, alcohol use was found to be more prevalent in the North-East or

North Central regions, in adults with college education or more, and among persons employed full-time.

The prevalence of alcohol consumption in Greece was studied by Madianos, Gefou-Madianou, & Stefanis (1995) by means of a nation-wide home survey. The study showed that males were found to drink more frequently than females in all age groups. Higher proportions of females in all age groups were abstainers than their male counterparts. Moreover, the majority of the sample population aged 24–44 years among both men and women were drinkers. In this group the lowest proportions of abstainers were observed. The authors also indicated that problem drinking was found to be associated with sex and excessive drinking in the family, the use of tobacco, psychotropic and illicit drugs, school drop-out, and an average socio-economic status.

Using the educational level as an independent variable, van Oers, Bongers, van de Goor, & Garretsen (1999) conducted a general population survey among 8,000 people to obtain more insight into the relation between Social Economic Status (SES), alcohol consumption, alcohol-related problems, and problem drinking in Rotterdam. The authors found that abstinence decreased significantly with educational levels in both sexes. For men, excessive drinking, and notably very excessive drinking, was more prevalent in the lowest educational group. For women, no significant relation between educational level and prevalence of excessive drinking was found. The study concluded that differences existed between educational levels with respect to abstinence, but only limited differences were found with respect to excessive drinking.

The same Rotterdam data were used to assess the prevalence of alcohol among the total population and sub-populations defined by sex, age, marital status, educational level, daily activities and income (Bongers, van Oers, van de Goor, & Garretsen, 1997). The study found that the majority of the respondents were light or moderate drinkers. Prevalence of excessive drinking, alcohol- related problems (one or more), and problem drinking in the total population was 8 percent, 28 percent and 9 percent respectively. It was shown that women tend to report many alcohol-use-related problems despite their relatively low consumption pattern. Further, young men have a high prevalence of problem drinking, especially if they are single, unemployed, and have been declared unfit to work.

Varvasovszky & McKee (2000) conducted a study into the prevalence of problem drinking among the hospitalised population in Hungary. The study used a survey of self-reported

alcohol consumption and current or life-time problem drinking among hospitalised patients in the four teaching hospitals in Hungary. The subjects were all patients (n = 3140) admitted to medical, surgical, trauma, psychiatric and neurological wards over a two-week period in 1997 who stayed in hospital for at least 24 hours. The study results showed that 23.5 percent of men and over 53.5 percent of women reported never drinking alcohol. Of those who did drink, about one in eight men and less than 1 percent of women reported drinking five or more drinks a day when they drank. With respect to the prevalence of problem drinking, the authors indicated that approximately 19 percent of men and 2 percent of women were problem drinkers. Furthermore, problem drinking was higher among men aged 35–44 years. According to the authors, employment or education did not seem to vary significantly among problem drinkers. However, the rate of problem drinking was higher among those who were divorced.

Generally, despite some variance from one country to another, the above population surveys show that alcohol consumption is more prevalent among men than women and among the young than other age groups. Excessive drinking and problem drinking, however, are most likely to occur among men who are unmarried (single, separated or divorced), young, poorly educated and unemployed (or in part-time jobs).

Another point that could be drawn from the above reviewed studies is that, unlike Saudi Arabia and the rest of the Arab countries, studies to assess alcohol consumption and its related problems are continuously carried out by many countries around the world. Such assessments would help towards a better understanding of alcohol-related problems and the design of more effective solutions. It is clear also that an integral part of understanding a problem is the identification of those most affected, such as teenagers, minorities and women.

Characteristics of drinkers in treatment settings

Although studies examining the characteristics of people receiving treatment for alcohol problems do not reflect the characteristics of the entire populations of people with drinking problem, they provide valuable information that can be utilised for both prevention and treatment programmes. Such studies differ in terms of the size and type of the sample being studied (for example, in-patient alcoholic women (Herzog & Wilson, 1978), adolescents (Weiss & Moore, 1994), rural dwellers (Booth et al., 1999), and the elderly (Colsher & Wallace, 1990), the methodology, and the aims of the study. While

Hesselbrock, Stabenau, Hesselbrock, Meyer, & Babor (1982) attempt to examine the consequences of alcohol abuse using the demographic characteristics, Connors, Tarbox, & McLaughlin (1986) attempt to categorise alcoholics as binge or continuous drinkers according to a number of demographic and drinking-history variables.

The characteristics of clients receiving treatment for alcohol problems in the United States were examined by the National Evaluation Data and Technical Assistance Centre (June 2001). The results indicated that those abusing alcohol as opposed to any other drug tended to be older, more often white, somewhat more educated, and more likely to be employed before entering treatment than users of other drugs. The results also showed that, with the exception of driving under the influence (DUI) and driving while intoxicated (DWI) offences, clients who had used only alcohol exhibited fewer instances of criminal behaviour and arrests before treatment.

In Israel the background characteristics of 1,173 alcoholics hospitalised for three months in the Residential Centre for Alcoholics have been explored (Weiss, 11 July 2001). The authors indicate that the profile of the typical hospitalised alcoholic is that of a Jewish, urban, married, unemployed man, born in Asia/Africa (or in Israel), who has been living for many years in Israel, has many children, and a low educational level. They usually started drinking in adolescence (have family relatives who drink) and come to the centre after more than fifteen years of drinking, mainly at home and alone.

The risk factors associated with discharge from in-patient alcoholism treatment against medical advice (AMA) and the underlying reasons for these discharges have been examined by Cook, Booth, Blow, McAleenan, & Bunn (1994). The study attempts to analyse the characteristics of patients and their index hospitalisation obtained from a systematic review of medical records for 186 alcoholics who were discharged AMA and 201 alcoholics who completed treatment. The authors have found that college education, vocational or other training, being employed, and having a history of previous AMA discharges significantly increased the risk of AMA.

In an attempt to understand the relationship between depression and drinking excessively, Beck, Steer, & McElroy (1982) conducted a study on 76 male and 29 female out-patient alcoholics. A number of instruments to assess the subjects' level of depression were administered. The authors indicated that depression was described by 45.7 percent of the alcoholics as having preceded their starting to drink heavily; 15.2 percent denied ever

having been depressed; and 39.1 percent stated that their alcoholism had preceded the development of depression. When analysing the psychosocial characteristics of the subjects, the authors concluded that persons who described themselves as having been depressed prior to developing alcoholism were more likely to be women, white, and previously hospitalised for alcoholism.

The different demographic characteristics of alcohol abusers in different populations have led clinicians to suggest the use of varying treatment and preventive approaches according to the population concerned. Price (1987), for example, has made a comparison between those receiving alcohol treatment in two different centres – Queensland, Australia, and Merseyside, England. The author has found that more drinkers in Queensland were divorced or separated, fewer were employed and far fewer expected to return to their families after discharge from the units. The author also indicated that Queensland families were reported as more often unaware of the drinking, more rejecting, less concerned and less aware of alcohol-related physical symptoms and put less pressure on the drinker to eat properly.

The characteristics of relapsed alcoholics have been examined by Yates, Booth, Reed, Brown, & Masterson (1993) using a high-risk alcoholism relapse (HAR) model. Applying the model to 299 male alcoholics, the authors found that the HAR model identified 107 (35.8%) alcoholics at high-risk for relapse prior to discharge. Of the HAR group, 61 percent were re-admitted within 6 months, compared to 28 percent of the low-risk alcoholism relapse (LAR) group. When testing the characteristics of both HAR and LAR, the author concluded that the HAR group was older with a lower socio-economic status, fewer legal problems, more physical and mental health problems, and decreased evidence of social support. However, Booth, Yates, Petty, & Brown (1991), after studying 255 patients discharged from alcoholism treatment at a midwestern rural medical centre, have found that socio-demographic variables do not appear to predict the time for re-admission.

In terms of their choice of admission (voluntary versus involuntary), the characteristics of alcoholic patients undergoing treatment have been examined by Calsyn, Reynolds, O'Leary, & Walker (1982). 78 males were separated into two groups based upon the demographic dimension of whether or not the patient was in treatment primarily as a result of legal pressures imposed due to alcohol-related motor vehicle violation (N = 23) or for a variety of personal/non-legal reasons (N = 57). Although no differences were found on any

of the personality or demographic measures, the authors found that the legal group did not appear to suffer as severely from the effects of alcohol as the non-legal group, perhaps because it represented an earlier stage of problem drinking.

It is clear that the characteristics of people utilising alcohol treatment facilities vary from one country to another. Whereas, for example, unemployment characterises the patients in Israel, it does not in the United States. In addition, divorced or separated patients are more prevalent among clients in Australia, while married clients are more prevalent in Israel. Moreover, the characteristics of those entering treatment vary according to their reasons for seeking it (for example, voluntary versus involuntary admission).

The variation in demographic and social characteristics of individuals undergoing treatment, as revealed in the findings of different studies, indicates that these characteristics interact with others (such as time, place, culture, personality, laws, and the expectations of oneself and others) to produce the particular problems of each individual. This suggests the need for studies that periodically compare the characteristics and alcohol-related problems of those entering treatment in different countries.

The demographic and social characteristics of hospitalised problem drinkers in Saudi Arabia, therefore, are expected to be somewhat different from those of other populations either inside Saudi Arabia or abroad.

Patterns of drinking

Drinking patterns and their relationship with the demographic and social characteristics have been the subject of many studies. Studying 3000 survey respondents, Knibbe, Drop, & Muytjens (1987) found that periodic drinking occurs in younger groups while daily home drinking was more often found in older age groups. The authors also found that heavy drinking occurs more often among the unemployed. The study concludes that people with less structured lives are inclined to intensify their consumption and are more vulnerable to harmful effects.

According to the Office of Applied Studies (June 2001), in 1997 approximately 7 percent of those aged twelve or older in the United States were daily or almost daily drinkers: that is, they had consumed alcohol on twenty or more days in the past month. Males were more likely than females to drink daily or almost daily in the past month. Daily alcohol use was

more than twice as likely among adults older than 34 years compared with those aged 18–25. A small percentage of youths aged 12–17 (only 0.8%) reported daily or almost daily drinking. Daily drinking was more than twice as prevalent among whites as among either blacks or Hispanics, whose frequencies of drinking were about equal. Rates of drinking over periods of twenty to thirty days and five to nineteen days did not differ across regions. With regard to adult education, the lowest rate of daily drinking occurred among persons who had not completed high school, and college graduates were two to three times more likely to use alcohol daily or almost daily.

The survey also indicated that nearly 15 percent of the total population of household residents aged twelve or older reported binge drinking in the past 30 days. Overall and in every age group, males were more likely than females to report binge drinking; in the adult age groups, the ratio was two or three to one. Overall and in each age group except the 35 or older cohort, whites and Hispanics were more likely than blacks to have 'binged' on alcohol in the past month. Among adults aged 18–34, the prevalence of 'binge' drinking among whites also was significantly higher than among Hispanics.

The location of drinking, as a part of the patterns of drinking, and its association with the demographic characteristics have been investigated by Treno, Alaniz, & Gruenewald (2000). Their study was carried out on 24,778 current drinkers from four California and two South Carolina communities. The result showed that the highest percentage of subjects reported drinking at home (3.85 times per month) followed by the usage in the homes of others (0.83 times per month), usage at bars and restaurants (0.77 times per month), and usage at parties and special events (0.37 times per month). Also, the authors found that the use of home as a drinking place was greater among respondents over 50 years of age, males, and those with incomes between $50,000 and $60,000 per year. It was less for those under the age of 30, female, Hispanic and blacks. Drinking at others' homes was greatest for minors, males, single persons and the unemployed, and least for female. Bars and restaurants were most frequently used by respondents aged 21–30; single, separated, or divorced males; and those with annual incomes between $50,000 and $60,000. They were infrequently used by females, married or widowed, those with less than a high school education, blacks and Hispanics, and those with 'other' employment status. Drinking at parties and special events was most frequent for those under 21, single people, the unemployed, and those with incomes between$50,000 and $60,000. It was least frequent for widowed individuals.

The relationship between the pattern of drinking and health risks is very well established in the literature. Examining hospital admission histories covering periods of up to six years, Kolb & Gunderson (1981) found that their alcohol abuse group had a significantly higher mean number of hospital admissions and days hospitalised for conditions other than alcoholism than did the controls. The authors also indicated that mental diseases were a major cause of morbidity in the alcohol abuse group but not in the control group. The study concluded that differences in illness rates were related to identification as alcohol abusers

The authors indicated that different variables measured in 1989 were predictive of changes in alcohol consumption in 1991. Those who quitted alcohol intake were most likely to be unmarried, to consume sleeping pills, and to perceive themselves as having bad health status, whereas those who decreased their alcohol intake were most likely to be non- or ex-smokers, less exposed to occupational risks, on a diet, and heavy drinkers. Finally, those who increased their alcohol consumption were more likely to work in unfavourable conditions, have more disease, and to be smokers.

Alvarez & del Rio (1994) found that males who drank more frequently (with a high intake of alcohol) were more likely to be hazardous drinkers, and started drinking earlier than females. The authors also found that both sexes drank beer in a similar way, but not wine and spirits. In another article (1994), but using the same data, the same authors indicated that the percentages of single and unemployed subjects among problem drinkers were higher than among non-problem drinkers.

The physical, psychological and social consequences of drinking habits on the drinker throughout his or her lifespan was the subject of a study by Colsher & Wallace (1990). In a population-based (N = 1,155, mean age = 73.7 years) longitudinal survey of community-dwelling elders, the authors examined the characteristics of elderly men with self-reported histories of having been heavy drinkers (H+). 10.4 percent of the men reported that they had been heavy drinkers at some time during their lives. The results showed that H+ men were younger and less educated than non-heavy drinkers (H–) or never drinkers (N). In addition, the authors found that mortality was higher among H+ men who were current drinkers than among H– or N men. H+ men reported more major illnesses, poorer self-perceived health status, more physician visits, more depressive symptoms, lower levels of life satisfaction and smaller social networks than did H– or N men. Self-reported ability to perform activities of daily living and instrumental activities of daily living was poorest among H+ men, who also scored the lowest on a mental status examination. The study concluded that a history of having ever been a heavy drinker is predictive of widespread impairments in physical, psychological and social health and functioning among elderly men.

Many research studies have also focused on the drinking patterns of the young people. According to the Royal College of Physicians and the British Paediatric Association (1995), at thirteen years of age 80 percent of boys and 73 percent of girls have

experimented with alcohol in Britain. By the age of fifteen 91 percent of boys and 90 percent of girls have tested alcohol. Moreover, the average consumption of thirteen year-old boys is eight units per week, compared to six units for girls. The average consumption for fifteen year-old boys is fifteen units per week, compared to nine units for girls.

In addition, 28 percent of boys and 15 percent of girls aged thirteen reported having been drunk at least once in the previous year, and among the fifteen year olds the percentages were 55 percent for boys and 48 for girls.

After studying a sample of teenagers aged 14–16 in England, Plant, Bagnall, & Foster (1990) indicated that heavy drinkers were significantly more likely to report drinking in a mixed sex group than were other teenagers. They were also more likely than others to have drunk illegally in licensed premises, and were distinctive from other teenagers in relation to their self-reported reasons for drinking and their alcohol-related beliefs. In another study carried out in Scotland on 7009 Scottish teenagers aged 14–16, Plant & Foster (1991) estimated that 18.9 percent of males and 10.3 percent of females reported consuming eleven or more units on their last drinking occasion. The authors concluded that Scottish teenagers were more likely than those in England to drink heavily and rather less frequently. Forsyth & Barnard (2000) have raised cautions about the risky drinking behaviour of a proportion of Scottish schoolchildren who consume alcohol in a variety of public or hidden outdoor locations where intoxication, high alcohol content and large volumes are likely to occur.

While alcohol is used moderately by most people, heavy use is most common among those who are male, young, unemployed, poorly educated, and have a less structured life. Moreover, binge drinking is more prevalent among male, young minors, and white and unemployed populations. As far as drinking locations are concerned, young people are most likely to drink outside their homes while old people are most likely to drink at home.

However, there are great differences in the patterns of drinking between groups, regions, social classes, religions, cultures, and countries. Such differences suggest the need to assess and understand the drinking patterns of Saudi problem drinkers. Such understanding would help in identifying the risk factors to oneself and others in practising certain drinking behaviours.

Health and drinking

Health professionals are increasingly becoming convinced of alcohol-related health problems. Balabanova & McKee (1999) indicate that alcohol consumption is a major cause of disease and premature death. In addition, alcohol is responsible for health problems such as injuries (Risser, Bonsch, & Schneider, 1996), assaults (Blair & New, 1991), domestic violence (Felitti et al., 1998), and road accidents (Senseman, 1971).

Problem drinkers are believed to have many health problems. A comparison study between problem drinkers (n=3729) and non-problem drinkers to evaluate their utilisation of injury medical services was carried out by Blose & Holder (1991). The study findings revealed that, after controlling for age, gender, and number of years of enrolment with the same company medical plan, problem drinkers utilised injury-related medical care at a rate 1.6 times that of the comparison group and experienced injury-related medical care costs which were three times as high. The result of this study was consistent with another study carried out by Rush & Brennan (1990) in Canada.

Examining the prevalence rates of alcohol problems among emergency room patients in Thailand, Lapham et al. (1998) interviewed all patients seeking emergency room care at one of the three participating hospitals between 18:00 and 02:00 hours who were aged fourteen or older. Of the 992 patients who completed the questionnaire (Alcohol Use Disorder Identification Test), 39 percent of the male and 8 percent of the female patients were alcohol abusers. The authors identified the risk factors for alcohol problems to include male gender, an age of 20–49, a high monthly income, less than university graduate education status, and of those admitted to the North-East region hospitals.

Alcohol as a cause of premature death has been examined by Liskow et al. (2000), who followed up 360 male alcoholics over a period of 10–14 years. The authors found that 26.6 percent of the total sample were confirmed as deceased at the 10–14 years follow-up. The demographic characteristics of the subsequently deceased men were older, had less education, lower psychosocial functioning, more medical problems and greater psychiatric severity. The study concluded that alcoholic men, especially those in the group aged 35–44 years, had a significantly higher risk of premature death than a reference group of men.

Although many studies have showed the association between alcohol consumption and mortality, other researchers have indicated that the consumption of alcohol can be

beneficial for the heart. For example, San Jose, van de Mheen, van Oers, Mackenbach, & Garretsen (1999) attempted to examine the relationship between average alcohol intake and mortality. The study was carried out within the framework of a general population survey conducted in Eindhoven, The Netherlands (N = 18,973). The study findings showed that although mortality rates were high among frequent heavy drinkers and abstainers, not only did light or moderate drinkers have lower mortality but their other health burdens were also lower than for either abstainers or heavier drinkers. The study concluded that a U-shaped pattern was observed for mortality as well as for several other health measures. A similar conclusion has been reached by another study by Kannel & Ellison (1996).

The type of alcoholic beverage consumed and its relationship to health problems have also interested some researchers. Chou, Grant, & Dawson (1998) have conducted a study using a recent national household survey of the general US population on drinking practices, alcohol-use disorders and their associated disabilities in order to examine the prevalence of a broad range of alcohol-related diseases with respect to preferred beverage type, as well as consumption level. The study findings showed a reduced health risk associated with beer and wine drinking for a number of physical disorders, and a somewhat favourable cardio-vascular effect of these two beverage types in relation to abstention. Among those who preferred beer, wine, and liquor, the results indicated that liquor preference was associated with increased morbidity for several medical conditions. However, high association was established between rectal cancer and the consumption of beer (The Royal College of Physicians, 1991), and between laryngeal cancer and drinking in general (Hedberg, Vaughan, White, Davis, & Thomas, 1994).

Although the consumption of alcohol in small amounts and less frequently is shown to be associated with reduced health risks, more alcohol-related health problems are associated with excessive drinking. It follows that the demographic and social characteristics of heavy drinkers and alcoholics are the same characteristics of those who suffer from alcohol-related health problems.

Whereas studies on alcohol-related health problems are well established, no single study identifying health problems of alcohol users and abusers in Saudi Arabia is available. The patterns of drinking and the lifestyle of the drinker, along with other factors (such as guilt feelings or fear of being caught or seen), are all factors that might affect the health of Saudi problem drinkers. A knowledge of the health problems particularly related to drinking

behaviour would at least make Saudi problem drinkers aware of the health risks surrounding them.

Drinking and driving

One of the main problems related to alcohol is driving while intoxicated. Statistical reports and research studies documenting the involvement of alcohol with traffic accidents are overwhelming (e.g. Deery & Love, 1996; Holder et al., 1997; Li, Shahpar, Soderstrom, & Baker, 2000; Runge, Pulliam, Carter, & Thomason, 1996).

Many studies have attempted to identify the characteristics of drunk drivers, their patterns of drinking, and their reasons for drinking and driving. For example, it has been estimated that about 10 percent of high school students were identified as drunk drivers (Beck & Summons, 1987). Chang, Lapham, & Barton (1996) have attempted to investigate the relationships between drinking locations, socio-demographic characteristics and drinking-environment-related factors of convicted driving while intoxicated (DWI) offenders. The subjects were clients (N = 5,154, 79% male) referred to the Lovelace Comprehensive Screening Programme for alcohol-related assessment and were interviewed by counsellors using a structured, computer-based questionnaire. The study findings showed that those who were young, single, male, of Hispanic or Mexican nationality, and divorced/separated/widowed had a higher rate of DWI convictions, compared to the overall adult population of the country. Moreover, the study found that older, educated or employed offenders reported drinking more in bars/lounges, while younger offenders were more likely to drink at private parties. Also, Hispanic and Mexican men showed an equal likelihood of drinking with friends and relatives in bars/lounges, whereas non-Hispanic white males reported drinking more with friends. In addition, the study showed that native Americans were associated with higher blood alcohol concentration (BAC) and alcohol-related problems.

A cross-sectional descriptive study was conducted by Rogers, Gijsbers, Raymond, McMahon, & Whelan (1997) to compare the socio-demographic characteristics, patterns of alcohol consumption and driving histories of women and men drink-drivers. The study subjects were all 156 women who attended the Drink-Drive Programme at St Vincent's Hospital, Melbourne, between January 1990 and December 1993, and an age-matched sample of 298 men attending in the same period. The authors found that the women had a higher educational level than the men, and were more likely to be managers or

professionals and to live in areas of high socio-economic status. According to the authors, the women reported lower levels of weekly alcohol consumption at both apprehension and during the programme. 60 percent of the women drank wine, or wine, beer and spirits, while 75 percent of the men drank beer. Finally, the women had lower Michigan Alcoholism Screening Test scores than the men, and were less likely than the men to have prior convictions for drink-driving or other traffic offences.

Another study was conducted by Holubowycz & McLean (1995) to examine the demographic characteristics, usual drinking and drink driving patterns, incidence of problem drinking, pre-crash drinking behaviour and attitudes towards drink-driving. The study was carried out by interviewing a sample of 302 male drivers and motorcycle riders admitted to the Royal Adelaide Hospital in Adelaide, South Australia. Using Blood Alcohol Concentration (BAC) on admission, along with other instruments, the study findings showed that high BAC was associated with a high percentage of subjects reporting a high quantity and frequency of alcohol consumption. Beer was the preferred drink, as was drinking alone, in a hotel, and for various less socially acceptable reasons than those with lower BAC. In addition, subjects with high BAC were more likely to have frequent drink-driving offences, previous drink-driving suspension and more liberal attitudes towards drink-driving.

Similarly, Metzger & Platt (1987) found that drinking drivers referred to the Philadelphia Alcohol Highway Safety Program were most likely to be older, male, and to demonstrate an unusually high degree of familial and social disruption. The authors also indicated that prior arrest histories for similar offences and impairment of functioning at the time of arrest also characterised those drinking drivers.

When testing the cultural factor among 249 Mexican-American and 250 white drinking drivers, Cherpitel & Tam (2000) found that risk-taking/impulsivity and sensation-seeking were positively associated with multiple-offender status among Mexican Americans, but not among whites. The study findings also showed that Mexican Americans were more likely than whites to believe they would not be arrested and to consider that driving while intoxicated was not a problem.

It is clear that not all alcohol consumers drive their vehicles under the influence of alcohol. However, there have been serious attempts to identify the risk factors associated with those who drink and drive. In general, being relatively young, male, unmarried (single, divorced

or separated), with a previous history of drink-driving, social and family problems, and a liberal attitude toward drinking and driving are most common characteristics of drink-drivers.

As is the case for many alcohol-related problems, the subject of drinking and driving has never been discussed or studied in Saudi Arabia. It is important to assess the prevalence of drink-driving among Saudi problem drinkers, especially since we know that alcohol consumption is illegal, and that some people practise their drinking outside the city or in others' homes. Being unaware of the risks of driving under the influence of alcohol may cause them to harm themselves or others. One of the aims of the present study is to assess the problem of driving under the influence of alcohol.

Discussion

Before proceeding to the discussion, it should be made clear that there is a huge amount of related literature on alcohol that cannot be included in this review, for the aspects of alcohol use investigated in this research are too many. Therefore, it was hard to concentrate on reviewing the literature through focusing on only one or two aspects. Also, due to the scarcity of the Arabic literature on the subject of alcohol, the literature of alcohol from around the world is reviewed.

Needless to say, the selection of the studies has been based on their relevance to the topic of this research. It has been the attempt of the researcher to provide various examples of the views and results of alcohol studies from different parts of the world. Finally, the selection of such studies was brought as self-evident that each country has felt the need to assess their own problems with regards to alcohol consumption.

It is clear from reviewing the literature that alcohol consumption is a very complex subject, and that the patterns of alcohol consumption and the problems associated with it are changing all the time. This may explain why there are huge numbers of alcohol studies in the west. However, because of the complexity and changing patterns, further investigations in certain areas (such as the dynamics behind alcohol and aggression), and periodic examination to keep track of the changes are constantly needed.

Studies on alcohol consumption among the general population, and of those on high-risk populations in particular, are very useful in the devising of treatment and prevention plans.

Owing to the complexity of the subject of alcohol use, it is quite difficult to draw a specific conclusion about all related aspects of alcohol consumption at a macro level. Avis (1993) points out that 'alcohol abusers are black, white, and oriental, old and middle-aged; rich, poor and in between; male and female; highly educated and abysmally ignorant'. However, a conclusion can be reached with more confidence if the unit being studied is well defined (e.g. a population of specific age, alcoholic patients, an ethnic group, offenders, or drunk drivers), and the variables are well established (e.g. patterns of drinking, personality of drinkers, demographic and social characteristics, health of the drinkers, or road accidents related to alcohol).

It is very clear that the wider the population or group (or multi-groups) the more diverse and complex it would be in terms of identifying the demographic and psychosocial characteristics or the patterns of drinking. For example, it might be easier to identify certain characteristics of hospitalised problem drinkers than to identify the characteristics of problem drinkers in the general population. The smaller the unit being studied the more specific the results will be. However, generalisability of the results to other populations is hard to achieve.

Another point is that studies on alcohol consumption can be best understood if they are carried out within the social, cultural, religious, political and economic context of the population being studied. Unfortunately, alcohol studies with reference to Saudi Arabia and the rest of the Arab world are lacking, while they are well established in elsewhere.

Although most of the reviewed studies do not directly concern alcohol-related problems in Saudi Arabia, the topics addressed by these studies are not irrelevant to the topics examined by the present study. Moreover, the massive amount of studies carried out on alcohol around the world show the weakness of Saudi and Arab researchers in the area of alcohol.

Given the argument above, it is reasonable to say that each of the variables in this study – the population of the study (Saudi hospitalised problem drinkers), the topic (alcohol), the place (all treatment centres), the time (now), or the variables being tested (psychosocial profile) – provides sufficient justification for the present research.

Chapter 4. Methodology and design

Introduction

The purpose of this chapter is to describe the methodology design as well as the procedures of this research. However, it is worthwhile, before proceeding with the description of the research methodology and design, to discuss an issue related to measurement. That is the issue of applying standardised measures, originated in a certain culture, to be used in another culture. Therefore, this chapter is divided into two sections. The first section (pre-methodology) discusses the applicability of standardised measures to other cultures: case example of assessing individuals with an alcohol problem in Saudi Arabia.

The second section is the description of the study methodology and procedures. It is divided into two subsections too. The first is devoted to describing the methodology and procedures used for collecting data from the patients. The second subsection is describing the design and procedures for collecting data from the therapists.

Wrong Assessment, Wrong Intervention

(The applicability of standardised measures to other cultures: case example of assessing individuals with an alcohol problem in Saudi Arabia)

Introduction

'Standardised measures' (SM) are tools or instruments that are pre-tested for their validity, reliability, sensitivity and specificity. They can be used by researchers and/or professionals to assess, screen or diagnose problems, events or people. The use of standardised measures in other cultures is widely recognised and acceptable. However, little attention has been given to their efficiency, applicability and/or the validity of their results when applied to different cultures. It is the aim of this paper to draw attention to the limitations of using what I call the *cutting and pasting* of standardised measures without giving enough consideration to their applicability to a given culture.

The misuse of SM can give rise to both methodological and ethical problems, as well as producing misleading results. These problems can be avoided if cultural variables and differences are taken into account.

In an attempt to address the issue of applying SM to other cultures, some SM relating to alcoholism are presented and used as an example of how their use can be problematic when applied to Saudi Arabian society.

There are more than 70 standardised instruments that can be directly related to alcohol. These instruments can be used to screen, assess or diagnose (Cooney, Zweben, & Fleming, 1995) many alcohol-related symptoms. Some of the most popular measures are the Michigan Alcoholism Screening Test (MAST) (Selzer, 1971), Short Michigan Alcoholism Screening Test (sMAST) (Selzer, Vinokur, & van Rooijen, 1975), CAGE (Mayfield, McLeod, & Hall, 1974), Munich Alcoholism Test (MALT) (Feuerlein, Ringer, Kufner, & Antons, 1979), and Alcohol Use Disorder Identification Test (AUDIT) (Babor, de la Fuente, Saunders, & Grant, 1992). These tests are widely used for research and clinical purposes. Other alcohol-related instruments are available but they are less commonly used. Some of the standardized instruments are designed to measure one or more aspect of alcohol consumption in particular situations or types of population. Examples of these special instruments are the (TWEAK[1]) (Russell et al., 1994), specifically developed for pregnant women, and Problem-Oriented Screening Instrument for Teenagers (POSIT) (Gruenewald, Stewart, & Klitzner, 1990).

The term 'standardized measures' refers to those instruments, scales, inventories, questionnaires or tests that are used to measure certain objects or events (clients or problems) (Bloom & Fischer, 1982).

The development of an SM involves complex procedures that are meant to test the tool and assure the validity, reliability, sensitivity, specificity and interpretability of the instrument. The validity of an instrument has to do with whether the instrument is really measuring what it is supposed to measure (Meenaghan, Powers, & Toomey, 1985). Its reliability, on the other hand, is concerned with how consistent and stable it is (Meenaghan et al., 1985). An SM needs be tested for its sensitivity and comparability (Bloom & Fischer, 1982). Its sensitivity is the extent to which it correctly detects positive cases, while its specificity is the extent to which it correctly detects other cases as not having the condition being tested (Miller et al., 1995).

[1] TWEAK are the first letters of the words Tolerance, Worried, Eye opener, Amnesia , and Cut down.

The validity of an instrument is usually based on a theoretical model that defines the problem to be measured (Berger & Patchner, 1988). The adoption of a theoretical model is determined by the developer of the instrument according to how he or she defines the problem to be measured (Berger & Patchner, 1988). Thus we can conclude that an instrument is the result of the developer's views, which are based on the theoretical model and the society in which it is generated.

Literature review

It is observed that many research studies have used western standardized instruments to measure problems in other cultures (e.g. Melendez, 1994). Some of these research studies claim to have achieved positive results and that the instruments they used were valid when applied to other cultures. For example, Rubinstein (1995) used the Right-Wing Authoritarianism (RWA) scale to evaluate conservatism in Jewish people in Israel. The study findings confirmed the construct validity of the RWA scale with respect to Israeli culture. Another example is the comparison study conducted by Suzuki and Rancer (1994), who attempted to test the argumentativeness of college students in both the United States and Japan using two western scales, the Argumentative Scale and the Verbal Aggressiveness Scale. The authors concluded that both scales provided a reasonable overall fit to both samples, and that these scales had satisfactory construct validity for the Japanese sample.

In contrast, Dolan and Ford (1991) examined the validity of the Binge Scale Questionnaire (BSQ) and the Restraint Scale (RS) if applied to Arab culture, as in Egypt for example. The authors' findings suggested poor validity of the scales, especially when applied to Egyptian men. Moreover, Chattopadhyaya, Biswas, Bhattacharyya, & Chattoraj (1990) administered the English form of the Eysenck Personality Questionnaire (EPQ) to 180 male and 124 female, educated, middle-class Bengalis to determine the applicability of the EPQ to this population. The authors found that, in contrast to English norms, the Bengali sexes did not differ significantly on any of the four EPQ scales. The study suggested limited applicability of the EPQ to Bengali culture.

Although some studies support the applicability of some standardised measures to other cultures, this is not the case for all standardised measures. To clarify the problem, four western measures will be discussed. These are the Michigan Alcoholism Screening Test (MAST), CAGE, the Munich Alcoholism Test (MALT), and the Alcohol Use Disorder

Identification Test (AUDIT). These scales are used to assess alcoholism, and they are believed to be objective and have high validity and reliability (Kinney & Leaton, 1991). In the following section, the validity of these measures in respect to Saudi Arabian culture is examined.

Michigan Alcoholism Screening Test (MAST)[2]

Michigan Alcoholism Screening Test (MAST) (see appendix 4) is used to assess alcoholic problems in clients. It consists of 24 questions to be answered 'yes' or 'no'. The areas addressed by MAST include the person's perception of his/her drinking behaviour, family problems related to alcohol consumption, loss of control, prior treatment, job impairment, problems with physical health, and the presence of legal difficulties (Kinney & Leaton, 1991). Scoring five points or more would categorise the subject as an alcoholic, four points would be suggestive of alcoholism, and three points or less would indicate the subject was not alcoholic.

Applying this instrument to Saudi Arabia may result in classifying many Saudis who drink occasionally or slightly (say once a month) as alcoholic. It might not yield any discrimination among Saudis who have experienced alcohol, no matter what their drinking behavior has been. A Saudi individual who drinks once a month would easily score more than five points on this scale, whereas an American, for example, who is in the same state, would score lower points.

For example, let us consider the following questions asked by MAST:

1. Does your wife, husband, parent, or other near relative ever worry or complain about your drinking?

2. Do you ever feel guilty about your drinking?

3. Has your drinking ever created problems between you and your wife, husband, a parent or other relative?

4. Has your wife, husband, or another family member ever gone to anyone for help about your drinking?

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[2] A full copy of the MAST, CAGE, MALT, and the AUDIT is in the appendix.

A Saudi who drinks alcohol even slightly, might answer 'yes' to the above questions since the drinking of alcohol is religiously, legally, and socially unacceptable, and is considered deviant behaviour. Such behaviour could lead to family problems and even divorce. A family would seek help from available resources to solve the problem. The person concerned would be likely to experience a feeling of guilt since he or she would have done something contrary to social norms, the law and, above all, religion. This would be especially likely if the questions asked whether the feeling of guilt about drinking alcohol had *ever* occurred (i.e. in the person's entire life).

Another set of questions included in the instrument is related to the legal aspect of drinking. These are likely to be answered positively by Saudis since drinking alcohol is illegal in Saudi Arabia. For example, one of MAST questions asks if the respondent has ever been arrested for driving while drunk. In Saudi Arabia, however, the individual in such a situation would be arrested, not for driving while drunk,but for drinking whether driving or not.

Other questions of MAST are:

1. Have you ever been seen at psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem?

2. Have you ever gone to anyone for help about your drinking?

3. Have you ever been in a hospital because of drinking?

The expected answers to these questions, if asked in Saudi Arabia, are likely to be 'yes' because drinking alone (as opposed to problem drinking or alcohol dependency) is enough to get the individual into a treatment facility. Referral for treatment can be suggested by a family, an authority, an employer or any party to the act of drinking. Individuals who are caught drinking are directed or pressurised to enter an alcohol treatment centre even if they were drinking for the first time.

Also, what ever a Saudi's level of drinking might be, it would cause him or her a lot of trouble either in the work place or in school. Thus the answer might be a 'yes' if a Saudi

respondent is asked a question like 'Have you ever been in trouble at work or school because of drinking?'.

In addition, the MAST instrument contains questions that do not apply or are inappropriate to be asked. For example, one of the questions asks 'Do you feel that you are a normal drinker?' Such a question is hard to be asked since any kind of alcohol drinking is abnormal in Saudi Arabia.

The CAGE Questionnaire

An even simpler tool for diagnosing alcoholism than MAST is the CAGE Questionnaire (see appendix 5). CAGE offers a simple and rapid means of self-evaluation, which anyone can use to evaluate their own alcohol consumption. It can also be used by a physician or other health worker to identify excessive alcohol consumption, with the aim of prevention and early treatment of alcohol problems, and has proved effective as a screening tool for physicians in general practice (Seppèa, Mèakelèa, & Sillanaukee, 1995). It consists of questions that focus on four main ideas: *cutting down* alcohol consumption, *annoyance* by criticism, *guilty* feelings associated with alcohol use, and *eye-openers,* or early-morning drinking . The title of the questionnaire was derived by extracting the first letter of the four main ideas and formulating the word CAGE. According to Kinney & Leaton (1991), it has been tested for validity among a number of populations of possible alcoholics. Two or more positive answers would strongly suggest the presence of alcoholism (Mayfield, McLeod, & Hall, 1974).

If the CAGE test is applied to many Saudis who drink, in western standards, lightly, perhaps most of the responses would be positive answers. Take, for example, annoyance by others or feeling guilty because of drinking. The answers to these two questions might be 'yes' for a Saudi who consumes alcohol, however little. Consequently the test may provide incorrect and misleading results if applied in a Saudi context. However, practical testing of the validity of these measurements in Saudi culture is needed.

It seems that neither measure is a valid gauge of alcoholism in respect to the Saudi culture. Part of the problem is that these measures do not directly measure the quantity and frequency of alcohol consumption in order to determine the existence of alcohol dependency but instead rely on indirect indicators. These indirect indicators or variables, however, are not valid in Saudi Arabia, especially if the instrument is being used to

measure alcoholism or alcohol dependency. In other words, a Saudi could be asked if he/she has ever been referred to a treatment centre. But this question (along with other questions) is not a good indicator of alcohol dependency. The subject could have been referred to a treatment centre only because he consumes alcohol.

Munich Alcoholism Test (MALT)

The MALT questionnaire (see Appendix 6) is a composite test which measures consumption, physical signs and symptoms, and biological abnormalities. It was developed by Feuerlein et al. (1979), who selected 250 from more than 1000 items relating to alcohol that they found in the literature. The final form of the questionnaire makes use of 31 items which have been tested and validated both separately and together. The MALT test consists of two sections: the first, with seven items, requires clinical evaluation by a physician (MALT-P); the second is a questionnaire of 24 items to be filled in by the patient (MALT-S) (Feuerlein et al., 1979).

According to the MALT test's developers, the validity of the test is 0.94 with a reliability of 0.84. In addition, it is a cost effective and easy-to-use instrument for identifying alcoholic subjects in groups of all types of patients, and for confirming the diagnosis of alcoholism.

Each positive response in the physician's section scores four points, whereas a positive response in the self-assessment section scores only one point. Patients scoring six to ten, even in the absence of clinical symptoms, are suspected of alcoholism or having an alcohol problem. It can be assumed that patients with a weighted score of eleven should be diagnosed as alcoholic (Feuerlein et al., 1979).

In examining the applicability of the MALT test to Saudi alcohol drinkers, only one out of the 31 items can be said to be problematic. This item is Question 7 in the physician's section: 'Spouse, family members or good friends have sought help because of alcohol-related problems of the patient.' Since drinking alcohol is a problem in itself, the respondent may answer 'yes' to this question even if the patient does not have alcohol-related problems. Having said this, the misinterpretation of this question is less likely to occur since the question is clearly asking about alcohol-related problems rather than alcohol drinking itself.

Apart from Question 7, which would require minor modification, the MALT test can be said to be more applicable to the measurement of Saudi alcoholics than the previous measures.

Alcohol Use Disorder Identification Test (AUDIT)

AUDIT (see appendix 2A) is questionnaire developed as part of the six-country World Health Organisation (WHO) collaborative project on identification and management of alcohol-related problems (Babor, de la Fuente, Saunders, & Grant, 1992). By placing emphasis on heavy drinking and frequency of intoxication rather than on signs of dependency, it is designed specifically to detect problem drinkers rather than alcoholics. The questions refer to lifetime alcohol experiences as well as those in the past year, thus distinguishing between current and previous problems. Its development in a broad range of cultures is thought to enhance cross-cultural validity (Haggerty, 1994).

It is a ten-item (three subscales) screening questionnaire with three questions on the amount and frequency of drinking, three questions on alcohol dependence, and four questions on problems caused by alcohol. Responses to each question are scored from 0-4 and a total score of 8 or more is taken to indicate hazardous or harmful alcohol use (Conigrave, Saunders, & Reznik, 1995).

According to Babor et al. (1992) AUDIT is aimed at screening adult populations. It can be used in a variety of settings and programmes, including primary care, the emergency room, surgery and psychiatry. It can also be used on a variety of subjects, such as: driving while intoxicated (DWI) offenders; criminals in court, jail, and prisons; enlisted men in the Armed forces; and workers encountered in employee assistance programmes and industrial settings. In addition to clinical use, AUDIT can also be used in a variety of research projects and epidemiological studies (Saunders, Aasland, Babor, de la Fuente, & Grant, 1993).

AUDIT has been normed on heavy drinkers and alcoholics. Since it was first established, it has been widely adopted as a screening instrument (Conigrave et al., 1995). It has been shown that AUDIT detected a higher portion of problem drinkers than the short Michigan Alcoholism Screening Test (Barry & Fleming, 1993).

As the sensitivity and specificity of the instrument, AUDIT was reported to have a sensitivity of 92% and a specificity of 94% in detecting hazardous or harmful alcohol use in a sample of 913 people (Conigrave et al., 1995).

Tested theoretically for possible use in Saudi Culture, the AUDIT questionnaire seems more promising than the measures discussed so far. However, to allow more promising results, a minor modification is needed to Question 10, which asks about relatives' and friends' concerns about the person's drinking. So, instead of asking 'Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you cut down?', a suggested alternative might be: 'Has a relative or friend or a doctor or other health worker been concerned about your drinking or suggested you *quit drinking*?'. The remaining questions are highly applicable to Saudi alcohol drinkers. However, as it has been said earlier, in order to reach a concrete conclusion, a practical testing of all of these measures is needed.

Discussion

The above examples are used to illustrate the issue of applying standardized measures to other cultures. Two things should be noted: first, that not all measures are invalid or inapplicable for cross cultural studies, and, second, that the first two examples are too extreme. They show clearly how misleading some questions are. However, the situation is even more confusing because the unsuitability of some of the questions is less obvious in some cultures than in others..

Using an SM in another culture without paying enough consideration to its applicability and usability in this context can result in misleading findings and/or a wrong diagnosis, which in turn can lead to a wrong intervention or treatment. Another important issue that might emerge from such misuse is the ethical dilemma that can result from wrong findings. Ethics in research have been the subject matter of many disciplines including social science. Research ethics are codes that provide guidelines for the proper conduct of research (Gillespie, 1995). One important purpose of these codes is to protect the participant subjects, organisations, and society from potential risks which may result from research studies (American Psychological Association, 1990). For example, it is unethical for a researcher or a professional to present wrong data about his subjects or clients. Such presentation is a violation of the code of ethics of most research and professional societies.

In conducting research studies, the researcher should make sure that the instrument he/she uses is truly measuring what it is supposed to measure and should give full consideration to the cultural differences that may be present. Different subjects may understand a question differently and, whether we analyse the data within or between cultures, we often uncover different interpretations of the question (Triandis, 1990).

Research methodology and design

Introduction

The method of triangulation means the use of one method, more than one data source, more than one tool, more than a theory, and/ or more than one observer (Denzin, 1989). This strategy helps to increase the reliability and validity of the study, and overcomes the limitations associated with the use of one method, one data source, one tool, one theory, and/ or one observer. This study employed method triangulation, data source triangulation, tool triangulation, and theory triangulation. Only observer triangulation was excluded because it does not apply.

Descriptive research usually aims at providing information about the characteristics of a certain population (Marlow, 1993). So does this study. Through the method of social survey, it attempts to explore the various aspects of hospitalised Saudi problem drinkers. More specifically, the study aims to explore:

1. The demographic characteristics of hospitalised Saudi problem drinkers.

2. The drinking patterns of hospitalised Saudi problem drinkers.

3. The types of drinks consumed by hospitalised Saudi problem drinkers.

4. The hospitalised Saudi problem drinkers' first experience with drinking.

5. The hospitalised Saudi problem drinkers' reasons for drinking.

6. The availability and accessibility of alcohol to hospitalised Saudi problem drinkers.

7. The relationship between alcohol use and smoking among hospitalised Saudi problem drinkers.

8. The relationship between alcohol use and the use of other drugs among hospitalised Saudi problem drinkers.

9. The views of those who provide alcohol treatment services to hospitalised Saudi problem drinkers regarding the patients, problem drinking, and the provided treatment services.

Research questions

In order to achieve these aims more specific research questions require investigation. These include the following:

1. What are the demographic characteristics of hospitalised Saudi problem drinkers?

2. What are the patterns of drinking of hospitalised Saudi problem drinkers?

3. Why do hospitalised Saudi problem drinkers drink?

4. What types of drinks hospitalised Saudi problem drinkers consume?

5. How prevalent is smoking among hospitalised Saudi problem drinkers?

6. How prevalent is the use of illegal drugs among hospitalised Saudi problem drinkers?

7. How available and accessible is alcohol to hospitalised Saudi problem drinkers?

8. How do hospitalised Saudi problem drinkers first experience alcohol?

9. How do the therapists perceive hospitalised Saudi problem drinkers?

10. How do the therapists perceive problem drinking in Saudi Arabia?

11. How do the therapists perceive the treatment services provided for hospitalised Saudi problem drinkers?

First: Methodology for patients data

This section is describing the methodology design and procedure for collecting data from the patients. More specifically it attempts to describe the population of the study (Hospitalised Saudi Problem drinkers), setting description (where the data have been collected), and the tools and instruments (means of data collection). It also describes the procedures of how and when the data were collected.

The population of the study (patients)

The population of this study was composed of hospitalised Saudi male problem drinkers. It should be noted, however, that at the time of data collection no treatment services was provided for females with alcohol problems in any of Al-Amal hospitals. The sample included all those who, at the time of data collection, were admitted to the four treatment hospitals in Saudi Arabia, and were diagnosed as having drinking problems. These treatment hospitals represent four different regions, and they are the only hospitals that are licensed to treat substance use and abuse. No sophisticated sampling procedures were involved since all of the available population was included.

Of the 158 hospitalised patients, 149 agreed to take part in the study. Of these, thirteen respondents did not complete their questionnaires. So the questionnaires of 136 respondents were accepted for the final analysis. Table 10 details the number of respondents included and excluded from the study in each hospital.

Table 10. Total number of respondents included in and excluded from the study

Hospital	Patients	Excluded owing to incomplete questionnaire	Excluded owing to refusal to participate	Final number of respondents included
Riyadh	57	4	3	50
Jeddah	37	2	2	33
Dammam	35	4	3	28
Qaseem	29	3	1	25
Total	158	13	9	136

Moreover, the population of the study can be categorised into two types (Table 11). The first consists of those respondents who had been admitted to voluntary wards. This means they came for treatment of their own accord. Some voluntary patients, however, do come under some external pressure, such as that of parents, spouse or employer. The second type

consists of those who had been brought for treatment against their will, and had to be kept in a secure ward until the end of their treatment programmes.

Patients in the secure wards are normally brought for treatment by the recommendation of a court, either as a result of being caught drinking (by the police or some other of authority), or because they have received in excess of four treatments in any of Al-Amal hospitals. In the latter case, the patient may have come to treatment voluntarily on previous occasions, but if the record shows that he is coming for treatment for the fifth time, he would be transferred to the involuntary wards in order to be sent to court for a sentence. He would then be compelled to continue his treatment.

Table 11. Numbers of respondents according to type of admission in each hospital

	Type of ward		Total
	Voluntary	Involuntary	
Hospital			
Riyadh	38	12	50
Jeddah	23	10	33
Dammam	19	9	28
Qaseem	19	6	25
Total	99	37	136

Setting description

Data were collected from respondents (problem drinkers) entering Al-Amal hospitals for treatment. Since these hospitals are the place where the study was carried out, it is worthwhile to give a brief description of the setting.

Due to the growing numbers of alcohol and drugs users and abusers, the government of Saudi Arabia has designed and implemented a comprehensive strategy to overcome this problem. One element of this strategy is the development of four alcohol and drugs treatment facilities, called Al-Amal hospitals, in which substance abusers, including problem drinkers, are usually treated. These hospitals are Al-Amal hospital in Riyadh, Al-Amal hospital in Dammam, Al-Amal hospital in Jeddah, and the Psychiatric Hospital in Qaseem. These hospitals are located in western, central and eastern provinces of Saudi Arabia. However, the north and south provinces have not been served yet.

Al-Amal hospitals in Dammam and Riyadh were opened in 1987, the former four months earlier than the latter (Abdulraman, February 1987). Al-Amal in Jeddah did not start operating until 1990. Five years later, the Qaseem hospital began to receive addicts.

All of these hospitals, with the exception of the Qaseem Psychiatric Hospital, are very similar in almost everything, including the design of the building. In Qaseem, the addiction treatment centre is very small (30 beds) compared to the others. Although it is attached to a psychiatric hospital, the administrative and medical operation of the centre is separate, and very similar to that of the other three treatment hospitals.

Between 25 and 30 patients with alcohol problems are admitted for in-patient treatment nearly every month. A 30-day minimum stay for patients is required. The patient's discharge is determined by the physician and treatment team, who take into account all relevant factors (*Al-Amal Hospital-Riyadh Medical Manual*, July 1998).

The Ministry of Health manages all of the four treatment centres through a so-called self-operating programme. Not long ago, these hospitals were privatised (operated and managed by a medical company under the supervision of the Ministry of Health). Not much has changed since the Ministry of Health started operating Al-Amal hospitals, except control of the budget. Since these hospitals are very similar, to describe one is to describe them all. Therefore, only Al-Amal hospital in Riyadh will be described here.

Al-Amal hospital in Riyadh first started in 1987 as the second hospital providing addiction treatment services in the Kingdom. The 280-bed hospital is open 24 hours to everybody who wants or is in need of treatment for any type of substance abuse. The services provided are free of charge, as is the case for all health services.

In addition to inpatient treatment, outpatient treatment services are also provided. Both programmes are available for individuals who use or abuse alcohol or/and other drugs. However, the outpatient programme is still in its initial stage as it was only introduced a year ago.

The hospital is divided into four building units. The first is the administrative unit, which includes the hospital administration, public relations office, reception office, communication office, and Drug Control office. The second unit includes the admission

and outpatient departments. It also includes the reception area, laboratory, departments of dental and eye-care, X-ray, and intensive care, a CT scanner, and a pharmacy.

The third is the inpatient unit, which is composed of four wards. Three of these wards are devoted to voluntary admissions. The fourth ward is for those patients who are admitted against their will. Although the latter ward is managed and operated by the health and medical team, it is supervised by the Ministry of Interior (Sidi, March 1987). Each of these wards has offices for health professionals, such as psychiatrists, social workers and psychologists. The fourth unit is composed of allied health facilities and services such as occupational therapy, library, gymnasium, mosque, laundry, and theatre.

According to *Al-Amal Hospital-Riyadh Medical Manual* (July 1998), the treatment of substance users and abusers is based on a holistic and comprehensive approach. Patients undergo a complete physical, psychological and social assessment performed by a multidisciplinary treatment team. A typical treatment team includes: a psychiatric specialist, a psychiatric resident, a psychologist, an internist, a psychiatric nurses, chemical dependency counsellors, social workers, an occupational therapist, a physical educator, a physiotherapist, a dentist, a librarian, Alcoholic Anonymous and Narcotics Anonymous volunteers, and volunteer religious instructors.

Moreover, the hospital manual indicates that the primary objectives of the multidisciplinary treatment team are the assessment, treatment and rehabilitation of each patient in an environment that fosters positive behavioural change. All treatment is conducted in a highly structured setting based on the "twelve steps" of Alcoholic Anonymous.

Within this framework, treatment includes each patient's involvement in the following modalities: individual psychotherapy, group therapy (i.e. group psychotherapy, psychoeducational groups, community meetings, recovery groups), family therapy, activity therapy (i.e. occupational therapy, art therapy, recreational and physical therapy, library activity), religious training, Alcoholics/Narcotics Anonymous meetings, pharmacotherapy, auricular (ear) needle acupuncture, cranial electrical stimulation, biofeedback and relaxation (*Al-Amal Hospital-Riyadh Medical Manual*, July 1998).

Tools and instruments

In selecting the questionnaire to be used for the research several criteria were taken into consideration. The first was that these instruments should be closely related to the research questions. That is, the questions contained in these instruments should collect information that specifically answers the research questions. Secondly, the instruments should be standardized and have an acceptable level of validity and reliability.

The third criterion was that these instruments should be applicable to Saudi problem drinkers, that is, to the context of Saudi cultural, legal, and religious attitudes to alcohol consumption. Many alcohol-related instruments have been ruled out because of this criterion. An example of such an instrument is the Michigan Alcoholism Screening Test (MAST) (Selzer, 1971). The applicability of measures to be used in other cultures is discussed in the first section of this chapter.

Data for the first part of this study was collected using two self-administered questionnaires. One of the two self-administered instruments was the Alcohol Use Disorders Identification Test (AUDIT) whereas the other one is devised by the researcher. A full copy of the instruments is presented in the appendices. Description of these instruments is detailed below:

Alcohol Use Disorders Identification Test (AUDIT)

A description of the AUDIT is discussed earlier in the first section of this chapter. Although the AUDIT (see Appendix 2A for English version and 2B for Arabic version) is normally used to detect problem drinkers in primary health care settings, it is used in this research for the following reasons:

1. Since alcohol consumption is not allowed in Saudi Arabia, some drinkers claim they are addicts when discovered by police or significant others in order to avoid punishment or blame. As a result of such a claim, they are referred to hospitals for treatment. It is therefore assumed that some people receive treatment even though they are not problem drinkers or alcohol dependants. AUDIT, in such cases, would help identify those patients whose drinking is genuinely problematic.

2. Since AUDIT is considered a valid and reliable measure to assess the quantity and frequency of alcohol consumption, it was regarded as a suitable instrument to apply to the respondents of this study.

3. Since AUDIT is useful in assessing the level of health and harmful hazardous consumption, it is used in this way on the study subjects.

Problem drinker psychosocial profile

This instrument has been developed by the researcher (see appendix 1A for English version and Appendix 1B for Arabic version) to collect information in many aspects of the respondent's life as well as alcohol-involvement. These include information about demographic characteristics, family history, social and economic status, health status, legal history, smoking history, drinking history, patterns of drinking, use of other drugs, treatment attempts, and religious practice.

The instrument is composed of 300 closed-ended questions that cover all the areas (for each area there is at least one item or more) addressed by the research questions. Most of these items are derived from other instruments as well as from the literature. Some of the instrument's questions are nominal. Others are ordinal. Likert scales are also used in the questionnaire. Instructions are provided in writing to the respondent when needed. Examples of such instructions include asking the respondent to select only one choice, skip a question, specify a place or a date, or clarify a question.

The questionnaire passed through many stages before being finalised. The initial stage involved writing down all the related questions that came to mind and were thought to address the research questions. Consulting other questionnaires and reviewing the literature provided a basis for forming these questions. The second stage involved grouping the questions so that each group related to a research question. This helped in a more filttering of the questions that should be included in the questionnaire. As a result, some items were deleted because they were not related to a research question. Others were deleted because they were included in the other instrument. For example, the questions addressing the quantity and frequency of drinking were taken out and the AUDIT was used instead.

Modifying the questionnaire was the third stage. Such modification included deleting, adding, ordering and checking the wording of the questionnaire items. In stage four, the

questionnaire was given to five professional and academic experts in the field of addiction to examine and judge the validity and reliability of the instrument. Additional modification to the questionnaire has been done as a result of the experts' review. To maximize the level of validity and reliability, the instrument was pre-tested and even more modification was implemented.

Validation of the instruments

It should be mentioned that all instruments used in this research have passed through the following stages:

1. *Translating the questionnaires into Arabic.* Since the original versions of the questionnaires, including the questionnaire developed by the researcher, were in English, translating them into Arabic was essential so that they could be understood by the respondents. It took a great deal of effort to ensure that the translations could be understood by the respondents and, at the same time, did not affect the meaning of the questionnaires' items.

2. *Checking the wording and style of the Arabic version.* In this stage the questionnaires were rechecked for their wording, style and format by the researcher. Then, five professional and academic experts in the field of addiction were asked to judge the Arabic versions of the instruments, and provide comments and suggestions. In relation to the questionnaire developed by the researcher, the experts' went beyond their remit and offered comments on the content as well as the expression of the instrument. Some changes were made based on that judgement.

3. *Retranslating the Arabic versions into English.* In an even more complicated step, a group of three bilingual academic experts were asked to translate the Arabic version of the questionnaire back into English. The purpose of this was twofold. First, by comparing the original with the retranslated version it was possible to check the accuracy of the Arabic translation. Second, since the validity and reliability of the standardized instruments are already established, comparing the retranslated versions to the originals would help to ensure that the validity and reliability were not affected. In light of the experts' translations, minor modifications to the Arabic version, such as changing some words and phrases, were carried out.

Pilot study

An essential step in conducting a survey is to pilot test (or pre-test) the questionnaire (Oppenhein, 1992) as well as the procedures (de Vaus, 1996). Pre-testing is very important because it serves many purposes (de Vaus, 1996).

1. It identifies unforeseen problems in the wording of questions which might affect respondents' comprehension, in question sequence, and in questionnaire administration, so that they can be eliminated before the actual study.

2. It may indicate the need for additional questions on some topics or the elimination of others.

3. The length of the interview can be determined (and possibly the necessity for shortening it).

4. Open-ended responses can be collected to permit the phrasing of alternatives closed-ended response questions for the final questionnaire.

5. The pre-test may constitute part of the interviewers' training if the study involves interviewers.

For this research, those questionnaires administered to the patients were pre-tested – the Alcohol Use Disorders Identification Test and the problem-drinker psychosocial profile. As a result of the pre-testing, the instruments were modified, and the implementation procedures of the data collection were taken into account.

Approval obtainment

The process of collecting the data started with the researcher's obtaining the necessary approvals to conduct the study. This included securing the approval of both the hospitals' authorities and the Bureau of Drug Control. In each hospital, co-ordination with the hospital authority was established prior to the administration of the research questionnaires. In addition, the data collection procedures were discussed in great detail with the chiefs of social services departments in each of the hospitals. Arrangements to implement the study and to identify the respondents, place and time were agreed upon with

the heads of social services departments in each hospital, as well as with the research assistants.

Research assistants' training

Training of the research assistants was provided by the researcher a day prior to data collection. Training involved describing the aim of the study, explaining the questionnaires, and giving instructions on their implementation. Between four and six social workers from each hospital attended the training sessions. The research assistant role was to help with assigning the patients to their seats, explaining the purpose of the research to patients, assisting those patients who have difficulties reading or writing, and insuring that the return questionnaires are complete.

Implementation of the questionnaires

In each hospital and on the same day of the assistants' training session, the prospective respondents were identified according to the criteria mentioned earlier. The respondents were informed about the nature of the research by the research assistants.

When the respondents gathered in either an auditorium or a lounge, the researcher introduced himself, and explained the aim of the study to the patients. The confidentiality of the information provided by the participants was guaranteed by the researcher. An option not to participate in the research was also given to all patients. Only nine patients refused to participate.

Instructions to fill in the questionnaires were provided by the researcher or one of his assistants. For those respondents who could not read or write, assistance was provided. The respondents were then distributed about the room so that they could not affect each other's answers, and were given the questionnaires and provided with pens to check their answers. Assistance was offered only as necessary and appropriate, and providing it did not affect or compromise the respondents' answers. Each completed questionnaire was then given a label and a number.

Time of data collection

Data collection began on 1 October 2000 and ended on 22 December the same year. Because the targeted number of respondents to be included in the study was not met on the

first occasion, data collection was repeated again three weeks later by the research assistants in each hospital so that more and different respondents were included in the study.

Data analyses

Data processing and analyses were performed using the Statistical Package for Social Science (SPSS) for Windows, Version 9.0.

Methodology for therapists data

In order to explore, in more depth, and from different angle, the issues related to hospitalised Saudi problem drinkers have been discussed with the therapists who provide alcohol treatment to such patients. Through the medium of a semi-structured interview the therapists perception of hospitalised Saudi problem drinkers, provided treatment services, and the problem drinking in Saudi Arabia are examples of the issues discussed. Hence, in this subsection the methodology and procedures pertaining the therapists' data collection are described. More specifically, a description of the respondents (the therapists), and how and from where they were recruited is detailed. Moreover, the subsection explains the tool used for data collection, and how it has been implemented. Finally, the time of data collection as well as the process of data analysis is also presented.

Population of the study

The selection of the therapists to be included in the study was based on two criteria. 1) The interviewees should represent three disciplines (social work, psychology, and psychiatry). 2) They should have some years of experience in the field of addiction not less than 4 years. Of those who met these criteria only 15 agreed to participate in the study. However, four respondents did not return their answers whereas eleven did.

Therefore, eleven therapists aged between 28-47 (mean=33.3) were included in the study. They were four psychiatrists, four social workers and three psychologists. Their levels of education ranged from bachelor to PhD degree. Their years of experience ranged from 4-9 years (mean=5.4).

Setting description

Data were collected from respondents (full time therapists) working in Al-Amal hospital where problem drinkers receive treatment. A detailed description of Al-Amal hospital is mentioned earlier in this chapter.

Instrument and implementation

The therapists' interview was meant to be a tape-recorded semi-structured interview. However, most of prospective interviewees refused this method of interview, in spite of the great effort paid by the researcher to convince them. Such refusal is due to the fact that tape-recording, as a method of information gathering is uncommon in Saudi Arabia. The sensitivity of the subject matter could also be an additional factor for this refusal.

As a result of this refusal, only three therapists agreed for tape recording method. Those who agreed to tape-recorded, were interviewed by the researcher in their offices. Each interview lasted between one to one and half-hours. In implementing the interview, the researcher followed the topic guidelines to direct the interview.

For the majority who refused tape-recording an alternative self-administered instrument was designed. The therapists' instrument is composed of 28 open-ended questions (a full copy of the question is presented in the appendix 3A for English version and 3B for Arabic version). Drawing mostly from the results of the data gathered from the patients, these questions were devised to address the issues related to Saudi problem drinkers in treatment. Those therapists who participated in the study were encouraged to express their professional opinion freely, and more details. For all of the interviewees, the researcher explained the purpose of the interview, and made clear to them their privacy is assured.

It should be noted, however, that both types of interviews were carried out in Arabic although they were originally in English. The returned answers then were translated into English by the researcher.

Time of data collection

The therapists' data collection was carried out between 25 November 2001 to 2 January 2002. This period of time includes obtaining the necessary approval for conducting the

study from the hospital authorities. It should be noted also that the researcher paid a great effort in following the respondents up for their answers to be returned.

Analysis of the therapists' data

With the semi-structured interviews, the responses were coded and analysed manually. More specifically, with the audio –taped interviews, the interviews were transcribed. Both the transcribed interviews as well as the written form were translated into English. Guided by the research questions and by the results of the patients' data, the codes were developed that represented a category or a them found in the data and put directly into a text by attaching to segment of text. Each therapist interviewed was evaluated by the set of thematic codes developed. Unfitted themes were excluded from the final report. It should be noted, however, that an extra caution was paid to the translated quotations since they were originally said in Arabic. In that, each quotation was reviewed by a bilingual Ph D student.

Difficulties

1. The lack of Saudi and Arabic studies on alcohol have made it hard to define the research problem, as well as to review the literature properly.

2. Even the existing Arabic literature on the subject was difficult to obtain due to restrictions made by the universities, libraries or institutions.

3. The process of obtaining documents or materials from universities or other institutions was very slow.

4. Although the approvals to conduct the study were freely given, obtaining them was very slow.

5. Refusal of many of the therapists to take part in the study.

6. Of the therapists who agreed to participate, most of them refused the tape-recorded interview.

7. The therapists returning the answers took great deal of time and effort.

Chapter 5. The respondents' characteristics

Introduction

This chapter is devoted to describing the population of the study. The socio-demographic characteristics of the respondents are described both in general and in detail. The characteristics described include basic personal data (e.g. age, marital status) as well as more detailed data (e.g. employment, income). In addition, data about the respondents' family (e.g. parents' and wife's education) are described. This chapter analyses these characteristics according to the hospitals and the type of treatment wards in which the respondents were placed at the time of data collection.

Personal demographic characteristics

With regard to the respondents' age, only 1 (0.7%) respondent was under the age of 20. However, more than half of the respondents (58%) was between the age of 20 and 35. Furthermore, it is noticeable that the number of respondents tended to decrease as their ages got higher. Only 9.6 percent of the respondents were in the age group 46–50, and 8.1 percent were over 50.

However, an examination of the age within hospitals (Table 12) shows that as low as 12 percent of Qaseem respondents (n=25) were less than 30 years old. Also, more than 50 percent of Qaseem respondents were between the ages of 31 and 40. Clearly, older respondents were more concentrated in Riyadh and Qaseem than in the other two hospitals.

The highest percentage of respondents in the secure wards was found in the age group 30 and under with 40.5 percent in each group. Somewhat similarly, the highest percentage of respondents in voluntary wards was in the 30 and under with 36.4 percent.

None of the respondents in the secure wards was less than 20 years old, compared to only one of that age group in the voluntary wards. Of the voluntary ward respondents, 29.3 percent were aged 41 and over, compared to 27.0 percent of the respondents in involuntary wards.

Table 12. Respondents' age crosstabulated with name of hospital and type of ward

	Hospital					Ward		
Age	Riyadh	Jeddah	Dammam	Qaseem	All	Voluntary	Involuntary	All
30 and under	21	13	14	3	51	36	15	51
31-40	10	15	8	13	46	34	12	46
41 and over	19	5	6	9	39	29	10	39
Total	50	33	28	25	136	99	37	136

The results also show that the highest percentage of the respondents were "now married" (40.4%), whereas the widowed respondents formed the lowest percentage (1.5%). The percentage of "never married" respondents were the second highest percentage (36.8%). 11.3 percent of respondents were separated, and 8.3 percent were divorced.

Within hospitals (Table 13), however, only one respondent (n=23) of the Qaseem hospital had never married whereas 60.0 percent were now married. Compared to the other hospitals, the highest percentage of the divorced, separated, and widowed respondents was found in Qaseem (36.0%). "Never married" was the most common marital status among the Riyadh and Jeddah respondents, whereas the "now married" was the most common among the Dammam and Qaseem respondents.

Within wards, "now married" constituted the highest percentage (42.4%) of respondents in voluntary wards, whereas "never married" was the highest percentage (37.8%) of respondents in secure wards. Moreover, more than a quarter of the secure ward respondents were divorced, separated, or widowed.

Table 13. Respondents' marital status crosstabulated with name of hospital and type of ward

	Hospital					Ward		
Marital status	Riyadh	Jeddah	Dammam	Qaseem	All	Voluntary	Involuntary	All
Never Married	24	15	10	01	50	36	14	50
Now Married	19	08	13	15	55	42	13	55
other	07	10	05	09	31	21	10	31
Total	50	33	28	25	136	99	37	136

With respect to the respondents' educational status (Table 14), three quarters of the respondents had a secondary education or less. 4.4 percent were illiterate, and only nine respondents (6.6%) possessed a first or higher degree. Nineteen respondents (14.0%) had a vocational training, art, or other type of education.

Within hospitals, the percentage of respondents who possessed an elementary level of education was higher in Riyadh and Qaseem, with 44 percent and 40 percent respectively. Whereas 12 percent of the Qaseem respondents were illiterates, none of the Dammam respondents was. The Jeddah respondents had the highest percentage (12.1%) of those possessing a first degree or higher.

In general, educational status ratios of respondents in voluntary and involuntary wards were similar. However, 2.0 percent (2/99) of respondents in voluntary wards had a postgraduate education whereas none in involuntary wards did so.

Table 14. Respondents' educational status crosstabulated with name of hospital and type of ward

	Hospital					Ward		
Educational Status	Riyadh	Jeddah	Dammam	Qaseem	All	Voluntary	Involuntary	All
Illiterate	1	2		3	6	4	2	6
High school and under	41	23	21	17	102	72	30	102
College education or higher	3	4	1	1	9	7	2	9
Vocational, art, and other type of education	5	4	6	4	19	16	3	19
Total	50	33	28	25	136	99	37	136

Knowing where the respondents currently live could provide more information about the characteristics of the hospitalised problem drinkers, and the whether the location of the hospital can affect the accessibility and utilisation of the provided services. Table 15 shows that 112 respondents (83.6%) resided in cities while only 22 (16.4%) came from villages or hijras (a deserted area). Of those 22, only two lived in hijras while 20 lived in villages.

Within hospitals, 16.3 percent of the Riyadh respondents came from villages and 2 percent from hijras, compared to 20 percent and 4 percent of the Qaseem respondents respectively.

While 9.4 percent of the Jeddah respondents and 14.3 percent of the Dammam respondents came from villages, none of the respondents in either hospital came from hijras.

21.6 percent of respondents in involuntary wards were from villages compared to 12.4 percent in voluntary wards. None of the secure ward respondents came from hijra whereas 2.1 percent of the voluntary ward respondents did.

Table 15. Respondents' place of living crosstabulated with name of hospital and type of ward

	Hospital					Ward		
Place of Residence	Riyadh	Jeddah	Dammam	Qaseem	All	Voluntary	Involuntary	All
City	40	29	24	19	112	83	29	112
Village	8	3	4	5	20	12	8	20
Hijra	1	0	0	1	2	2	0	2
Total	49	32	28	25	134	97	37	134*

* Two respondents did not respond to this question.

The figures also indicate that almost 29.4 percent of respondents were living in homes that they themselves owned. However, 55 (40.4%) respondents were living in homes belonging to close relatives such as parents or brothers. Moreover, 23 (16.9%) respondents were living in residences that they rented, while only nine (6.6%) respondents lived in homes that were rented by other relatives. Also, 52.1 percent of respondents did not own or rent their homes.

Within hospitals, the highest percentage (36%) of respondents who owned their accommodation was at Qaseem . Moreover, 66.7 percent of the Jeddah respondents reported living in homes that were rented by them, while only 20 percent of the Qaseem respondents did. Also, 6 percent of the Riyadh respondents, 7.1 percent of the Dammam respondents, and 8 percent of the Qaseem respondents reported living in government housing, whereas none of the Jeddah respondents was living in this type of residence.

Within wards, more than half of the involuntary ward respondents reported living in homes that were owned by relatives, and 24.3 percent were living in houses that they owned. However, 36.4 percent of the voluntary ward respondents were living in houses owned by relatives and 31.3 percent were living in their own homes. The percentage of respondents living in government housing was similar in both types of ward.

Whether the respondent is living alone or with many people is related to many aspects of the respondent's problem drinking situation. For example, does the continuity/ discontinuity of drinking or treatment seeking is influenced by those people living with the respondent? In respect of the number of people living with the respondents (Table 16), twelve respondents (8.8%) reported that nobody was living with them. Also, the highest percentage of respondents (23.5%) reported living with seven to nine people. 30.9 percent of the respondents were living with 10 people or more while 14.7 percent were living with three people or less.

As high as 17.9 percent of the Dammam respondents reported that they were living by themselves, whereas only 4 percent of the Qaseem respondents did so. Moreover, more than 80 percent of the Riyadh respondents reported they were living with four or more people.

In addition, 8.8 percent of the involuntary ward respondents were living alone, and more than 81 percent were living with four or more people. However, 10.1 percent of respondents in voluntary wards were living by themselves, and more than 74 percent were living with four or more people.

Table 16. Number of people living with the respondents crosstabulated with name of hospital and type of ward

	Hospital					Ward		
No. of people	Riyadh	Jeddah	Dammam	Qaseem	All	Voluntary	Involuntary	All
None	4	2	5	1	12	10	2	12
1-3	5	8	3	4	20	15	5	20
4-6	8	10	5	7	30	20	10	30
7-9	12	6	9	5	32	24	8	32
10-12	11	5	4	5	25	17	8	25
More than 12	10	2	2	3	17	13	4	17
Total	50	33	28	25	136	99	37	136

The results also reveal that 79 respondents (58.5%) earn less than 3000SR (£500) monthly. In addition, more than 80 percent of the respondents earn 5000SR or less a month. As few as ten respondents (7.4%) reported earning more than 9000SR.

Of all the study population, the results show that the Dammam respondents had the highest monthly income. More than 30 percent of the Dammam respondents earned more than 5000SR, while 95 percent of the Qaseem respondents earned less than 5001SR. Moreover,

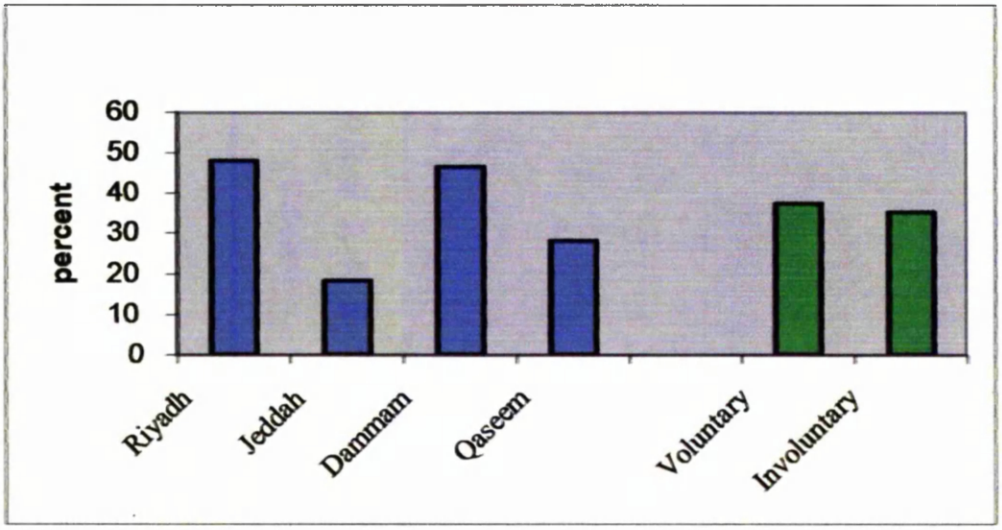
80 percent of the Riyadh respondents and 84.8 percent from the Jeddah respondents earn less than 5001SR, compared to 67.8 percent of the Dammam respondents.

Within wards, there were similarities with regard to the respondents' monthly income in both types of ward. However, 13.1 percent of respondents in voluntary wards had more than 7000SR compared to 8.3 percent of the respondents in involuntary wards.

With regard to employment (Figure 1), 86 respondents (63.2%) reported that they currently did not have a job. Al-Damigh (1997) found that 56.9 percent of alcoholics in three hospitals (Riyadh, Jeddah, and Dammam) were unemployed.

Although, the percentage of unemployment was generally high among the respondents of the study, it was highest among the Jeddah and Qaseem respondents (81.8% and 72% respectively). Whereas, in this study, 52 percent of the Riyadh respondents were unemployed, Al-Anazi (1999) found that only 40.4 percent of alcoholic patients in Al-Amal Riyadh did not work. Moreover, although the percentages of unemployed in Riyadh and Dammam were very similar, they remained lower than the percentage of unemployed in the total study population. Although very similar, the unemployment percentage among respondents of involuntary wards (64.9%) was higher than among those of voluntary wards (62.6%)

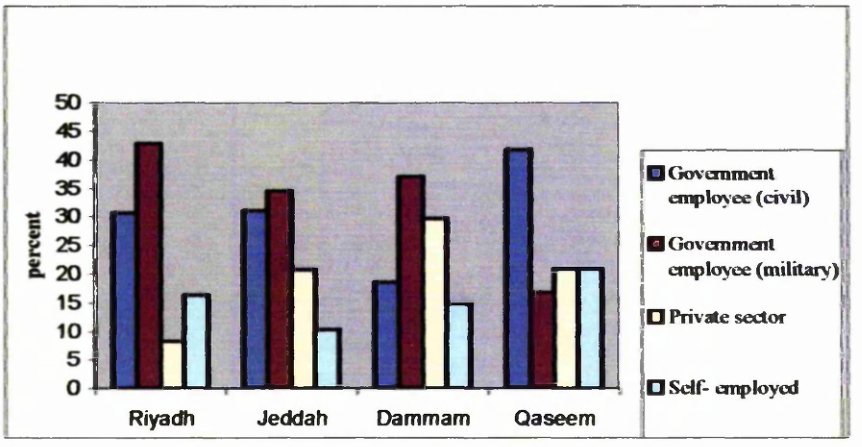
Figure 1. Percentage of respondents who had a job presented by hospital and sort of admission



The results also indicate that 39 respondents (30.2%) of the total population reported working as government employees. Surprisingly, of the total study population, 45 respondents (34.9%) claimed to work or to have worked for the military. 23 respondents (17.8%) reported working in the private sector in their current or previous jobs. 20 respondents (15.5%) reported that they were self-employed in either the present or the past.

Between hospitals (Figure 2), Riyadh had the highest percentage of respondents (42.9%) who worked for the military, while Qaseem had the lowest (16.7%). Since Dammam is an industrial region, 29.6 percent of Dammam respondents worked in the private sector. With regard to self-employment, Qaseem had the highest percentage (20.8%) while Jeddah had the lowest (10.3%).

Figure 2. Type of employment presented by hospital name



More than 60 percent of the respondents in each of the voluntary and involuntary wards worked for the government (Table 17). 42.4 percent of involuntary wards' respondents worked in the military sector alone. Also, as high as 24.2 percent of the involuntary wards reported working as self-employed, compared to 12.5 percent of the voluntary wards. Although very similar, the unemployment percentage among respondents of involuntary wards was higher than among those of voluntary wards. The percentage of unemployment (64.9%) among respondents in the secure wards was the highest if compared to the respondents of voluntary wards (62.6%) or to the total respondents of the study (63.2%).

Table 17. Respondents' type of job crosstabulated with name of ward

Type of job	Voluntary	Involuntary	All
Government employee (civil)	33	6	39
Government employee (military)	31	14	45
Private sector	19	4	23
Self- employed	12	8	20
Other	1	1	2
Total	96	33	129*

* Six respondents did not respond to this question.

As far as the nature of the respondents' jobs is concerned, 42 respondents (32.6%) were in administrative work. The second highest percentage was the art jobs, at 17.8 percent. Professional jobs came third with a percentage of 17.1 percent. It is worth noting however, that both art and professional jobs can accommodate unskilled, semi-skilled, skilled, and very skilled people.

Furthermore, the results (Table 18) reveal that 42.9 percent of the Riyadh respondents had administrative jobs, the highest proportion of all four hospitals, whereas only 18.5 percent of the Dammam respondents had administrative jobs. Dammam recorded the highest percentage of professional jobs with 22.2 percent. Also, the highest percentage of trading jobs was in Jeddah (17.2%) while the lowest was in Riyadh (4.1%). In spite of the fact that the region of Qaseem is agricultural, none of the Qaseem respondents reported working in the field of agriculture.

Table 18. Respondents' nature of job crosstabulated with name of hospital

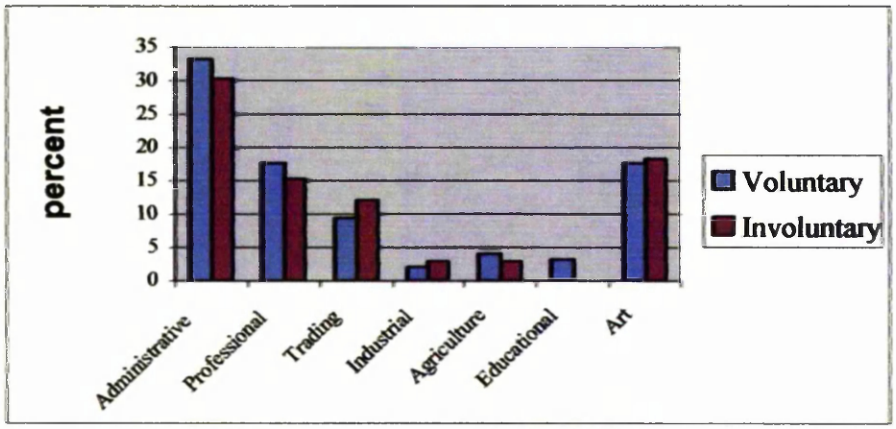
	Hospital				
Nature of job	Riyadh	Jeddah	Dammam	Qaseem	All hospitals
Administrative	21	9	5	7	42
Professional	6	3	6	7	22
Trading	2	5	3	3	13
Industrial	1	--	2	--	3
Agriculture	2	1	2	--	5
Educational	1	1	--	1	3
Art	10	4	6	3	23
Other	6	6	3	3	18
Total	49	29	27	24	129*

* Six respondents did not respond to this question.

The differences in the nature of jobs between wards were not large (Figure 3). However, none of the involuntary wards' respondents worked in the educational sector. Moreover,

the percentages of those who worked in trading (12.1%) and art (18.2%) were higher in the involuntary wards than in the voluntary wards.

Figure 3. Nature of Respondents' job presented by ward



While fifteen respondents (11%) had no hobby, sport was the most chosen hobby and was accounted for 31.6 percent of the respondents. Painting (1.5%) and writing (1.5%) came in last. TV watching came in second place at 15.4 percent . Music (14%) and reading (14%) were chosen by respondents as the third hobby of interest.

Sport was also the hobby that most of the respondents of each hospital selected as their favourite hobby. The Qaseem respondents had the highest percentages of those who reported having no hobby (16%), and of those who claimed the hobby of reading (24%). Moreover, none of the Qaseem respondents had a hobby of writing or painting. Music was most prevalent among the Jeddah respondents, at 21.2 percent, whereas the Qaseem respondents reported only 4 percent . The hobby of TV watching was most practised in Dammam (21.4%) whereas poetry was mostly practised in Riyadh (8%).

The percentage of respondents whose hobby was reading was higher in involuntary wards (16.2%) than in voluntary wards (13.1%). Moreover, TV watching was more prevalent among respondents of involuntary wards at 21.6 percent, whereas only 13.1 percent of the voluntary wards' respondents practised this hobby.

Family status

In order to gain more understanding about the respondents' family structure and the how this structure influences drinking, the respondents were asked about their family status. As

far as the family status is concerned, the results indicate that 41.9 percent of the respondents reported that both of their parents were alive and living together. However, two respondents (1.5%) claimed that both parents were alive but divorced, while six respondents (4.4%) said their parents were alive but separated. 13.2 percent reported that both parents were dead. Respondents who claimed to have dead fathers and living mothers (31.6%) were more than those respondents who claimed to have dead mothers and living fathers (7.4%).

The figures (Table 19) also show that Jeddah respondents recorded the highest percentage of parents being alive and living together (48.5%) while Qaseem reported the lowest (28%). None of the Dammam or Qaseem respondents reported their parents as alive but divorced. Furthermore, deceased fathers and living mothers were reported among 40 percent of the Qaseem respondents but among only 18.2 percent of the Jeddah respondents.

The percentage of respondents having both parents alive and living together was higher in respondents of involuntary wards (43.2%) than in those of voluntary wards (41.4%). Moreover, the decease of both parents was also higher among involuntary respondents (18.9%) than among voluntary respondents (11.1%).

Table 19. Status of respondents' parents crosstabulated with name of hospital and type of ward

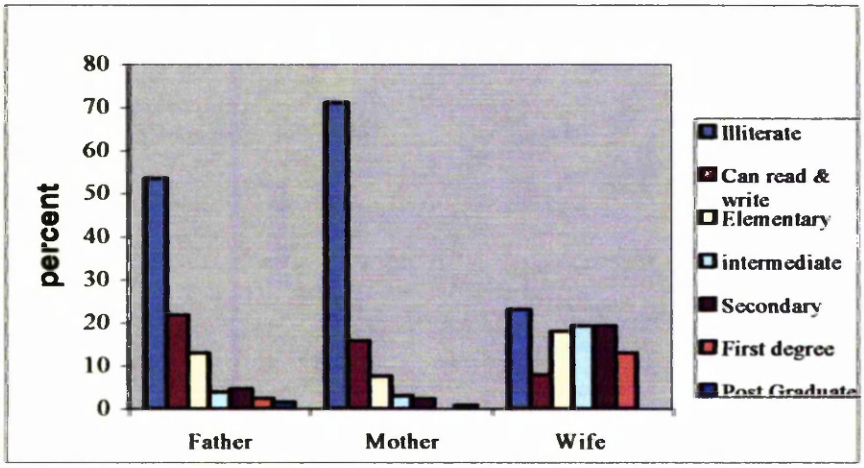
Parents status	Hospital					Ward		
	Riyadh	Jeddah	Dammam	Qaseem	Total	Voluntary	Involuntary	Total
Both alive and living together	23	16	11	7	57	41	16	57
Both alive but divorced	1	1	--	--	2	1	1	2
Both alive but separated	--	3	2	1	6	5	1	6
Both dead	6	7	1	4	18	11	7	18
Father alive but mother dead	3	--	4	3	10	9	1	10
Mother alive but father dead	17	6	10	10	43	32	11	43
Total	50	33	28	25	136	99	37	136

With regards to parents and the wife educational status (Figure 4), the highest percentage of respondents (53.4%) claimed that their fathers were illiterate. The percentage having illiterate mothers was even higher at 71.1 percent. Also, 21.8 percent of the fathers and 15.6 percent of the mothers had no formal education but could read and write. While two

respondents (1.5%) claimed that their fathers had a postgraduate degree, none claimed their mothers had any postgraduate education. Moreover, three fathers (2.2%) had a first degree but only one mother had one.

Moreover, of those respondents who got married, 23.1 percent (n=78) of the wives were illiterates, and 7.7 percent could read and write but lacked any formal education. The number of wives who had reached an intermediate level of education was the same as those who had reached a secondary level. None of the wives had a postgraduate degree but ten (12.8%) had a first degree.

Figure 4. Educational status of the respondents' father, mother, and wife



The Qaseem respondents had the highest percentage of illiterate fathers (69.6%) and mothers (91.7%). 4.3 percent of the Qaseem respondents reported fathers had only an elementary level of education, and none of the mothers of the Qaseem respondents had had any education at all. In the four hospitals, the Dammam respondents had the lowest percentage of father illiteracy (44.4%), and the second lowest percentage of mother illiteracy (60.7%). Jeddah respondents had the highest percentage having a father with a first or higher degree (9.1%), and a mother with a university degree (3%).

The highest percentage with illiterate wives was among the Qaseem respondents (36.4%, n=22), whereas the lowest percentage was among those in Dammam (5.9%, n=17). While none of the Riyadh sample had a wife with a university degree (n=22), 29 percent in Jeddah (n=17), 17.6 percent in Dammam (n=17), and 9.1 percent (n=22) in Qaseem did so.

Voluntary wards' respondents had a higher percentage of illiterate fathers (57.3%) and mothers (76.5%) than respondents did in involuntary wards. Moreover, the percentage having a father with a first or higher degree was higher in respondents of involuntary wards (8.1%) than of voluntary wards (2.1%). In addition, in involuntary wards 23.8 percent (n=21) of respondents' wives could not read or write, and more than 75 percent had an elementary or higher level of education. On the other hand, 22.8 percent (n=57) of wives of the voluntary wards respondents were illiterates, and 66.5 percent had an elementary level of education or more.

The way of socialisation and upbringing has much to do with the life structure and stability of the parents, and how that effect the quality of care and responsibility devoted to their children. When the respondents were asked whether their parents have ever got married to a person other than the respondent' s father or mother (Table 20), the results reveal that 77 fathers (56.6%) had a wife or wives in addition to the respondents' mothers. On the other hand, 37 mothers (27.2%) had married a man other than the respondents' fathers.

Qaseem reported the highest percentages of parents' remarriage in both fathers (76%) and mothers (36%), whereas the Jeddah respondents had the lowest percentages of both fathers' (42.4%) and mothers' (21.2%) remarriage. 60 percent of the Riyadh respondents reported fathers having married another woman compared to 50 percent of the Dammam respondents. Also, 24 percent and 21.2 percent respectively of mothers of the Riyadh and Dammam respondents had got married to another man than the respondents' fathers.

Within wards, fathers' remarriage was at 55.6 percent among respondents in voluntary wards, and at 59.5 percent among respondents in involuntary wards. The percentage of remarried mothers was far higher in respondents of involuntary wards than voluntary wards.

Table 20. Number of respondents' fathers (mothers) who ever married to a woman (man) other than the respondents' mother (father) presented by name of hospital and type of ward

	Hospital					Ward		
	Riyadh	Jeddah	Dammam	Qaseem	All	Voluntary	Involuntary	All
Father married to another woman	30	14	14	19	77	55	22	77
Mother married to another man	12	7	9	9	37	20	17	37

As far as the employment of the wife is concerned, the figures reveal that 84.6 percent of all wives (n=78) had no job. However, nine wives (11.5%) were teachers, one wife (1.3%) was an administrator, one (1.3%) was a government employee, and one (1.3%) was a student.

Within hospitals, the Dammam respondents had the highest percentage of working wives (29.4%) while Riyadh respondents had the lowest percentage (4.5%). Also, 23.5 percent of wives of the Jeddah respondents were working, compared to 9.1 percent of the wives of the Qaseem respondents.

14.3 percent of the respondents in involuntary wards reported their wives to be working as teachers and 85.7 percent as housewives. In voluntary wards however, the percentages of the wives' types of jobs were relatively similar to those of the wives of the total study population.

Regarding the number of wives respondents currently had (Table 21), 20 percent (N=80) claimed having no wife currently. Of those 80 respondents, 61 (76.3%) reported having one wife while three (3.8%) claimed having two wives at the current time.

Of the Riyadh respondents, 25 percent (n=24) reported having no wife currently, 66.7 percent having one wife, and 8.3 percent having two wives. Dammam had the highest percentage of respondents who claimed having one wife (82.4%, n=17).

As many as 36.4 percent (n=22) of the married respondents in involuntary wards reported having no wife at the current time compared to 13.8 percent in voluntary wards. Also, 9.1 percent of the respondents in involuntary wards had two wives compared to 1.7 in voluntary wards.

Table 21. Numbers of wives respondents currently have crosstabulated with name of hospital and type of ward

No. of wives	Hospital					Ward		
	Riyadh	Jeddah	Dammam	Qaseem	Total	Voluntary	Involuntary	Total
None	6	3	3	4	16	8	8	16
1	16	13	14	18	61	49	12	61
2	2	1			3	1	2	3
Total	24	17	17	22	80	58	22	80*

* Only those who have a history of marriage responded to this question.

Concerning the number of children the respondents have (Table 22), 18.8 percent (n=80) of the respondents had no children. Of those 80 respondents, 35 respondents (43%) had four children or more while 30 respondents (22%) had between one and three children. Moreover, as many as 52.9 percent of the Jeddah respondents (n=17) reported having no children, compared to 5.9 percent of the Dammam respondents (n=17). More than 70 percent of the Riyadh respondents (n=24) had three or more children, compared to 11.8 percent of the Jeddah respondents (n=17). Also, the Riyadh respondents had the highest percentage (33.3%) with more than six children.

Of the respondents in involuntary wards, 31.8 percent (n=22) had no children, 22.7 percent had more than six children, and 45.4 percent had three children or more. In the voluntary wards, on the other hand, 13.8 percent (n=58) of respondents reported having no children, 17.2 percent had more than six children, and 53.4 percent had three children or more.

Table 22. Numbers of children respondents have crosstabulated with name of hospital and type of ward

	Hospital					Ward		
No of children	Riyadh	Jeddah	Dammam	Qaseem	Total	Voluntary	Involuntary	Total
None	02	09	01	03	15	08	07	15
1	03	03	03	03	12	09	03	12
2	02	03	03	04	12	10	02	12
3	02	--	02	02	06	04	02	06
4	04	--	02	03	09	08	01	09
5	02	01	03	03	09	07	02	09
6	01	--	01	--	02	02	--	02
More than 6	08	01	02	04	15	10	05	15
Total	24	17	17	22	80	58	22	80*

* Only those who have a history of marriage responded to this question.

Discussion

The finding that most hospitalised Saudi problem drinkers are of younger age is supported by many Saudi studies. For example, Al-Anazi (1999) has found that 49 percent (n=47) of alcoholic patients in Riyadh Al-Amal Hospital were less than 31 years old. Al-Damigh (1997) also found that more than 80 percent (n=72) of Saudi alcoholic patients were under the age of 35. Such findings may be due to the fact that alcohol drinking is relatively a new phenomenon in Saudi Arabia. Therefore, it seems that alcohol drinking attracts younger more than older people.

Moreover, although four Saudi studies [i.e. Al-Angari (1988); Al-Ryias (1995)] have found that the highest percentage of those receiving alcohol treatment were unmarried, the "now married" respondents composed the highest percentage of this study. A possible explanation is that unlike the four studies, the data of this study more comprehensive and included all of the four hospital.

The low educational status of the respondents was also found by Al-Angari (1988) and Al-Ryias (1995). Moreover, with respect to the Riyadh respondents, levels of education were very similar to those shown in Al-Anazi's (1999) study, except that vocational and art education variables were not included in his study.

Whereas many studies, including this study, have found that the majority of the respondents were unemployed, the study of Al-Angari (1988) contradicted such findings. Such contradiction may be due to the fact that unlike the other studies, Al-Angari's study was relatively old. This may resulted in changes of some characteristics of the patients through time change.

Considering the fact that the average monthly income is 5000 SR (Ministry of Finance and National Economy, August 2001), the finding that the majority of the respondents were of low incomes was supported by other studies. Al-Anazi (1999) for example, found that most of his study's subjects were earning less than 3000 SR.

In general, there were differences between hospitals (regions) in some of the respondents' demographic characteristics. However, such characteristics were very similar when examined between the respondents in the involuntary wards and voluntary wards. One possible explanation is that some patients are admitted to the involuntary wards because the police brought them to hospital either by family or court request although they are no different than those who choose to come to hospital by themselves. Another explanation is that most of problem drinkers who are in the involuntary wards are usually transferred from voluntary wards because the number of their admissions exceeded four times. Having said that, a more investigation is needed.

Moreover, the result that the highest percentage of respondents was of military background was not supported by any other Saudi study as such variable has not been examined before. However, a possible explanation is that due to the nature and strict system of military work, it is expected to discover alcohol drinkers more easily than those working in the civil

sector. In addition, problem drinkers when discovered, they find more pressure from their administrators to receive treatment, and some times may take the form of military order.

Summary

On the basis of the research analysis of the respondents' characteristics, it would appear that most hospitalised Saudi problem drinkers came from extended and low educated families. Many had been raised in families where both or one of the parents had got married to another partner at one point of the respondent's life. Most of them were young (under 36 years old), and most were married. The majority of married respondents had one wife only, and three children or more.

In addition, a very high percentage of them were living in the cities. They had a low level of education, and most of them were unemployed. Most of those who currently or previously had a job, worked for the government, and more specifically in the military sector. More than half of the respondents had a monthly income of less than 3000 SR (£500). Sport and TV watching were the hobbies they most often practised.

In this section the respondents' demographic profile is discussed. In the next chapter, the respondents' drinking behaviour will be presented.

Chapter 6. The respondents' drinking behavior

Introduction

In the previous chapter, the psychosocial characteristics of the respondents were presented and discussed. This chapter is concerned with patterns of alcohol consumption in Saudi Arabia, even though this is still a subject about which relatively little is known. Four main areas are considered. The first of these is current drinking behaviour, including the types of drink consumed and preferred by the respondents, drinking situations, places and times of drinking, quantity and frequency of alcohol consumption, and the rates of hazardous alcohol consumption and dependency. The availability and accessibility of alcohol to the respondents are the second area. The third area is the respondents' reasons for drinking. The fourth is the respondents' first experience of drinking. Finally, a thorough discussion and a summary are provided.

Current Drinking Behaviour

Types of drinks consumed

As to types of drink, the respondents were asked what drinks they consumed mostly. Table 23 shows that araq was consumed by 64 percent of the respondents (n=136). Cologne was the second most popular drink, consumed by 25 percent of the respondents. Only 4.4 percent reported beer as their drink, one respondent drank wine, and 5.9 percent drank hard spirits.

Testing the consumed drink against the respondents' characteristics reveals significant differences between the age groups (χ^2 (4) = 20.6, p<.001). The consumption of araq, for example, tended to decrease as the age increased. While 74.5 percent of the respondents aged 30 years and under consumed araq, only 43.6 percent of those aged 41 and over consumed this type of drink. On the other hand, cologne was consumed by 46.2 percent of the age group 41 and over, compared to only 7.8 percent of those aged 30 years and under.

Table 23. Type of drinks mostly consumed presented by the respondents' age

Age	Araq	Cologne	Beer, wine, and hard spirits	All drinks	N
30 and under	74.5%	7.8%	17.6%	100.0%	51
31–40	69.6%	26.1%	4.3%	100.0%	46
41 and over	43.6%	46.2%	10.3%	100.0%	39
Total	64.0%	25.0%	11.0%	100.0%	136

The cross-tabulation of marital status and type of drink consumed (Table 24) shows that 78.0 percent of single respondents consumed araq, whereas 54.8 percent of the divorced, separated and widowed consumed this type of drink. Also, the highest percentage (35.5%) of those who consumed cologne was found among divorced, separated and widowed respondents

Table 24. Type of drinks mostly consumed presented by the respondents' marital status

Marital status	Araq	Cologne	Beer, wine, and hard spirits	All drinks	N
Never married	78.0%	12.0%	10.0%	100.0%	50
Now married	56.4%	30.9%	12.7%	100.0%	55
Divorced, separated, or widowed	54.8%	35.5%	9.7%	100.0%	31
Total	64.0%	25.0%	11.0%	100.0%	136

As far as the respondents'educational status was concerned, it had some though not a significant effect on the types of drink they consumed (χ^2 (6) = 14.03, $p<.05$) (Table 25). For example, 83.3 percent of the illiterate respondents consumed cologne, compared to 11.1 percent of those who had a college education or higher. While 88.9 percent of those who had a college education or higher consumed araq, only one respondent in the illiterate group did so.

Table 25. Type of drinks mostly consumed presented by educational status

Educational status	Araq	Cologne	Beer, wine, and hard spirits	All drinks	N
Illiterate	16.7%	83.3%	00	100.0%	6
High school and under	64.7%	22.5%	12.7%	100.0%	102
College education or higher	88.9%	11.1%	00	100.0%	9
Vocational, art, and other type of education	63.2%	26.3%	10.5%	100.0%	19
Total	64.0%	25.0%	11.0%	100.0%	136

As regards monthly income, Table 26 shows that cologne was consumed by 30.4 percent of the respondents who had a monthly income of SR3000 (£500) or less. However, 11.4 percent of this monthly income group consumed beer, wine and spirits. The percentage of those who consumed araq tended to increase as the monthly income increased, except that the group which earned SR7001–9000 consumed less araq than both lower and higher earners, and half of whom consumed beer, wine and hard spirits.

Table 26. Type of drinks mostly consumed presented by the respondents' monthly income

Monthly income	Araq	Cologne	Beer, wine, and hard spirits	All drinks	N
Less than 3000	58.2%	30.4%	11.4%	100.0%	79
3000–5000	71.0%	22.6%	6.5%	100.0%	31
5001–7000	88.9%		11.1%	100.0%	9
7001–9000	33.3%	16.7%	50.0%	100.0%	6
More than 9000	90.0%	10.0%		100.0%	10
Total	64.4%	24.4%	11.1%	100.0%	135*

* One respondent did not answer the monthly income question.

The figures also show that of the employed respondents, 60.0 percent consumed araq, 22.0 percent consumed cologne, and 18.0 consumed beer, wine and hard spirits. Of the unemployed respondents, 66.3 percent, 26.7 percent, and 7.0 percent respectively consumed araq, cologne, and wine, beer and hard spirits.

As regards the different regions, Table 27 shows that, while none of the respondents of Dammam reported consuming cologne, 44.0 percent of Qaseem respondents did so. Moreover, beer, wine, and hard spirits were consumed more by the respondents of Dammam (17.9%) than by any of the other regional groups.

Table 27. Type of drinks mostly consumed presented by the hospitals where respondents received treatment

Hospital	Araq	Cologne	Beer, wine and hard spirits	All drinks	N
Riyadh	54.0%	34.0%	12.0%	100.0%	50
Jeddah	72.7%	18.2%	9.1%	100.0%	33
Dammam	82.1%		17.9%	100.0%	28
Qaseem	52.0%	44.0%	4.0%	100.0%	25
Total	64.0%	25.0%	11.0%	100.0%	136

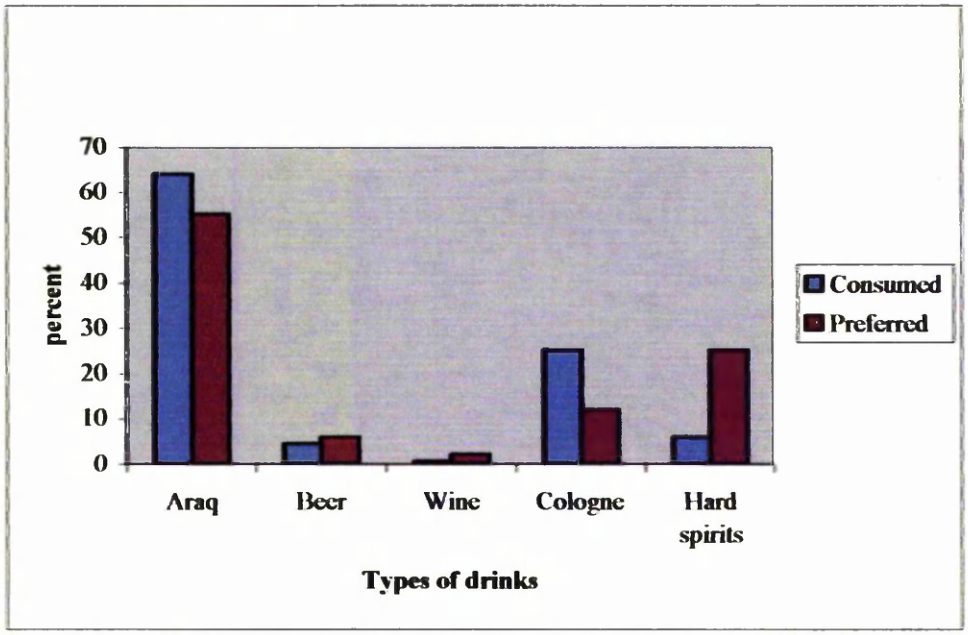
Between hospital wards, the difference with regard to the type of drink mostly consumed was not significant (χ^2 (2) = .11, n.s.). As shown in Table 28, 64.6 percent of the voluntary ward respondents consumed araq, 24.2 percent consumed cologne, and 11.1 percent consumed beer, wine and hard spirits. In the involuntary ward, however, 62.2 percent, 27.0 percent, 10.8 percent respectively consumed araq, cologne, and beer, wine and hard spirits.

Table 28. Type of drinks mostly consumed presented by the sort of ward where respondents received treatment

Sort of ward	Araq	Cologne	Beer, wine and hard spirits	All drinks	N
Voluntary	64.6%	24.2%	11.1%	100.0%	99
Involuntary	62.2%	27.0%	10.8%	100.0%	37
Total	64.0%	25.0%	11.0%	100.0%	136

The consumption of a particular type of drink did not necessarily mean it was the respondents' preferred drink. Results (Figure 5) show that while 64 percent of respondents consumed araq, 55.1 percent chose it as their preferred drink. Also, the percentage of those who preferred cologne dropped to 11.8 percent compared to 25.0 percent who reported consuming it. Interestingly enough, beer, wine and hard spirits were preferred by a higher number of respondents than reported consuming them. 25 percent, for example, reported hard spirits as their preferred drink compared to only 5.9 percent who consumed it.

Figure 5. Type of drinks mostly consumed and those mostly preferred by the respondents



Furthermore, the statistics reveal significant differences between the preferred types of drink and the drinks actually consumed (χ^2 (4) = 69.88, p<.001). The figures also show that, of those who chose araq as their preferred drink, 20.0 percent consumed cologne and 4.0 percent consumed beer, wine and hard spirits. Of those who preferred beer, wine and hard spirits, only 26.7 percent consumed them, 66.7 percent consumed araq, and 6.7 percent consumed cologne. Moreover, none of the respondents who reported preferring cologne (16 respondents) consumed a different type of drink.

The respondents' drinking behaviour also included mixing their drink with water or soft drinks. 74.3 percent reported adding water or a soft drink to their drink. However, 14 percent did not add anything, while 11 percent did sometimes.

Moreover, the figures reveal that of those respondents who said "no" to adding any material to their drink, 63.2 percent drank araq, 21.1 percent drank cologne, and 15.8 percent drank beer, wine and hard spirits. Of those who said "sometimes", 46.7 percent drank araq, 33.3 percent drank cologne, and 20.0 percent drank beer, wine and hard spirits.

Drinking companion

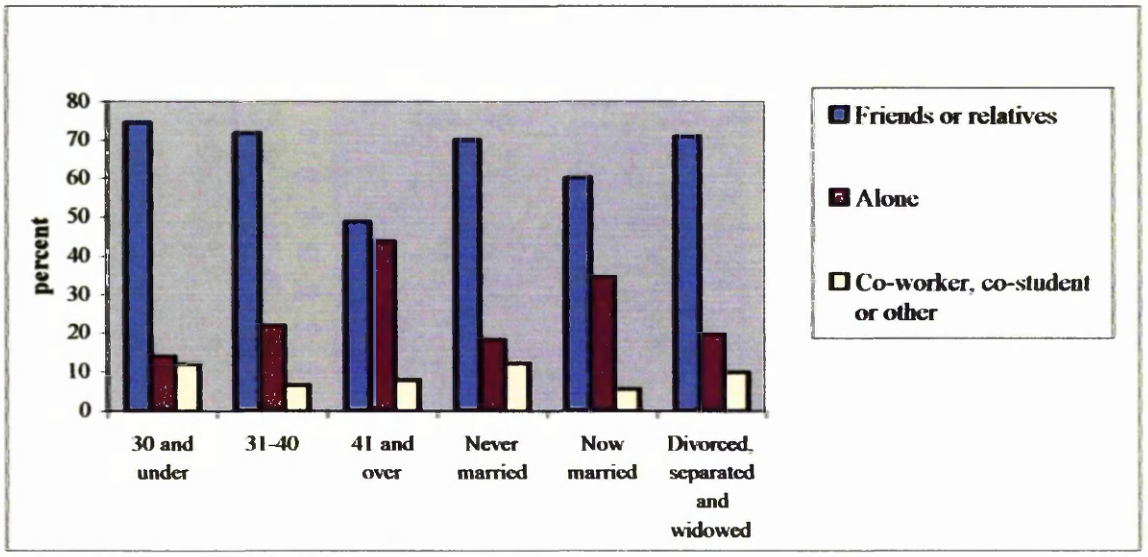
More than half (61.0%) of respondents reported a friend as their usual drinking companion, while 25.0 percent reported drinking alone. Drinking with a relative accounted for 5.1

percent of the respondents, with a co-worker 4.4% percent, and with a co-student 2.9% percent.

Further, by examining the age groups against the drinking situation, the results (Figure 6) show that drinking with a friend or relative was more prevalent among younger age groups, and that the percentage who drank alone increased as the age increased. The figures also show that of those aged 30 years and under, 74.5 percent drank with a friend or relative, 13.7 percent alone, and 11.8 with a co-worker, a co-student or others. Of those aged 41 and over, 48.7 percent drank with a friend or a relative, 43.6 percent drank alone, and 7.7 percent drank with a co-worker, a co student or other companion.

In addition, the figures reveal that 18.0 percent of single respondents, 34.5 percent of married respondents, and 19.4 percent of divorced, separated or widowed respondents reported drinking alone. Drinking with a friend or a relative was reported by 70.0 percent of single respondents, 60.0 percent of married respondents, and 71 percent of divorced, separated or widowed respondents.

Figure 6. Drinking companion presented by the respondents' age and marital status



Place and time of drinking

In relation to the place where drinking usually occurred, the figures (Table 29) show that 43.4 percent of respondents reported drinking in their homes, 16.9 percent at others'

houses, 11.0 percent in a private resort (*Istraha*)[1], and 21.3 percent outside the city. Also, 7.4 percent of the respondents reported drinking in other places like beaches or inside hotel rooms. Moreover, home was the most common drinking place for all age groups. However, whereas more than half of the respondents (56.4%) aged 41 and older reported drinking at home, only 37.3 percent of the respondents aged 30 and under reported drinking at home. In addition, drinking at others' houses was reported by 23.5 percent of the age group 30 years and older, compared to only 5.1 percent of the respondents aged 41 and older.

Similarly, drinking at home was most common among all marital groups. However, it was most prevalent among divorced, separated or widowed (54.8 %). Moreover, 24.0 percent and 26.0 percent of the single respondents reported drinking in others' houses, and outside the city respectively, compared to only 12.9 percent and 16.1 percent of the separated, divorced or widowed respondents. 43.0 percent of married respondents reported drinking at home, 12.7 percent at others' houses, 14.5 percent at a private resort, and 20.0 percent outside the city.

Table 29. Place of drinking presented by age and marital status

	At home	At others' houses	In a private resort	Outside the city	Elsewhere	All places	N
Age							
30 and under	**37.3%**	**23.5%**	**7.8%**	**25.5%**	**5.9%**	**100.0%**	**51**
31–40	**39.1%**	**19.6%**	**13.0%**	**19.6%**	**8.7%**	**100.0%**	**46**
41 and over	**56.4%**	**5.1%**	**12.8%**	**17.9%**	**7.7%**	**100.0%**	**39**
Total	**43.4%**	**16.9%**	**11.0%**	**21.3%**	**7.4%**	**100.0%**	**136**
Marital Status							
Never married	**36.0%**	**24.0%**	**6.0%**	**26.0%**	**8.0%**	**100.0%**	**50**
Now married	**43.6%**	**12.7%**	**14.5%**	**20.0%**	**9.1%**	**100.0%**	**55**
Divorced, separated or widowed	**54.8%**	**12.9%**	**12.9%**	**16.1%**	**3.2%**	**100.0%**	**31**
Total	**43.4%**	**16.9%**	**11.0%**	**21.3%**	**7.4%**	**100.0%**	**136**

With regard to the days of drinking, the highest percentage (53.7%) was found to be those who reported drinking on any day of the week (Table 30). Only 4.4 percent of respondents restricted their drinking to work days, and 41.9 percent reported drinking only at weekends. Moreover, drinking any day of the week was most common in all age groups:

[1] Istraha is a resort or a place with plenty of entertainment that is usually located outside the city, and can be owned by those who can afford it, otherwise it can be rented as a whole.

52.9 percent of those aged 30 and under, 54.3 percent of those aged 31–40, and 53.8 percent of those aged 41 and over.

The figures in Table 30 also show that drinking on any day of the week was most common among single respondents (66.0%) and divorced, separated or widowed respondents (61.3%). However, drinking during weekends was most common among married respondents (58.2%).

Table 30. Days of usual drinking presented by age and marital status

	Work days	Week-ends	Any day of the week	All	N
Age					
30 and under	**5.9%**	**41.2%**	**52.9%**	**100.0%**	**51**
31–40	**4.3%**	**41.3%**	**54.3%**	**100.0%**	**46**
41 and over	**2.6%**	**43.6%**	**53.8%**	**100.0%**	**39**
Total	**4.4%**	**41.9%**	**53.7%**	**100.0%**	**136**
Marital Status					
Never married	**6.0%**	**28.0%**	**66.0%**	**100.0%**	**50**
Now married	**3.6%**	**58.2%**	**38.2%**	**100.0%**	**55**
Divorced, separated, or widowed	**3.2%**	**35.5%**	**61.3%**	**100.0%**	**31**
Total	**4.4%**	**41.9%**	**53.7%**	**100.0%**	**136**

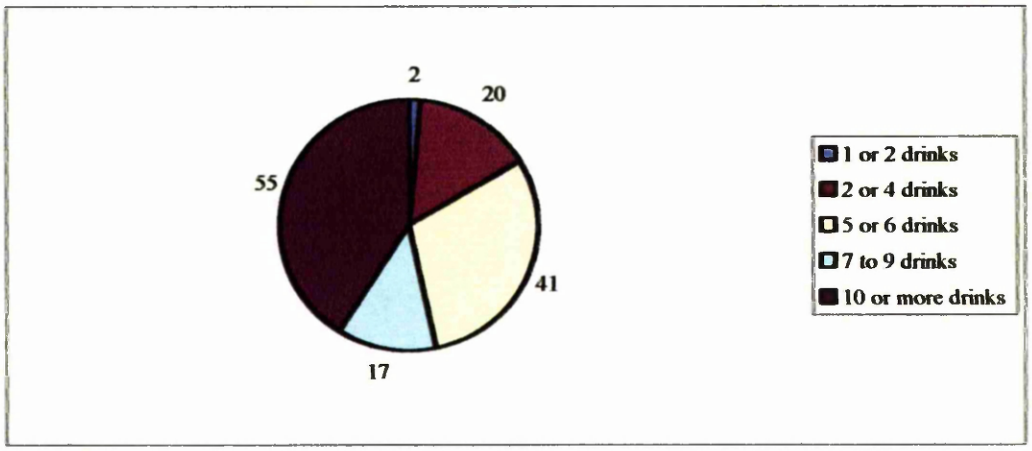
Quantity and frequency

In assessing the quantity and frequency of alcohol consumption a standard drink is used as a measure. A standard drink is one unit (eight grams) of pure alcohol (The Royal College of Physicians, 1991). According to Conigrave et al. (1995), a daily alcohol intake of five drinks or more (international measure) is considered hazardous drinking for males. However, The Royal College of Physicians (1991) has demonstrated that the consumption of three or more drinks (British measure) are enough for a male to enter the area of hazardous consumption. The figures show that the highest percentage of respondents consumed ten or more drinks per day (40.7%), 30.1 percent of respondents consumed five or six drinks per day while 21.5 percent consumed seven to nine drinks per day.

Using the British measure, only two respondents (Figure 7) reported consuming below the hazardous level. But when the international measure was applied, the proportion of respondents drinking below the hazardous level increased to 15 percent. However, whether using the British or the international measure, the existence of respondents whose drinking

is below the hazardous level is an indication that not only the quantity of drinking but the drinking itself is a problem in Saudi Arabia. A side from that, it is clear that the majority (85%) of the respondents would be likely to meet the international criterion for hazardous drinking.

Figure 7. Number of drinks often consumed by the respondents daily



As far as the frequency of having a drink containing alcohol is concerned, 17.8 percent of subjects reported drinking once a month or less (Table 31). Drinking two to four times a month was reported by 24.4 percent of subjects. Drinking four or more times a week was the most common frequency (35.6%).

Table 31. Frequency and percentage of having drink containing alcohol

Frequency of having a drink containing alcohol	Frequency	Percent
Monthly or less	24	17.8
2–4 times a month	33	24.4
2–3 times a week	30	22.2
4 or more times a week	48	35.6
Total	135	100.0

In addition, having six drinks or more per occasion was recorded by more than 90 percent of respondents. 27.2 percent reported having 6 drinks or more four times or more per week whereas 24.3 percent said they did once a month.

Hazardous alcohol consumption

Hazardous alcohol consumption was measured by summing the scores of the first three questions of the Alcohol Use Disorders Identification Test (AUDIT). These questions were: 1) How often do you have a drink containing alcohol? 2) How many drinks containing alcohol do you have on a typical day when you are drinking? 3) How often do you drink six or more drinks on one occasion?

The total sores for these three items range from 0–12. These scores were then collapsed into three categories. Scoring 0–4 indicated low hazardous consumption, 5–8 mild hazardous consumption, and 9–12 high hazardous consumption. According to this scoring system, results showed that 12.5 percent of the respondents scored 0–4, 43.4 percent scored 5–8, and 43.4 percent scored 9–12.

When scores of hazardous alcohol consumption were examined against some of the respondents' characteristics, the results in Table 33 revealed that the highest percentage of those aged 30 years and under (47.1%) scored 9–12, whereas only 9.8 percent of this age group scored 0–4 on the hazardous alcohol consumption scale. Of those aged 31–40, 46.7 percent scored 5–8, 40.0 percent scored 9–12, and 13.3 scored 0–4. Of those aged 41 and over, however, 15.4 percent scored 0–4, 41.0 percent scored 5–8, and 43.6 percent scored 9–12.

Table 32. Scores of alcohol hazardous consumption presented by respondents' characteristics

	Alcohol consumption scores				
Age	**0–4**	**5–8**	**9–12**	**Total**	**N**
30 and under	9.8%	43.1%	47.1%	100.0%	51
31–40	13.3%	46.7%	40.0%	100.0%	45
41 and over	15.4%	41.0%	43.6%	100.0%	39
All respondents					135*
Marital Status					
Never married	8.0%	44.0%	48.0%	100.0%	50
Now married	18.5%	42.6%	38.9%	100.0%	54
Divorced, separated or widowed	9.7%	45.2%	45.2%	100.0%	31
All respondents					135*
Educational Status					
Illiterate	33.3%	16.7%	50.0%	100.0%	6
High school and under	8.9%	45.5%	45.5%	100.0%	101
College education or higher	33.3%	55.6%	11.1%	100.0%	9
Vocational, art, or other type of education	15.8%	36.8%	47.4%	100.0%	19
All respondents					135*
Monthly Income					
Less than 3000	12.7%	41.8%	45.6%	100.0%	79
3000–7000	7.7%	46.2%	46.2%	100.0%	39
More than SR7000	25.0%	50.0%	25.0%	100.0%	16
All respondents					134**
Employment					
Employed	22.0%	42.0%	36.0%	100.0%	50
Unemployed	7.1%	44.7%	48.2%	100.0%	85
All respondents					135*
Hospital region					
Riyadh	18.0%	32.0%	50.0%	100.0%	50
Jeddah	9.1%	54.5%	36.4%	100.0%	33
Dammam	--	59.3%	40.7%	100.0%	27
Qaseem	20.0%	36.0%	44.0%	100.0%	25
All respondents					135*

* One respondent did not respond to the question of alcohol consumption scale.
** One respondent did not respond to the question of monthly income.

In addition, of the single respondents, 48.0 percent scored 9–12 while only 8.0 percent scored 0–4. Among the married respondents, scoring 5–8 was the most prevalent (42.6%), and scoring 0–4 was the least prevalent (18.5%). Of the divorced, separated or widowed respondents a percentage of 45.2 was recorded for both scores 5–8 and 9–12.

Scores of hazardous alcohol consumption were also assessed in relation to respondents' educational status. 50.0 percent of the illiterate group scored 9–12, and 33.3 percent scored

0–4. Scoring mild to high hazardous consumption (5–8, 9–12) was most common among respondents with a high school education or less (91.0%), whereas scoring low to mild (0–4, 5–8) was most common among respondents with a college education or higher (88.9%).

Between regions (hospitals), half of the Riyadh respondents scored the maximum on the scale, whereas only 18.0 percent scored the minimum. Scoring 5–8 was the highest among Dammam respondents (59.3%). However, none of the Dammam respondents scored the minimum, 0–4. 36.4 percent of Jeddah respondents scored the maximum, and 9.1 percent scored the minimum. Scoring 9–12 accounted for 44.0 percent of Qaseem respondents, and 40.7 percent of Dammam respondents.

When alcohol hazardous consumption scores were related to the monthly incomes of the respondents, the results showed that scoring 0–4 accounted for 12.7 percent of respondents earning less than SR3000, 7.7 percent of respondents earning SR3000–7000, and 25.0 percent of those earning more than SR7000. Whereas a scoring of 9–12 was reported for 45.6 percent of those earning less than SR3000, and 46.2 percent of those earning SR3000–7000, only 25.0 percent of those respondents earning more than SR7000 had the same score.

As regards employment, the percentage of employed respondents who scored the minimum (0–4) was higher than the percentage of unemployed respondents who did so (22.0% and 7.1% respectively). Moreover, scoring 9–12 was more prevalent among the unemployed (48.2%) than the employed (36.0%).

As far as the sort of admission is concerned, the results showed that 45.9 percent of those in involuntary wards scored 9–12, compared to 42.9 percent of those in voluntary wards. However, scoring 0–4 was more prevalent in the involuntary wards (21.6%) than in the voluntary wards (9.2%). Scoring 5–8 accounted for 48.0 percent of respondents in voluntary wards, and 32.4 percent of those in involuntary wards.

Alcohol Dependence

As in the case of hazardous alcohol consumption, similar procedures were used to measure alcohol dependence, except that alcohol dependence was measured by summing up the scores of questions four to six of the Alcohol Use Disorders Identification Test (AUDIT). These questions were: 1) How often during the last year have you found that you were

unable to stop drinking once you had started? 2) How often during the last year have you failed to do what was normally expected from you because of drinking? 3) How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

The scores for these three items range from 0–12. These scores were then collapsed into three categories. Scoring 0–4 indicated low hazardous consumption, 5–8 mild hazardous consumption, and 9–12 high hazardous consumption. According to this scoring system, results (Table 34) showed that 12.5 percent of respondents scored 0–4, 43.4 percent scored 5–8, and 43.4 percent scored 9–12.

Table 33. Scores of alcohol dependence presented by respondents' characteristics

	Alcohol dependence scores				
Age	0–4	5–8	9–12	Total	N
30 and under	45.1%	27.5%	27.5%	100.0%	51
31–40	28.9%	46.7%	24.4%	100.0%	45
41 and over	35.9%	33.3%	30.8%	100.0%	39
All respondents					135*
Marital status					
Never married	40.0%	34.0%	26.0%	100.0%	50
Now married	35.2%	40.7%	24.1%	100.0%	54
Divorced, separated or widowed	35.5%	29.0%	35.5%	100.0%	31
All respondents					135*
Educational status					
Illiterate	16.7%	66.7%	16.7%	100.0%	6
High school and under	36.6%	36.6%	26.7%	100.0%	101
College education or higher	55.6%	22.2%	22.2%	100.0%	9
Vocational, art, or other type of education	36.8%	26.3%	36.8%	100.0%	19
All respondents					135*
Monthly income					
Less than SR3000	41.8%	30.4%	27.8%	100.0%	79
SR3000–7000	28.2%	48.7%	23.1%	100.0%	39
More than SR7000	37.5%	31.3%	31.3%	100.0%	16
All respondents					134**
Employment					
Employed	44.0%	36.0%	20.0%	100.0%	50
Unemployed	32.9%	35.3%	31.8%	100.0%	85
All respondents					135*
Hospital region					
Riyadh	42.0%	24.0%	34.0%	100.0%	50
Jeddah	51.5%	36.4%	12.1%	100.0%	33
Dammam	14.8%	48.1%	37.0%	100.0%	27
Qaseem	32.0%	44.0%	24.0%	100.0%	25
All respondents					135*
Sort of ward					
Voluntary	36.7%	34.7%	28.6%	100.0%	98
Involuntary	37.8%	37.8%	24.3%	100.0%	37
All respondents					135*

* One respondent did not respond to the question of alcohol dependence scale.
** One respondent did not respond to the question of monthly income.

In comparing alcohol dependence scores among age groups, the results reveal that of the respondents aged 30 and under 45.1 percent scored 0–4, 27.5 percent scored 5–8, and a similar percentage scored 9–12. The highest percentage scoring 9–12 among all age groups was found for those aged 41 and older (30.8%).

As with marital status, scoring 0–4 accounted for 40.0 percent of single respondents, 35.2 percent of married, and 35.5 percent of divorced, separated or widowed respondents. In addition, the highest percentage scoring 9–12 among all marital groups were the divorced, separated or widowed respondents (35.5%).

When relating alcohol dependence scores to educational status, the results show that, of all educational groups, scoring 0–4 was most common among the respondents who had a college education or higher (55.6%). Those who had vocational, art and other types of education had the highest percentage of scoring 9–12 of all groups (36.8%).

The figures also show that, of those respondents with less than SR3000, 41.8 percent scored 0–4, 27.8 percent scored 9–12, whereas, of the respondents earning more than SR 7000, 37.5 percent scored 0–4, and 31.3 percent scored 9–12. In addition, of those earning SR3000–7000, 28.2 percent scored 0–4, 48.7 percent scored 5–8, and 23.1 percent scored 9–12.

With respect to employment, scoring 0–4 on the alcohol dependence scale was more prevalent among employed respondents (44.0%) than among unemployed (32.9%). Moreover, 20.0 percent of the employed respondents scored 9–12, compared to 31.8 of the unemployed.

Among the regions, the lowest alcohol dependence scores of 0–4 were found among Jeddah respondents with 51.5 percent and Riyadh with 42.0 percent. 48.1 percent of Dammam respondents scored 5–8, and 37.0 percent scored 9–12. Of Qaseem respondents 32.0 percent scored 0–4, 44.0 percent scored 5–8, and 24.0 scored 9–12.

Furthermore, scoring 0–4 on the alcohol dependence scale accounted for 36.7 percent of the voluntary ward respondents, and 37.8 percent of the involuntary ward respondents. In addition, scoring 9–12 was more prevalent among respondents in the voluntary wards (28.6%) than those in the involuntary wards (24.3%).

Drinking during Ramadan

The figures show that 58.0 percent reported abstaining totally from drinking during the holy month of Ramadan. Further, of those who abstained totally, 23.1 percent scored 9–12 on an alcohol dependence scale (Table 32).

Table 34. Respondents' drinking during Ramadan presented by their scores on the alcohol dependence scale

	Alcohol dependence scores			
Drinking during Ramadan	0-4	5-8	9-12	All
Don't stop drinking	3	7	6	16
Drink only during Ramadan nights	15	10	12	37
Abstain totally during Ramadan	31	29	18	78
Others	1	1	1	3
Total	50	47	37	134*

* One respondents did not answer Alcohol Dependence scale, another did not answer drinking during Ramadan question.

Accessibility and availability of alcohol

In order to assess the accessibility and availability of alcohol to hospitalised Saudi problem drinkers, the source of alcohol, its cost, and the type of alcohol consumed by the respondents were investigated. The figures show that the highest percentage of respondents reported obtaining alcohol from dealers (39.7%). Getting drink from a friend was reported by 24.3 percent of the respondents, from a bar or a store by 22.8 percent, from a relative by 5.9 percent, and from their own manufacture by 4.4 percent.

The results show that, of those who obtained drink from a friend, 69.7 percent consumed araq, 12.1 percent consumed cologne, and 18.2 percent consumed beer, wine and hard spirits. Moreover, the highest percentage of those who obtained drink from dealers was of those respondents who consumed araq (85.2%), whereas the highest percentage of those who obtained drink from a store was of those who consumed cologne (83.9%).

As with the cost of drink, more than half of the respondents (60.3%) reported paying less than SR500 (£80) per month for their drink, and 14.7 percent paid more than SR1,000 per month. Paying SR500–750 accounted for 11.1 percent of the respondents.

The figures show that of those who drank araq, 78.2 percent spent less than SR750 per month, and 21.8 percent spent more than SR750 per month. Of those who drank cologne, 62.5 percent spent less than SR750 per month, 37.5 spent more than SR750 per month. Similar percentages were found for those who drank beer, wine and hard spirits.

Results in Table 35 show no statistically significant difference between monthly income and spending on alcohol (χ^2 (2) = 3.96, n.s.). However, of those respondents earning less

than SR3000 a month, 21.8 percent spent more than SR750 on alcohol per month, compared to those respondents who earned SR3000–7000 and more than SR7000 per month (37.5% for each group).

No statistically significant difference was found between employment status and spending on alcohol (χ^2 (1) = 2.42, n.s.). The figures show that 36.0 percent of the employed respondents spent more than SR750 per month on alcohol, whereas only 23.5 percent of the unemployed respondents reported spending the same amount of money.

Table 35. Cost of drink per month presented by income, employment, and type of consumed drink

	Less than SR750 per month	SR750 and more per month	Total	N
Monthly income				
Less than SR3000	**78.2%**	**21.8%**	**100.0%**	**78**
3000–7000	**62.5%**	**37.5%**	**100.0%**	**40**
More than SR7000	**62.5%**	**37.5%**	**100.0%**	**16**
Employment				
Employed	**64.0%**	**36.0%**	**100.0%**	**50**
Unemployed	**76.5%**	**23.5%**	**100.0%**	**85**
All respondents	**71.9%**	**28.1%**	**100.0%**	**135**

*** One respondent did not answer the monthly income question.**

Reasons for drinking

Figures in Table 36 reveal that 27.9 percent of respondents reported they drank to forget problems, 22.1 percent to relax, and 21.3 percent to relieve anxiety. Moreover, the figures in the same table reveal that the highest percentage of those aged 30 and under as well as those aged 31–40 reported drinking to forget problems, whereas those aged 41 and older reported drinking to relax. Although overall not high, drinking as a response to peer pressure mostly occurred among respondents aged 30 and under.

Table 36. Reasons for drinking presented by respondents' age

Main reason for drinking	Age			All ages
	30 and under	31–40	41 and over	
Relax	11	9	10	30
Release anxiety	11	10	8	29
Forget problems	14	15	9	38
Enhance sexual ability	0.0	1	1	2
Respond to peer pressure	5	1	1	7
Feel happy	7	8	5	20
Only for the sake of drink	3	2	5	10
Total	51	46	39	136

Table 37 reveals that the highest percentage of the never married (36.0 %) reported drinking to forget problems while the highest percentage of the now married (27.3 %) drank to relax. Of the divorced, separated and widowed respondents, the highest percentage (29.0%) reported drinking to relieve anxiety. Although very low, drinking to enhance the sexual ability was found only among the now married respondents (3.6%).

Table 37. Reasons for drinking presented by the respondents' marital status

Main reason for drinking	Marital status			All
	Never Married	Now Married	Divorced, Separated, and widowed	
Relax	8	15	7	30
Relieve anxiety	7	13	9	29
Forget problems	18	13	7	38
Enhance sexual ability	0.0	2	0.0	2
Respond to peer pressure	4	1	2	7
Feel happy	10	6	4	20
Only for the sake of drink	3	5	2	10
Total	50	55	31	136

Table 38 shows that the highest percentage of those earning less than SR3000 drank to forget problems, whereas the highest percentage of those earning more than SR7000 drank to relax. To relieve anxiety and forget problems were found to be the most common reasons for those who earned SR3000–7000. Moreover, 31.3 percent of respondents earning more than SR7000 drank to feel happy. However, only13.9 percent of those earning less than SR 3000 drank to feel happy.

Table 38. Reasons for drinking presented by the respondents' monthly Income

	Monthly income			
Main reason for drinking	Less than SR3000	SR3000–7000	More than SR7000	All
Relax	17	7	6	30
Release anxiety	16	12	1	29
Forget problems	25	12	1	38
Enhance my sexual ability	0.0	1	1	2
Respond to peer pressure	4	2	1	7
Feel happy	11	3	5	19
Only for the sake of drink	6	3	1	10
Total	79	40	16	135

* One respondent did not answer the monthly income question.

The relationship between the type of ward where the respondents were admitted and the reasons for drinking was not statistically significant (χ^2 (6) = 8.72, n.s.). However, the figures in Table 39 show that the percentage of drinking to forget problems was higher among respondents of voluntary wards (30.1%), whereas the percentage of drinking to relieve anxiety was higher among those in involuntary wards. Moreover, whereas 10.1 percent of respondents in voluntary wards drank only for the sake of drink, none of those in voluntary wards did so.

Table 39. Reasons for drinking presented by the sort of ward where respondents were admitted

	Sort of ward		
Main reason for drinking	Voluntary	Involuntary	All wards
Relax	21.2%	24.3%	22.1%
Relieve anxiety	17.2%	32.4%	21.3%
Forget problems	30.3%	21.6%	27.9%
Enhance sexual ability	1.0%	2.7%	1.5%
Respond to peer pressure	6.1%	2.7%	5.1%
Feel happy	14.1%	16.2%	14.7%
Only for the sake of drink	10.1%	0.0	7.4%

Among the regions (Table 40), the highest percentage of Riyadh respondents (30.0%) reported drinking to forget problems, while drinking to feel happy was most common among Jeddah respondents. Drinking to forget problems was most common among Dammam respondents (46.4%) and Riyadh respondents (30.0%). However, drinking to

feel happy was most common among Jeddah respondents. Relieving anxiety was most common among Qaseem respondents.

Table 40. Reasons for drinking presented by the hospital where the respondents were admitted

Main reason for drinking	Hospital				
	Riyadh	Jeddah	Dammam	Qaseem	All hospitals
Relax	20.0%	21.2%	21.4%	28.0%	22.1%
Release anxiety	18.0%	15.2%	21.4%	36.0%	21.3%
Forget problems	30.0%	15.2%	46.4%	20.0%	27.9%
Enhance sexual ability	2.0%	3.0%	0.0	0.0	1.5%
Respond to peer pressure	4.0%	12.1%	3.6%	0.0	5.1%
Feel happy	14.0%	30.3%	3.6%	8.0%	14.7%
Only for the sake of drink	12.0%	3.0%	3.6%	8.0%	7.4%
%	100.0%	100.0%	100.0%	100.0%	100.0%
Total	50	33	28	25	136

Almost half (46.7%) of those who drank to relax reported drinking at home, and the same percentage drank outside the city or in private resorts, whereas only 6.7 percent drank at others' houses. Moreover, the highest percentage of those who drank to forget problems (47.4 %) reported drinking outside the city or in private resorts. While more than half of those who drank as a response to peer pressure did so at others' houses, none of these respondents reported drinking at home.

First drinking experience

Age when first drink consumed

Table 41 shows that 16.9 percent of respondents had their first drink under the age of 15. However, almost half had their first drink between 15 and 20 years old. Small percentages of respondents reported their first drinking experience after the age of 30, and all by the age of 45.

Table 41. . Age of first drinking experience presented by number and age of respondents

Age when first drink consumed	Number	%
Less than 15 years old	23	16.9
15–20	66	48.5
21–25	28	20.6
26–30	11	8.1
31–35	3	2.2
36–40	4	2.9
41–45	1	.7
Total	136	100.0

Table 42 shows the respondents' age and the source of drink for their first drinking experience. 59.6 percent of those who started their drinking under the age of 20 years old obtained their first drink from a friend. Half of those who started their drinking at the age of 31 and over reported obtaining their first drink from a bar or a store. Obtaining the first drink by self-manufacture was found only respondents under 20 years of age.

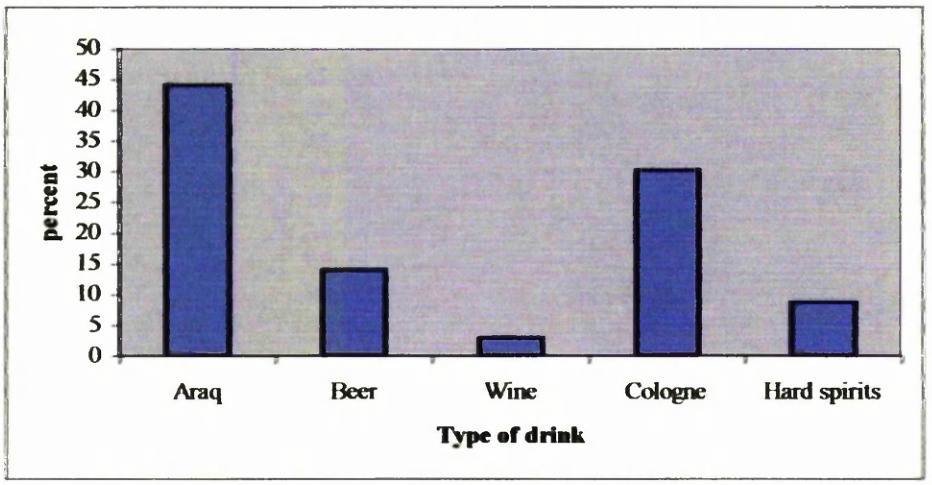
Table 42. Age at first drinking experience presented by the source of first drink

	Source of first drink					
Age of first drinking experience	Friend	Relative	Dealer	Bar or store	Self-manufacture	N
20 and under	53	14	4	15	3	89
21–30	26	3	2	8	—	39
31 and over	3	1	—	4	—	8
Total	82	18	6	27	3	136

Type of first drinking experience

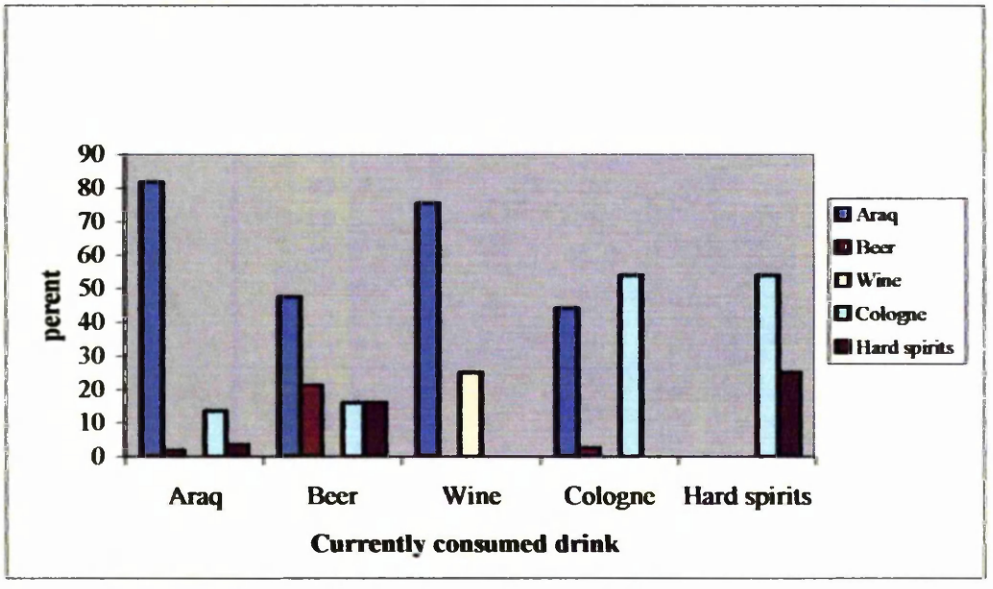
The results (Figure 8) reveal that 44.1 percent had araq as their first drink, whereas 30.1 percent had cologne. Having beer as the first drink was recorded by 14.0 percent. Hard spirits and wine were the first drink of 8.8 percent and 2.9 percent respectively.

Figure 8. Types of the respondents' first drink



Comparing the type of drink during the first experience with the current type of consumed drink, the results (Figure 9) show that 81.7 percent of those who had araq as their life first drink continued using it. However, only 21.1 percent of those who chose beer as their first drink continued to drink it. More than half of those who first had cologne continued to use it.

Figure 9. Types of currently consumed drinks presented by the respondents' first type of drink



When the type of the first drink is compared with the preferred drink, the statistics show (Table 43) that 75.0 percent of those who first experienced hard spirits preferred drinking it although not the same percentage reported consuming it. Also, of those who first

experienced araq, 71.7 percent chose it as their preferred drink. Wine was not the preferred drink of any who reported it as their first drinking experience.

Table 43. The type of first drink cross-tabulated with the preferred current drink

	Type of drink currently preferred						
Type of First drink	Araq	Beer	Wine	Cologne	Hard spirits	Total	N
Araq	71.7%	3.3%	1.7%	3.3%	20.0%	100.0%	60
Beer	26.3%	26.3%	5.3%	15.8%	26.3%	100.0%	19
Wine	75.0%	—	—	—	25.0%	100.0%	4
Cologne	51.2%	2.4%	2.4%	26.8%	17.1%	100.0%	41
Hard spirits	25.0%	—	—	—	75.0%	100.0%	12
Total	55.1%	5.9%	2.2%	11.8%	25.0%	100.0%	136

Source of first drink

60.3 percent of respondents were introduced to drinking through a friend, and 13.2 percent through a relative. Almost 20.0 percent obtained their first drink from a bar or a store. Obtaining the first drink from a dealer or from self-manufacture accounted for 4.4 percent and 2.2 percent respectively.

When a comparison is made between the source of the first drink and the current source of drink, the figures show that 27.2 percent of those who obtained their first drink from a friend continued the use of this source to obtain drink. However, 40.7 percent of those who got their first drink from a friend shifted to dealers as their current source. Moreover, 50 percent of those who obtained their first drinks from dealers continued to rely on this source as their current source. Also, 66.7 percent of those who made their first drink themselves, continued to do so to obtain their current drinks.

Country of the first drinking experience

More than three-quarters (76.3 %) of respondents reported that they had their first drink inside the country. Almost half who had their first drink outside the country did so in Egypt or Bahrain. The remainder had their first drink in other Arab or non-Arab countries.

Companion of the first drink

Most of the respondents reported that they had their first drink with a friend (63.0 %) or a relative (20.0%). Only 6.7 percent of the respondents had their first drink alone. However,

when the companion of the first experience was compared with companion of current drinking, the results showed that almost half the respondents continued practising the same pattern, although not necessarily with the same individuals. For example 44.1 percent of the respondents reported a friend as the companion of their first drinking experience and continued to drink with a friend as their current drinking companion.

Sixty one respondents (44.9% of the total sample) shifted their drinking companion since their first drinking experience. Of those, 29 respondents (47.5%) reported drinking alone as their current drinking behaviour and 23 (37.7%) shifted to drinking with a friend.

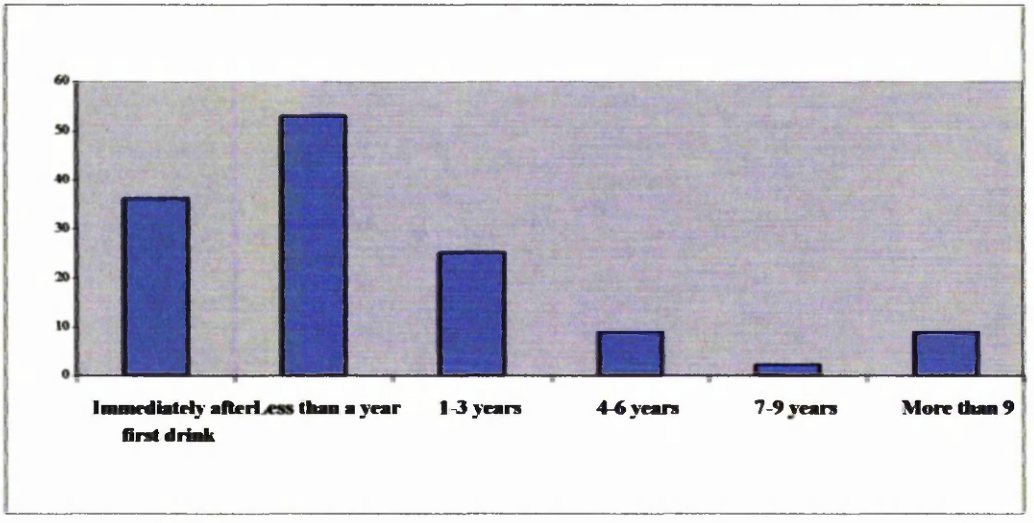
The effect of first drinking experience

62.4 percent of respondents claimed feeling happy during their first experience, whereas only 15.0 percent reported having bad feelings. The remainder stated they did not know what their feelings were.

Time between first drinking experience and drinking regularly

66.4 percent of respondents reported starting drinking on a regular basis within a year of their first experience (Figure 10). Less than 7.0 percent of respondents started drinking regularly more than nine years after their first drinking experience.

Figure 10. Time between first drink and drinking regularly presented by number of respondents



When the relationship between the age of the first drinking experience and the time when the respondent started drinking on a regular basis was examined, the result showed significant differences (χ^2 (4) = 22.8, p<.00). The younger the age of the first drink the shorter the period between the first drink and drinking in a regular base. Table 44 shows that of those who reported drinking regularly within a year of their first drinking experience 41.7 percent were in the age group 20 or less, compared to 19.4 percent of those aged 31 or over. Moreover, starting drinking in a regular basis after 3 years or more was accounted for 44.7 percent of the respondents over 30 years old whereas only 6.4 percent of those aged 20 or less did so.

Table 44. The time between drinking regularly and the first drinking experience presented by the respondents' age at the first drinking experience

	Age at first drinking experience			
Start drinking regularly	20 and under	21–30	31 and over	All ages
Less than a year	41.7%	38.9%	19.4%	36
1–3	9.4%	54.7%	35.8%	53
Over 3 years	6.4%	48.9%	44.7%	47
Total	16.9%	48.5%	34.6%	136

Discussion

It is clear from the results that the vast majority of the respondents consumed araq, an alcoholic beverage that is made locally, or cologne, a product that is made for purposes other than drinking. Beer, wine and hard spirits are little used by the respondents. Unfortunately, no study concerning the types of drink consumed in Saudi Arabia supports this finding. However, Weiss (11 July 2001) reported that araq is preferred by 14.3 percent of the patients who received alcohol treatment in Israel (where many Arabs live). Also, she found that 2.9 percent preferred beer, 1.3 percent preferred wine, and 43.8 percent preferred distilled spirits.

In addition, in a study of 1,210 alcoholic men who received inpatient treatment in the Alcohol Dependence Treatment Program at the Lyons Veterans Administration Medical Centre, USA, Ornstein & Cherepon (1985) found that 7.8 percent of the respondents consumed wine, 32.2 percent consumed beer, and 60.0 percent consumed distilled spirits.

However, the consumption of araq and cologne in preference to other types of alcoholic beverages might be the result of various factors. One possible factor is the problem of

availability and accessibility of alcoholic beverages since they are all outlawed in Saudi Arabia. Another factor is that, even if other kinds of alcoholic drinks were available, their cost would be higher, since, unlike araq and cologne, they can only be obtained in the country as a result of smuggling; and it should be borne in mind that 58.5 percent of the respondents earned less than SR3000 (£500) a month.

The respondents being mostly from younger age groups is consistent with other findings (e.g. Al-Damigh, 1997; Al-Anazi, 1999). However, the prevalence of araq drinking among younger age groups and cologne drinking among older age groups needs further investigation. Lack of knowledge about the health risks associated with cologne drinking (Kinney & Leaton, 1991) might be one of the reasons that could explain such behaviour. Cologne was found to be more widely used by illiterate respondents (83.3%) than educated ones (11.1%), and the older respondents had a generally lower level of education than the younger.

Another possible explanation for the wider use of cologne among the older respondents is that cologne is more affordable than araq. It is clear from the findings that the consumption of cologne was mostly prevalent among those respondents with a low income. Earning a high income is normally, though not necessarily, associated with high education. The majority of respondents were of low educational levels and a large segment of these poorly educated respondents were of more advanced age. Since many of the older respondents had a low education, their incomes may have been so low that they could not afford to buy alcohol other than cologne

The consumption of cologne was found to be more prevalent among divorced, separated and widowed respondents, whereas araq was mostly consumed by married respondents. Such findings need more investigation. Also, cologne was found to be more prevalent among unemployed respondents, again perhaps because of its lower cost. However, it could also be that the very strong smell of cologne makes it easily discovered by an employer, making it it inadvisable for employees to drink cologne before going to work.

Among the hospitals, cologne drinking was most common among respondents of Qaseem hospital. Low education, low income and a high rate of unemployment are all factors that might contribute to the preference for cologne over other types of alcohol in the Qaseem region. Other possible explanations are that, of all provinces of Saudi Arabia, Qaseem is the most conservative, and that in Qaseem there exists a very strong Religious

Enforcement Authority. These two factors might reduce the manufacture and sale of araq, making it very hard to obtain. Cologne was consumed by a large segment of the Qaseem respondents.

Cologne consumption was found to be more prevalent among respondents in involuntary than in voluntary wards. Since those in the involuntary wards are mostly referred by authorities after they have been caught drinking, it is possible that the strong smell of cologne had been the cause of their being apprehended.

Araq, cologne and hard spirits have a greater alcohol content than beer or wine. The consumption of such beverages without diluting them with water, soft drinks or juice results in faster intoxication (Rutherford, 1997) and more health-related problems (Chou et al., 1998). Among the respondents who reported they always do such risky behaviour 63.2 percent were araq drinkers, in 21.1 percent of cologne drinkers, and in 10.5 percent of hard spirits drinkers. Of those who reported "sometimes" practised this risky behaviour, 46.7 percent were araq drinkers, 33.3 percent cologne drinkers, and 31.3 percent hard spirits drinkers. Awareness of such risky behaviour needs to be emphasised by clinicians and other health professionals.

The percentage of those who drank at home and in others' houses was higher in this study than in Weiss's (11 July 2001) study of drinking habits in Israel. However, the tendency for younger and single respondents to drink with a friend or outside home, and for older and/or married respondents to drink alone and at home is consistent with the findings of other research studies (e.g. Treno et al., 2000).

Given the fact that the respondents were receiving treatment for alcohol, it was no surprise that more than half of them were drinking during any day of the week. However, the limiting of drinking to weekends by 41.9 percent of the respondents can have two possible explanations. One is that, although they receive treatment, they are not necessarily alcohol dependent. They may go for treatment in response to a legal order or pressure from family or friends (Tucker, 1995). The second explanation could be that they can be classified as the type of alcohol dependants who can control their times of drinking. Drinkers of this type have been called Epsilon alcoholics (or periodic drinkers) by Jellinek (1976); periodic drinkers do not drink daily, and they may abstain for days, weeks or months on end (Estes & Heinemann, 1986). Periodic drinkers have also been recognised in Spanish speaking countries (Saunders, Aasland, Amundsen, & Grant, 1993).

With more married respondents limiting their drinking to weekends, and more single, and separated, divorced and widowed drinking on any day, the notion that drinkers with a more structured life are more able to control their drinking than those with a less structured life (Knibbe et al., 1987) may apply here.

As far as the source of alcohol is concerned, it was no surprise to find in a country where alcohol consumption is illegal that the highest proportion of respondents obtained alcohol from dealers. However, obtaining alcohol could still be hard for many. Consequently, a high percentage of respondents who could not themselves obtain alcohol from dealers, did so through a friend who maybe had better access to dealers. Buying alcohol from a store is only an option for cologne drinkers. Beer, wine and hard spirits can only be bought from bars by those who travel abroad, such as frequent visitors to Bahrain or neighbouring countries where alcohol is permitted.

The finding that a high rate of alcohol consumption is most likely among younger age groups, the single, separated or divorced, the unemployed, and the poorly educated is supported by many research studies (e.g. Claussen & Aasland, 1993; Colsher & Wallace, 1990; The British Department of Health, June 2001). While Balabanova & McKee (1999) found that heavy drinkers in Bulgaria had high incomes, this study found that the lowest percentage of respondents who scored the maximum in hazardous alcohol consumption were those with the highest incomes.

Among the different regions, the highest rate of alcohol consumption was among respondents in Riyadh hospital. The regions of Qaseem, Dammam and Jeddah then followed in descending order of alcohol consumption. No study was available to support these findings.

It was interesting to discover that respondents in involuntary wards had a lower rate of alcohol consumption than those in voluntary wards. Such findings are understandable in view of the fact that many of the involuntary ward respondents are referred for treatment by a court order after their involvement in an incident under the influence of alcohol, regardless of the amount or the frequency of alcohol consumption. Linsky et al. (1986) have found that driving while intoxicated and other alcohol-related offences do not appear to arise as a result of the total amount of drinking. Instead, such alcohol-related problems appear to be a consequence of a strong cultural disapproval of drinking.

Although the younger respondents reported a higher rate of consumption, the older respondents reported a greater level of alcohol dependency. Such findings need further investigation. Moreover, the highest rate of alcohol dependency was found to be most prevalent among divorced, separated and widowed respondents, those with a high school education or lower, those with the highest incomes, and the unemployed. In addition, while Jeddah region had the lowest rate of alcohol dependency, Dammam had the highest.

Respondents in voluntary wards had a higher dependency rate than those in involuntary wards. This finding is consistent with that of Calsyn et al. (1982), who found that the legal group did not appear to suffer as severely from the effects of alcohol as the non-legal group.

Although selling, manufacturing and distributing alcohol is illegal in Saudi Arabia, it seems that by various means the respondents could easily gain access to alcohol . While dealers, for example, in araq or hard spirits constitute a main source of alcohol, alcohol can also be obtained through self-manufacture, or through friends and relatives. Another important source of alcohol is cologne, which can be bought anywhere in the country. Although cologne was the preferred drink for some respondents, others used it as a substitute for their preferred drink.

It seems that alcohol is affordable, bearing in mind that most of the respondents were alcohol dependants. A two litre bottle of araq costs SR100–150 (£20–25), and 100 ml bottle of cologne costs SR10–15 (£2–3). It should be noted, however, that the accessibility and availability of alcohol to non-hospitalised problem drinkers are not considered here.

Most hospitalised Saudi problem drinkers drink to forget their problems, to relax, or to relieve anxiety. Contrary to public belief, drinking to respond to peer pressure or to enhance sexual ability were not common reasons for drinking among the respondents.

Young people's need to forget problems or relieve anxiety by drinking can be explained by the massive life stresses that they face in trying to find an appropriate life style. For some respondents who started drinking at a very early age, the drinking itself may be one of the problems with which they have had to cope.

Those with no more than a high school education tended to drink in order to forget their problems, while those with a college education or higher often drank to feel happy. A

possible explanation for such findings is that those with little or no education may have more problems than those with a good education. Difficulties in finding jobs, or jobs that are not too arduous, and financial difficulties are examples of such problems. The finding that most of the respondents earning less than SR3000 a month drink to forget problems supports such an explanation.

The high percentage of divorced, separated and widowed respondents who reported drinking mainly to relieve anxiety is to some extent plausible considering the stress that might be the result of losing a spouse and/or children.

The finding that the main reason for drinking among respondents from Riyadh and Dammam was to forget problems, while for those from Qaseem it was to relieve anxiety, and for those from Jeddah it was to make themselves feel happy, needs more investigation. A partial explanation could be that many Jeddah respondents had a higher education and higher monthly incomes than those elsewhere, with the result that they had fewer problems.

Although Cutter & O'Farrell (1984) have found a strong association between drinking alone and drinking in order to forget problems, the results here found that only 21.1 percent of those who drank to forget problems reported drinking alone. Such findings also need further investigations.

Drinking in order to enhance sexual ability was reported by only 1.5 percent of the respondents. This finding contradicts other research findings in Saudi Arabia (e.g. Al-Qahtani, 1990).

Most of the hospitalised Saudi problem drinkers had their first drink under the age of 20, and started drinking regularly within a year of their first drinking experience. Araq and cologne were the drinks mostly consumed during the first experience. A friend was the most common source of the drink as well as the most common drinking companion during the first drinking experience. The first drinking experience mostly occurred inside the country. For those whose first experience occurred outside the country, Egypt and Bahrain were the countries where it usually happened. During the first experience most of them did not get drunk although most of them vomited. Feeling happy was the most common feeling during the first drinking experience.

The finding that the first drinking experience mostly occurred before the age of 20 is similar to results of a study of alcoholics receiving treatment in Israel (Weiss, 11 July 2001). In addition, the result that the younger the age of the drinker when drinking for the first time, the shorter the time between the first experience and drinking regularly, is reported by many researchers (e.g. Buydens-Branchey, Branchey, Noumair, & Lieber, 1989; McBride, Farringdon, & Midford, 2000).

It appears that there is often a continuity between the type of drink first consumed and the type of drink consumed (or at least preferred) in later life. Consumption of the same drink continually, however, is often not practicable in Saudi Arabia owing to the difficulty of obtaining the desired alcoholic beverages. For some respondents a change in understanding of the health risks associated with some types of alcoholic drinks, such as cologne, may be a reason for a change in their preference of drink, if not in their consumption.

In countries where alcohol is allowed, the first drinking experience normally occurs through family and friends (Forsyth & Barnard, 2000). However, most of the respondents in this study had their first drinking experience through friends. Such findings are supported by some researchers in Saudi Arabia (e.g. Al-Turki, 1989; Al-Khalidi, 1983).

Contrary to public belief in Saudi Arabia that drinking is a behaviour that is learned outside the country, approximately three-quarters of the respondents had their first drink inside the country. Such findings should be considered when educational materials are designed.

It seems also that the circumstances surrounding the first drinking experience have a bearing on the drinking behaviour later on (Connors, O'Farrell, & Cutter, 1991). Most of the respondents reported that they did not get drunk, and felt happy during their first drinking experience.

Most hospitalised Saudi problem drinkers consume araq and cologne (but prefer araq and hard spirits), drink with a friend, at home, and on any day of the week. Moreover, the consumed drinks are usually obtained from dealers or friends. Also, most of the respondents consume ten or more drinks per day, four times a week. In addition, most of them get binged at least once a month. Surprisingly, most of the hospitalised Saudi problem drinkers abstain totally during the holy month of Ramadan. Even those who do drink during Ramadan usually have the ability to limit their drinking to the night-time.

Summary

Araq and cologne are the drinks mainly consumed by hospitalised Saudi problem drinkers. However, beer, wine and hard spirits are preferred by nearly a quarter of the respondents. Cologne is most likely to be consumed by respondents who are in the older age group, who are divorced, separated or widowed, are on low incomes, have a low level of education, are unemployed, have been admitted to involuntary wards, and were admitted to Qaseem hospital.

Both single and younger age groups drink mostly outside their homes with a friend or a relative. Married and older age groups mostly drink at home with a friend, a relative, or alone.

High rates of alcohol consumption were observed mainly in among the young, the single, the poorly educated, those on low–middle incomes, the unemployed, those from Riyadh hospital, and those who had been admitted to involuntary wards. However, high rates of alcohol dependency were mostly observed among the old, the divorced, separated or married, those with a vocational or art education, those with high incomes, the unemployed, those from Dammam hospital, and those admitted to voluntary wards.

In addition, alcohol is easily accessible to those who want to drink but do not care what type of drink they consume. However, preferred drinks are not always available.

Hospitalized Saudi problem drinkers drink mainly to forget problems, to relax, or to relieve anxiety. Very few drink as a response to peer pressure. The first drinking experience is most likely to occur before the age of 20. The first drinking experience usually occurs inside the country and is often accompanied by pleasant feelings. Further, it seems that the first drinking experience may have an effect on later drinking behaviour.

The next chapter is devoted to a discussion of the respondents' use of tobacco, as well as their use and abuse of other illegal drugs.

Chapter 7. Smoking and the use of illegal drugs

Introduction

In the previous chapter the respondents' drinking behaviour (current pattern of drinking, availability and accessibility to alcohol, reasons for drinking, and the first drinking experience) was presented. In the first section of this chapter the respondents' smoking behaviour is discussed. That includes presenting the prevalence of smoking among the patients, the preferred type of smoked tobacco, and the rate of daily consumption of tobacco. The second section is devoted to describing the use of other illegal drugs. Mainly this section is attempting to explore the prevalence of illegal drug use, the type of drugs used, the relationship between some of the patients' demographic characteristics and the use of illegal drugs. The section is also attempting to explore the relationship between the level of alcohol consumption and dependence and the use of illegal drugs. A discussion of both sections then follows.

Respondents' smoking behaviour

Although smoking is legally permitted in Saudi Arabia, among some groups it is not wholly acceptable on social or religious grounds. For example, it is known that most older people see smoking as a form of deviant behaviour (Al-Turki, 1989). Moreover, in some rural areas a smoker does not smoke in public and tries to hide his/her smoking from others. For very religious people, smoking is a sin that a good Moslem should not commit (Al-Muateq, 1985).

In spite of that, according to *Al-Riyadh Daily Newspaper* (30 August 2001) it is estimated that 21 percent of the male population smoke, and that of those smokers, 60 percent, of those who smoke, smoke more than 20 cigarettes daily. In the same report, the behaviour of smoking is indicated to be more prevalent among the young. Half (49.9%) of male and 1.1 percent of female students (high school or under) are smokers. Also, 37.5 percent of smokers reported smoking cigarettes and shisha[1] together. Whereas these figures indicate the prevalence of smoking in the general population, the prevalence of smoking among alcoholics is not known.

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[1] Shisha is a type of tobacco that is smoked through a water pipe which is believed to filter the smoke through water (Hookah and Shisha Central, October 19, 2001). It is mostly smoked in coffee shops situated outside the city or in homes (*Al-Riyadh Daily Newspaper*, 28 October 2001).

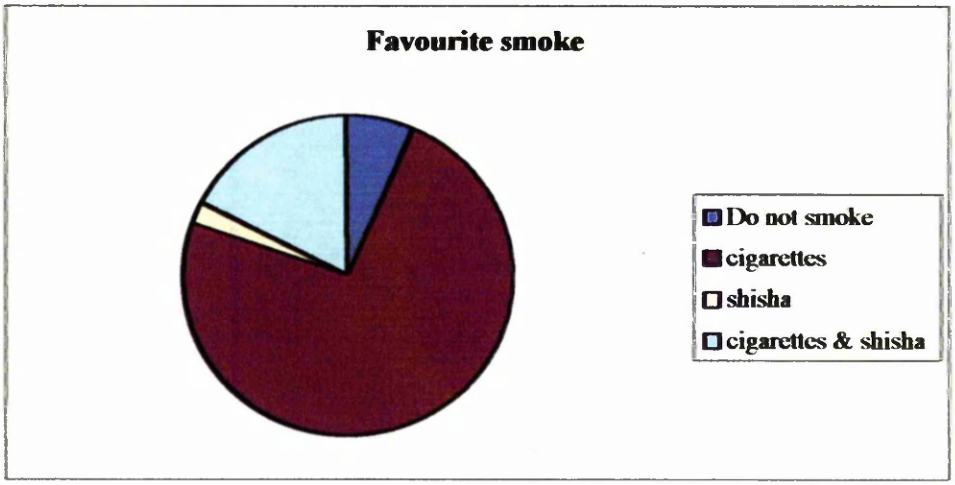
Because of the exploratory nature of this research, and because the relationship between smoking and drinking has remained unreported in Saudi Arabia, a descriptive analysis of smoking behaviour among the respondents is worthwhile. Is the prevalence of smoking among them similar to that among the general population? What types of smoking material are mostly used by the respondents?

It has been found that drinking encourages smoking and vice versa (Bien & Burge, 1990). However, this interrelationship between drinking and smoking can be best understood in societies where both drinking and smoking is permitted. In a country like Saudi Arabia, where drinking is not permitted, many people smoke but do not drink. So it cannot so easily be said that smoking encourages drinking in Saudi Arabia. Therefore, examining the prevalence of smoking among hospitalised problem drinkers, and comparing it to the prevalence of smoking among drinkers in the west is one step towards understanding the relationship between smoking and drinking in Saudi Arabia.

In assessing the smoking behaviour of respondents, the results reveal that of all respondents, 90.4 percent reported smoking regularly, 2.9 percent smoked occasionally, and 6.6 percent did not smoke. Non-smoking was more prevalent among those respondents aged 41 and over (10.3%), married (9.1%), at college or with a degree (11.1%), and among those respondents in Riyadh hospital (12.0%).

The results also reveal (Figure 11) that of those who reported smoking, 78.7 percent preferred cigarettes, 2.4 percent preferred shisha, and 18.9 had no preference.

Figure 11. Percentage of smokers and non-smokers and the type of smoked tobacco



To assess the type of tobacco consumed against the respondents' characteristics, those smoking cigarettes only were compared to those smoking both cigarettes and shisha. The results show that smoking both cigarettes and shisha is most prevalent among those aged 30 and under (26.5%), the divorced, separated and widowed (29.6%), those with a high school education or less (20.4%), and those respondents in Jeddah hospital (38.7%). It is interesting to note that none of the respondents earning more than SR7000 reported smoking both kinds of tobacco.

A more interesting result comes from correlating the smoking of both types of tobacco with heavy drinking and alcohol dependence. Smokers of cigarettes and shisha were less inclined to heavy drinking and alcohol dependence than smokers of cigarettes only. Smoking both cigarettes and shisha was more prevalent among those scoring 8 points or under on the Alcohol Hazardous Consumption Scale than among those scoring 9 points or over. Moreover, only 6.3 percent of those scoring 9 points or more on the Alcohol Dependence Scale reported smoking both cigarettes and shisha whereas more than a quarter of those scoring 8 points or under did so.

Further, when the rate of tobacco consumed by the respondents was assessed, the results (Table 45) showed that, of the cigarette smokers, 58.2 percent reported smoking 20 cigarettes or less. Moreover, 45 subjects (36.9 percent) reported smoking 21–40 cigarettes a day. Those who smoked more than 40 cigarettes a day accounted for 4.9 percent of all smokers.

In addition, half the shisha smokers (n=30), reported smoking one head (15–30g of tobacco) a day, while 30 percent reported smoking more than three heads a day. Those who reported smoking two heads and three heads accounted for 10 percent each.

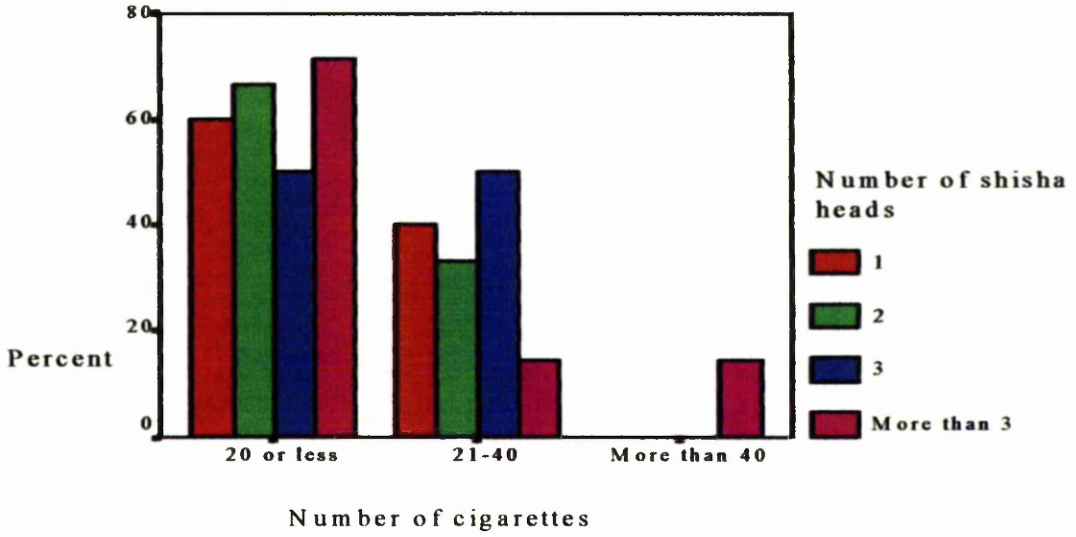
Table 45. The respondents' daily rate of cigarettes and shisha heads smoking

	Frequency	Percent
Number of cigarettes smoked per day		
20 or less	**71**	**58.2**
21–40	**45**	**36.9**
More than 40	**6**	**4.9**
All	**122***	**100.0**
Number of shisha heads smoked per day		
1	**15**	**50.0**
2	**3**	**10.0**
3	**3**	**10.0**
More than 3	**9**	**30.0**
All	**30****	**100.0**

*** Total number of cigarette smokers.**
*** Total number of shisha smokers.**

As the smoking of both shisha and cigarettes is believed to increase health risks, an attempt was made to assess the total rate of consumed tobacco by the smokers of both shisha and cigarettes. The results (Figure 12) show that 14.3 percent of the smokers consumed more than 40 cigarettes as well as more than three heads of shisha daily, the highest amount of tobacco consumed by the respondents. Further, of those who smoked more than three heads of shisha per day, 71.4 percent smoked 20 cigarettes or less, and 14.3 percent smoked 21–40 a day. Moreover, of those who reported smoking one head of shisha a day, 60.0 percent reported smoking 20 cigarettes or less while 40.0 percent reported smoking 21–40 a day.

Figure 12. Number of cigarettes smoked by the respondents presented by the number of shisha heads smoked per day



When the relationship between the length of time since starting smoking and the length of time since starting drinking was examined, the results showed that 89.7 percent of the respondents who smoke reported that they had started smoking before drinking. However, 3.2 percent started smoking after they had started drinking and 7.1 percent started drinking at the same time as smoking.

The use of other illegal drugs

Although alcohol is treated as an illegal drug in Saudi Arabia, there is a belief (especially among drinkers) that alcohol is illegal only because it is forbidden in Islam, and not because of its related problems (Al-Damigh, 1997). This belief is a result of the drugs campaign that concentrates heavily on the risks associated with drugs, and leaves people to think that alcohol is not an addictive drug and has less problems (Al-Bar, 1986; Al-Damigh, 1997).

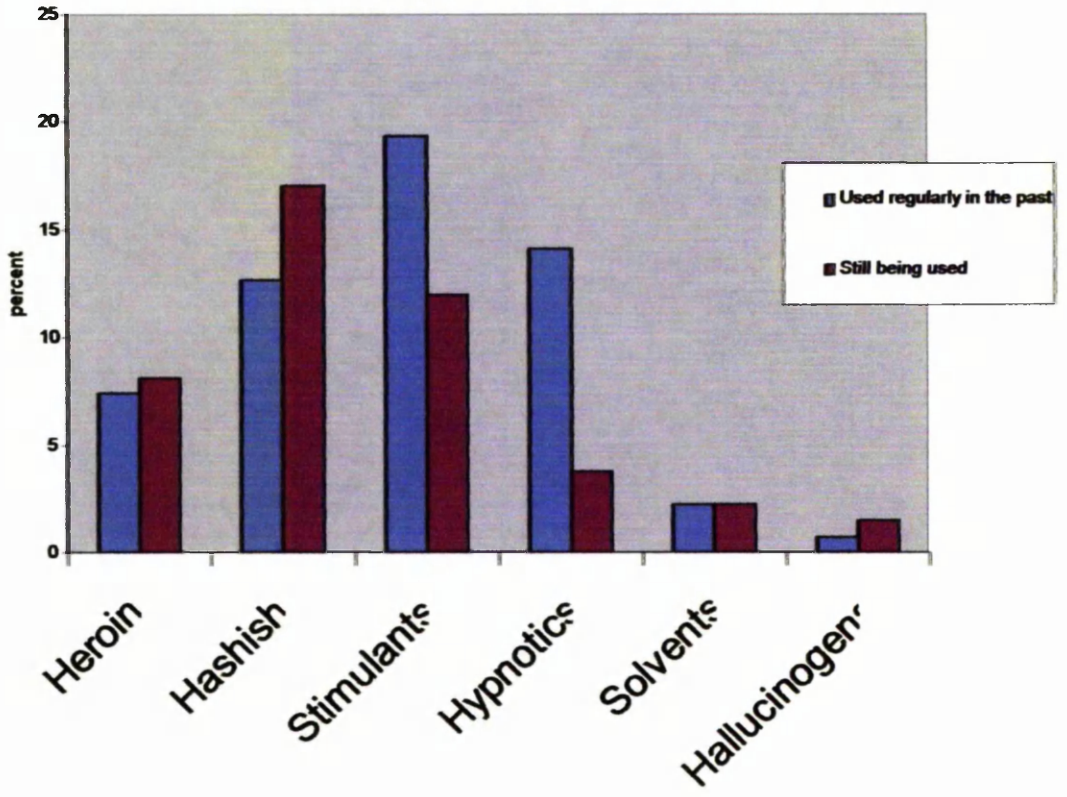
Whereas alcohol but not the other drugs are permitted in many countries, both alcohol and drugs are forbidden in Saudi Arabia. Moreover, whereas the use of illegal drugs is well documented in western literature, it is not in Saudi Arabia. However, it is the researcher's

belief that the use of illegal drugs by Saudi problem drinkers is higher than by western drinkers. It would appear that the legal prohibition may deter the western drinker from using illegal drugs. But for a Saudi drinker, since drinking already puts him/her in a criminal category, it is easier to progress from alcohol to other drugs. In addition, since alcohol is not always available or accessible, the Saudi drinker may use another substance as a substitute for alcohol. The choice of any particular substance is determined by its availability, its price, and the user's preference (Petry 2001). Consequently, it is worthwhile to examine the prevalence of drug use among hospitalised Saudi problem drinkers. This section also explores the reasons behind the respondents' use of other drugs and examines the relationship between the use of illegal drugs and heavy alcohol consumption and dependence.

When the respondents' use of other illegal drugs was assessed, the results revealed that 91 respondents (67.4%) reported having tried one type or more of other illegal drugs at least once in the past. Hashish and stimulants were the drugs mostly tried, with 54.8 percent for each. Moreover, the results in (Figure 13) show that stimulants were the drug mostly used on a regular basis by respondents (19.3%) in the past, whereas hashish was the drug mostly used now (17.0% of respondents).

The relationship between the use of alcohol and the use of other illegal drugs was assessed in terms of which use came first? Although those who reported using alcohol first were more than those who used other illegal drugs first, the difference was small. 38 respondents (41.8%) stated that they had tried or used drugs before trying alcohol.

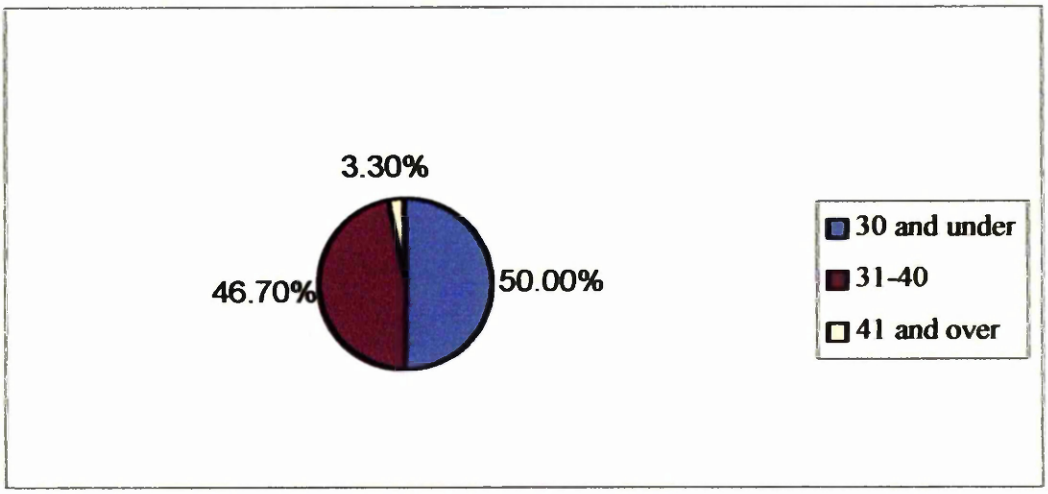
Figure 13. Regular past and current use of other illegal drugs



Where respondents stated that they had used one type or more of illegal drugs on a regular basis but did not use it any more, the reasons for stopping such use were assessed. Twenty-three respondents (33.3%) stated they stopped the use of illegal drugs because they found alcohol had a better effect than other illegal drugs. Not liking the illegal drugs was the second reason and accounted for 31.9 percent of respondents. The third reason for stopping the use of illegal drugs was that they were hard to get and this accounted for 10.1 percent.

Moreover, 30 respondents (22.1%) said they were regular current users of one type or more of other illegal drugs (Figure 14). The current regular use of illegal drugs was found to be statistically significant between the age groups ($\chi 2$ (2) = 12.01, $p < .01$). Half of the current users of one type or more of other illegal drugs were 30 years old or under, whereas only one patient of those 41 years old or over did so.

Figure 14. Current users of illegal drugs presented by age groups



As for the respondents marital status, the results reveal significant statistical differences between this and the current users of illegal drugs (χ^2 (2) = 11.10, p< .01). The highest percentage of current drug users was among those who were divorced, separated or widowed (43.3%). Among current regular users of illegal drugs, the never married respondents constituted 36.7 percent compared to 20.0 percent of the now married.

No significant statistical differences were found between educational status and the use of illegal drugs (χ^2 (3) = .66, n.s.). However, the results reveal that 80.0 percent of current illegal drug users were those respondents with a high school education or less (Table 46).

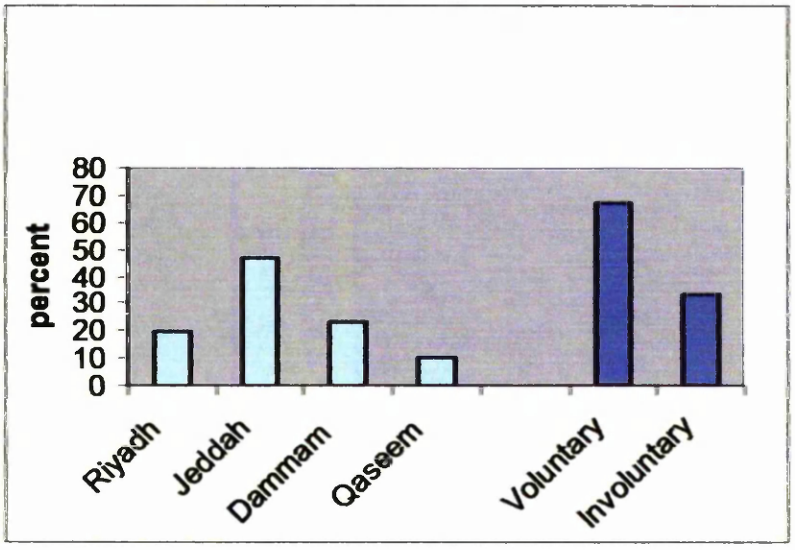
Table 46. Respondents who reported current use of illegal drug presented by educational status

Educational status	%	n	
Illiterate	3.3%	1	(χ^2 (3) = .66, n.s.)
High school and under	80.0%	24	
College or higher	6.7%	2	
Vocational, art, and other types of education	10.0%	3	
All	100%	30	

The result also reveal that the highest percentage of respondents who reported current use of illegal drug were of those who had a monthly income of less than SR3000 with 46.7 percent. Those respondents who had a monthly income of SR3000-7000 were accounted for 36.7 percent whereas the percentage of those earning more SR7000 was found to be 16.7 percent of the respondents who reported current use of other illegal drugs.

Moreover, the highest percentage of current illegal drug use was also found in the respondents of Jeddah hospital (Figure 15) with 46.7 percent, whereas the lowest percentage was found in Qaseem hospital with 10.0 percent. Dammam hospital had 23.3 percent of the current illegal drug users. With regard to the sort of ward, the results reveal that most of the respondents who reported using other illegal drugs were those admitted to the voluntary wards with 66.7 percent.

Figure 15. Respondents who reported ccurrent use of illegal drug presented by admitting hospital and sort of ward



It was found that there was no statistically significant differences between the amount of alcohol consumed, as measured on the Alcohol Hazardous Consumption Scale, and the use of illegal drugs (χ^2 (2) = 3.05, n.s.). However, the results showed that only one patient of all respondents who currently reported using illegal drugs scored 0–4 whereas the remainder scored 5–8 (50%) and 9–12 (46.7%). Also, no statistically significant differences were found between alcohol dependence, as measured on the Alcohol Dependence Scale, and the use of illegal drugs (χ^2 (2) = 5.38, n.s.) (Table 47).

Table 47. Alcohol Hazardous Consumption and Alcohol Dependence scores of the respondents who were currently users of other illegal drugs

Scores of alcohol hazardous consumption	percent	N	(χ2 (2) = 3.05, n.s)
0-4	3.3	1	
5-8	50.0	15	
9-12	46.7	14	
All	100	30	
Scores of alcohol dependence			(χ2 (2) = 5.38, n.s)
0-4	20.0	6	
5-8	50.0	15	
9-12	30.0	9	
All	100	30	

The reasons behind the continuous use of illegal drugs by the current users were investigated. The results (Table 48) revealed that the belief that all substances are alike (chosen by 15 (32.6%) respondents) was the most important reason. The second reason was that the use of more than one substance at the same time got them higher and accounted for 28.3 percent of respondents. Although not very different from the previous reason, liking the combination of alcohol and other illegal drugs was the third reason and accounted for 26.1 percent.

Table 48. The respondents' reasons for still using illegal drugs

Reasons	Frequency	Percent
All substances are the same	15	32.6
I like to drink alcohol with the use of other drugs	12	26.1
I use what is available	1	2.2
More than one drugs get me higher	13	28.3
I can't get rid the habit of using this drug	4	8.7
Others	1	2.2
All	46	100.0

Discussion

The finding that more than 90 percent of the respondents were smokers was consistent with many western research studies. Bien & Burger (1990) found that over 90 percent of alcoholic in-patient were smokers. DiFranza & Guerrera (1990) mentioned that, in the literature, 83 percent of alcoholics were smokers, compared to 34 percent of non-alcoholic subjects. However, in their study these authors found that 92 percent of their alcoholic

subjects were regular smokers. Furthermore, the percentage of smokers among alcoholics is far higher than the average percentage of smokers (21%) in the Saudi male population (*Al-Riyadh Daily Newspaper*, 30 August 2001).

Although the association between smoking and drinking is well documented, the nature of the association is not very well known. Bien & Burger (1990) suggested that the intake of nicotine appears to facilitate ethanol consumption and vice versa, in Saudi Arabia more research needs to focus on the relationship between methanol and nicotine since a quarter of the respondents in this research were consuming cologne.

Another point worth mentioning is that although some researchers (e.g. Rohsenow et al., 1997) have pointed out that alcoholics may drink and smoke for similar reasons, this may not be the case for Saudi problem drinkers. In Saudi Arabia the legal and social context affects smoking and drinking differently, for, whereas the consumption of both alcohol and tobacco is allowed in most countries, only tobacco is allowed in Saudi Arabia. The reason behind alcohol consumption would therefore appear be different or, at least, stronger than the reason behind smoking. However, it might be the case that smoking, as a learned behaviour with a certain associated experience, leads to another learned behaviour, drinking, which may be associated with a somewhat similar experience.

An interesting finding is that many of the hospitalised Saudi problem drinkers smoked both cigarettes and shisha. However, those who did so were most likely to be of younger age, and divorced, separated or divorced. In addition, the finding that smoking both types was found mostly among Jeddah respondents is possibly because Jeddah is known to be the city where both cigarette and shisha smoking started in Saudi Arabia. However, this information is not documented.

Also, those respondents who smoked both types showed lower scores on the Alcohol Hazardous Consumption Scale and the Alcohol Dependency Scale. This may be due to the nature and tradition of shisha smoking. Unlike cigarette smoking, shisha smoking mostly takes place in coffee shops. For those who are heavy drinkers or alcohol dependent it is hard to drive or appear in public places. However, if they choose to smoke shisha at home, the shisha preparation takes more effort (cleaning the pipes, lighting the charcoal, and putting the tobacco) and time (5–15 minutes) compared to cigarettes. Therefore, it is easier for very heavy drinkers and the alcohol dependent to use cigarettes than shisha.

With regards to the number of cigarettes consumed by the respondents, although the findings of this study are concordant with those of many other researchers (e.g. Gulliver et al., 1995; Patten et al., 2001; Weiss, 17 July 1997), one particular issue emerged from this research. In addition to cigarette smoking, many reported smoking shisha as well, which made it hard to measure the amount of daily consumption of tobacco. The smoking of shisha needs comprehensive investigation with regard to its associated health hazards since such studies are lacking in Saudi Arabia.

The finding that smoking started before drinking is consistent with the study of DiFranza & Gurrera (1990), however, the percentage of those respondents who started smoking first is higher in this study (89.7%). One possible explanation is that, unlike in many countries, the visibility and availability of alcohol in Saudi Arabia are much less than of tobacco.

Although excessive drinking of alcohol is associated with many health problems (Curry et al., 2000), the combination of alcohol and illicit drugs is even more hazardous to health (Petry, 2001). The abuse of illegal drugs by problem drinkers and its effects have been the subject of many research studies (e.g. Greenberg, 1993; Greene, 1979; Jensen, Cowley, & Walker, 1990).

Since both alcohol and other types of drugs are illegal in Saudi Arabia, it was expected that the use of drugs by the respondents would be higher than in many countries where alcohol is allowed. Perhaps the belief of current drug users among the problem drinkers of this study that "all substances are alike" is the most important reason for using illegal drugs.

Also, since the use of both alcohol and other drugs is illegal in Saudi Arabia, and since alcohol is not always available and accessible, it was expected that the problem drinker might use another type of substance as a substitute for alcohol. For the same reason it was also expected that the prevalence of other drugs use by the hospitalised problem drinkers would be very high. However, it was not. The findings here of the abuse of illegal drugs by the respondents were very similar to many western studies.

For example, Caetano & Weisner (1995) and Ross (1989) found heroin to be used by 7–10 percent of alcoholics. 8.1 percent of the respondents in this study stated that they were still using heroin. Moreover, 17.0 percent of the respondents were current users of hashish, a finding that is not very much lower than those of Martin et al. (1996) and Caetano & Weisner (1995) whose studies produced figures ranging from 20 to 50 percent. In addition,

the extent of use of stimulants by the respondents is consistent with the findings of other studies, such as that of Ross (1989).

Although many studies have reported the abuse of cocaine by a large proportion of alcoholics in the west (e.g. Martin et al., 1996), not one of the respondents in the present study reported such use. A plausible explanation for this is that cocaine is rarely used in Saudi Arabia by drug abusers.

In addition, compared to those abusing alcohol only, respondents who were using illegal drug are mostly of a younger age group and unmarried. Such findings are concordant with many previous research studies (e.g. Carroll, Malloy, & Kenrick, 1977; Schmitz et al., 1993).

Although many studies have investigated the interaction of ethanol alcohol with many types of drugs, such as sedatives (Greenberg, 1993), LSD (Batzer, Ditzler, & Brown, 1999) and heroin (Kreek, 1984), there is also a need to investigate the effects of methanol alcohol on the human body and its interaction with different types of illegal drugs.

In spite of the fact that alcohol is classified as an illegal drug in Saudi Arabia, it is worthwhile to understand how problem drinkers perceive both alcohol and the other types of drugs. Also, there is a need to assess how different punishments for different classes of drugs would affect their use.

Summary

Consistent with many western studies, the majority of hospitalised problem drinkers were current smokers. The majority started smoking before they started drinking. Unlike smokers in the west, many smoked shisha in addition to cigarettes. Those who smoked both types drank less and had less alcohol dependency than those who smoked only cigarettes.

In addition to alcohol, most of the hospitalised Saudi problem drinkers had used one or more types of illegal drugs in the past. Further, more than a fifth of them were current regular illegal drug users. Although most of the respondents who were current illegal drug users were using more than one type of illegal drugs, hashish was the type of drug most commonly used by them. Further, compared to those who abused alcohol only,

respondents who use illegal drug were more likely to be young, unmarried, poorly educated, and with a monthly income of less than SR3000. In addition, there seemed to be no strong association between the degree of alcohol dependence or level of consumption and the use of illegal drugs.

Now that the prevalence of smoking and the use of illegal drugs among hospitalised Saudi problem drinkers have been discussed in this chapter, in the next chapter alcohol use and treatment from the therapists, perspective will be presented.

Chapter 8. Therapists' perspective on their patients

Introduction

In the previous chapters, many issues relating to hospitalised Saudi problem drinkers have been analysed on the basis of patients' responses. This chapter considers these issues from the therapist's point of view. It reports how the therapists see hospitalised problem drinkers in terms of their demographic characteristics, their patterns of drinking, and the treatment and services they receive. A detailed account on the chapter's methodology is presented in the second section of Chapter Three

Profile of hospitalised problem drinkers

Age

Although almost all of the therapists agreed that most of their clients were under 30 years old, they offered different explanations for their being so young. The chief reason provided by most of the respondents was that younger people were more likely than older people to experiment with new experiences such as alcohol drinking). One therapist put it like this:

> Young people are more vulnerable. They can be tempted more easily by dealers or friends than old people can. They are more adventurous, and they like to experience new things.

The example of movie stars and other famous people is another explanation for alcohol's attraction to young people. "A youngster watches a famous actor holding a glass of whisky or beer and in a happy situation, or wishing to shed some despondency", said one therapist, and the sight is a "free invitation" to try alcohol.

Two therapists saw the problem of drinking as similar in all age groups but thought older people were more likely to avoid treatment than the younger. One therapist explained why:

> Older people not coming for treatment does not mean that they do not drink or they don't have a drinking problem. We do not see them here [in the hospital] because the stigma is more painful for them than for youngsters.

Even if they wanted to come for treatment, their families would not allow them. "People may tolerate the stigma of having an alcoholic son, but they cannot tolerate the stigma of having an alcoholic father", one therapist explained.

Having more work and family responsibilities was another reason for the older age group to avoid coming for treatment. It is very hard to leave your responsibilities behind you and come for treatment. One therapist blamed the treatment policy, saying,

> With the absence of reliable outpatient or halfway-house treatment, many treatment seekers do not dare to come ... When you get older, your responsibility increases. Staying for four weeks in a hospital far from your work and from wife and children and friends is too much.

However, not all the therapists agreed that most of the alcohol treatment seekers were of a younger age group. "I doubt the results of your research", said one therapist. Another said that the information was new to him. Two things might explain these responses. The treatment facilities provide both alcohol and drug treatment, and it is true that those with alcohol problems are generally older than those with drug problems. So a therapist seeing that those who come for alcohol treatment are older than those who come for drug treatment could mistakenly conclude that most of hospitalised problem drinkers were of an older age group. However, the fact is that while most of the hospitalised older people are problem drinkers, most of the hospitalised problem drinkers are not older people.

The other possibility is that in Riyadh hospital, where the therapists' interviews were carried out, the research shows that patients with drinking problems were older than those in the other hospitals.

Education

All interviewed therapists agreed with the finding that most problem drinkers who received treatment were poorly educated. However, their explanations of this characteristic varied. Whereas some therapists thought that the characteristics of the hospitalised patients were representative of the characteristics of problem drinkers in society as a whole, others thought that problem drinkers were more prevalent among educated than among uneducated people. In fact one therapist (a psychologist) said,

> Poorly educated people have a tendency to be subordinate and to be controlled by more highly educated people. They drink because they see better educated people drink.

Whereas educated people drink as much uneducated people do, those seeking treatment in Al-Amal hospitals is most likely among the uneducated. "Well educated people drink sensibly, and even if they don't, they have their own ways to avoid problems", said one therapist.

Some therapists who considered that their patients were representative of drinkers at large thought that uneducated people had a greater tendency than educated to drink alcohol and use other illegal drugs because they were less aware of the health hazards. Others thought that because uneducated people had fewer chances of employment they had more free time, and "free time may lead to many types of deviant behaviour", said one of the interviewed social workers.

Others went further and attributed the problem to socialisation, arguing that alcohol was only a symptom of a larger problem. One respondent explained by saying,

> Because of a family's mistakes during upbringing, the teenager doesn't feel the importance of education, and even when the teenager quits school, the family isn't bothered. A family with such values has many problems that put the children at risk of deviant behaviour, including alcohol drinking.

Income

> Most of our patients have low incomes because many of them have no work at all, and even if they have work, they do not get good salaries owing to their poor education.

This response illustrates the view of some therapists. However, in explaining the relationship between low financial status and problem drinking, one social worker said,

> I see it as a circle: having a low income or no income at all leads to financial problems that in turn lead to family, legal or social problems. As a way of coping with these problems, some people use alcohol, and some of them may become alcoholics. Being alcoholic creates even more problems, including financial problems.

Whereas some therapists considered that low incomes led to drinking, one respondent thought the reverse was true. He explained how drinking led to impoverishment:

> I have seen many patients who used to be well off, but lost their jobs because of drinking. Their families would stop giving them any money because they were afraid they would use it to buy alcohol or drugs, or because they were angry with them.

Although all of the respondents agreed that most of the patients had a low income status, two respondents explained this fact in a slightly different way. "Rich people also drink and have drinking problems", said one respondent. But when asked why fewer of the medium or high income problem drinkers came for treatment, he said,

> Alcoholics who have money do not come for treatment here. They look for treatment either in private clinics here or abroad. They are afraid of being seen. Poor people would do the same if they could afford it.

Employment

In explaining why most of the hospitalised problem drinkers were unemployed, most of the respondents saw unemployment as a direct result of drinking. One of the respondents (a psychiatrist) explained,

> Merely to drink in the kingdom is to invite all kinds of problems. If you drink and go to work you will be discovered. Your boss may give you a second or a third chance. But eventually your boss will not give you another chance and will fire you.

Dismissal from work can also be the direct result of drinking if someone is caught drinking by the police. Since alcohol is not legal, those who are caught are considered criminals, are subject to punishment, and may be fired from work.

Losing a job can also be an indirect result of drinking. As one psychologist put it,

> If an alcoholic is drinking all night long, it is hard for him to go work, and even harder here [in Saudi Arabia] to be seen in this state. His absence from work would result in losing his job.

Whereas most of the respondents saw the problem of unemployment as a result of drinking, one respondent had another view:

> At the present time, if you have a poor education you have little or no chance of getting a job. Spending your life with no job and with a plenty of free time leads you to drink to get rid of the boredom and stress caused by people's view of you as unemployed.

Type of work

The fact that most of the hospitalised problem drinkers were those who were working or had been working for the military sector was explained by the therapists in different ways. Most of them saw it as a result of the military referral system. According to one respondent,

> The type of work you do has nothing to do with drinking. You can see as many people from the civil sector as from the military who drink or use drugs. But people who work for the military come for treatment because they are referred to the hospital by their employer. The civil sector doesn't have this kind of referral.

But what about those patients who were not working for the military any more, were they too referred to the hospital by their former employer? One respondent commented by saying,

> You see, at the beginning, while he [the patient] is working he would be referred to the hospital by work as soon as his drinking is discovered. If his treatment is not successful, and if he continues drinking, he would be fired. Since he has been introduced to treatment through work and now knows that there is alcohol treatment available for him, he wouldn't mind seeking treatment again.

It seems that the referral of the patient to the hospital by his work serves two goals: 1) making the patient aware of the services available to him, and 2) helping the patient to utilise the services by putting pressure on him to seek treatment. Both goals are useful in introducing both the patient and the service to each other.

Other views about why most of the patients were working for the military were that the nature of the work conditions (such is the tight restrictions and onerous duties) contributed to drinking and maybe to problem drinking. The working conditions of military personnel also require most of them to be far from family and friends, a factor that may lead to drinking. A social worker said,

> Usually those who work in the military are assigned to places far from their families and friends. Being far away from family and friends is stressful. This stress, and being alone, with nobody from your family to see you, are all factors that encourage drinking.

Another view was that working for the military gave the person an unrealistic sense of security that he could not be incriminated for drinking, which in turn encouraged him to drink, thinking that he was safe.

Another therapist believed the prevalence of problem drinking was the same in both the military and the civil sectors. However, the person who worked for the military could be discovered easily if he drank:

> You are drinking, and suddenly you are called in the middle of the night to work. In this case, you have to go with the smell of alcohol on you, and you may act weirdly. Your boss would know that you had been drinking and he would have to do something about it.

Moreover, one of the respondents thought drinking was more prevalent among military workers because most of them had a poor education. As a result of this, they were less aware of the health and social problems associated with alcohol. Therefore, "drinking is more prevalent in the military than in the civil sector", a psychologist concluded.

Voluntary versus involuntary patients

There was some disagreement among the therapists about what was meant by "voluntary" and "involuntary" patients. Whereas some therapists believed that voluntary patients were those admitted to any wards except the secure ward, others thought that only motivated patients were voluntary patients. One psychiatrist said,

> Not all of those in the voluntary wards come for treatment of their own accord. Inside the so-called voluntary wards, you can find many patients who come for treatment only because they are pressurised by their family or work to do so.

In addition to those coming for treatment under the pressure of significant others, there are patients who come for treatment only to "regain their health", not to solve their drinking problem, and then "get out and drink again as usual", as one psychologist put it. Other patients come for treatment because they feel that they are under police surveillance, and they might get caught. So, to avoid being caught by the police, "they come to the hospital pretending that they are willing to be treated", a psychologist explained.

In spite of disagreement about the definition of voluntary and involuntary patients, the therapists generally agreed on the differences in the psychological condition between the two types. Some therapists thought that, unlike those patients treated in voluntary wards,

those treated in secure wards were likely to have more symptoms of psychological and mental problems. A psychiatrist said,

> Most patients who are brought to secure wards or against their will are likely to have schizophrenic or anti-social personalities.

"Aggressiveness", "carelessness", "impatience", and "denial" are other distinctive personality traits that can be seen in many of the patients admitted to secure wards. Two therapists used the term "abnormal" to describe the personalities of those patients in secure wards, and the term "normal" to describe the personalities of those admitted to the voluntary wards.

As far as the patients' compliance with treatment is concerned, some of the respondents found that the patients in voluntary wards were more co-operative with the treatment team, and adhered more closely to the treatment programme. However, one therapist had a different opinion:

> Compliance with the treatment programme is not conditioned by which ward the patient is admitted to. If the patient has an adequate self-insight into his problem, and he is motivated to solve this problem, then he will be co-operative, no matter which ward he is in.

Place of residence (region)

Most of the interviewed therapists agreed that most of the hospitalised problem drinkers came from cities where the treatment facilities were located. Asked to comment on this, many therapists believed that the distance between treatment facility and treatment seeker could function as a geographical barrier. A psychologist said,

> Given the psychological nature of the alcoholic, it is very hard for an alcoholic who is living in another city or village to travel and come for treatment. Even if he does, when he knows that he would have to stay for four weeks for treatment, he may refuse to be admitted.

A social worker saw the problem from a social point of view:

> Imagine leaving your family, friends and work behind to travel to another city seeking treatment for a problem that you deny or you don't want to solve, or afraid of what might happen to you. Being close to your family and children gives you more sense of security.

Two therapists, however, attributed the problem to a lack of information. One thought that because the hospitals were located in cities, urban people were more aware than others of the health hazards related to alcohol. Consequently, "treatment is sought either through the patient himself or significant others". The second therapist thought that problem drinkers from other regions had another reason for not coming:

> Many people living in the big cities do not know about the role of Al-Amal hospitals, and even if they know, they think that these hospital treat only drug addiction, not alcohol addiction. The people's ignorance about the role of Al-Amal hospitals in small cities and villages is even worse.

A totally different point of view of why only a few people from other cities and villages are coming for treatment is expressed by a psychologist,

> Some of my patients come from different areas and places. But I think that the hospital is centred where the majority of people are having alcohol and drug problems.

Non-treatment seekers

Just as a profile of treatment seekers was sought from the therapists, an attempt to gather some information regarding non-treatment seekers was also made. The therapists were asked about the type of people who avoided coming to Al-Amal hospitals. In answering this question they identified many groups of people. Most of the respondents thought that people with high social, educational and economic status were less likely to come for treatment. The following comment as noted by a social worker illustrates most of therapists' views on this point:

> Socially high class, rich and educated people often don't come to the hospital because of the shame and stigma. Rich people can go to private clinics or can go abroad for treatment if they have an alcohol or drugs problem. Because of the stigma, high class people and others who are afraid of being recognised don't come to the hospital, even if they can't afford the treatment in private clinics or abroad.

Another therapist had a different point of view as to why rich people didn't come for treatment. The therapist said,

> Most rich people mistakenly think that because they drink good quality drinks, such as beer, wine, or other smuggled drinks that they can afford, they can't have problems with alcohol. They think that alcohol problems are coming only from drinking cheap stuff such as cologne.

Another group of people who avoid coming to treatment were those who "mistakenly think that they are going to be questioned and legally punished for their alcohol drinking", a psychiatrist explained. In addition to these groups, there was another in real need of treatment, as a social worker elucidated:

> They remain uninformed about the role of Al-Amal hospitals. Many people call asking me what Al-Amal hospital treats. Other people do not even know that such hospitals exist.

Some people, even though they know exactly the role of the hospital, do not come because they think "their drinking is not problematic", and they "may come if they get worse", said a psychologist.

Many non-treatment seekers live far from the treatment centres. One of the respondents emphasised this point by saying,

> It is hard for those who live far away from the hospital to leave everything behind and come for treatment.

In spite of the fact that treatment for women and adolescents has just been launched, a number of therapists expressed their concerns about the refusal of these groups, especially the women, to come for treatment. A psychologist noted,

> Since the opening of the female unit [five months ago], the number of women who have come to the hospital hasn't exceeded five patients. We don't know whether it is the stigma or the fact that drinking women are very rare.

As to how the therapists think these groups could be encouraged to seek treatment, many suggestions have emerged. First, these groups could be encouraged by informing people about the role of Al-Amal hospitals. One of the therapists (a social worker) called for this by saying,

> Intensive media coverage (television, newspapers, schools, mosques, etc) about the role of Al-Amal hospitals and the risks of avoiding treatment should be initiated so that it reaches every house in the country.

A psychologist added,

> The process of admission, and a detailed description of the treatment programmes should be made clear to everyone. It is a hospital not a prison. There is no need for anyone to be scared of the hospital.

The second suggestion to encourage people to come to treatment was to open more treatment centres in different regions in the country. The following remark from a psychiatrist explains why and how this proposal should be implemented:

> Instead of waiting for people to come to us, why shouldn't we go to them? Those who live far from Al-Amal hospital should have a hospital or at least a unit attached to a general hospital that is close to the patient so he doesn't have to travel.

The third suggestion was to allow the private health sector to provide alcohol treatment. This would attract more patients, especially rich and high class people. However, some therapists expressed their concerns about private clinics treating alcohol or drug problems. A psychiatrist noted,

> If the private sector were allowed to deal with alcohol and drug addicts, its work should be carried out under very close supervision by the government; otherwise the treatment outcome would be useless. We know about cases of patients who, during their hospitalisation in private clinics, have been allowed to use drugs.

Other therapists opposed the idea totally. Their opposition was based on the view that money is the main objective of private clinics. A psychologist clarified this by saying,

> I don't think the treatment of alcohol or drugs in private hospitals would be beneficial. Given the nature of addiction, these hospitals would do whatever it took to have the money in your pocket. They would exploit the patient and his family.

The fourth suggestion was to improve the treatment services and reorganise the wards in Al-Amal hospitals so that they attracted more treatment seekers. One therapist, for example, suggested that there should be a special word for people with high status, such as VIPs.

Drinking behaviour

Type of consumed drink

All of the therapists agreed that cologne and araq were the types of drinks mostly consumed by hospitalised problem drinkers. When asked why these two types of drink were most prevalent among patients, all the therapists emphasised their easy availability, accessibility and cheapness compared to other types of drinks. One social worker said,

> It is certain that cologne and araq are the substances that are consumed more than any thing else by the patients, because they are available and easy to get here [in Saudi Arabia], whereas other alcoholic drinks are hard to get and very expensive.

Another therapist (a psychiatrist) stressed the importance of cost:

> You can go to any department store and by a bottle of cologne for 10 Riyals [£2]. And you can get a bottle of araq from a dealer for 30 Riyals [£6]. Alternatively, you can make it yourself at home.

How different are araq and cologne from other types of drinks? Although all the therapists believed that both araq and cologne had a high concentration of alcohol, there seemed to be disagreement as to exactly how great the concentration was in each. Whereas some therapists thought that the alcohol concentration in cologne was not less than 80 per cent, others thought it was between 45 and 80 per cent. Araq, with an alcohol concentration of 35–60 per cent was considered by most of the therapists to be less strong than cologne. However, one therapist thought that both drinks "contained not less than 70 per cent of alcohol".

With regards to the health hazards associated with the consumption of araq and cologne, all the therapists believed both drinks to be very hazardous owing to their high alcohol concentration. One psychiatrist said,

> Both types have a high percentage of alcohol in them. They are more poisonous than other types of drinks. I have many patients who are suffering from liver and ulcer problems.

Another psychiatrist noticed that those who drank araq or cologne had "longer withdrawal symptoms than drinkers of other types". The health hazards associated with araq or cologne, according to the therapists, derived from other causes as well as their high alcohol concentration. As a psychologist pointed out,

> Araq is locally made. There is no certain way to make it. Its concentration depends on how it is made and who makes it. It may kill the drinkers or cause them a lot of damage.

Whereas the danger of araq is caused by the absence of manufacturing health standards, the dangerous effect on health of cologne is caused by the type of alcohol of which it is

made. One of the psychiatrists have noted that "Cologne is not made for drinking. It contains wood alcohol. It is very health damaging".

As to whether cologne drinkers are different from araq drinkers, some therapists thought they were. One psychologist noted that cologne drinkers were "more alcohol dependent" than araq drinkers. Another therapist (a psychologist) expressed the view that

> Cologne drinkers are more likely to have had psychological problems than araq drinkers. They are also lower in education and income.

As far as treatment is concerned, the overall treatment programme for those who consume araq or cologne is the same as it is for those who consume other types of alcohol. However, a psychiatrist noted,

> Some araq or cologne drinkers experience longer withdrawal symptoms. The detox period for such patients should be longer.

Heavy drinking and alcohol dependence

The results of this research showed that some of the patients were neither heavy drinkers (as measured on an alcohol consumption scale) nor alcohol dependent (as measured on an alcohol dependence scale). When the therapists were asked what they thought were the reasons behind the admission of such patients, the responses, although somewhat similar, varied in some respects. One therapist said,

> We are Muslims. Drinking is a deviant behaviour no matter how much is drunk or how dependent the person on alcohol is. We should help those who drink even occasionally; otherwise they may become alcoholics.

Another therapist (a social worker) noted that "some light drinkers come for treatment of their own accord", and therefore raised the question:

> Why should we refuse treatment for those who feel they need it? Some patients, even though they do not drink heavily, come asking for treatment because they are afraid they will become addicts. Other types of patients are brought for treatment by the family or others as soon as their drinking is discovered.

Justifying the provision of treatment services to non-heavy drinkers and to non-dependants, a psychiatrist explained,

> It is no surprise to find some patients who are not alcohol dependent nor heavy drinkers. The admission to Al-Amal hospitals is controlled by family, social, administrative and political factors.

Although most of the respondents admitted that some patients could not really be classified as heavy drinkers or alcohol dependent, a social worker questioned the results of the research on the grounds that some patients understated their drinking habits. He said,

> I think that all of those patients who participated in your study are alcohol dependent. However, it is well known that alcoholics tend to lie about their drinking. Therefore, I think that the results regarding the quantity of drinking are not correct.

As to whether the treatment programme for such patients is different from the treatment programme of alcohol dependent or heavy drinkers, most of the therapists said that the treatment programme was the same for all patients. However, as one therapist said,

> There is no specific treatment programme designed for those patients. But although the treatment programme is the same in general, at the same time each case is treated individually.

Another response agreed with the previous one, although it was slightly different:

> The difference in treatment between the light and occasional drinker and the alcohol dependent is during the first phase of the treatment, the detox phase. As you may know, the detox and the medication period depend on the level of alcohol dependency and the amount taken. Other than that, the educational and rehabilitation programmes are the same for all patients.

Another view, differing from this, was that the patients with less dependency and lighter drinking were provided with more counselling services in the social and psychological effects of drinking and with less concentration on medical treatment (detoxification). A psychiatrist noted that "Those patients should be given intensive lectures that address the harmful effect of drinking".

Reasons for drinking

The responses elicited from the patients indicated that the main reason for drinking was to forget problems, and to relax was the second reason. However, when therapists were asked what the reasons behind the patients' drinking were, their responses were slightly different.

Somewhat like the patients', most of the therapists thought that "getting rid of problems" was the main reason for drinking. One respondent said,

> Many of our patients told us they drank because of the problems surrounding them – problems like family or financial problems.

However, whereas relaxation was the second most important reason for drinking according to the patients, the therapists gave "looking for enjoyment" as the second main reason for drinking. A psychologist noted,

> Because of the influence of the media, some people mistakenly believe that drinking can bring happiness to their lives and help them deal with their problems effectively.

Unlike the therapists, the patients thought wanting to feel happy was fourth in importance.

"Having a psychological disorder" was suggested by many therapists as a cause of drinking. As one respondent said, "Some of our patients drink to overcome a psychological problem they are having". This reason was not mentioned by the patients, who gave "relieving anxiety" as the third most important reason for drinking.

Other reasons given by the therapists for drinking were the imitation of others, experimentation, having "plenty of free time", the "influence of bad friends", travelling abroad, and the "wrong belief that alcohol is not an addictive substance".

Abstinence during Ramadan

Consistent with the findings of this research, the therapists noticed that most of the patients totally abstained during the holy month of Ramadan. One therapist noted that "those patients who come for treatment a month before Ramadan have more chance of successful treatment". The therapist explained that

> If the patient is admitted on the first of Shaaban [the month proceeding Ramadan], he will spend four weeks in the hospital with no drinking. As soon as he is discharged, Ramadan is starting, and he abstains for another four weeks. This gives him a good chance to abstain for a longer period, and to quit drinking.

In explaining the phenomenon of why most problem drinkers stop drinking during Ramadan, the therapists reported different possible explanations. Although most of the

therapists attributed the patients' abstinence during Ramadan to the strength of their religious belief, they differed in explaining how this religious belief worked. A social worker noted:

> The fact that some patients stop drinking in Ramadan may be seen as a way of asking Allah for forgiveness for their past drinking days during which they were pursued by a feeling of guilt for not being good Muslims.

Another social worker had a slightly different explanation:

> Ramadan is a holy and spiritual occasion that all Muslims respect. People tend to increase their religious acts during the 30 days of this month, and our patients are no exception. Their sense of the sanctity of the holy month encourages them to follow the instructions of Islam by avoiding alcohol.

Whereas these views attribute the patients' abstinence from drinking during Ramadan to an internal motive, another sees it as the result of an external factor. A therapist (a psychologist) explained:

> Although drinking is forbidden, and is a sin at all times, drinking during Ramadan is considered an even greater sin. People can't tolerate seeing anyone committing a sin during the holy month. Consequently, no-one dares to drink, for if he is discovered, he will be in great trouble.

From a different perspective, a psychiatrist considered abstinence during Ramadan as only for those who, "according to scientific diagnosis, are non-alcohol dependent". "If they were dependent, they wouldn't be able to stop drinking", he continued.

When the therapists were asked how they could benefit from this phenomenon in the treatment of problem drinkers, many suggestions emerged. A strengthening of patients' religious belief by including intensive religious programmes in treatment was the dominant suggestion. As one therapist put it,

> Since these people stop drinking during Ramadan from a religious motive, we should use this motive during treatment to encourage people to stop drinking at all times.

A psychologist suggested that the patients' ability to stop drinking during Ramadan should be used as a teaching example to show the patients that they have the ability to stop drinking. "Since the patient is able to stop drinking during Ramadan, he can stop at all times", the psychologist said.

The first drinking experience was inside the country

Although many people believe that alcohol drinking is first experienced by Saudi drinkers outside the country, the finding of this research contradicts this belief. The importance of this finding is that it should encourage alcohol-prevention campaigners, who are supported by many health, education, religious, and political leaders, to look to the real source of the problem instead of blaming foreign travel for the initial contact with alcohol.

Most of the patients reported that their first drinking experience took place inside the country. The therapists' views regarding the place of drinkers' initial contact with alcohol were generally consistent with this finding, even though, one psychologist noted that "For me, this is new information". Therapists' comments on varied, but many of them can be summarised by this comment made by a psychiatrist:

> The patients' learning alcohol drinking inside the country is due to the easy availability and accessibility of alcohol compared to other drugs. Also, it is very cheap.

Another therapist commented:

> If we agree that most of the patients start drinking at a young age, between 12 and 20, it is logical to discover that their first experience with alcohol happened in this country. They are too young to travel alone.

The moral environment, not the place itself, is the main factor in learning behaviour, as a social worker pointed out:

> Drinking, as a deviant behaviour, is learned through the environment, no matter where. So, if this environment is contaminated with people, such as bad friends who drink, those living in this environment will be influenced by it, whether here or abroad.

Prevalence of drinking

The therapists were asked how, on the basis of their experience, they saw the problem of drinking in Saudi Arabia in the present and future. A few therapists thought that the problem of drinking was not serious. A psychologist responded:

> Owing to the increasing level of family education, and of people's awareness of the hazards of alcohol, the prevalence of alcohol problems is less than before.

Another psychologist, who thought the problem of drinking was not as serious as people might think, commented:

> Drinking has not yet reached the level where it can be considered a serious problem. Those who drink will remain very few compared to those who don't, as long as there are no public drinking places, and very strict law for drinking.

However, in general, the therapists' responses rang a warning bell. Many described how extensive the alcohol problem was now, and predicted worse for the future. A social worker said:

> The phenomenon of alcohol drinking is getting much larger. The number of those coming to Al-Amal hospitals is very small compared to those who don't.

The increase in the number of drinkers in the country resulted from many factors, according to one of the respondents:

> Owing to the rapid population increase, a decline in family control, poor enforcement of drinking laws, and a weakening adherence to religious and social norms, the problem of alcohol drinking is getting worse.

In order to keep the consumption of alcohol to a minimum, a psychiatrist called for the collaboration of all parties in society:

> Education about the dangers of alcohol should be carried out by health, religious, and educational institutions. The media, mosques and treatment centres can be used to warn people about alcohol-related problems.

Almost all the respondents offered a view as to the extent of drinking in Saudi Arabia, but one respondent was more cautious:

> Regarding the phenomenon of alcohol drinking in the kingdom, there are no accurate statistics that tell us how many drinkers there are. That is because most of those who drink hide their drinking, and their families try hard to conceal the drinking of the family member from others to avoid embarrassment.

Treatment Services

Treatment objectives

When the therapists were asked about the treatment objectives they hoped to achieve with problem drinkers, different answers emerged. While some therapists eagerly advocated controlled drinking, most of them viewed total abstinence as the final goal of treatment. One of the latter noted:

> Alcohol is like any other drugs. They are all evil. The patient should be encouraged to quit drinking completely, as with other drugs.

Another advocate of total abstinence said:

> Suppose he [the patient] is in the hospital because of the use of heroin, should I ask him to continue using heroin but in a sensible way? This is nonsense.

Another therapist (a social worker) recommended complete abstinence on religious grounds:

> As we are Muslims, we shouldn't drink at all. Drinking is not allowed at all, so we, as therapists, should try our best to help the drinker quit forever. Drinking per se, even without any other problems, is a problem from a religious point of view.

Other therapists who thought that controlled drinking should be the objective argued that stopping drinking completely was very hard to achieve, and that therefore a level of drinking that reduced problems to a minimum was the best that could be achieved. One therapist (a psychiatrist) explained:

> Of course our optimal goal is to help the patient stop drinking completely. However, if we cannot do that, we should help the patient to drink less so that the associated problems disappear or at least can be kept to a lower level.

Helping the patient to control the problems resulting from drinking was the sole objective for one psychologist, who explained:

> What brought the patient to the hospital is the problems that emerged from his drinking. If we can help him to deal with these problems effectively that is the goal we hope to achieve.

In addition to reducing the level of drinking, some therapists hoped to achieve other goals. A psychiatrist, for example, noted:

> We hope we are able to help the patient to return to society and be a good citizen so that he can become an active member in his family and in society at large.

Effectiveness of the provided services

The therapists were asked to evaluate the provided treatment services. Many described the services as "generally good". However, a very few therapists saw the provided services as "bad". Between the two extremes, some therapists thought the services were "not bad" but capable of improvement.

One who considered the treatment to be ineffective explained why by saying:

> The treatment plan is excellent on paper. However, the treatment plan is distorted when it is put into practice. I don't know why we can't execute the treatment as planned.

Another therapist attributed the low level of success in the treatment to "a lack of qualified human personnel and the absence of an effective organisational system". One of the respondents (a psychiatrist), although he saw the provided services as excellent, criticised the treatment programme by saying,

> Interference of others is what ruins our provided services. Sometimes we feel, as a treatment team, that a patient is ready to be discharged. Suddenly, with no legitimate reason, we receive an order from an external source to keep the patient for a longer time. This non-professional interference affects the treatment team, the patient, and the service in general.

To gain more understanding about the provided services and treatment in general, the therapists were asked their opinion about their strengths as well as their weaknesses. Many respondents thought that having an excellent treatment facility was one of the strongest points. Having well designed buildings that served the treatment needs, modern medical instruments, and the existence of necessary medications were what constituted an excellent facility, according to the respondents.

Another strong point of the provided services was the fact that it was free, said a psychologist:

> Here [in hospital] the treatment costs a lot of money. The patients receive this treatment for free. A patient may stay one month, three months or even a year. All is free.

An additional strong point was the well-designed treatment plan, as explained by a psychiatrist:

> The services are provided by the treatment team, guided by a very good treatment plan. It is very clear, and covers all of the treatment aspects of the patient.

A final strong point of the provided services was the easy access to the services. "All the patient needs to get admitted is to come to hospital – no waiting list, no rejection", a psychiatrist pointed out.

As far as the weak points of the services were concerned, most of the therapists thought that the non-existence of out-patient treatment was the most important weakness of the treatment programme. A social worker has summarised this point:

> A patient has to be hospitalised to get treatment. We have many patients who aren't in need of hospitalisation. They would be better served in an out-patient department if we had one. I am sure also that there are some people out there who want to get the service but don't come because they don't want to be hospitalised.

The second weak point of the treatment programme is the shortage of qualified professionals. This point was suggested by many of the therapists. The shortage is affecting the success of the treatment, a social worker explained. A psychologist has explained how the shortage of qualified professionals affected his work:

> I don't have enough time to see five new patients every day, and to see my old patients at the same time –bearing in mind that both the new and the old patients need comprehensive attention from me – and to deal with their problems effectively.

One of the weak points of the treatment programme was its neglect of the social as compared to the medical aspects of patients. One social worker said,

> The treatment plan is mostly concentrated on the medical problems of the patients. The patients' social needs are not met most of the time. Consequently, no wonder they relapse.

Stressing the same point but more specifically, another social worker said,

> The social worker tries his best to help a patient to find a job. Nobody inside or outside the hospital can co-operate with us to achieve this goal.

Other weak points of the treatment programme that were suggested by the therapists were "mixing the new with the old admissions", mixing problem drinkers with other drugs users, and the unclear plans for patient follow-up.

As to whether the therapists felt some gaps in the provided services, several points were made. The weak or non-existent co-operation between the hospital and the families was considered by the therapists as one of the main gaps of the treatment programme. The families' "ignorance of the nature of addiction", and the stigma and shame were factor contributing to the lack of family co-operation with the treatment team. One social worker pointed out:

> Most families believe that the hospital will take care of everything for the patients. If we contact them regarding the patient, they say they are coming to see us but they never do.

A psychiatrist explained why:

> Because of the stigma, the family refuses to come to the hospital, and even if we ask if we can visit them they say no. It seems that we remind them of their problem and shame.

Another very important point was some patients' refusal of the treatment. Such patients "negatively affect other patients", and consequently the whole treatment programme, said a psychologist. Another psychologist explained that

> Many patients who are brought by force or under pressure of others try to trivialise what we are doing. They sometimes ruin the community or group meetings by distracting their attention or complaining about trivial things.

The lack of proper and effective communication between the hospital and the external environment, including the family, the community, and the wider society, is another weakness in the service that affects treatment. A social worker pointed out that

> The patient receives good care in the hospital, but once he is out, no one tries to help him to solve his social, financial and occupational problems. People don't

> want to forget that he is an ex-drinker. These problems put him under whole a lot of pressure, and he may go back to drinking.

The therapists were also asked to evaluate the success rate of the treatment. Surprisingly, there was a disagreement among the therapists about this. Whereas some therapists saw the success rate as low as 15–20 percent, others estimated it as high as 40–60 percent. Between the two, some thought that 20–40 percent of the treatment was successful, and others did not provide any numbers, but provided an estimation in words, such as low or high. However, it is not known whether total abstinence, temporary abstinence, or controlled drinking was considered a success by the therapists.

What are the factors affecting the success of the treatment? The therapists gave different answers to that. Some thought factors associated with the patient were most important, whereas others attributed success mainly to the hospital or to the external environment. The patients' lack of motivation for treatment, dropping out of treatment, and discontinuing the follow-up were all factors in treatment failure.

Unmotivated patients "not only harm themselves but also affect other patients", a psychologist said. Unmotivated patients became this way because they "want anything but to be treated", another noted. They are the ones who "are brought by the police, the family, work, or just to satisfy others", a social worker explained.

Why do some patients drop out of treatment? These reasons were offered by one social worker:

> Some patients ask to be discharged before their treatment is complete because either they get bored by the long stay in hospital or they have some things to do outside.

A psychiatrist offered another reason for the discharge against medical advice: "They don't like to be hospitalised, they want to be free".

As far as the follow-up is concerned, some patients ceased coming to hospital because they "do not see its importance". Another reason was pointed out by a psychologist:

> It is very hard for those who are living far from the hospital, or living in another city to come to the hospital only to attend a lecture or take advice from a consultant.

The existence of unmotivated workers seems to be one of the factors leading to the ineffectiveness of treatment. Because they "lack interest in their work", some workers "do not work effectively with the patients", a social worker explained. Another respondent, a psychologist, explained why some workers lost interest in their work:

> Some workers get disappointed when they work hard with their clients and see them relapse.

Another therapist explained the lack of motivation in workers by "the lack of training programmes for employees that can enhance their abilities in the field of addiction", said a psychiatrist.

Another factor affecting treatment was the inconsistency in decisions, policies, and procedures that were adopted by the hospital administration. One of the respondents noted that

> Continuous changes of treatment policies and procedures confuse the workers as well as the patients. One day they implement a non-smoking policy, another day they permit smoking. This is too confusing.

The external factors that affect the treatment, according to the therapists, were the lack of family support and the lack of family and society trust in patients.

Conclusion

The therapists' interviews have provided valuable information about some issues related to Saudi problem drinkers in treatment. Such information also helps in explaining and interpreting many of the research findings. In general, the therapists' responses were consistent with the research results. However, it must be said that some of the respondents views either contradicted these, and that certain results were unexpected by them.

Moreover, there were some discrepancies between the therapists in their views of certain issues. Regarding treatment objectives, the patients themselves, and the effectiveness of the provided services there was significant variation of view. Such differences could affect both the treatment process as well as its outcome. There is therefore a need for a common view of treatment objectives and the hospital's mission, and a philosophy that is fully understood and shared by all therapists.

Many therapists expressed doubts about the treatment outcome, and others did not even know their success rates. These uncertainties, the lack of clarity about treatment objectives, and the complaints about the shortage of qualified professionals and the lack of training programmes are all indications of an unhealthy work atmosphere.

Moreover, if alcohol treatment is to be more effective the treatment plans and the procedures they involve should be very clear to all staff. Also, they should be free from external and non-professional interference that could directly or indirectly affect their success. The therapists all need to have a positive attitude towards their patients, and should never regard them as immoral or criminal.

Although cologne and araq are the drinks mostly consumed by the patients, and although all the therapists agree about the high health risks associated with them, there is no treatment programme specifically designed for cologne and araq drinkers. Nor are there any regulations or policies aimed at preventing the consumption of these types of drinks. Changing the design of cologne containers by asking manufacturing companies to give the bottles a spray instead of the usual spout so that they are harder to drink from is one example of such preventive regulations.

The fact that most of the patients were those who were working or had been working in the military sector is due, as reported by the therapists, to the well designed patient referral system between the military sectors and the hospitals. This successful patient referral system should be adopted by the civil sector too.

Since some patients were found to be neither heavy drinkers nor alcohol dependent, it is more practical, as suggested by some therapists, to start operating out-patient treatment clinics. These would be particularly suited to the situation in Saudi Arabia where alcohol drinking is a problem in itself. Moreover, out-patient treatment would allow more problem drinkers to seek treatment, since it would mean that their family or work responsibilities need not be interrupted. Those in the early stages of problem drinking who do not want to be hospitalised could be prevented from slipping into a worse state by suitable out-patient treatment. At present they tend to come to hospital only when their drinking habit has got out of hand. Perhaps this is why most of the respondents were unemployed and in a bad financial situation.

In order to attract more treatment seekers, alcohol treatment should, as many therapists recommended, be available and accessible to everyone. This would involve increasing the number of treatment centres so that all regions of the country were covered. A further step would be to allow the private health sector to provide alcohol treatment under government supervision in order to attract more treatment seekers, especially the rich. In addition, improving the provided services would not only improve the treatment and help achieve its objectives, but also attract more people to come for treatment.

Since the stigma of drinking is for many people an obstacle to seeking treatment, more consideration should be given to client privacy. Perhaps, as suggested by one therapist, attaching treatment units to general hospitals, so that treatment seekers would not be embarrassed when they came to hospital, would be one solution. Informing people through the media that avoiding treatment makes their problems worse might also help.

Although many therapists expressed their worries about the problem of drinking in Saudi Arabia, they also warned about the limited treatment and prevention services that were available. The hospitals themselves were insufficient without other forms of treatment. A fully developed treatment programme should include the family, the workplace and other institutions. It should also extend beyond discharge with a follow-up programme. Creating mutual avenues to link the hospitals to religious, social and advisory institutions is essential. Helping the patient get a job or to return to his job, providing marriage and family counselling, and solving the patient's financial problems are examples what can be achieved through co-operation between the hospitals and other organisations.

Collaborative effort should not be restricted to treatment only, but should also be directed towards prevention. With the help of the hospitals, concerned institutions can prevent many alcohol problems. Increasing people's awareness of alcohol's health hazards, providing constructive leisure opportunities, creating more job opportunities, and issuing regulations and policies that minimise alcohol drinking are examples of prevention procedures.

Summary

This chapter addresses the therapists point of view on various issues related to problem drinkers in treatment. Such issues include the demographic characteristics of hospitalised

Saudi problem drinkers and the nature of their drinking behaviour. The therapists also provided information regarding the services provided by the alcohol treatment centres.

Chapter 9. Conclusion

Introduction

The results of the research have yielded vast information about the hospitalised problem drinkers in Saudi Arabia. However, any information is useless unless it can be utilised. This chapter summarises the main points that can be inferred from the research results. The chapter is divided into five sections. The first section points out the related issues related to the hospitalised Saudi problem drinker. More specifically, it provides, for the first time, a general profile of the hospitalised Saudi problem drinkers, their patterns of drinking, their use of tobacco and other illegal drugs.

The second section, however, provides some implications of the results to the social work profession, as to how the social workers benefit from the facts related to hospitalised problem drinkers as well as the problem of drinking in general in Saudi Arabia. The third section of this concluding chapter discuses some issues related to alcohol studies in Saudi Arabia. In the forth section, a discussion with regards to the legalisation of alcohol in Saudi Arabia is presented. The fifth section discusses the extent of the applicability of the findings to other societies. Finally, brief recommendations for policy makers, social work professionals, educators, and researchers are summarised at the end of the chapter.

Profile of hospitalised Saudi problem drinkers

Based on the results, it can be said that the profile of a hospitalised Saudi problem drinker is most likely to be of younger age (20-35 years old), married, low educated (high school or less), with low income (less than 3000 SR), and unemployed. In addition, if currently or previously employed, the hospitalised Saudi problem drinkers are likely to work for the military and hold an administrative work. Furthermore, they tend to live in a city, stay in a house that is owned by others, and is sharing the house with seven people or more.

In terms of the patients' family status, the parents of a typical hospitalised Saudi problem drinker are most likely not living together, either as a result of separation, divorce, or the death of one or both of them. The parents are most likely to be illiterate, and have a history of remarriage. Furthermore, if married or has been married, the hospitalised Saudi problem drinker is most likely to have a low educated housewife, and to have more than three children.

It should be noted that this profile can only generalised to those Saudi problem drinkers entering alcohol treatment. Implication of these results includes designing alcohol treatment programmes that address the needs of those who fit this profile. For example, helping those unemployed to find a job.

In addition, efforts could be intensified to educate about and recruit to alcohol treatment those people who fit this profile. For example, educational recruitment programmes for treatment should be more targeted at young age groups (20-35). In addition, alcohol educational programmes should be concentrated on adolescents since drinking starts during intermediate and high school levels. Moreover, further studies to explore drinking problems on those who doe not fit this profile, and why they, if problem drinking is prevalent among them, do not come for treatment.

Drinking behaviour

In exploring the drinking behaviour of hospitalised Saudi problem drinking many points can be inferred. For example, contrary to the drinking practices in many countries where alcohol allowed, araq and cologne are the most common types of alcohol that are consumed by of hospitalised problem drinkers. Although it is forbidden, alcohol is easily accessible, especially in the form of cologne. It is very cheap and can be bought from any shop. Furthermore, cologne drinking is most common among older, single, divorced or separated, low educated, unemployed, and those with the lowest monthly income patients. Also, drinking of cologne is most prevalent among patients in the region of Qasseem than in any other region. Due to the health risks associated with these two types of drinks, especially cologne, Health professionals should educate their patients, and people in general, about these health hazards. More attention should be given to those who fit the profile of cologne drinkers, for example, liver functioning test should be recommended. The health professionals should be aware of the fact that many drinkers consume the drink without mixing it with any type of soft drink. Such practice constitutes an additional health hazard to the drinker, and he/she should be made aware of this hazardous practice.

In order to limit the use of cologne, decision makers, should ask the manufacturers of cologne to change the design of the bottle (by changing to a spray bottle) so the content of the bottle can not be easily poured in a glass. The manufacturers should be also asked to use ethyl alcohol instead of methyl alcohol in cologne, so if it is drunk it becomes less

harmful. Restricting shops from selling cologne to children and those under 18 years old, and from selling in certain times are also recommended.

A unique feature of drinking in Saudi Arabia is that of the preferred versus the actually consumed drink. Unlike in country where alcohol is allowed, the drinker most probably consumes the drink that he/she prefer, the drinker in Saudi Arabia, due to the problem of availability and accessibility, may not consume the drink he/she prefer. Having said that, there still some Saudi drinkers who consume what they prefer. For that, further studies to investigate why some drinkers prefer the consumption of certain type of drink should be conducted.

Another unique feature about drinking in Saudi Arabia, is that drinking mostly take place in hidden places, home, private resorts, or outside the city. Such practice is plausible since alcohol is not allowed in the country. Hidden places can be safe so the drinker can be a way from being seen or caught by police or significant others. Health workers, however, should educate those who drink outside home, about the risks of driving while intoxicated.

The finding that many hospitalised problem drinkers restrict the time of their drinking to weekends maybe an indication of low dependence. Especially that another finding, in this research can support that, and it shows that about a quarter of the patients are not really alcohol dependants. The hospital admission of such patients is another unique feature of drinking in Saudi Arabia. Such patients probably would not be admitted in western hospital for example. Health professionals should be alert to those patients with low level of alcohol dependence and design special treatment programme for them; a programme that concentrate in alcohol education, and in the family and social aspects to help the patient utilise his energy and time in more constructive way, away from alcohol and drugs is suggested.

Another striking characteristic is that most of the patients, including those with high alcohol dependence, abstain during the holy month of Ramadan. Such a characteristic on why they do so need to be investigated. However, health professionals in alcohol treatment need to find away to utilise such feature to help those with problem drinking get treated.

High level of alcohol is most common those patients who are young, single, low educated, unemployed, those with low monthly income. High level of alcohol consumption is also mostly prevalent among patients of Riyadh hospital than any other hospital. High level of

alcohol dependence, however, is most common among those patients who are older (41 and over), Divorced, separated, or widowed, low educated, unemployed, and among those with middle income. Moreover, the highest level of alcohol dependence is among the patients of Dammam hospital. Again, other health professionals should focus on those patients who fit these profiles to educate them about the health hazards associated with high level of alcohol consumption and/or alcohol dependence. Also, the treatment of those who fit these profiles should include helping them to improve their external factors (such as finding employment and improving their financial status) as well as helping them to gain high level of self-esteem. The high consumption of alcohol in Riyadh, and the high alcohol dependence in Riyadh worth more investigative study.

Although the highest proportion of the patients drink to forget problems, those who do are most likely to be single, middle aged (31-40), and with low income. Moreover, whereas most of Dammam patients drink to forget their problems, most of Jeddah patients drink to relax. Such regional differences with regards to the reasons for drinking needs to be studied.

The patients' first experience with drinking showed that the majority begins drinking under the age of 20. Furthermore, almost 17 percent even start drinking before the age of 16. Education about alcohol related problems, therefore, should be targeting these age groups, school age. Schools should design preventive educational programmes for student and their parents. As a first step towards alcohol education and prevention, the message should be clear and simple so it can be easily understood by both the student and parents who may have low level of education. In addition, further preventive strategies, as suggested by researchers (e.g. Spooner & Hall, 2002), could be utilised.

The facts that the majority had obtained their first drink from a friend, the first experience had occurred inside the country, and that drinking in a regular bases is occurs within a year of the first drinking experience have a clear message to educators and parents and social and religious advocates. Blaming alcohol and drug problem on travelling is not a solution. Those concerned should look and search for the reality from within. Parents should be close to their children physically, mentally, and allow children to discuss their problems openly. Parents have to know that bad friends can not influence others unless others are ready to be influenced. Children should be taught how to deal with such influence and to

see no alcohol and drugs. Children have the right to find in a clean atmosphere, and to play and learn constructively.

Smoking and the use of illegal drugs

As the results reveal that the majority of hospitalised problem drinkers are smokers, constitute an additional health hazard to the patients. Especially if we know that a quite high proportion of them smoke shisha (a practise that is very seldom seen in western countries). In addition, the author has heard physicians in Saudi Arabia claim that shisha is more harmful than cigarette smoking, although there would seem to be a lack of empirical evidence. Furthermore, the fact that more than third of the patients smoke between 21-40 cigarettes a day is an additional health concern.

Because all these health risks, education about the health hazards of this combined dependency should be lunched. Alcohol treatment should develop a treatment programme to help the patient quit both drinking and smoking. Further, further studies are needed in the area of shisha smoking, its prevalence, and it associated health risks.

The use of other illegal drugs is also prevailing among hospitalised problem drinkers. Hashish is the most drug used by the patients, stimulants is the second. The high prevalence of use of illegal drugs among the patients is a unique characteristic of Saudi problem drinkers. It is possible, as said earlier, that such wide usage of illegal drugs is due to the fact that both alcohol and other illegal drugs are seen by the patients are similar in terms of their illegality, stigma, religious sin. For example, a drinker may believe that if all are sins, using one drug over the other does not make a difference. However, why the Saudi user consume one drug more than the others is a matter of preference, availability, and prices.

In order to tackle the problem of illegal drug use, these drugs should be classified according to their social and health effect. Based on that classification, punishment should be also classified. Alcohol smuggler, for example, should not be given the same punishment as heroin smuggler. Not doing so, as it is the case now, may allow heroin smuggling to increase giving the fact that heroin is easier to hide and far more expensive to sell.

In terms of treatment, health professionals should be aware that dependence on certain drugs might needs certain intervention. For example if behaviour modification approach is to be used, the therapist needs to know they type of drug taken, when, how, the quantity and frequency, and the condition in which the drug is taken.

Therapists' perspective about hospltalised problem drinkers and alcohol treatment

The therapists' interviews have provided very valuable information in filling the missing piece of the picture of the problem drinkers in treatment. Through these interviews, the therapists have given their own perspectives about the problem drinkers. They helped in explaining or sometimes providing new information regarding many of the issues related to problem drinkers in treatment.

Based on these interviews, it seems that although effort to provide services to people with alcohol problem is obvious, there still much to be done. Tackling the problem of alcohol needs co-operative and co-ordinate effort from many institutions and agencies. Effort to tackle the problem needs to be concentrated on prevention as much as on treatment. In the area of treatment many further steps could be taken.

First, the treatment should be made available and accessible to everybody who needs it. This means that the treatment services should reach out people in their regions, cities, and villages. In a very large country like Saudi Arabia, four treatment centres are not enough. Giving the social and psychological aspect of alcohol dependence, and of the dependent him/herself, it is hard for the treatment seeker to travel. Even if he/she does, the treatment is considered incomplete without a follow-up care. As the therapists pointed out, the client being far from the hospital is one problem that makes the follow-up services incomplete.

Secondly, in order to attract more people for alcohol treatment, in addition to increasing the number of alcohol treatment centres, as said earlier, small alcohol treatment clinics that could be attached to general hospitals around the country are suggested. The development of such clinics serves two purposes; the first is that the services through these clinics could be reachable and available to all. The second purpose is that by attaching the clinics to general hospitals, the privacy as well as the confidentiality of the clients is given more consideration. Most importantly is that, because of the stigma, providing treatment through these clinics can help treatment seekers come to treatment with less fear. For example, it is

easier for those who are afraid of stigma to be seen coming to a general hospital rather than to separate and special alcohol and drug centre. In fact, giving the social, legal, and religious view of people about the drinker in Saudi Arabia, these attached clinics could be, in future, an alternative project that could replace Al-Amal hospitals. These clinics would be also more convenient for special groups like female problem drinkers since the fear of stigma may be worse for them than for men.

Another procedure to attract more people to treatment is to have the information about treatment reach every one. Information about treatment may include description about the treatment programme, eligibility for treatment, length of stay, and the admission procedures. Such information could reach people through the use of various media means such as newspapers, television, radio, and pamphlets as well as visiting other institutions and agencies such as schools.

The improvement of the existing services would also help in increasing the effectiveness of the treatment as well as attracting more people to treatment. Such improvement could be achieved through the following:

1. When they were asked to evaluate the treatment services, many of the therapists expressed their concerns about the lack of qualified and motivated staff. Such a complaint, even if it is not real, is an indication of a problem. The shared feeling among many therapists of this problem is enough to effect the quality of the provided services. Therefore, if the therapists' concern is true, the recruitment of well qualified and motivated staff is recommended. Another solution is to provide alcohol training programmes to staff, and to create a better work atmosphere that can help motivate them.

2. Even for qualified and motivated staff, establishing continuous training programmes in the field of alcohol and drug addiction for staff and personal is highly recommended. Especially that the country's experience with alcohol and drug treatment is relatively new. In addition, these training programmes are really needed as many therapists have expressed this need.

3. When the therapists were asked about the treatment, it was clear that there were some inconsistencies among the therapists regarding their views about the treatment goals and objectives or the patients (e.g. a patient or a criminal). In order to help solve this

issue, and to improve the provided services, several steps to insure more consistency among the therapists and the rest of the hospital staff are recommended as follow, a) the hospital should establish a statement of mission that should be clear and recognised by everyone. b) The hospital should make sure that all staff members hold a common and shared view about alcohol and dependency as well as about the patients themselves. c) A clear, practical, and achievable treatment plan and objectives should also be developed and shared by all staff members.

4. As many therapists complained about the lack of effective co-operation with other agencies and institutions, it is clear that such a problem would negatively effect the success of the treatment. The patient as well as the hospital can not be isolated from the outside world, as it is a fact that individuals, groups, and organisation are in mutual and continuos interactions. Therefore, the hospital should establish an effective network of communication with other institutions and agencies. Such communicative network could, if effective, help improve the provided services. Through the co-ordination and co-operation with these institutions and agencies, patients could be recruited to treatment, also patients could be refereed from the hospital to these institutions and agencies to receive extended help, such as job replacement, marriage counselling, or vocational training.

5. As the results show that some hospitalised patients are not alcohol dependent, therefore, hospitalisation is not needed, out-patient treatment programme should be started. Such a programme would help attract more people, especially those who can not leave their responsibilities behind. Out-patients programmes would also help improve the quality of the provided services for those hospitalised patients as the in-patient treatment will be concentrated on those who only deserve to be hospitalised.

6. According to the Al-Amal hospital Policy and procedures manual (1998), the treatment is provided for those who are male aged 18 and over. Moreover, in the part of children, the results showed that most of the hospitalised problem drinkers have started drinking under the 18 of age. In addition, in spite of the strong stigma associated with women drinking it is a fact that women are not immune from drinking, or, for some, becoming problem drinkers. Saudi Arabia is part of the world, and women drinking may exist regardless of the size of drinking problem. Therefore, females and children who have problems with alcohol should have a treatment available to them. such a treatment

shouldn't only be available but also should be easily accessible considering the stigma and the hardship that might be even worse for the children and female with alcohol problem than for adult male.

7. Treatment of patients with alcohol problems is considered incomplete without after-care services. When asked about treatment, the therapists have indicated that the there was a lack of effective after-care services. Therefore, a well designed programme to follow up the patients after discharge is really needed.

8. Although the results showed that the majority of the hospitalised problem drinkers were living with either a spouse or parents, the therapists have complained about the lack of family co-operation in treatment. In alcohol and drug treatment, the family is an important part of the recovery process (e.g. Billings & Moos, 1983). Therefore, in order to improve the service, and to attract more people in return, the treatment of alcohol should include the family, in spite the fact that the family can in some cases be part of alcohol problem, as an integral part of the treatment, and a programme to encourage the involvement of the patient family in treatment is very important.

9. As some therapists indicated that there is non-professional external and internal interference with treatment. Such interference effects the patient himself, other patients, and the effectiveness of treatment. Therefore, in order to improve the quality of the services and for the treatment to be more effective, it is recommended that the treatment should be freed from this non-professional interference.

In addition, it was clear, based on the therapists interviews, that the referral system adopted by the military sectors to refer the employees who are at risk of being problem drinkers proved to be successful. Such referral system should be adopted as well by other sectors, such as civil employees. Moreover, in order to attract more people to treatment, the experience of many countries could be adopted. For example, primary care physicians and other health professional (like social workers) could also be good sources for case finding for problem drinkers. They should be trained to screen, identify, and refer to Al-Amal hospitals those people at risk of being problem drinkers.

Since alcohol treatment is provided only through Al-Amal hospitals (government and free health services), it might be possible that there are treatment seekers who do not like to come to these hospitals for one reason or another. Moreover, the therapists believed that

high class and rich people do not like to come to Al-Amal hospitals in spite of their needs for treatment. Therefore, it is recommended that a further study to investigate whether the therapists' belief is true or not should be carried out. If it is true, one possible option to attract those segments of people is to improve the quality of services. Another option is to think about and study the possibility of providing alcohol treatment through the private health sector.

In terms of alcohol prevention, giving the fact that the prevalence of alcohol drinking as well as its treatment is relatively new in the country, the hospital should organise, along with other agencies and institutions, alcohol education programmes to inform the public about the risks associated with alcohol drinking. Educational materials should be based on the fact that most hospitalised problem drinkers and their families are with low education. Therefore, alcohol education should consider their level of understanding so that the message can achieve its goals. Alcohol education also should be directed mainly at those who have the potential of fitting the profile of hospitalised problem drinkers, as mentioned earlier, without ignoring other segment of people.

Role of social workers in response to alcohol problems in Saudi Arabia

Introduction

The role of social worker in prevention and treatment of alcohol abuse is very well known. In this section of the concluding chapter, based on the results that emerged from this research, some implications for social work practice to meet the need of hospitalised Saudi problem drinkers are discussed. More specifically, this section points out the role of social worker with relation to treatment as well as prevention of alcohol problems in Saudi Arabia. General points of promote the social work practice with alcohol dependence in Saudi Arabia is also discussed.

The role of social workers in Alcohol Treatment centres (Al-Amal hospitals)

Treatment

A proper treatment intervention should be based on full understanding of the client, his/her problem and needs, and the environment surrounding the client. All these elements should be dealt with within the cultural framework. These elements are essential for the success of the treatment. In order to promote the treatment and/or bridge the gaps in treatment, the social workers have many tasks to accomplish, as part of the treatment process. Based on the research results, the following are some implications that the social worker could implement in treatment for hospitalised problem drinkers in Saudi Arabia.

Full understanding (person in environment)

Giving the complexity of alcohol problems, and the unique characteristics of alcohol drinking in the Saudi society, the treatment programme should be designed to fully understand the patient in his/her environment. Why a person drink or/and can not stop drinking in a society where it is socially, legally, and religiously unaccepted has some thing to do with the personality of the person as well as the surrounding environment. Therefore, it is recommended that social workers in treatment should view and understand the patient as a person in a situation. Such view and understanding can increase the effectiveness of all stages of treatment.

Moreover, given the hard effect of the stigma that accompanies alcohol in Saudi Arabia, and because of that, according to the therapists, many avoid coming for treatment. Therefore, the social workers in treatment should think of ways to assure more privacy for the patient and the family. Treatment like group therapy, for example, is less adequate in Saudi society as people feel very hesitant to discuss their personal problems in front of others. Therefore, perhaps, more individualised treatment should be encouraged.

In addition, the stigma, lack of appropriate follow up treatment programme, the patient unwillingness to follow up, and the lack of co-operation of other agencies with the hospital, suggest that the social workers should adopt case management approach in dealing with their patients. Such approach could be more adequate to Saudi problem drinkers especially that the social worker, according to this approach, often carries more tasks than the patient does.

Family involvement

The role of family in the treatment of people with problem drinking is very important. However, the research showed that the family involvement in the treatment of hospitalised Saudi problem drinkers is incomplete or some times lacking. The social worker should look for the real reasons behind such a problem. Then, effort should be paid to encourage the family participation on treatment. As pointed out by many interviewed therapists, it is also suggested that this effort should consider the family fear of the stigma associated with having a member with alcohol problem. The social workers could educate wives how to deal with their drinking husbands, and how to encourage them to seek treatment, or at least cut down their level of consumption (e.g. Thomas, Yoshioka, & Ager, 1996; Barber & crisp, 1995; Yoshioka, Thomas, & Ager, 1992).

Furthermore, the social workers who are working in alcohol treatment or in other settings should be aware of the fact that some wives and children of alcohol abusers can be victims of violence and abuse (Harter & Taylor, 2000; Johnson & Leff, 1999; Langeland & Hartgers, 1998; McGaha & Leoni, 1995; Orme & Rimmer, 1981; Widom, Ireland, & Glynn, 1995). Hence, the social workers can play an important role in exploring cases of abuse and violence, and providing them with needed assistance, such as counselling, or referring to appropriate resource.

In addition, for the social workers, and other health professionals working in alcohol treatment, effort should be concentrated on involving the wife of the problem drinker in the treatment since the results reveal that the highest proportion of hospitalised problem drinkers are married. Such involvement of the wife in treatment includes contacting, encouraging, and educating the wife on how to be part of the treatment plan, and training her what to do.

The fact that the majority of the patients' parents and/or wives were illiterates, social worker should use very simple methods in explaining alcohol addiction, and the treatment programme for the parents and wives, a method that can be easily understood by such people. Special attention should be paid to the region of Qaseem since the findings here reveals that this region has the highest percentage of illiterate parents and wives.

Furthermore, the facts that most of the parents and wives were illiterates, most of parents had a history of remarriage, and most of the patients were living in large size family are all possible, but not necessarily, indication of family instability. Social workers in alcohol treatment should bear in mind such family situation and work with the family to help overcome other family problems that might be the result of or the main factor for such instability. As a preventive tool, social workers should start a programme to co-operate with other agencies, such as family planning, family and marriage counselling to prevent factors that may resulted in family instability.

Job finding

Considering that the age of the majority of hospitalised Saudi problem drinkers fell between 20-35, social workers should initiate treatment programmes that meet the needs of this age group. For example, job-finding programme is needed given the fact that most of these patients were without job.

Social workers also could help the patients with job finding, especially that the result shows that the majority of them are unemployed. This job finding service should not be lift to chance. Since employment is essential for recovering alcoholic, and is part of the full recovery, social workers should develop a programme that helps unemployed patients find a job. Such a programme may be based on full co-operation and co-ordination with other related agencies that deal with the personnel recruitment, and with those agencies that

provide training programmes for job applicants (e.g. job skills, interview skills, etc). Keeping up to date database of vacant position is also suggested.

Harm reduction

Since drinking is not allowed in Saudi Arabia, the treatment final goal is to help the patient abstain totally. Total abstinence or no treatment should not be the only choices a patient could have. If the treatment can not help the patient to stop drinking, helping the patient to learn new behaviours to minimise the problems resulted from the patterns of drinking is highly suggested. For example, the social workers could also use their professional experience in educating the patients about risky drinking behaviour associated with cologne and araq drinking. Since cologne and araq drinking is more prevalent among older, divorced, separated, poor, and unemployed patients, emphasis in that matter should be directed towards those patients who fit this profile. Another example is that the social worker could use a simple method of education to show the patients the health risks associated with the consumption of alcohol without mixing it with a soft drink.

That fact that more than 90% of the problem drinkers smoke, and that the smoking experience of the majority started before drinking give the social workers additional task whether working with patients in treatment or in prevention. As it is well known both drinking and smoking has health risks of its own, especially that many smoke shisha which believed by some doctors to have more health hazards than cigarettes. The combined consumption of both is even riskier. Therefore, the social worker in treatment should help patient learn those health risks and help them to quit both if possible.

In the area of prevention, the social worker should look for, and concentrate more on those schools children who began smoking to educate them about smoking and drinking health problems. Educational effort should also be extended to reach those adolescents who smoke shisha in the shish coffee shops outside the city.

With regards to the use of illegal drugs, eliciting information about the specific type of drugs used by the patients is essential task for the social workers during the patient' s evaluation stage. For the treatment of those problem drinkers who consume drugs, the treatment should not only concentrate on the treatment of alcohol but also include other drugs treatment. The social workers should also help the patients and their families learn and understand how dangerous it is to combine alcohol with other drugs.

Drinking and driving

Driving while drunk is an expected practice of many of the problem drinkers, especially that the results showed that many of Saudi problem drinkers do drink outside their homes; most of the therapists agreed to this finding as well. In treatment, while the social worker evaluating the pattern of drinking, questions about the patients driving while drunk should be asked. Moreover, the social worker should warn the patients as to how relatively low doses of alcohol can affect motor skills, such as using machinery or driving. Education may be needed to warn people that these skills are compromised long before they feel any physical effects.

Patients with Non-alcohol dependency

Since many hospitalised patients showed no sign of alcohol dependence, the social workers play the major role in treating such patients. Since those patients are not dependants, they need a special kind of treatment, a treatment that pays more concentration to the social aspect of the patient rather than the medical. Social workers should design a programme that can help prevent those patients of reaching the dependence level. Such a programme could utilise the family and social network to support the patient.

Abstinence during Ramadan

As the majority of the problem drinkers maintained that they abstain totally during the holy month of Ramadan, this pattern of drinking should not be left unutilised. Social workers along with other health professional should give this feature more attention and more investigation. In the mean time, the social workers could help such a patient realises his ability to abstain for 30 days, so why can not abstain for longer or for the rest of his/her life.

Prevention (leadership)

Prevention is one of the main goals of the social work profession. In addition to treatment, therefore, the social workers should assume a leadership role in tackling the problem of alcohol through alcohol education campaigns. In other words, the social workers should not only participate in these campaigns but also take the initiative step in leading and encouraging others to participate.

Alcohol education (leadership, requirement)

In order for the social workers to assume this role, they should have the necessary knowledge. For example, they should be knowledgeable about alcoholism, alcohol problems, targeted populations and other interested parties in alcohol prevention. Also, they need to have the necessary skills on prevention, on how to approach people, what is the suitable way to convey the message for example.

Education role inside and outside the hospital

The first drinking experience has provided valuable information that can be utilised in the area of alcohol prevention. As part of their professional tasks, social workers should co-operate with others to educate the public and those on potential risk of becoming problem drinkers. Knowing that the majority of hospitalised problem drinkers now has started their first drinking experience in their adolescence stage, and that such drinking experience took place inside the country, entail the social worker to look for the right target of potential problem drinkers. That is children in schools and more specifically in intermediate school. The social workers could co-ordinate with schools principles for example to give lectures and presentation to student and their parents about alcohol and dependency.

For alcohol education to be effective, suitable educational materials should consider the illiteracy of parents and wives, not only those who have a problem drinker, so it can help them understand alcohol problems, and, as a result, help prevent theses problems. Moreover, the social workers could use simple methods convey the message to young children.

The role of social workers in other settings

Social workers dealing with clients in settings other than the alcohol and drug field can also have a role in tackling the problem of alcohol and drug. Giving the fact that so few individuals with alcohol and drug problems enter treatment (Tucker & King, 1999), there may be other roles that social workers on other settings can play related to alcohol and drug problems of their clients and, clients' families, and the community. This is true especially in country like Saudi Arabia where alcohol is not allowed, and, as a result, there might be some people who possibly hide their drinking because of the stigma or they are unaware of their drinking problem. Or, as the therapists pointed out, that there are people who do not know if there is alcohol and drug treatment available to them.

The roles of social workers in these settings related to alcohol and drug problems may include: 1) work as a good source of referral to Al-Amal hospitals, through identifying clients with alcohol and drug problems, especially those in the early stages of substance abuse. 2) Brief interventions, including harm reduction related to the abuse and misuse of substance. 3) Advocacy for client needs with treatment systems. 4) Linking clients to Al-Amal hospitals for treatment. 5) Following up recovery process and minimising relapse with clients, after discharge from Al-Amal hospitals, especially those who live far away from Al-Amal hospitals.

However, for the social workers in these setting to play these roles, they first have to have the necessary knowledge about alcohol and drugs. In addition, they should obtain the skills necessary to identify, assess screen, and intervene with clients who have alcohol or drug problems. For such knowledge and skills to be obtained, alcohol and drug training programmes for social workers should be lunched.

Further needs to promote the role of social workers in alcohol treatment and prevention

Training

Since the country's experience with alcohol and drug dependency is relatively new, and as the therapists pointed out the need for qualified staff, training programmes in both alcohol prevention and treatment are really needed. Al-Amal hospitals should give the therapists, including the social workers, the opportunity to gain the specialised knowledge and skills to prevent and treat alcohol problems. The universities can play a major part to design training programmes for the social workers in the field of alcohol treatment and prevention. These training programmes could be achieved through multi-co-operation efforts between universities, Al-Amal hospitals, and the any other institution where social work is being practised.

Social work education

It is surprising to know that in the Department of Social Studies at King Saud University[1], where the researcher is originally working, that there is no single course on alcohol and drug related problems is provided. That is true for both graduate and post graduates

[1] King Saud University was established 1956 as the oldest and the largest university in Saudi Arabia.

programmes. Although the social work student who graduate from King Saud University can work in Al-Amal hospitals, they are not taught a single course about alcohol or drugs.

During the therapists' interviews, many have expressed the issue of unqualified professional staff. Therefore, in order to have qualified social workers in the field of alcohol and drugs, the social work curriculum should contain courses as well as training practice that help prepare the social work students to work effectively in alcohol and drug treatment and education. Moreover, the possibility of providing training programmes through the university and Al-Amal hospitals for those social workers who are already graduated is highly recommended.

Research

When searching for Saudi literature related to alcohol and drugs, the researcher found difficulties finding relevant literature. Finding literature related to the social work and alcohol and drug problems in Saudi Arabia is even more difficult in spite the fact that the social work has long been one of the closest profession to the treatment and prevention of alcohol and drug problems the social work. Social work academicians and researcher have excellent opportunity to conduct endless number of studies in the field of alcohol and drug in Saudi Arabia.

Alcohol research problems in Saudi Arabia

This section is devoted to discuss some issues related to alcohol research in Saudi Arabia. Although these issues are specifically related to alcohol studies, they may apply some other areas of research in general.

Alcohol measurement

The fact that most of the hospitalised problem drinkers consume araq, which is locally made so that it has no manufacturing standards, makes difficult to quantify how much of pure alcohol in each container. Moreover, it is even hard to know how much alcohol is consumed by a person in form of the number of glasses. What makes the situation is even worse is the unknown size of the drink used by the drinker, since alcohol is consumed at in hidden places like homes for example, where the size of used glass vary widely from one person to another. The absence of standard size of drinking containers face researchers as well as therapists with difficult challenge in quantifying how much of pure alcohol is exactly and normally consumed by the drinker. Clearly this problem has impact on assessing alcohol consumption. Therefore, this is an invitation for those interested in alcohol field to find methods on how to quantify how much of pure alcohol consumed in Saudi Arabia.

Alcohol questionnaires

Also, it was clear that since there was not much research relevant to drinking in Saudi Arabia, there was a lack of standardised measures that can, for example, measure, assess, or diagnose problems related to alcohol in Saudi problem drinkers. Such measures are really needed and can be of great benefit, especially of they were based on Saudi culture where alcohol is legally, religiously, and socially unaccepted. So, from here, researchers as well as those who are interested in alcohol should pay more effort in developing some standardised measures that are suitable to Saudi culture.

Alcohol epidemiological studies

During the search for the literature relevant to alcohol in Saudi Arabia, It was clear that there is not much available. The problem of the availability of the research studies is not only in alcohol but also in other fields. The lack of social surveys has a direct impact on people accepting to participate in a study. In this research, for example, the researcher

found difficulties involving the patients in the study. With the therapists, the situation was even worse, especially when they were asked to be tape-recorded.

Whereas it is easy for a western qualitative researcher, for example, to ask people to participate in a study and that people do not mind to do so, it was very difficult for the researcher to convince, even more educated people like the therapists, to accept tape-recording. The rarely conducted studies in Saudi Arabia could be one of the main reasons for hesitant participation. How sensitive the subject being studied is, may add more resistant on the part of the interviewees to participate.

Alcohol legalisation: is it good or bad?

The findings showed that the majority of the hospitalised Saudi problem drinkers:

1. Maybe because of alcoholic beverages are not easily available and accessible, they consume either cologne (methanol alcohol) or Araq (local made, with no standards), which both are harmful to health.

2. Consume other illegal drugs, because alcohol is not available some times, and because all drugs, including alcohol, are illegal.

3. Drink usually in hidden places, which may create an atmosphere for, even more illegal behaviours.

Because of these and some other results, the readers may conclude that legalising alcohol in the country is a legitimate conclusion. Especially that many western literature (e.g. Lewis, 2001; Levin & Levin, 1990) indicate that alcohol prohibition is not the solution for alcohol problems. Moreover, some studies stated that alcohol prohibition strengthen the influence of organised crime (Levine & Reinarman, 1991). Those who support alcohol legalisation take the experience of alcohol prohibition in the United States in the early of the last century (Beauchamp, 1976).

However, taking the United States experiment as an evidence of alcohol prohibition failure may not be applicable to other societies of different backgrounds and environment. The success or failure of any national policy or law is determined by many factors. The following is a comparison between Saudi Arabia and the United States experiment (in the 1920s) in relation to alcohol prohibition.

Religious variance

Whereas all Saudis are said to be Moslems, the United States is a country of many religions although most people align themselves with some form Christianity. In some religions, alcohol drinking is a religious practice (Akel, July, 1976). Therefore, the prohibition of alcohol in the United States might have been resisted by some religious groups. However, since Islam prohibits alcohol, opposing alcohol prohibition is not a case from religious point of view in Saudi Arabia, even in the part of those Saudis who drink.

When Akabaliev & Dimitrov (1997) compared the attitude of Bulgarians-Christians and Turks-Muslims towards in Bulgaria, For example, they found that a greater percentage of Turks-Muslim than of Bulgarians-Christians (including those respondents who regularly use alcohol) are in favour of an official prohibition of alcohol in society and even moderate use on special occasions is inadmissible to them.

Constitutions

Unlike the United States, the laws and policies in Saudi Arabia are normally based on Islamic Shriea (instructions). So, alcohol prohibition in Saudi Arabia is an execution of an Islamic law. Such law is based on a religion that is embraced by all Saudis. In the case of the United States, however, although alcohol prohibition was driven by Christian movement (Engs, 1997), the law and constitution is not based entirely on religion.

Homogeneous versus Heterogeneous culture

One of the main characteristics of the United States is that it comprised of multi-cultural population (Roberts, 1995). Such cultural variations made it difficult to accept alcohol prohibition. Brady (1995) indicated that some cultural contexts may foster drug and alcohol use rather than discouraging it. Some American groups have emigrated from countries where alcohol is culturally and socially acceptable. However, although some cultural diversity exists, it can be said that Saudi culture is homogeneous. The Saudi culture and social life is built around Islamic religion which prohibits drinking.

Timing

One of the reasons of alcohol prohibition failure in the United States was that drinking was part of the American social life in general. Drinking was the normal practice. Therefore, it was difficult to enforce the prohibition law in a culture where alcohol is socially needed. Ritson (1994) indicated that prohibition is inappropriate except where it has widespread support within the culture. However, in Saudi Arabia, to be abstinent is the norm. As indicated in chapter 2, alcohol is socially unacceptable, and it is not an essential part of people social life in Saudi Arabia.

What is bad?

Alcohol prohibition in the United States was based on the view that alcohol is problematic because of the bad users (Beauchamp, 1976). Whereas in Saudi Arabia, alcohol is seen (from Islamic point view) as a bad substance. Such different views have their impact on the implementation and enforcement of the prohibition, as well as on the acceptance of such prohibition by people.

Total versus partial prohibition

The prohibition experience of the United States was partial, buying or self-making of alcohol was legal (Article XVIII, Constitution of the United States, 27 June 2002). That means drinking was not totally banned rather it was minimised. Because of that, the enforcement of the law was not effective. In the case of Saudi Arabia, however, any involvement with alcohol is made illegal. Although it has to have more laws and policies to support it, alcohol prohibition policy is comprehensive to ban any activity related to alcohol drinking. That includes banning drinking, buying, selling, manufacturing, carrying, receiving, producing, gifting any type of alcoholic beverages (Al-Shazili, 1984).

Is alcohol prohibition totally bad?

Although national prohibition of alcohol was not very much effective in the United States 1919-1933 (Katcher, 1993), many recent studies (e.g. Chiu, Perez, & Parker, 1997); Chiu & Perez, 1998); Wilson, Niva, & Nicholson, 1993; Johnson, 1989); proved that alcohol prohibition does more good than harm to people' health and social life. Grant (1997), for example, reported that alcohol use and dependence were much more common among cohorts born after Prohibition and after World War II.

Based on the discussion mentioned earlier, unlike the United States, alcohol prohibition in Saudi Arabia does more good than harm to the society. Because of cultural, social, and for most, religious factors, the legalisation of alcohol in Saudi Arabia is inappropriate. Although prohibition may worsen the effect of drinking in the part of those who drink, and those who are dependent, there is no proof that prohibition increases the total number of drinkers. Prohibition, therefore, functions as a deterrent towards an increase in the total

number of drinkers, and consequently, towards the increase of total number of alcohol dependants.

In fact, the probability of having problem drinkers or/and alcohol dependants is more likely to occur when alcohol is allowed and available than when it is not. Simply because the more people are exposed to alcohol the more the number of people who drink, and the amount of alcohol consumed. As a result, because of the addictive nature of alcohol, the number of alcohol dependants would increase (Chiu, Perez, & Parker, 1997).

It is a fact that alcohol prohibition in Saudi Arabia does not guarantee a society with a complete abstinence. However, dealing with a small proportion of the population (those who drink and who have a drinking problem), when alcohol is illegal, is much easier than dealing with the problem in the whole population, when alcohol is legal. In addition, in order for the prohibition to be more effective, there should be other policies and laws that support it. For example, polices and laws could be established to deal with the problem emerging from the prohibition.

In addition to the reasons mentioned above, giving the well known related problems to alcohol which discussed in chapter 1, and the perception of alcohol in Saudi Arabia, it is wise to conclude that the illegalisation of alcohol in Saudi Arabia should be continued. Effective efforts to deal with those who drink and/or have drinking problems as well as with those problems emerging from such prohibition should be paid.

To whom the findings may apply?

As to conclude this chapter, someone might think whether the findings of this research could be of any befit to countries other than Saudi Arabia. In spite the fact that the findings showed that some of the characteristics of the Saudi hospitalised problem drinkers are comparable to those in other countries, they might not be of much benefit to those countries where alcohol drinking is permissible. However, the findings as well as their implications could be useful to those Islamic counties where alcohol is prohibited. More specifically, they are very useful in those countries that resemble the situations in Saudi Arabia in terms of the religious, political, economic, social, and cultural aspects in addition to alcohol prohibition. Countries of that nature are like Kuwait, Qatar, and Oman.

Generally, the findings and the recommendations found in this research are very much applicable to alcohol problems in these countries. However, of the findings, there are some that are more applicable than the others. The following are example of some applicable findings to these countries.

Due to the social, economic, religious, and cultural similarities between Saudi Arabia and these Gulf countries, some of the personal and family characteristics of the problem drinkers entering alcohol treatment might also be very similar. However, no literature has been found to support such a claim.

Since drinking is illegal in these countries, so it is very much expected that cologne drinking is common, as a substitute of normal alcoholic beverages. Cologne drinking is reported in Qatar (Al-Eisa, 1983) and in Oman (country profile of Oman, 15 June 2002) for example. Therapists, alcohol educators, policy makers can very much benefit from the recommendations mentioned in this research to deal with the problem of cologne drinking.

Moreover, like Saudi Arabia, because of alcohol prohibition, it is expected in these countries that alcohol consumption occur in hidden places. Such practice, as mentioned earlier, may cause the drinker to drive, to back home, under the influence of alcohol. Therefore, laws pertaining drinking and driving should be established. Alcohol as well as therapists should also educate people about the risks of driving under the influence of alcohol.

Moreover, since alcohol is prohibited, problem drinkers in these countries (like those in Saudi Arabia) may use other drugs in case of alcohol unavailability. in order to reduce the health risks associated with other illegal drug use, therapists in these countries, alcohol and drug educators, and policy makers can apply the recommendations mentioned earlier.

Also, because of the similarities between Saudi Arabia and these countries, it is expected that the stigma of being a drinker or a problem drinker in these countries is hard, and may cause treatment seekers to avoid treatment. as recommended before, encouraging problem drinkers to seek treatment, as well as insuring the privacy of the treatment seeker and the family are some solutions to the problem.

In addition, it is also very much expected that because of the stigma associated with alcohol taking, the family involvement in treatment (like the situation in Saudi Arabia) is ineffective in these countries. If that so, therapists should design and implement treatment programmes that best suits the family in the Arabic Gulf, and insure their involvement in the treatment of their family member.

As it is the case in Saudi Arabia, alcohol as well as drug studies in the Arabic Gulf are very rare. The researcher faced great difficulties in finding enough alcohol-related studies, let alone epidemiological studies. So, a research centre that is aiming at searching alcohol and drug problems in the entire Gulf countries is highly suggested. This research centre should be funded by all of the Gulf countries. Co-operation with researchers from abroad as well as from inside these countries is also recommended.

Finally, although the research findings and their implications are specifically related to hospitalised Saudi problem drinkers, their applicability to other societies depend on the reader and how he/she might benefit from this research.

Summary of recommendations

Recommendations for policy makers

1. Alcohol treatment should, as recommended by many therapists, be available and accessible to everyone.

2. Establishing more effective laws and policies to prevent driving while drinking.

3. More effective laws and policies against Cologne drinking are needed, owing to the serious harm resulting from this.

4. Increasing the number of alcohol and drug treatment facilities so the services can cover all regions in the country.

5. Allowing the private sector to provide alcohol treatment services.

Recommendations for treatment centres (Al-Amal hospitals)

1. Dispelling the ambiguity surrounding certain aspects of alcohol consumption, such as whether an alcohol drinker should be considered a criminal or a patient.

2. Providing treatment services for women and children.

3. Because of the hard stigma associated with drinking, more procedures are needed to insure the privacy of patients.

4. The process of admission and a detailed description of the treatment programmes should be clarified to the patients and the patients' family.

5. To improve the quality of services, the hospital should provide continuous training programmes to its staff.

Recommendations for social work professionals and educators

1. The Social workers in treatment should fully understand the patient in his surrounding environment.

2. The social workers should think about individualised treatment when dealing with patients. Case management approach is more suitable to Saudi problem drinkers.

3. The social workers should develop strategies to encourage the family involvement in treatment.

4. The Social workers should explain the treatment process and the dependence for both the patient and the family.

5. The Social workers should develop a programme to help the patients with job finding.

6. The Social workers should help the patients realise the harm associated with some certain drinking practices like the combination of drinking and the use of other drugs, and cologne drinking.

7. The Social workers should help the patient realise the danger for self and others by driving under the influence of alcohol.

8. The Social workers should work on linking the patients to other human service institutions to meet their needs.

9. The Social workers should concentrate on the psychosocial aspect of those patients who are not alcohol dependants.

10. The Social workers should have a leading role on alcohol education for the patient as well as for the public.

11. The Social workers working in settings other than alcohol treatment should be trained to identify, screen, assess, and briefly intervene with clients and the clients' family with alcohol related problems.

12. Alcohol Courses as well as student internship should be essential part of the curriculum in the social work schools.

13. Social work researchers should have a leading position in conducting studies on the social aspect of alcohol.

Recommendations for researchers

1. Alcohol epidemiological studies are highly needed to explore and assess drinking problem in the country.

2. Studies are needed to explore problem drinking on those who doe not fit profile of hospitalised problem drinkers, and why they, if problem drinking is prevalent among them, do not come for treatment.

3. More investigations are needed to understand the differences between problem drinkers hospitalised in voluntary wards and those hospitalised in involuntary wards in terms of their personality characteristics and motivation for treatment.

4. The prevalence of araq drinking among younger age groups and cologne drinking among older age groups needs further investigation.

5. The consumption of cologne was found to be more prevalent among divorced, separated and widowed respondents, whereas araq was mostly consumed by married respondents. Such findings need more investigation.

6. Although the younger respondents reported a higher rate of consumption, the older respondents reported a greater level of alcohol dependency. Such findings need further investigation.

7. The finding that the main reason for drinking among respondents from Riyadh and Dammam was to forget problems, while for those from Qaseem it was to relieve anxiety, and for those from Jeddah it was to make themselves feel happy, needs more investigation.

8. Although Cutter & O'Farrell (1984) have found a strong association between drinking alone and drinking in order to forget problems, the results here found that only 21.1 percent of those who drank to forget problems reported drinking alone. Such findings also need further investigations.

9. The health hazards associated with smoking of shisha needs comprehensive investigation, especially when it is combined with drinking.

10. The abstinence during the Holy month of Ramadan by the majority of hospitalised problem drinkers deserves more investigation on how to utilise such a fact in treatment.

11. Since most of the hospitalised problem drinkers are low educated, unemployed, and with low income, further investigation are needed to examine whether these characteristics are the result or the cause for problem drinking.

12. There is a need to develop Saudi standardised measures to assess, screen, evaluate various aspects of the drinker and alcohol drinking that are suitable to Saudi society.

13. There is a need to develop an adequate method to quantify alcohol drink (a an agreeable measure of a standard drink) so that it can be used to assess quantity of drinking for treatment and research purposes.

Recommendations for alcohol educators

1. Appropriate strategies for increasing people's awareness of alcohol-related problems, such as choosing the right target, place, and time.

2. More effort and more effective approaches need to be applied to the areas of prevention and treatment.

3. Effective utilisation of the media, local leaders, and famous sportsmen should be carried out to educate people about alcohol related problems.

4. Cologne drinking is very dangerous to health, it should be given special consideration when educating people about the health hazards associated with drinking.

5. Approximately three-quarters of the respondents had their first drink inside the country. Such finding contradicts the public belief that the first drinking experience occurs abroad. Therefore, this new fact should be considered when educational materials are designed.

Appendices

Appendix 1.A

Questionnaire of

Psychosocial Profile

For Saudi Problem Drinkers

Dear patient,

I wish you a fast cure,

As way of introduction, I am a Ph D student conducting a research regarding the psychosocial profile of the problem drinkers hospitalised in Al-Amal hospitals. This study aims at better understanding those suffering from problem drinking so that treatment and prevention programs could be more effective and suitable to Saudi society.

So, allow me to take some of your time in answering this questionnaire. To answer the questions, please read each question carefully and choose the answer that suit you by putting (?) in front of the answer that best suit you.

Please do not forget to answer every question unless you are instructed to. Finally, I would like to assure you that all information you are providing are confidential and will not be used for any purpose other than scientific research.

Thanks again for your co-operation

Researcher Abdulaziz Al-Dakhil

A. *Personal Data*

A.1 How old are you?

Less than 20 years old	1	36-40	5
20-25	2	41-45	6
26-30	3	46-50	7
31-35	4	More than 50	8

A.2 What is your Marital Status?

Never married	1	Separated	4
Now married	2	Widowed	5
Divorced	3		

A.3 What is your current educational status?

Illiterate	1	College	6
Can read and write	2	Post Graduate	7
Elementary	3	Vocational training	8
Intermediate	4	Art Education	9
Secondary	5	Other, Specify _____	10

A.4 What city, village, or hijra do you currently live in?
Please specify _____.

A.5 Is this place of current living a-

City	1	Hijra	3
Village	2		

A.6 For how long have you been living in this place?

Less than a year	1	11-15	4
1-5	2	16-20	5
6-10	3	More than 20 years	6

A.7 What type is your accommodation?

Palace	1	Traditional House	4
Villa	2	Tent	5
Flat	3	Other , specify-------	6

A.8 How many rooms do you have in this accommodation?
DO NOT count kitchen, bathrooms, or halls.

One	1	Six	6
Two	2	Seven	7
Three	3	Eight	8
Four	4	Nine	9
Five	5	More than nine	10

A.9 Is this accommodation-

Owned by you	1	Rented by others	4
Owned by Others	2	Government Housing	5
Rented by you	3	Other, specify ----------	6

A.10 How long have you been living in this accommodation?

Less than a year	1	11-15	4
1-5	2	16-20	5
6-10	3	More than 20 years	6

A.11 From the following list, select those persons who are currently living with you:

None	1	Wife -------	6
Father	2	Children	7
Mother	3	Other relatives	8
Brothers --------	4	Friends	9
Sisters --------	5	Others, specify -----	10

A.12 What is the total number of people currently living with you in the same accommodation?

0	1	7-9	4
1- 3	2	10-12	5
4-6	3	More than 12	6

A.13 Since when have you been living with these people?

Less than a year	1	11-15	4
1-5	2	16-20	5
6-10	3	More than 20 years	6

A.14 What is your monthly income?

Less than £ 500	1	1501-2000	4
500-1000	2	More than 2000	5
1001-1500	3		

A.15 From the following list, select your source of income:

Employment	1	Social Insurance	4
Investment	2	Charity	5
Family	3	Other, specify -------	6

A.16 From the following list, select those persons for whom you are financially responsible:

None	1	Wife -------	6
Father	2	Children	7
Mother	3	Other relatives	8
Brothers --------	4	Friends	9
Sisters --------	5	Others, specify -----	10

A.17 Do you currently have a job?

Yes	1	No	2

A.18 What is your current or past occupation?

Government Employee (civil)	1	Private sector Employee	4
Government Employee (military)	2	Others, specify ------ ---------	5

self-employed [3]

A.19 What is the nature of your current or past job?

Clerical	1	Farming	5
Vocational	2	Teaching	6
Trading	3	Art	7
Industrial	4	Other, specify -------	8

A.20 How long ago was your longest full time job?

Never had a full-time job	1	6-10	4
Less than a year	2	11-15	5
1-5	3	More than 15	6

A.21. If you currently do not have a job, select the statement that best describe your situation:

I have never had a job	1
I am still a Student	2
I used to have a job, but I got fired	3
I used to have a job, but I left it	4
I used to have a job, but I resigned	5
I am retired	6

A.22 Have you ever lost a job because of drinking?

Yes [1] No [2]

A.23 How troubled or bothered have you been by these employment problems?

Not at all	Slightly	Moderately	Considerably	extremely
1	2	3	4	5

A.24 How important to you now is solving these employment problems?

Not at all	Slightly	Moderately	Considerably	extremely
1	2	3	4	5

A.25. What is your most preferred Hobby: (select one)

None	1	Writing	6
Sports	2	Poetry	7
Music	3	TV watching	8
Painting	4	Other, specify -------	9
Reading	5		

A.26 Are you still practising this hobby?

Yes [1] No [2] Some times [3]

B. Family Status

B.1 From the following list, select the statement that best describe your parents' situation. (Only select one)

My parents are a live and they are living together	1
My parents are alive but they are divorced	2
My parents are alive but they are separated	3
Both of my parents are dead	4
My father is alive but my mother is dead	5
My mother is alive but my father is dead	6
Other specify, ----------	7

B.2 If your parents are not living together any more, since when they were in this state?

Less than a year	1	11-15	4
1-5	2	16-20	5
6-10	3	More than 20 years	6

B.3 What is your father 's educational status?

Illiterate	1	College	6
Can read and write	2	Post Graduate	7
Elementary	3	Vocational training	8
Intermediate	4	Art Education	9
Secondary	5	Other, Specify	10

B.4 What is your mother's educational status?

Illiterate	1	College	6
Can read and write	2	Post Graduate	7
Elementary	3	Vocational training	8
Intermediate	4	Art Education	9
Secondary	5	Other, Specify	10

B.5 Has your father had more than one wife?

Yes [1] No [2]

B.6 If yes, how many times has your father got married to a woman other than your mother?

One time	1	Four times	4
Two times	2	More than four	5
Three times	3		

B.7 If your father has got married to a woman other than your mother, has one of those marriages occurred during your childhood?

Yes [1] No [2]

B.8 Has your mother got married to someone other than your father?

Yes [1] No [2]

B.9 If yes, has this occurred during your childhood?

Yes [1] No [2]

IF YOU ARE NOW OR PREVIOUSLY MARRIED, ANSWER QUESTIONS 10-15. IF YOU HAVE NEVER MARRIED, SKIP TO QUESTION B18.

B.10 How old is your wife? (IF MARRIED TO MORE THAN ONE WIFE, STATE THE LAST ONE).

Less than 20 years old	1	36-40	5
20-25	2	41-45	6
26-30	3	46-50	7
31-35	4	More than 50	8

B.11 What is your wife' s educational status? (IF MARRIED TO MORE THAN ONE WIFE, STATE THE LAST ONE).

Illiterate	1	College	6
Can read and write	2	Post Graduate	7
Elementary	3	Vocational training	8
Intermediate	4	Other	9
Secondary	5	Specify _____	

B.12 What is/was the last occupation of your wife?

Please specify _____

B.13 What is the total number of your marriages?

None	1	Two times	3
One time	2	More than two	4

B.14 How many wives do you currently have?

0	1	Three	4
One	2	Four	5
Two	3		

B.15 How many children do you have?

None	1	Four Children	5
One Child	2	Five Children	6
Two Children	3	Six Children	7
Three Children	4	More than six	8

B.16 The following are statements related to your living experience with your family during your childhood and adolescence. I would like you for each statement to indicate how strongly you agree or disagree by ticking the most appropriate response for you.

B.16.a My family treated me very harsh.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

B.16.b My family never understood me.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

B.16.c The relationship between my family and me was excellent.

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

B.16.d My family used to help me financially.

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

B.16.e My family loved me very much.

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

B.16.f The relationship between my parents was excellent.

Strongly disagree	Disagree	Agree	Strongly agree
4	3	2	1

B.16.g My parents loved my brothers and sisters more than they loved me.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

B.16.h I did not like my father.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

B.16.i I did not like my mother.

Strongly disagree	Disagree	Agree	Strongly agree
1	2	3	4

B.16.j I have lived a happy childhood compared to other peers in the neighbourhood.

Strongly disagree	Disagree	Agree	Strongly agree

4	3	2	1

C *Alcohol consumption*

C.1 What age were you when you had had your first drink?

Less than 15 years old	1	31-35	5
15-20	2	36-40	6
21-25	3	41-45	7
26-30	4	More than 45	8

C.2 What type of liquor was your first drink?

Araq	1	Cologne	4
Beer	2	Spirits	5
Wine	3		

C.3 How did you get it?

From a friend	1	From a store or bar	4
From a relative	2	I made it myself	5
From a dealer	3	Other, specify -------	6

C.4 Your first experience of drinking was:

Inside the country [1] Abroad [2]

C.5 If your first drinking experience was abroad, in what country was it?

Please, specify ----------.

C.6 Your first experience with drinking was-

With a friend	1	With a school-mate	4
With a relative	2	Alone	5
With a work-mate	3	Other, specify -------	6

C.7 When you drank for the first time, did you get drunk?

Yes [1] No [2] Do not know [3]

C.8 When you drank for the first time, did you vomit?

Yes [1] No [2] Do not know [3]

C.9 How do you describe your feelings of the first drinking experience?

Exciting [1] Bad [2] Do not know [3]

C.10 How long did it take you after your first drinking experience to drink in a regular basis?

Immediately after my first experience	1	4-6 years later	4
Less than a year later	2	7-9 years later	5
1-3 years later	3	More than 9 years later	6

D *Current Drinking Behaviour*

D.1 What is your most consumed drink? (SELECT ONLY ONE TYPE)

Araq	1	Cologne	4
Beer	2	Spirits	5
Wine	3		

D.2 What is your most favourite drink? (SELECT ONLY ONE TYPE)

Araq	1	Cologne	4
Beer	2	Spirits	5
Wine	3		

D.3 When drinking, do you normally mix the drink with another material? (ex. Water, soft drink).

Yes [1] No [2] Some times [3]

D.4 With who do you usually have your drink:

With a friend	1	With a school-mate	4
With a relative	2	Alone	5
With a work-mate	3	Other, specify -------	6

D.5 Where do you usually have your drink?

At home	1	Outside the city	4
At others' house	2	Other, specify -------	5
At a private resort	3		

D.6 In what days of the week do usually drink?

Work days [1] Weekends [2] Any day [3]

D.7 The following statements are related to your feelings of fear in situations when you are drinking or immediately after having a few drinks BUT NOT DRUNK. I would like you for each statement to select the appropriate response that best describe your feelings of fear.

D.7.a I feel afraid of being caught by authorities.

Not at all	Slightly	Moderatel y	Considerabl y	extremely
1	2	3	4	5

D.7.b I feel afraid of being seen by some one I know.

Not at all	Slightly	Moderatel y	Considerabl y	extremely
1	2	3	4	5

D.7.c I feel afraid of being seen by any one.

Not at all	Slightly	Moderatel y	Considerabl y	extremely
1	2	3	4	5

D.7.d I feel afraid of being seen by a friend.

Not at all	Slightly	Moderatel y	Considerabl y	extremely
1	2	3	4	5

D.7.e I feel afraid of being seen by a member of the family.

Not at all	Slightly	Moderatel y	Considerabl y	extremely
1	2	3	4	5

D.8 Now, the following statements are related to your feelings of fear in situations when you are DRUNK. I would like you for each statement to select the appropriate response that best describe your feelings of fear.

D.8.a I feel afraid of being caught by authorities.

Not at all	Slightly	Moderatel y	Considerabl y	extremely
1	2	3	4	5

D.8.b I feel afraid of being seen by some one I know.

Not at all	Slightly	Moderatel y	Considerabl y	extremely
1	2	3	4	5

D.8.c I feel afraid of being seen by any one.

Not at all	Slightly	Moderatel y	Considerabl y	extremely
1	2	3	4	5

D.8.d I feel afraid of being seen by a friend.

Not at all	Slightly	Moderatel y	Considerabl y	extremely
1	2	3	4	5

D.8.e I feel afraid of being seen by a member of the family.

Not at all	Slightly	Moderatel y	Considerabl y	extremely
1	2	3	4	5

D.9 Since when did you start feeling that you have a drinking problem?

I don't have a drinking problem	1	4-6 years ago	4
Less than a year ago	2	7-9 years ago	5
1-3 years ago	3	More than 9 years ago	6

D.10 Why do you drink?

(PLEASE RANK THE REASONS FOR YOUR DRINKING BY ASSIGNING A NUMBER RANGING FROM 1-8. 1 IS THE MOST IMPORTANT REASON, 2 THE LESS IMPORTANT REASON AND SO ON).

1	To relax	
2	To release anxiety	
3	To forget problems	
4	To enhance my sexual ability	
5	To respond to my friends pressure	
6	To feel happy	
7	Only for the sake of drink	
8	Others, specify ----------	

D.11 How much does alcohol cost you a month?

Less than £100	1	151-200	3
100-150	2	more than £200	4

D.12 From where do you usually get your drink?

From a friend	1	From a store or bar	4
From a relative	2	I made it myself	5
From a dealer	3	Other, specify -------	6

E Smoking History

E.1 Do you smoke?

Yes [1] No [2] Some times [3]

(IF YOU ARE A SMOKER OR YOU SMOKE SOMETIMES, ANSWER QUESTIONS E2-E8. IF YOU DON'T, SKIP TO THE NEXT SECTION).

E.2 What is your preferred smoke?

Cigarettes	1	Cigarettes and shisha	3
Shisha	2	Other, specify -------	4

E.3 When did you start smoking?

Prior to my drinking	1	After I started drinking	3
At the same time I started drinking	2		

E.4 If you smoke cigarettes, how many packs a day do you smoke?

One	1	Three	3
Two	2	More than three	4

E.5 If you use shisha, how many times do you smoke a day?

Once	1	Three	3
Twice	2	More than three	4

E.6 If you use shisha, how many heads do you have per occasion?

One	1	Three	3
Two	2	More than three	4

E.7 How troubled or bothered have you been by these smoking problems?

Not at all	Slightly	Moderately	Considerably	extremely
1	2	3	4	5

E.8 How important to you now is treatment for these smoking problems?

Not at all	Slightly	Moderately	Considerably	extremely
1	2	3	4	5

F Health Status

F.1 How many times, during the last year, have you visited a physician to seek a treatment?

None [1] Three times [4]
One time [2] More than three [5]
Two times [3]

F.2 How many times in your life have you been hospitalised? (DO NOT COUNT ADDICTION TREATMENT HOSPITALZATION).

None [1] Three times [4]
One time [2] More than three [5]
Two times [3]

F.3 How long ago was your last hospitalisation for a physical problem?

Less than a year ago [1] 7-10 years ago [4]
1-3 years ago [2] 11-14 years ago [5]
4-6 years ago [3] More than 14 years ago [6]

F.4 Do you have any chronic medical problems, which continue to interfere with your life?

Yes [1] No [2]

F.5 If yes, specify ----------

F.6 How long ago did you have this medical problem?

Less than a year ago [1] 7-10 years ago [4]
1-3 years ago [2] 11-14 years ago [5]
4-6 years ago [3] More than 14 years ago [6]

F.7 Have you ever visited a psychiatrist for treatment of emotional or psychological problem?

Yes [1] No [2]

F.8 If yes, please specify ---------.

F.9 If yes, how long ago was this visit?

Less than a year ago [1] 7-10 years ago [4]
1-3 years ago [2] 11-14 years ago [5]
4-6 years ago [3] More than 14 years [6]

[ ] ago [ ]

F.9 If yes, have you been hospitalised for this problem?

Yes [1] No [2]

F.10 How troubled or bothered have you been by these health problems?

Not at all	Slightly	Moderately	Considerably	extremely
1	2	3	4	5

F.11 How important to you now is treatment for these health problems?

Not at all	Slightly	Moderately	Considerably	extremely
1	2	3	4	5

G Legal Status

G.1 Is this admission prompted or suggested by criminal justice system (judge, police, religious authority, etc).

Yes [1] No [2]

G.2 Have you ever been arrested?

Yes [1] No [2]

(IF YOU ANSWER YES TO THE PREVIOUS QUESTION, ANSWER THE REMAINING QUESTIONS OF THIS SECTION. IF YOUR ANSWER IS NO, SKIP TO TE NEXT SECTION).

G.3 Please state why you have been arrested:

Because of drinking [1]
Because of Driving while drunk [2]
Because of Fighting while drunk [3]
Other reason not related to drinking. Specify, ------- [4]

G.4 How long ago was your last arrest?

Less than a year ago [1] 7-10 years ago [4]
1-3 years ago [2] 11-14 years ago [5]
4-6 years ago [3] More than 14 years ago [6]

G.5 Have you ever been imprisoned due to drinking?

None [1] Three times [4]
One time [2] More than three [5]
Two times [3]

G.6 If *you* have been imprisoned, for any reason, How long ago was your last imprisonment?

Less than a year ago [1] 7-10 years ago [4]
1-3 years ago [2] 11-14 years ago [5]
4-6 years ago [3] More than 14 years ago [6]

G.7 Are you presently awaiting charges, trial or sentence?

Yes [1] No [2]

G.8 How troubled or bothered have you been by these legal problems?

Not at all	Slightly	Moderately	Considerably	extremely
1	2	3	4	5

G.9 How important to you now is solving these legal problems?

Not at all	Slightly	Moderately	Considerably	extremely
1	2	3	4	5

H *Other drugs*

H.1 Have you ever used any of the following materials?

Heroin

Never	once	More than once	Used it in the past	Still using it
1	2	3	4	5

Hashish

Never	once	More than once	Used it in the past	Still using it
1	2	3	4	5

Barbiturates

Never	once	More than once	Used it in the past	Still using it
1	2	3	4	5

Amphetamines

Never	once	More than once	Used it in the past	Still using it
1	2	3	4	5

Inhalants

Never	once	More than once	Used it in the past	Still using it
1	2	3	4	5

Hallucinogens

Never	once	More than once	Used it in the past	Still using it
1	2	3	4	5

Others ----------

Never	once	More than once	Used it in the past	Still using it
1	2	3	4	5

H.2 If you have used any of these substances, has any of this usage occurred prior to drinking?

Yes [1] No [2]

H.3 If you have used other drugs in the past but you stopped them, state why you did so:
(PLEASE, SELECT ONE RESPONSE ONLY)

I did not like it	1	I got treated	5
Alcohol is a good substitute	2	Alcohol is less addictive	6
Alcohol has a lesser punishment	3	Alcohol is less harmful	7
This drug was hard to get	4	I can not afford it	8

H.4 If you are still using other drugs, state why:

Other drugs are as same as alcohol	1	Using more than one drug get me higher	4
I like to combine alcohol with other drugs	2	I can not get rid of it	5
I use what a available to me	3	Other, specify-------- ----------	6

I *Family alcohol, drugs and psycho history*

I.1 Have any of your relatives had what you would call a significant drinking, drug use or psycho problem?

Yes [1] No [2]

I.2 If yes, please indicate your relationship to that person and the type of the problem.

	Relationship e.g. father, brother, or uncle, etc.	Problem e.g. alcohol, drug, or psycho.
Relative 1	----------	----------
Relative 2	----------	----------
Relative 3	----------	----------

I.3 Do you live with anyone who has alcohol problem?

Yes [1] No [2]

I.4 Do you live with anyone who has a drug problem?

Yes [1] No [2]

J *Family/Social relations*

J.1 With whom do you spend most of your free time?

Family [1] Friends [2] Alone [3]

J.2 Are you satisfied with spending your free time this way?

Yes [1] No [2]

J.3 How many close friends do you have?

None [1] 7-9 [4]
1-3 [2] More than 9 [5]
4-6 [3]

J.4 How strong is your relation with the following people?

	Very weak	weak	mild	strong	Very strong
Father	1	2	3	4	5
Mother	1	2	3	4	5
Wife	1	2	3	4	5
Children	1	2	3	4	5
Brother	1	2	3	4	5
Sister	1	2	3	4	5
Friends	1	2	3	4	5

J.5 During your drinking problem, have you had problem getting along with:

Father	yes	1	No	2
Mother	yes	1	No	2
Wife	yes	1	No	2
Children	yes	1	No	2
Close Friends	yes	1	No	2
Neighbours	yes	1	No	2
Co-workers	yes	1	No	2
Class-mate	yes	1	No	2
Other relatives	yes	1	No	2
Others, specify,--	yes	1	No	2

J.6 Did any of these people abuse you?

Emotionally	Yes	1	No	2
Physically	Yes	1	No	2
Sexually	Yes	1	No	2

J.7 Does any one still help you financially?

Yes [1] No [2]

J.8 If yes, please state who help you financially. (e.g. father, mother, wife,etc)

a.----------.
b.----------.
c.----------.

J.9 If married, prior to your marriage was your wife aware of your drinking?

Yes [1] No [2]

J.10 Whose in the family is aware about your drinking?

Father [1] Wife [5]
Mother [2] Son [6]
Brother [3] Daughter [7]
Sister [4] Other, specify--- ---- [8]

J.11 Who in your family is the most concerned about your drinking? (PLEASE, SELECT ONE CHOICE).

Father [1] Wife [5]
Mother [2] Son [6]
Brother [3] Daughter [7]
Sister [4] Other, specify--- --- [8]

J.12 What is your family's standpoint of your drinking problem? (PLEASE, SELECT ONE CHOICE).

They advised me not drink again [ ]
They do not care [ ]
They treated me bad [ ]
They tried to solve the problem within the family [ ]
They expelled me from home [ ]
They discussed the problem with me dialectically. [ ]
Other, specify ---------- [ ]

J.13 How troubled or bothered have you been in the past three-month by family problems?

Not at all	Slightly	Moderately	Considerably	extremely
1	2	3	4	5

J.14 How troubled or bothered have you been in the past three-month by Social problems?

Not at all	Slightly	Moderately	Considerably	extremely
1	2	3	4	5

J.15 How important to you now is solving these family problem?

Not at all	Slightly	Moderately	Considerably	extremely
1	2	3	4	5

J.16 How important to you now is solving these social problem?

Not at all	Slightly	Moderately	Considerably	extremely
1	2	3	4	5

K Religious practices

K.1 How often do you perform the following religious practices?

	Prior to drinking				During drinking			
Prayers	**Always**	**Most of the time**	**Seldom**	**Never**	**Always**	**Most of the time**	**Seldom**	**Never**
	1	2	3	4	1	2	3	4
Prayers on time	**Always**	**Most of the time**	**Seldom**	**Never**	**Always**	**Most of the time**	**Seldom**	**Never**
	1	2	3	4	1	2	3	4
Prayers in Mosque	**Always**	**Most of the time**	**Seldom**	**Never**	**Always**	**Most of the time**	**Seldom**	**Never**
	1	2	3	4	1	2	3	4
Going to Mosque	**Always**	**Most of the time**	**Seldom**	**Never**	**Always**	**Most of the time**	**Seldom**	**Never**
	1	2	3	4	1	2	3	4
Friday prayer	**Always**	**Most of the time**	**Seldom**	**Never**	**Always**	**Most of the time**	**Seldom**	**Never**
	1	2	3	4	1	2	3	4
Fasting Ramadan	**Always**	**Most of the time**	**Seldom**	**Never**	**Always**	**Most of the time**	**Seldom**	**Never**
	1	2	3	4	1	2	3	4
Attending religious lectures	**Always**	**Most of the time**	**Seldom**	**Never**	**Always**	**Most of the time**	**Seldom**	**Never**
	1	2	3	4	1	2	3	4

K.2 Have ever performed Haj? Yes [1] No [2] Yes [1] No [2]

K.3 Have ever performed Umra? Yes [1] No [2] Yes [1] No [2]

K.4 If prayer time comes while you are drinking, what would you do?

Make up prayer some other time	1
Perform prayer immediately	2
Not performing the prayer completely	3
Other, specify ----------	4

K.5 What do you do during Ramadan about your drinking?

I completely abstain from drinking	1
I only drink in the evenings	2
I drink day and night	3
Other, specify ----------	4

L Treatment Attempts:

L.1 How many times have you been hospitalised for the treatment of your drinking problem?
(Please specify the Number of all previous and current treatment attempts) _____ .

L.2 How long have you been hospitalised in this hospital?

Less than a week	1	Less than 4 weeks	4
Less than 2 weeks	2	4 weeks or more	5
Less than 3 weeks	3		

The following timetable is concerning your treatment attempts (including this time). I would like to remember the last four treatment attempts when answering these questions.

L.3 No of admission	L.4 Source of admission (Please tick all that apply)	L.5 Length of stay	L.6Hospital
1st	Self ❒1 family ❒2 friend ❒3 police ❒4 work ❒5 Religious authority ❒6	Less than 1 month ❒1 One month ❒2 Two months ❒3 Three months ❒4 More than three ❒5	Alamal Jeddah ❒1 Alamal Riyadh ❒2 Alamal Damam ❒3 Alamal Qassem ❒4 Private clinic ❒5 Abroad ❒6
2nd	Self ❒1 family ❒2 friend ❒3 police ❒4 work ❒5 Religious authority ❒6	Less than 1 month ❒1 One month ❒2 Two months ❒3 Three months ❒4 More than three ❒5	Alamal Jeddah ❒1 Alamal Riyadh ❒2 Alamal Damam ❒3 Alamal Qassem ❒4 Private clinic ❒5 Abroad ❒6
3rd	Self ❒1 family ❒2 friend ❒3 police ❒4 work ❒5 Religious authority ❒6	Less than 1 month ❒1 One month ❒2 Two months ❒3 Three months ❒4 More than three ❒5	Alamal Jeddah ❒1 Alamal Riyadh ❒2 Alamal Damam ❒3 Alamal Qassem ❒4 Private clinic ❒5 Abroad ❒6
4th	Self ❒1 family ❒2 friend ❒3 police ❒4 work ❒5 Religious authority ❒6	Less than 1 month ❒1 One month ❒2 Two months ❒3 Three months ❒4 More than three ❒5	Alamal Jeddah ❒1 Alamal Riyadh ❒2 Alamal Damam ❒3 Alamal Qassem ❒4 Private clinic ❒5 Abroad ❒6

L.7 If previously admitted, time between last discharge and use of alcohol (lapse):

Less than a week	1	4-6 months	4
1-4 weeks	2	can not remember	5
1-3 months	3		

L.8 If previously admitted, time between last discharge and regular use of alcohol (relapse):

Less than a week	1	4-6 months	4
1-4 weeks	2	can not remember	5
1-3 months	3		

L.9 What is your motive behind coming to hospital this time: (select one choice).

To stop drinking	1
To satisfy others	2
To regain my health	3
Because I have been brought here by authority	4
Others, specify ----------	5

Appendix 1.B

استمارة

الجوانب الاجتماعية النفسية

للكحوليين

المنومين في مستشفيات الأمل

في المملكة العربية السعودية

بسم الله الرحمن الرحيم

عزيزي المريض . . . . . أتمنى لك شفاء عاجلا

كمقدمة، أنا طالب في مرحلة الدكتوراه، أقوم بدراسة الجوانب الاجتماعيـــة والنفســية للكحوليين المنومين في مستشفيات الأمل في المملكة العربية السعودية. تلك الدراسة التي تهدف بعد التعـــرف على تلك الجوانب والخصائص إلى تصميم واعداد البرامج العلاجية والوقائيـــة الملائمـــة للمجتمـــع السعودي.

لذا اسمح لي عزيزي المريض أن آخذ من وقتك كي تجيب على الأسئلة الواردة في تلك الاستمارة. فبعد قراءة الأسئلة الواردة بعناية تامة، آمل منك التعاون في الإجابة على كل سؤال عن طريق وضع علامة (✓) في المربع الموجود أمام الإجابة التي تعتقد بأنها صحيحة بالنسبة لك.

كما أود منك أن لا تترك سؤالا دون إجابة، حيث أن ذلك النقص يؤثر كثيرا في نتائج الدراســـة، إلا عندما يطلب منك ذلك من خلال التعليمات الموجودة داخل الاستمارة.

أخير، أود أن تعرف أن المعلومات التي تدلي بها ستعامل بسرية ولن تستخدم إلا لأغـــراض البحـــث العلمي، علما أن ذكر الاسم غير مطلوب.

هذا ولك جزيل شكري على تعاونك

مع تمنياتي لـــك بالشـــفاء

الباحث/ عبد العزيز الدخيل

أ. معلومات أولية

١. ما عمرك؟

أقل من ٢٠ سنة	١	٣٦-٤٠	٥
من ٢٠-٢٥	٢	٤١-٤٥	٦
٢٦-٣٠	٣	٤٦-٥٠	٧
٣١-٣٥	٤	أكثر من ٥٠	٨

٢. ما حالتك الاجتماعية؟

لم يسبق لي الزواج	١	مطلق	٤
حاليا متزوج	٢	أرمل	٥
منفصل	٣		

٣. ما مستواك التعليمي؟ (آخر شهادة حصلت عليها).

أمي	١	الشهادة الجامعية	٦
يقرأ ويكتب	٢	دراسات عليا	٧
الشهادة الابتدائية	٣	تدريب مهني	٨
الشهادة المتوسطة	٤	تعليم فني	٩
الشهادة الثانوية	٥	أخرى تذكر -----	١٠

٤. في أي مدينة أو قرية أو هجرة تقيم حاليا؟

أذكر ذلك ---------- .

هل مكان الإقامة هذا _

مدينة؟	١	هجرة؟	٣
قرية؟	٢		

٥. منذ متى وأنت تقيم في ذلك المكان؟ (المدينة أو القرية أو الهجرة)

منذ أقل من سنة	١	١١-١٥ سنة	٤
١-٥ سنوات	٢	١٦-٢٠ سنة	٥
٦-١٠ سنوات	٣	أكثر من ٢٠ سنة	٦

٦. ما نوع السكن الذي تعيش فيه؟

قصر	١	بيت شعبي	٤
فيلا	٢	بيت شعر (خيمة)	٥
شقة	٣	أخرى، تذكر --------	٦

٧. كم غرفة توجد في هذا السكن؟ (لا تعد المطبخ، الحمامات، الصالات).

غرفة	١	٦ غرف	٦
غرفتين	٢	٧ غرف	٧
٣ غرف	٣	٨ غرف	٨
٤ غرف	٤	٩ غرف	٩
٥ غرف	٥	أكثر من ٩ غرف	١٠

٨. هل هذا المسكن_

ملك لك	١	مستأجر بواسطة أحد غيرك	٤
ملك لأحد غيرك	٢	إسكان حكومي	٥
مستأجر بواسطتك	٣	آخر، يذكر --------	٦

٩. منذ متى وأنت تقيم في ذلك المسكن؟

منذ أقل من سنة	١	١١-١٥ سنة	٤
١-٥ سنوات	٢	١٦-٢٠ سنة	٥
٦-١٠ سنوات	٣	أكثر من ٢٠ سنة	٦

١٠. من القائمة التالية، ضع علامة ✓ أمام الأشخاص الذين يسكنون معك حاليا؟

لا أحد	١	زوجة	٦
الوالد	٢	أطفال	٧
الوالدة	٣	أقارب آخرون	٨
أخوه	٤	أصدقاء	٩
أخوات	٥	آخرون، تذكر ----	١٠

١١. ما العدد الكلي للأشخاص الذين يسكنون معك حاليا؟

لا أحد	١	٥-٧ أشخاص	٤
١-٣ أشخاص	٢	٨-١٠ أشخاص	٥
٤-٦ أشخاص	٣	أكثر من ١٠ أشخاص	٦

١٢. منذ متى وأنت تعيش مع هؤلاء الناس؟

منذ أقل من سنة	١	١١-١٥ سنة	٤
١-٥ سنوات	٢	١٦-٢٠ سنة	٥
٦-١٠ سنوات	٣	أكثر من ٢٠ سنة	٦

١٣. ما مستوى دخلك الشهري؟ (شاملا الراتب، الاستثمارات، الاعانات، وغير ذلك)

أقل من ٣٠٠٠ ريال	١	٧٠٠١-٩٠٠٠	٤
٣٠٠٠-٥٠٠٠	٢	أكثر من ٩٠٠٠ ريال	٥
٥٠٠١-٧٠٠٠	٣		

١٤. من القائمة التالية، اختر مصادر دخلك.(يمكنك اختيار أكثر من إجابة).

الوظيفة	١	الضمان الاجتماعي	٤
استثمارات	٢	الاعانات	٥
الأسرة	٣	أخرى، تذكر --------	٦

١٥. من القائمة التالية، اختر هؤلاء الأشخاص الذين تعتبر مسؤولا عنهم ماليا.(يمكنك اختيار أكثر من إجابة).

لا أحد	١	زوجة	٦
الوالد	٢	أطفال	٧
الوالدة	٣	أقارب آخرون	٨
أخوه	٤	أصدقاء	٩
أخوات	٥	آخرون، تذكر ----	١٠

١٦. هل لديك عمل حاليا؟

نعم	١	لا	٢

١٧. ما هو عملك الحالي؟ (إذا لم يكن لديك عملا حاليا أذكر عملك السابق).

موظف حكومي (مدني)	١	أعمال حرة	٤
موظف حكومي (عسكري)	٢	أخرى، تذكر --------	٥
موظف قطاع خاص	٣		

١٨. ما طبيعة عملك الحالي أو (السابق)؟

إداري	١	زراعي	٥
مهني	٢	تعليمي	٦
تجاري	٣	فني	٧
صناعي	٤	أخرى، تذكر --------	٨

١٩. متى كانت آخر وظيفة عملت بها بشكل دائم؟

لم يسبق أن عملت	١	٦-١٠ سنوات	٤
منذ أقل من سنة	٢	١١-١٥ سنة	٥
١-٥ سنوات	٣	أكثر من ١٥ سنة	٦

٢٠. إذا كنت لا تعمل حاليا، فاختر من القائمة التالية الجملة الأكثر مناسبة والتي تصف السبب وراء وضعك الوظيفي الحالي. (إجابة واحدة فقط).

لم يسبق لي الحصول على عمل	١
لم يسبق لي العمل لأني لا زلت طالبا	٢
كنت أعمل لكني فصلت من الوظيفة	٣
كنت أعمل لكني تركت الوظيفة	٤
كنت أعمل لكني استقلت من الوظيفة	٥
كنت أعمل لكني تقاعدت من الوظيفة	٦

٢١. هل سبق أن فقدت وظيفة بسبب مشكلتك مع الشرب؟

نعم	١	لا	٢

٢٢. إلى أي حد أنت منزعج من وضعك الوظيفي؟

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

٢٣. إلى أي حد يهمك حل تلك المشكلات الوظيفية؟

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

٢٤. ما أكثر هواية مفضلة لديك؟ (اختر هواية واحدة فقط)

لا شيء	١	الكتابة	٦
الرياضة	٢	كتابة الشعر	٧
الموسيقى	٣	مشاهدة التلفزيون	٨
الرسم	٤	أخرى، تذكر -----	٩
القراءة	٥		

٢٥. هل لا زلت تمارس تلك الهواية؟

نعم [١] لا [٢]

ب. تاريخ الأسرة

١. من القائمة التالية اختر الجملة التي تصف وضع والديك. (اختر اجابة واحدة فقط).

والدي ووالدتي على قيد الحياة ويعيشان معا	١
والدي ووالدتي على قيد الحياة ولكنهما مطلقان	٢
والدي ووالدتي على قيد الحياة ولكنهما منفصلان	٣
كلا والداي متوفيان	٤
والدي على قيد الحياة لكن والدتي متوفاة	٥
والدتي على قيد الحياة لكن والدي متوفى	٦
آخر، يذكر ----------	٧

٢. إذا كان والداك لا يعيشان معا، فمنذ متى وهما لا يعيشان معا؟

منذ أقل من سنة	١	١١-١٥ سنة	٤
١-٥ سنوات	٢	١٦-٢٠ سنة	٥
٦-١٠ سنوات	٣	أكثر من ٢٠ سنة	٦

٣. ما مستوى والدك التعليمي؟ (آخر شهادة تعليمية).

أمي	١	الشهادة الجامعية	٦
يقرأ ويكتب	٢	دراسات عليا	٧
الشهادة الابتدائية	٣	تدريب مهني	٨
الشهادة المتوسطة	٤	تعليم فني	٩
الشهادة الثانوية	٥	أخرى تذكر -----	١٠

٤. ما مستوى والدتك التعليمي؟ (آخر شهادة).

أمية	١	الشهادة الجامعية	٦
تقرأ وتكتب	٢	دراسات عليا	٧
الشهادة الابتدائية	٣	تدريب مهني	٨
الشهادة المتوسطة	٤	تعليم فني	٩
الشهادة الثانوية	٥	أخرى تذكر -----	١٠

٥. هل سبق لوالدك أن تزوج بامرأة أخرى غير والدتك؟

نعم [١] لا [٢]

٦. إذا كانت الاجابة بنعم، فكم مرة سبق لوالدك الزواج بامرأة أخرى غير والدتك؟

مرة واحدة	١	أربع مرات	٤
مرتان	٢	أكثر من أربع مرات	٥
ثلاث مرات	٣		

٧. إذا كان والدك قد سبق له الزواج بامرأة أخرى غير والدتك، فهل حدثت إحدى تلك الزيجات خلال طفولتك؟

نعم [١] لا [٢]

٨. هل سبق لوالدتك الزواج برجل غير والدك؟

نعم [١] لا [٢]

٩. إذا كانت والدتك قد سبق لها الزواج برجل آخر غير والدك، فهل حدثت إحدى تلك الزيجات خلال طفولتك؟

نعم [١] لا [٢]

إذا كنت متزوجا الآن أو قد سبق لك الزواج فاجب عن الأسئلة من ١٠-١٥. أما إذا لم يسبق لك الزواج، فانتقل إلى السؤال ١٥.

١٠. ما عمر زوجتك؟ (إذا كان هناك أكثر من زوجة فاذكر عمر الزوجة الأخيرة).

١	أقل من ٢٠ سنة	٥	٣٦-٤٠ سنة
٢	٢٠-٢٥ سنة	٦	٤١-٤٥ سنة
٣	٢٦-٣٠ سنة	٧	٤٦-٥٠ سنة
٤	٣١-٣٥ سنة	٨	أكثر من ٥٠ سنة

١١. ما مستوى الزوجة التعليمي؟ (آخر شهادة).

١	أمي	٦	الشهادة الجامعية
٢	يقرأ ويكتب	٧	دراسات عليا
٣	الشهادة الابتدائية	٨	تدريب مهني
٤	الشهادة المتوسطة	٩	تعليم فني
٥	الشهادة الثانوية	١٠	أخرى تذكر -----

١٢. ما هي آخر وظيفة لزوجتك؟

فضلا، أذكرها _ _ _ _ _ _ _ _ _ _ _ _ _.

١٣. كم مرة تزوجت؟

١	لم يسبق لي الزواج	٣	مرتين
٢	مرة	٤	أكثر من مرتين

١٤. كم لديك من زوجة حاليا؟

١	ليس لدي أي زوجة	٤	٣ زوجات
٢	زوجة	٥	٤ زوجات
٣	زوجتان		

١٥. كم لديك من الأطفال؟

١	ليس لدي أطفال	٥	٤ أطفال
٢	طفل واحد	٦	٥ أطفال
٣	طفلان	٧	٦ أطفال
٤	٣ أطفال	٨	أكثر من ٦ أطفال

تتعلق العبارات التالية بخبراتك مع عائلتك خلال مرحلتي الطفولة والمراهقة. أود منك أن تذكر مدى موافقتك أو عدم موافقتك بوضع علامة ✓ في سلم الدرجات الموجود أسفل كل عبارة من العبارات التالية.

١٦.أ. كانت أسرتي تعاملني بقسوة.

غير موافق بشدة	غير موافق	موافق	موافق بشدة
١	٢	٣	٤

١٦.ب. لم تفهمني أسرتي مطلقا.

غير موافق بشدة	غير موافق	موافق	موافق بشدة
١	٢	٣	٤

١٦.ج. كانت العلاقة بيني وبين أسرتي ممتازة.

غير موافق بشدة	غير موافق	موافق	موافق بشدة
١	٢	٣	٤

١٦.د. كانت أسرتي تبخل علي ماديا.

غير موافق بشدة	غير موافق	موافق	موافق بشدة
١	٢	٣	٤

١٦.هـ. كانت أسرتي تدللني دلالا مبالغا فيه.

غير موافق بشدة	غير موافق	موافق	موافق بشدة
١	٢	٣	٤

١٦.و. كانت العلاقة بين والدي ووالدتي ممتازة.

غير موافق بشدة	غير موافق	موافق	موافق بشدة
١	٢	٣	٤

١٦.ز. كانا والداي يحبان أخوتي وأخواتي أكثر مني.

غير موافق بشدة	غير موافق	موافق	موافق بشدة
١	٢	٣	٤

١٦. ح. كنت لا أحب والدي.

غير موافق بشدة	غير موافق	موافق	موافق بشدة
١	٢	٣	٤

١٦.ط. كنت لا أحب والدتي.

غير موافق بشدة	غير موافق	موافق	موافق بشدة
١	٢	٣	٤

١٦.ي. عموما، كنت أعيش طفولة سعيدة مقارنة بأقراني.

غير موافق بشدة	غير موافق	موافق	موافق بشدة
١	٢	٣	٤

ج تعاطي الكحول

١. كم كان عمرك عندما شربت الكحول لأول مرة؟

أقل من ١٥ سنة	١	٣١-٣٥	٥
من ١٥-٢٠	٢	٣٦-٤٠	٦
٢١-٢٥	٣	٤١-٤٥	٧
٢٦-٣٠	٤	أكثر من ٤٥ سنة	٨

٢. ماذا كان نوع أول مشروب شربته في حياتك؟

عرق	١	كلونيا	٤
بيرة	٢	مشروبات قوية (مثلا، ويسكي، فودكا، بلاك ليبل)	٥
واين (نبيذ)	٣		

٣. كيف حصلت على أول مشروب تعاطيته؟

من صديق	١	من بار أو محل	٤
من قريب	٢	صنعته بنفسك	٥
من مروج	٣	أخرى، تذكر --------	٦

٤. أول خبرة لك مع الشرب كانت:

داخل البلد	١	خارج البلد	٢

٥. إذا كانت أول خبرة لك مع الشرب خارج البلد، ففي أي بلد كان ذلك؟

فضلا حدد البلد ---------- .

٦. مع من كانت أول خبرة لك مع الشرب؟

مع صديق	١	مع زميل دراسة	٤
مع قريب	٢	وحيدا	٥
مع زميل عمل	٣	أخرى، تذكر --------	٦

٧. عند أول مرة شربت فيها، هل شربت حتى درجة الثمالة (السكر)؟

نعم	١	لا	٢	لا أدري	٣

٨. عند أول مرة شربت فيها، هل حدث لك حالة استفراغ؟

نعم	١	لا	٢	لا أدري	٣

٩. كيف تصف مشاعرك خلال أول مرة شربت فيها؟

مبسوط	١	مستاء	٢	لا أدري	٣

١٠. ما المدة التي قضيتها بين أول كأس شربته في حياتك وبين بدأك بالشرب بشكل منتظم؟

حالا بعد أول كأس شربته	١	بعد ٤-٦ سنوات	٤
بعد أقل من سنة	٢	بعد ٧-٩ سنوات	٥
بعد ١-٣ سنوات	٣	بعد أكثر من ٩ سنوات	٦

د سلوكيات الشرب الحالية

١. نوع الشراب الذي تتعاطاه عادة؟ (فضلا أختر نوع واحد فقط).

عرق	١	كلونيا	٤
بيرة	٢	مشروبات قوية (مثلا، ويسكي، فودكا، بلاك ليبل)	٥
واين (نبيذ)	٣		

٢. ما نوع الشراب الذي تفضله عادة؟ (فضلا أختر نوع واحد فقط).

عرق	١	كلونيا	٤
بيرة	٢	مشروبات قوية (مثلا،	٥

ويسكي، فودكا، بلاك ليبل) [ ]

واين (نبيذ) [٣]

٣. عندما تشرب، هل تخلط الشراب بمواد أخرى؟ (مثل الماء، المشروبات الغازية).

نعم [١] لا [٢] أحيانا [٣]

٤. مع من تجلس للشرب عادة؟

مع صديق [١] مع زميل دراسة [٤]
مع قريب [٢] وحيدا [٥]
مع زميل عمل [٣] أخرى، تذكر ------- [٦]

٥. أين تشرب عادة؟

في المنزل [١] في البر [٤]
في منازل الآخرين [٢] أخرى، تذكر -------- [٥]
في استراحة [٣]

٦. في أي أيام الأسبوع تشرب عادة؟

في وسط الأسبوع [١] في نهاية الأسبوع [٢] في أي يوم من الأسبوع [٣]

تتعلق العبارات التالية بمشاعر الخوف لديك أثناء جلسة الشرب، أو مباشرة بعد تناولك لعدد من كؤوس الشراب. ولكن قبل أن تصل إلى مرحلة السكر (الثمالة). أود منك الآن أن تختار الاستجابة المناسبة التي تصف مشاعر الخوف لديك لكل عبارة من العبارات التالية.

٧.أ. أشعر بالخوف من أن يقبض علي بواسطة السلطات.

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

٧.ب. أشعر بالخوف من أن يراني أحد معارفي.

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

٧.ج. أشعر بالخوف من أن يراني أي أحد.

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

٧.د. أشعر بالخوف من أن يراني صديق لي.

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

٧.هـ. أشعر بالخوف من أن يراني أحد أفراد أسرتي.

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

لآن تتعلق العبارات التالية بمشاعر الخوف لديك عندما تكون سكرانا تماما (ثملا).
أود منك الآن أن تختار الاستجابة المناسبة التي تصف مشاعر الخوف لديك (وأنت في موقف السكر) لكل عبارة من العبارات التالية.

٨.أ. أشعر بالخوف من أن يقبض علي بواسطة السلطات.

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

٨.ب. أشعر بالخوف من أن يراني أحد معارفي.

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

٨.ج. أشعر بالخوف من أن يراني أي أحد.

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

٨.د. أشعر بالخوف من أن يراني صديق لي.

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

٨.هـ. أشعر بالخوف من أن يراني أحد أفراد أسرتي.

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

٩. متى بدأت تشعر بأن لديك مشكلة شرب؟

لا أشعر بأي مشكلة شرب	١	منذ ٤-٦ سنوات	٤
منذ أقل من سنة	٢	منذ ٧-٩ سنوات	٥
منذ ١-٣ سنوات	٣	أكثر من ٩ سنوات	٦

١٠. لماذا تشرب؟

أود منك أن تذكر أهم سبب يجعلك تشرب. (فضلا اختر إجابة واحدة فقط).

أشرب للاسترخاء والراحة	١
للتخلص من القلق	٢
لنسيان المشكلات	٣
لزيادة قدراتي الجنسية	٤
لمجاراة الأصدقاء	٥
لأشعر بالسعادة واللذة	٦
فقط لمجرد الشرب	٧
أخرى، تذكر ----------	٨

١١. كم من المال يكلفك الحصول على الشراب شهريا؟

أقل من ٥٠٠ ريال	١	٧٥١-١٠٠٠ ريال	٣
٥٠٠-٧٥٠ ريال	٢	أكثر من ١٠٠٠ ريال	٤

١٢. من أين تحصل عادة على المشروب؟

من صديق	١	من بار أو محل	٤
من قريب	٢	صنعته بنفسك	٥
من مروج	٣	أخرى، تذكر --------	٦

هـ تاريخ التدخين

١. هل تدخن؟

نعم	١	لا	٢	أحيانا	٣

إذا كنت مدخن، أو تدخن في بعض الأحيان، فأجب عن الأسئلة من ٢-٨. أما إن كنت لا تدخن أبدا، فانتقل إلى القسم (و) من الاستمارة.

٢. ما هو تدخينك المفضل؟

سجائر	١	سجائر وشيشة	٣
شيشة	٢	أخرى، تذكر --------	٤

٣. هل بدأت التدخين-

قبل أن تبدأ في شرب الكحول	١	بعد أن بدأت شرب الكحول	٣
في نفس الوقت الذي بدأت فيه بشرب الكحول	٢		

٤. إذا كنت تدخن السجائر، فكم سيجارة تدخن يوميا؟ (تحتوي العلبة على عشرين سيجارة)

أقل من ١٠ سجائر يوميا	١	٤١-٥٠ سيجارة	٥
من ١٠- ٢٠ سيجارة	٢	٥١-٦٠ سيجارة	٦
٢١-٣٠ سيجارة	٣	٦١-٧٠ سيجارة	٧
٣١-٤٠ سيجارة	٤	اكثر من ٧٠ سيجارة	٨

٥. إذا كنت تستخدم الشيشة، فكم مرة تدخنها يوميا؟

مرة واحدة يوميا	١	ثلاث مرات يوميا	٣
مرتان يوميا	٢	أكثر من ثلاث مرات يوميا	٤

٦. إذا كنت تستخدم الشيشة، فكم رأس تدخن في كل مرة؟

رأس واحد	١	ثلاثة رؤوس	٣
رأسين	٢	اكثر من ثلاثة رؤوس	٤

٧. إلى أي مدى تزعجك مشكلة التدخين؟

إطلاقا قليلا متوسطا كثيرا كثيرا جدا

١	٢	٣	٤	٥

٨. إلى أي مدى يهمك حل مشكلة التدخين تلك؟

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

و. التاريخ الصحي

١. كم مرة زرت طبيبا طلبا للعلاج من مرض جسمي خلال السنة الماضية؟

ولا مرة	١	٣ مرات	٤
مرة واحدة	٢	٤ مرات	٥
مرتان	٣	أكثر من ٤مرات	٦

٢. كم مرة، طوال حياتك، سبق لك أن نومت في مستشفى؟ (لا تحسب مرات التنويم بهدف علاج الإدمان)

ولا مرة	١	٣ مرات	٤
مرة واحدة	٢	٤ مرات	٥
مرتان	٣	أكثر من ٤مرات	٦

٣. متى كانت آخر مرة نومت فيها بهدف العلاج من مرض جسمي؟

منذ أقل من سنة	١	منذ ٧-٩ سنوات	٤
منذ ١-٣ سنوات	٢	منذ ١٠-١٢ سنة	٥
منذ ٤-٦ سنوات	٣	منذ أكثر من١٢ سنة	٦

٤. هل لديك مرض جسمي مزمن، يؤثر بحياتك بصورة مستمرة؟

نعم	١	لا	٢

٥. إذا كانت الإجابة بنعم، فاذكر اسم هذا المرض الجسمي المزمن.

_ _ _ _ _ _ _ _ _ _ _ _ _.

٦. إذا كانت الإجابة بنعم، منذ متى وأنت تعاني من هذا المرض الجسمي المزمن؟

منذ أقل من سنة	١	منذ ٧-٩ سنوات	٤
منذ ١-٣ سنوات	٢	منذ ١٠-١٢ سنة	٥
منذ ٤-٦ سنوات	٣	منذ أكثر من١٢ سنة	٦

٧. هل سبق لك أن زرت طبيبا نفسيا بهدف العلاج من مشكلة عاطفية أو نفسية؟

نعم	١	لا	٢

٨. إذا كانت الإجابة بنعم، فاذكر نوع هذه المشكلة.

_ _ _ _ _ _ _ _ _ _ _ _ _.

٩. إذا كانت الإجابة بنعم، منذ متى كانت تلك الزيارة؟

منذ أقل من سنة	١	منذ ٧-٩ سنوات	٤
منذ ١-٣ سنوات	٢	منذ ١٠-١٢ سنة	٥
منذ ٤-٦ سنوات	٣	منذ أكثر من١٢ سنة	٦

١٠. إذا كانت الإجابة بنعم، فهل نومت للعلاج من تلك المشكلة؟

نعم	١	لا	٢

١١. إلى أي مدى تزعجك تلك المشكلات الصحية؟

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

١٢. إلى أي مدى يهمك حل تلك المشكلات الصحية؟

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

ز. الحالة القانونية

١. هل دخولك هذا، لمستشفى الأمل اجباريا أو مقترحا ممن يملك سلطة رسمية؟ (مثل المحكمة، الشرطة، المكافحة، هيئة الأمر بالمعروف)

نعم [١] لا [٢]

٢. هل سبق أن القي القبض عليك من قبل السلطة؟

نعم [١] لا [٢]

إذا كانت إجابتك للسؤال السابق بنعم ، فاجب عن الأسئلة من ٣-٩. أما إذا أجبت بلا، فانتقل إلى القسم التالي من الاستمارة.

٣. لأي سبب كان القبض عليك في آخر مرة؟

- [١] بسبب تعاطي المسكر
- [٢] بسبب قيادة السيارة في حالة سكر
- [٣] بسبب مشادة أو منازعة أو مضاربة في حالة سكر
- [٤] بسبب آخر ليس له علاقة بالسكر

٤. متى كانت آخر مرة قبض عليك فيها؟

- [١] منذ أقل من سنة
- [٢] ١-٥ سنوات
- [٣] ٦-١٠ سنوات
- [٤] ١١-١٥ سنة
- [٥] ١٦-٢٠ سنة
- [٦] أكثر من ٢٠ سنة

٥. كم مرة تعرضت للسجن بسبب السكر؟

- [١] ولا مرة
- [٢] مرة واحدة
- [٣] مرتان
- [٤] ٣ مرات
- [٥] أكثر من ٣ مرات

٦. أن كنت قد سبق أن تعرضت للسجن سواء بسبب السكر أو لسبب آخر، فمتى كانت آخر مرة؟

- [١] منذ أقل من سنة
- [٢] ١-٥ سنوات
- [٣] ٦-١٠ سنوات
- [٤] ١١-١٥ سنة
- [٥] ١٦-٢٠ سنة
- [٦] أكثر من ٢٠ سنة

٧. هل أنت حاليا تنتظر محاكمة، أو تنفيذ حكم؟

نعم [١] لا [٢]

٨. إلى أي حد تزعجك مشكلاتك مع القانون؟

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

٩. إلى أي مدى يهمك حل تلك المشكلات القانونية؟

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

ح. تاريخ استعمال العقاقير الأخرى

١. هل سبق لك أن تعاطيت أي من المواد التالية؟

الهيروين:

لا	جربته فقط	كنت أتعاطاه في الماضي	لا زلت أتعاطاه
١	٢	٣	٤

الحشيش:

لا	جربته فقط	كنت أتعاطاه في الماضي	لا زلت أتعاطاه
١	٢	٣	٤

الحبوب المنبهة (المنشطة):

لا	جربته فقط	كنت أتعاطاه في الماضي	لا زلت أتعاطاه
١	٢	٣	٤

الحبوب المنومة (المثبطة):

لا	جربته فقط	كنت أتعاطاه في الماضي	لا زلت أتعاطاه
١	٢	٣	٤

مواد التشفيط

لا	جربته فقط	كنت أتعاطاه في الماضي	لا زلت أتعاطاه
١	٢	٣	٤

مواد الهلوسة:

لا	جربته فقط	كنت أتعاطاه في الماضي	لا زلت أتعاطاه
١	٢	٣	٤

مواد أخرى: أذكرها _ _ _ _ _ _ _ _ _ _ .

لا	جربته فقط	كنت أتعاطاه في الماضي	لا زلت أتعاطاه

١	٢	٣	٤

٢. هل سبق لك استعمال أي من تلك المواد قبل أن تبدأ شرب الكحول؟

نعم [١] لا [٢]

٣. إذا كنت تتعاطى أي مادة مخدرة (غير الكحول) في الماضي لكنك توقفت عن استخدامها، فلماذا توقفـــت؟ (اختر إجابة واحدة فقط).

لم أحب تلك المادة	١	تعالجت من تعاطي تلـــك المادة	٥
وجدت الكحول أفضل	٢	الكحول أقل أدمانا من تلك المادة	٦
عقوبة الكحول الشـــرعية أخف	٣	الكحول أقل ضرر من تلك المادة	٧
الحصول على تلك المـــادة أصعب من الحصول علـى الكحول	٤	لم أكن استطع ماديا شيء تلك المادة	٨

٤. إذا كنت لا زلت تتعاطى أي مادة مخدرة أخرى غير الكحول، فاذكر لماذا؟

جميع المخدرات تأثيرهـــا واحد	١	استخدام أكثر من مخـــدر يجعلني مبسوطا أكثر	٤
أحب الجمع بين الكحـــول وتلك المادة	٢	لم استطع التخلص مـــن تلك المادة	٥
استخدم أي مخدر أتمكـن من الحصول عليه	٣	أخرى، تذكـر _ _ _ _ _ _ _ _ _ _ _ _ _	٦

ط. تاريخ الأسرة مع الكحول أو العقاقير أو المشكلات النفسية

١. هل يوجد أحد من أفراد أسرتك ممن لديه أو لديـــها مشكلة تتعلق بتعاطي الكحول أو المخدرات ، أو مشكلة نفسية؟

نعم [١] لا [٢]

٢. إذا كانت إجابتك بنعم، فضلا أذكر درجة قرابتك بهذا الشخص، ونوع المشكلة التي يعاني منها.

	نوع القرابة مثال: أب، أخ، خال	نوع المشكلة مثال: كحول، مخدر، نفسية
القريب الأول	_____	_____
القريب الثاني	_____	_____
القريب الثالث	_____	_____

٣. هل تسكن مع أي شخص لديه مشكلة تعاطي الكحول؟

نعم [١] لا [٢]

٤. هل تسكن مع أي شخص لديه مشكلة تعاطي مخدر؟

نعم [١] لا [٢]

ي. العلاقات الأسرية والاجتماعية

١. مع من تقضي معظم أوقات فراغك؟

العائلة [١] الأصدقاء [٢] وحيد [٣]

٢. هل أنت راض عن قضاء وقتك بتلك الطريقة؟

نعم [١] لا [٢]

٣. كم لديك من الأصدقاء المقربين؟

ليس لي أي صديق	١	٧-٩ أصدقاء	٤
١-٣ أصدقاء	٢	أكثر من ٩ أصدقاء	٥
٣-٦ أصدقاء	٣		

٤. ما مدى قوة علاقتك بالأشخاص التاليين؟

	ضعيفة جدا	ضعيفة	وسط	قوية	قوية جدا
الأب	١	٢	٣	٤	٥
الأم	١	٢	٣	٤	٥
الزوجة	١	٢	٣	٤	٥
الأولاد	١	٢	٣	٤	٥
الأخوة	١	٢	٣	٤	٥
الأخوات	١	٢	٣	٤	٥
الأصدقاء	١	٢	٣	٤	٥

٥. هل سبق أن وقع بينك وبين أحد الأشخاص التاليين خلاف شديد؟

	قبل مشكلة الشرب		أثناء مشكلة الشرب	
الأب	نعم ١	لا ٢	نعم ١	لا ٢
الأم	نعم ١	لا ٢	نعم ١	لا ٢
الزوجة	نعم ١	لا ٢	نعم ١	لا ٢
الأولاد	نعم ١	لا ٢	نعم ١	لا ٢
أصدقاء	نعم ١	لا ٢	نعم ١	لا ٢
جيران	نعم ١	لا ٢	نعم ١	لا ٢
زملاء عمل	نعم ١	لا ٢	نعم ١	لا ٢
زملاء دراسة	نعم ١	لا ٢	نعم ١	لا ٢
أقارب آخرون	نعم ١	لا ٢	نعم ١	لا ٢
آخرون	نعم ١	لا ٢	نعم ١	لا ٢

٦. هل سبق لأحد من هؤلاء الأشخاص أن آذاك أو أساء إليك:

جسميا؟

نعم ١ لا ٢

عاطفيا؟

نعم ١ لا ٢

جنسيا؟

نعم ١ لا ٢

٧. هل هناك من أقاربك من لا يزال يساعدك ماديا؟

نعم ١ لا ٢

٨. إذا كانت الإجابة بنعم، فاذكر هؤلاء الأشخاص الذين يساعدونك ماديا. (مثال: أب، أم، زوجة، ألخ).

_ _ _ _ _ _ _ _ _

_ _ _ _ _ _ _ _ _

_ _ _ _ _ _ _ _ _

٩. إذا كنت متزوجا أو سبق لك الزواج، هل كانت زوجتك على علم بمشكلتك مع الشرب قبل زواجك بها؟

نعم ١ لا ٢ لا ينطبق ٣

١٠. من يعلم من بين أفراد عائلتك بمشكلتك مع الشرب؟ (يمكنك اختيار أكثر من إجابة).

الأب	١	زوجة	٥
الأم	٢	أبناء	٦
أخوة	٣	بنات	٧
أخوات	٤	آخرون، تذكر ------	٨

١١. من أكثر اهتماما من بين أفراد عائلتك لحل مشكلتك مع الشرب؟ (اختر إجابة واحدة فقط).

الأب	١	زوجة	٥
الأم	٢	أبناء	٦
أخوة	٣	بنات	٧
أخوات	٤	آخرون، تذكر ------	٨

١٢. ماذا كان موقف العائلة عندما علمت لأول مرة بأنك تشرب؟

نصحوني بعدم التشرب مرة أخرى	١
لم يهتموا بمشكلتي	٢
عاملوني بقسوة	٣
حاولوا حل المشكلة في إطار العائلة	٤
طردوني من المنزل	٥
ناقشوني بشكل واعي عن المشكلة	٦
أخرى، تذكر ----------	٧

١٣. إلى أي مدى أنت منزعج خلال الثلاثة أشهر الماضية بسبب مشكلاتك العائلية؟

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

١٤. إلى أي مدى يهمك حل تلك المشكلات العائلية؟

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

١٥. إلى أي مدى أنت منزعج خلال الثلاثة أشهر الماضية بسبب مشكلاتك الاجتماعية؟

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

١٦. إلى أي مدى يهمك حل تلك المشكلات الاجتماعية؟

إطلاقا	قليلا	متوسطا	كثيرا	كثيرا جدا
١	٢	٣	٤	٥

ك. ممارسة الشعائر الدينية

ما مدى ممارستك للشعائر الدينية التالية؟

	قبل مشكلتك مع الشرب				أثناء مشكلتك مع الشرب			
	أبدا	نادرا	غالبا	دائما	أبدا	نادرا	غالبا	دائما
الصلاة	١	٢	٣	٤	١	٢	٣	٤
الصلاة في أوقاتها	١	٢	٣	٤	١	٢	٣	٤
الصلاة في المسجد	١	٢	٣	٤	١	٢	٣	٤
الذهاب للمسجد	١	٢	٣	٤	١	٢	٣	٤
صلاة الجمعة	١	٢	٣	٤	١	٢	٣	٤
صيام رمضان	١	٢	٣	٤	١	٢	٣	٤
صلاة التراويح	١	٢	٣	٤	١	٢	٣	٤
حضور المحاضرات الدينية	١	٢	٣	٤	١	٢	٣	٤

	قبل مشكلتك مع الشرب				أثناء مشكلتك مع الشرب			
	نعم	١	لا	٢	نعم	١	لا	٢
٢. هل سبق لك أن أديت الحج؟								
٣. هل سبق لك أن أديت العمرة؟	نعم	١	لا	٢	نعم	١	لا	٢

٤. ماذا تفعل عندما يأتي وقت الصلاة وأنت تشرب؟

أصليها في وقت آخر	١
أصليها حالا (وأنا تحت تأثير السكر)	٢
لا أصليها أبدا	٣
أخرى، تذكر ----------	٤

٥. ماذا تفعل في رمضان فيما يتعلق بشربك؟

لا أتوقف عن الشرب	١
فقط أشرب في ليالي رمضان	٢
أتوقف تماما عن الشرب خلال شهر رمضان	٣
أخرى، تذكر ----------	٤

ل. المحاولات العلاجية السابقة

الجدول التالي يتعلق بالمحاولات السابقة للعلاج من تعاطي الكحول. أود منك أن تتذكر فقط الأربع محاولات الأولى، والإجابة على الأسئلة المتعلقة بكل محاولة علاجية.

١. الدخول	٢. مصدر الدخول	٣. مدة الإقامة	٤. المستشفى
الأول	الشخص نفسه ☐ ١ الأسرة ☐ ٢ صديق ☐ ٣ الشرطة ☐ ٤ العمل ☐ ٥ رجال الهيئة ☐ ٦	أقل من ٧ أيام ☐ ١ من ٧ أيام – ١٤ يوم ☐ ٢ من ١٥–٢١ يوم ☐ ٣ من ٢١ – ٢٨ يوم ☐ ٤ من ٢٩ – ٣٦ يوم ☐ ٥ من ٣٧ – ٤٤ يوم ☐ ٦ أكثر من ٤٤ يوم ☐ ٧	الأمل (جدة) ☐ ١ الأمل (الرياض) ☐ ٢ الأمل (الدمام) ☐ ٣ الأمل (القصيم) ☐ ٤ عيادة خاصة ☐ ٥ خارج المملكة ☐ ٦
الثاني	الشخص نفسه ☐ ١ الأسرة ☐ ٢ صديق ☐ ٣ الشرطة ☐ ٤ العمل ☐ ٥ رجال الهيئة ☐ ٦	أقل من ٧ أيام ☐ ١ من ٧ أيام – ١٤ يوم ☐ ٢ من ١٥–٢١ يوم ☐ ٣ من ٢١ – ٢٨ يوم ☐ ٤ من ٢٩ – ٣٦ يوم ☐ ٥ من ٣٧ – ٤٤ يوم ☐ ٦ أكثر من ٤٤ يوم ☐ ٧	الأمل (جدة) ☐ ١ الأمل (الرياض) ☐ ٢ الأمل (الدمام) ☐ ٣ الأمل (القصيم) ☐ ٤ عيادة خاصة ☐ ٥ خارج المملكة ☐ ٦
الثالث	الشخص نفسه ☐ ١ الأسرة ☐ ٢ صديق ☐ ٣ الشرطة ☐ ٤ العمل ☐ ٥ رجال الهيئة ☐ ٦	أقل من ٧ أيام ☐ ١ من ٧ أيام – ١٤ يوم ☐ ٢ من ١٥–٢١ يوم ☐ ٣ من ٢١ – ٢٨ يوم ☐ ٤ من ٢٩ – ٣٦ يوم ☐ ٥ من ٣٧ – ٤٤ يوم ☐ ٦ أكثر من ٤٤ يوم ☐ ٧	الأمل (جدة) ☐ ١ الأمل (الرياض) ☐ ٢ الأمل (الدمام) ☐ ٣ الأمل (القصيم) ☐ ٤ عيادة خاصة ☐ ٥ خارج المملكة ☐ ٦
الرابع	الشخص نفسه ☐ ١ الأسرة ☐ ٢ صديق ☐ ٣ الشرطة ☐ ٤ العمل ☐ ٥ رجال الهيئة ☐ ٦	أقل من ٧ أيام ☐ ١ من ٧ أيام – ١٤ يوم ☐ ٢ من ١٥–٢١ يوم ☐ ٣ من ٢١ – ٢٨ يوم ☐ ٤ من ٢٩ – ٣٦ يوم ☐ ٥ من ٣٧ – ٤٤ يوم ☐ ٦ أكثر من ٤٤ يوم ☐ ٧	الأمل (جدة) ☐ ١ الأمل (الرياض) ☐ ٢ الأمل (الدمام) ☐ ٣ الأمل (القصيم) ☐ ٤ عيادة خاصة ☐ ٥ خارج المملكة ☐ ٦

٥. إذا كنت قد سبق لك العلاج، فما المدة التي قضيتها بين آخر خروج من المستشفى وبين أول كأس شربته بعد ذلك الخروج؟

أقل من أسبوع	١	٤-٦ أشهر	٤
من ١-٤ أسابيع	٢	أكثر من ٦ أشهر	٥
من شهر- ٣ أشهر	٣		

٦. إذا كنت قد سبق لك العلاج، فما المدة التي قضيتها بين آخر خروج من المستشفى وبين العودة للشرب بصورة مستمرة؟

أقل من أسبوع	١	٤-٦ أشهر	٤
من ١-٤ أسابيع	٢	أكثر من ٦ أشهر	٥
من شهر- ٣ أشهر	٣		

٧. ما الدافع وراء مجيئك للمستشفى هذه المرة؟ (اختر إجابة واحدة فقط).

١	للتوقف عن الشرب
٢	فقط لإرضاء الآخرين
٣	لاستعادة صحتي
٤	فقط لأني حضرت هنا بواسطة السلطة
٥	أخر، يذكر ----------

Appendix 2.A

AUDIT

Please circle the answer that is correct for you

1. How often do you have a drink containing alcohol?

Never	Monthly or less	Two to four times a month	Two to three times per week	Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2	3 or 4	5 or 6	7 to 9	10 or more

3. How often do you have six or more drinks on one occasion?

Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week

4. How often during the last year have you found that you were not able to stop drinking once you had started?

Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?

Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never	Less than monthly	Monthly	Two to three times per week	Four or more times a week

9. Have you or someone else been injured as a result of your drinking?

No	Yes, but not in the last year	Yes, during the last year

10. Has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested you cut down?

No	Yes, but not in the last year	Yes, during the last year

٠	٢	٤

١٠. هل سبق لصديق أو قريب أو طبيب أو أي مختص صحي أن أبدى اهتماما بموضوع شربك أو اقترح عليك أن تتوقف عن الشرب؟

لا	نعم، ولكن ليس السنة الماضية	نعم، خلال السنة الماضية
٠	٢	٤

Appendix 3.A

Topic guides for the therapists' interview

Dear therapist,

The following are questions that are formed based on my research results, which I conducted six month ago regarding the hospitalised problem drinkers. Based on your work and professional experience, I hope that you answer these questions. Your answering these questions is would enrich the study.

To answer these questions you have two options: the first is that you can answer the questions in writing in separate papers. The second is through tape-recording interview (the second is more favourable to me). Together, we can arrange a time for this interview.

In either choice, I am hoping that the answer to each question is complete and comprehensive. Also, I would like, when answering, that you put all of your thought regarding the questions. I am expecting the answers to be based on what you are really thinking rather than ideal thinking (what ought to be).

Finally, I would like to remind you that the information you are providing are confidential, and will not be use for any propose other than scientific research.

Thank you for your co-operation.

Researcher: Abdulaziz Al-Dakhil

P.S. to arrange for a time for tape interview, you can reach me on mobile # 055233460.

First: demographic data

Name (optional): _____
Age: _____
Type of educational degree _____
Name of current job _____
Years of experience in this job _____

Second: Questions

1. The results indicate that most of the subjects were of younger age (less than 30 Y.O.), what do you think the reasons behind that?

2. The results indicate that most of the subjects were coming from the same cities where the treatment centers are located whereas smaller numbers of the patients have come from different cities and villages, could you please comment on that?

3. The results indicate that most of the subjects were of low education and low incomes, could you please comment on that?

4. The results indicate that more than half of the subjects was unemployed, what do you think the reasons behind that?

5. The results indicate that more than half of the subjects was working for the military sector, why do you think most of the patients came from military sector?

6. Although many people belief that alcohol drinking is first introduced to Saudi drinkers outside the country, the results indicate that most of the subjects have been introduced to alcohol inside the country, could you comment on that?

7. What do you think the reasons are behind drinking in the part of your patients?

8. Araq and cologne were the drink mostly consumed by the problem drinkers, why such types are so prevailing?

9. Do araq and cologne differ from other types of drinks in terms of their strength and effects, and in turn the treatment of those who depend on those types of drinks? If so, what are these differences?

10. The results show that some patients were not heavy drinkers nor they were alcohol dependants, however, they were admitted for alcohol treatment, why is that, and in what aspects the treatment of non-dependent vary from that of dependent patients.

11. How different is the treatment of those who consume alcohol only from those who consume alcohol along with other type of drugs?

12. What are the treatment goals hoped to be achieved with problem drinkers?

13. Although the association of smoking and alcohol was very well known in the western literature, how do you think such association applies to problem drinkers in Saudi Arabia in spite the fact that, unlike western societies, smoking is allowed while alcohol is not?

14. Many of the patients drive while intoxicated, as a therapist, how such risky behavior is dealt with during treatment?

15. Total abstinence during the month of Ramadan was seen by most of the patients, why is that, and how this can lead the treatment programs of such patients?

16. How do you see the problem of drinking in Saudi Arabia now and in future?

17. In your opinion how effective the services provided in achieving the treatment objectives toward solving alcohol problems?

18. As a therapist, what are the factors effecting your work with the patients?

19. In your opinion, what are the problems facing the patient towards their success in treatment?

20. How do you think your patients view the provided services?

21. What are the most important strength points of the treatment program?

22. What are the most important weak points of the treatment program?

23. What are the gaps of the treatment program?

24. How do you see the success rate of the treatment program for patients with alcohol problems?

25. How do you see the number of existing hospitals to provide alcohol treatment services for the patients in the kingdom?

26. In your opinion, what are the groups that avoid coming to Al-Amal hospitals, and how these groups could be encouraged to come for treatment?

27. How do you see providing alcohol treatment services through the private sector?

28. How do see the differences between those patients coming voluntarily for treatment and those who come involuntarily in terms of their personality, compliance with treatment, and treatment success?

Appendix 3.B

استمارة أسئلة المعالجين

بسم الله الرحمن الرحيم

عزيزي المعالج

تحية طيبة وبعد،

فيما يلي تجد بعض التساؤلات التي تمت صياغتها بناءا على نتائج الدراسة التي قمت بها خلال الستة أشهر الماضية عن الكحوليين المنومين في مستشفيات الأمل. آمل منكم الإجابة على تلك التساؤلات من واقع خبراتكم المهنية والعملية والتي سيكون لإجابتكم عليها أثرا عظيما في إثراء الدراسة إنشاء الله.

أما بالنسبة لطريقة الإجابة على تلك التساؤلات فهناك خياران: الأول وهو الإجابة على الأسئلة كتابيا على أوراق خارجية، أما الثاني فهو عن طريق المقابلة الشخصية والتسجيل (علما أن تلك الطريقة هي المفضلة لدي). وفي كلتا الحالتين أرجو أن تكون الإجابة شاملة ووافية وان تضع جميع تصوراتك دون حرج من الإطالة، كما أنى لا أتوقع أن تكون الإجابة مبنية على ما يجب ان يكون (مثالية) بل لما هو كائن بالفعل (واقعية). كما أذكرك عزيزي المعالج بان إجاباتك ستكون محل السرية التامة ولن تستخدم إلا للأغراض البحثية. شاكرا لك حسن التعاون.

الباحث/ عبد العزيز الدخيل

ملاحظة/ آمل التنسيق معي عن رغبتك في طريقة إجابة التساؤلات على الهاتف ٠٥٥٢٣٣٤٦٠.

أولا: بيانات أولية

الاسم (اختياري): _____

العمر _____

المؤهل العلمي: _____

طبيعة العمل الحالي: _____

سنوات الخبرة العملية في العمل الحالي: _____

ثانيا: التساؤلات

١. أشارت نتائج الدراسة إلى أن معظم الذين يتلقون العلاج من إدمان الكحول هم من صغار السن (ما دون سن الثلاثين)، فما هو تعليلكم لتلك النتيجة؟

٢. تشير النتائج إلى أن معظم المتلقين للعلاج يأتون من المناطق التي تقع بها المستشفيات، فمثلا معظم المبحوثين في مستشفى الأمل بالرياض هم أصلا من القاطنين في مدينة الرياض. بينما نجد نسب بسيطة جدا يأتون من مناطق مختلفة للعلاج، فما تعليقكم على ذلك؟

٣. تشير النتائج الى أن الغالبية العظمى من مجتمع البحث هم من ذوي التعليم المتدني، ومن ذوي الدخل المنخفض، فما تعليقكم على ذلك؟

٤. تشير النتائج الى أن أكثر من نصف المبحوثين هم من العاطلين عن العمل حاليا، فبرأيكم ما هي الأسباب.

٥. أشارت النتائج إلى ان أكثر من نصف المبحوثين هم ممن يعملون أو سبق أن عملوا في القطاع العسكري، فبرأيك ما هي الأسباب وراء ذلك، وهل تعتقد أن ذلك يعكس واقع المجتمع؟

٦. خلافا لما كان يعتقد، أكدت الدراسة أن معظم المبحوثين تعلموا الشرب داخل البلاد وليس خارجها، فما تعليقكم على ذلك؟

٧. برأيك ما هي الأسباب وراء تعاطي المتعالجين للكحول؟

٨. أوضحت الدراسة أن العرق والكلونيا هما المادتان التي يتم تعاطيهما أكثر من غيرهما من قبل معظم المبحوثين، فما هي الأسباب في نظرك؟

٩. بماذا يختلف في نظرك العرق والكلونيا عن غيرهما من أنواع المشروبات الكحولية الأخرى من حيث نسبة الكحول فيهما، ومن حيث تأثيرهما على شاربها، وهل يختلف الأسلوب العلاجي المتبع لمن يشرب هذين النوعين؟ ولو كان الأمر كذلك فما هو ذلك الاختلاف؟

١٠. أكدت الدراسة وجود عدد من المبحوثين (ليس كثيرا) ممن يتلقون العلاج على الرغم من انهم لا يشربون بمعدلات كبيرة، وليسوا ممن يمكن تصنيفهم تحت مسمى المعتمدون على الكحول، فما هو في رأيك السبب وراء تلقيهم العلاج، وبماذا يختلف أسلوب علاج هؤلاء عن غيرهم ممن المعتمدين على الكحول.

١١. ما هو بنظرك الاختلاف في الأسلوب العلاجي لأولئك الذين يتعاطون الكحول فقط عن الأسلوب العلاجي للذين يتعاطون الكحول والمخدرات معا.

١٢. برأيك ما هي الأهداف المؤمل تحقيقها وراء علاج متعاطي الكحول في المستشفى.

١٣. أوضحت النتائج أن جميع المبحوثين تقريبا هم من المدخنين، فما هي العلاقة برأيك بين تعاطي الكحول والتدخين، علما أن العلاقة بين التدخين وتعاطي الكحول أمر معروف في الأدبيات الغربية، إلا أنه خلافا للغرب، يعد التدخين هنا أمرا مقبولا بينما لا يعد الكحول كذلك، أما بالنسبة للغرب فكلاهما يعد أمر مقبولا.

١٤. أكدت الدراسة وجود عدد غير قليل من المبحوثين ممن هم يقودون السيارة تحت تأثير السكر، فكيف (برأيك كمعالج) يتم التعامل مع مثل ذلك السلوك الخطير أثناء العملية العلاجية.

١٥. لوحظ أن معظم المبحوثين يتوقفون تماما عن شرب الكحول أثناء شهر رمضان المبارك، فما هي الاسباب وراء ذلك وكيف يمكن أن يقود ذلك إلى فهم مشكلة التعاطي، وكيف يمكن أن تتم الاستفادة من ذلك في العلاج؟

١٦. كيف ترى ظاهرة شرب الكحول في المملكة من حيث انتشارها حاليا ومستقبلا؟

١٧. كيف ترى كفاءة ما يقدم من خدمات علاجية في تحقيق الاهداف النهائية لعلاج مشكلة الادمان الكحولي؟

١٨. ما هي بنظرك العوامل المؤثرة في عملك مع مرضى الكحول؟

١٩. هل لك ان تصف أهم المشكلات التي يواجهها مرضى الكحول نحو نجاحهم في العلاج؟

٢٠. هل لك ان تصف كيف ينظر مريض الكحول لما يقدم له من خدمات علاجية؟

٢١. بنظرك ما هي اهم نقاط القوة في الخدمات العلاجية المقدمة لمرضى الكحول؟

٢٢. بنظرك ما هي اهم نقاط الضعف في الخدمات العلاجية المقدمة لمرضى الكحول؟

٢٣. بنظرك ما هي اهم الفجوات في الخدمات العلاجية المقدمة لمرضى الكحول؟

٢٤. كيف ترى نسب نجاح الخطط العلاجية لمرضى الكحول؟

٢٥. ما رأيك في عدد المستشفيات الموجودة حاليا ومدى كفايتها لتقديم الخدمات العلاجية في المملكة؟

٢٦. بنظرك ما هي الفئات التي ترى انها لا تقبل على العلاج في مستشفى الامل، وما هي السبل المشجعة على طلب العلاج؟

٢٧. كيف ترى وجود مصحات خاصة (غير حكومية) لعلاج المدمنين؟

٢٨. بنظرك ما هي الاختلافات بين من يأتون طواعية وبين من يجبرون على العلاج من حيث السمات الشخصية، ومن حيث التجاوب مع العلاج، ومن حيث مدى الاستفادة من العلاج.

Appendix 4

Michigan Alcoholism Screening Test (MAST)

POINTS			YES	NO
	0	Do you enjoy a drink now and then?		
(2)	1	Do you feel you are a normal drinker?(By normal we mean you drink less than or as much as most other people)		
(2)	2	Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?		
(2)	3	Does your wife, husband, parent, or other near relative ever worry or complain about your drinking?		
(2)	4	Can you stop drinking without a struggle after one or two drinks?		
(1)	5	Do you ever feel guilty about your drinking?		
(2)	6	Do friends or relatives think you are a normal drinker?		
(2)	7	Are you able to stop drinking when you want to?		
(5)	8	Have ;you ever attended a meeting of Alcoholics Anonymous (AA)?		
(1)	9	Have you gotten into physical fights when drinking?		
(2)	10	Has your drinking ever created problems between you and your wife, husband, a parent, or other relative?		
(2)	11	Has ;your wife, husband, or another family member ever gone to anyone for help about your drinking?		
(2)	12	Have you ever lost friends because of your drinking?		
(2)	13	Have ;you ever gotten into trouble at work or school because of drinking?		
(2)	14	Have you ever lost a job because of drinking?		
(2)	15	Have ;you ever lost neglected your obligations, your family or your work for 2 or more days in a row because you were drinking?		
(1)	16	Do you drink before noon fairly often?		
(2)	17	Have you ever been told you have liver trouble? Cirrhosis?		
(2)	18	After heavy drinking have you ever had delirium tremens (D.T.□s) or severe shaking or heard voices or seen things that really weren□t there?		
(5)	19	Have you ever gone to anyone for help about your drinking?		
(5)	20	Have you ever been in a hospital because of drinking?		
(2)	21	Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?		
(2)	22	Have you ever been seen at psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem?		
(2)	23	Have ;you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? (If yes, how many times_____)		
(2)	24	Have you ever been arrested, or taken into custody, even for a few hours, because or other drunk behavior? (If yes, how many times? ____)		

Appendix 5

The Cage Questionnaire

Have you ever felt you should Cut down on your drinking?
Have people Annoyed you by criticizing your drinking?
Have you ever felt bad or Guilty about your drinking?
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (Eye-opener)?

Appendix 6

The MALT questionnaire

Items to be assessed by the Physician

1.Diseases of the liver (at least one symptom found on physical examination in addition to one positive laboratory test)
2.Polyneuropathy (only if no other cause, e.g., diabetes mellitus, is known)
3.Delirium tremens (on the present examination or previously)
4.Alcohol consumption of more than 150 ml (women 120 ml) of pure alcohol a day at least continued over several months.
5.Alcohol consumption of more than 300 ml (women 240 ml) of pure alcohol at least once a month (alcoholic benders)
6.Foetor alcoholicus (at the time of medical examination)
7.Spouse, family members or good friends have sought help because of alcohol-related problems of the patient (e.g., from a physician, social worker or other appropriate facilities)

Items to Be Assessed by the Patient Himself as Being "True" or "Not True"

1.My hands have been trembling a lot recently.
2.In the morning I sometimes have the feeling of nausea.
3.I have sometimes tried to get rid of my trembling and nausea with alcohol.
4.At the moment I feel miserable because of my problems and difficulties.
5.It is not uncommon that I drink alcohol before lunch.
6.After the first glass or two of alcohol I feel a craving for more.
7.I think about alcohol a lot.
8.I have sometimes drunk alcohol even against my doctor's advice.
9.When I drink a lot of alcohol, I tend to eat little.
10.At work I have been criticised because of my drinking.
11.I prefer drinking alone.
12.Since I have started drinking I have been in worse shape.
13.I have often had a guilty conscience about drinking.
14.I have tried to limit my drinking to certain occasions or to certain times of the day.
15.I think I ought to drink less.
16.Without alcohol I would have fewer problems.
17.When I am upset I drink alcohol to calm down.
18.I think alcohol is destroying my life.
19.Sometimes I want to stop drinking, and sometimes I don't.
20.Other people can't understand why I drink.
21.I would get along better with my spouse if I didn't drink.
22.I have sometimes tried to get along without any alcohol at all.
23.I'd be content if I didn't drink.
24.People have often told me that they could smell alcohol on my breath.

Accompanying Materials

وزارة التعليم العالي

كلية الآداب

سعـــــادة / المدير التنفيذي بمستشفـى الأمل الموقـــــر

السلام عليكم ورحمة الله وبركاته وبعـــــد ،،،،

يقوم الباحث / عبدالعزيز بن عبدالله الدخيل بإجراء دراسة حول : الكحول في المملكة العربية السعودية ويرغـــب في الحصول على بعض المعلومات المتعلقـــة بهذا البحث .

نأمـــــل من سعادتكـــم التعـــاون والتكـــرم بتسهيـل إجراءات بحثـــه .

** هذا .. ولسعادتكم خالص تحياتي وتقديري **

رئيس قسم الدراسات الاجتماعية

د . / صالح بن محمد الصغير

المملكة العربية السعودية
وزارة التعليم العالي
جامعة الملك سعود
كلية الآداب

بسم الله الرحمن الرحيم

الرقم ٢٨٢ / ٨ / ١٠
التاريخ ٢٩ / ٧ / ١٤٢٢هـ
المرفقات

الموضوع

سعادة الدكتور / مدير مستشفى الأمل بالرياض الموقـــر

السلام عليكم ورحمة الله وبركاته وبعـــــد ،،،،

نفيد سعادتكم بأن الباحث / عبدالعزيز بن عبدالله الدخيل والمبتعث من قبـــل جامعـــة الملك سعود يرغب في استكمال بيانات البحث الذي يقوم به عن مدمني الكحول في المملكة العربية السعودية .

نأمل من سعادتكم تسهيل مهمة الباحث، علماً بأن المعلومات لن تستخدم إلا للغـــرض العلمي فقط .

وتقبلوا خالص تحياتي وتقديري

رئيس قسم الدراسات الاجتماعية

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وزارة الصحة
المديرية العامة للشئون الصحية بمنطقة الرياض

وزارة الصحة
Ministry of Health

الرقم .....
التاريخ .....
المشفوعات .....

To whom it may concern

إلى من يهمه الأمر

This is to certify that Mr. A.AL- Dakhil has finished his interviews with therapists in Riyadh Al- Amal hospital on Jan 2nd, 2002

نفيدكم بان الباحث / عبدالعزيز عبدالله الدخيل قد انهى جمع البيانات المتعلقة بمقابلات المعالجين في مستشفى الأمل بتاريخ ٢/١/ ٢٠٠٢م .

مدير الشئون الادارية والمالية
بمجمع الأمل بالرياض
عبدالعزيز بن ناصر الريس

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