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Alcoholics' Characteristics in Saudi Arabia

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ABSTRACT

The object of this study is to look closely at the characteristics of Saudi alcoholics with regard to their levels of alcohol consumption. The study identified the subjects by a designed questionnaire and testing their level of alcohol by the Alcohol Use Disorders Identification Test (AUDIT). The study surveys the alcohol patients at Al-Amal hospital using its tools in order to answer the two questions; a) what are the main characteristics of an alcoholic, and b) what are their levels of alcohol consumption. This study concludes that all participants were ranked with high levels of alcoholism measured. This sample of alcoholics are likely to drink alcohol in a hazardous alcohol-use manner, smoke more than a packet of cigarettes a day, drink a great deal of coffee daily, have a high frequency of relapses indicated by high number of hospital admissions, and carry a strong belief in that craving is a factor of relapse. The study draws some recommendations for future research, policy makers, and alcohol treatment. The research ends by providing a theoretical framework for social work support.

Keywords: Alcoholics, Saudi Arabia, Personal characteristics, Alcohol consumption, Alcohol dependence.

INTRODUCTION

Increased alcohol use in Saudi Arabia

Alcohol in Saudi Arabia has a long history dating back to the first known ancient civilization on the Arabian Peninsula. Nevertheless, alcohol in Saudi Arabia has started a new history since the establishment of the Kingdom of Saudi Arabia in 1932. Saudi legislation; which is based on the rules of Islamic Shari'ah, very early-on prohibited using, manufacturing, and selling alcohol.

Despite its long history in Arabia, some people claim that alcohol should not be present at all, while others are concerned only with the rising number of users each year. This is located within a context where there is a lack of reliable information about the number of people who do consume alcohol. Notwithstanding the above, commentators have identified some factors that are believed to have led to the spread of alcohol in Saudi society. According to Al- Al-Dakhil (2002), Nahedy (1999) and Al-Najar (1998) these factors are:

a) The growth of the economy that has been faster since the 1980s.
b) The increasing number of people who travel to other countries where alcohol is legal.
c) The global revolution (in mass media and information technology) during 1990s, particularly those aspects associated with the internet, movies, and satellite television.
d) The high number of non-Saudi workers who have moved to Saudi Arabia since the developments of the 1980s.

All the above factors are in some way related to economic growth. In addition, there are social factors that in one way or another participated in the existence

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of alcohol phenomenon in the society.

Table 1. Alcohol-related incidents discovered by the police in selected years

Year	Number of Incidents
2000	8610
2001	9792
2002	9886
2004	9962
2005	10112
2006	10206
2007	10334
2008	12385

The Ministry of Interior's Statistical Books (2000; 2001; 2002; 2003; 2004; 2005; 2006; 2007 & 2008) record the increasing number of alcohol 'offences' as shown in tables 1 & 2.

Table 1 shows the significantly increased number of incidents since 2000, which may be read as confirming the economic explanation of the trend.

The increasing number of alcohol users is confirmed by another institution, the Religious Enforcement Council. The next table's data is from the General Presidency of the Enforcement Council's Statistical Reports (2000; 2004; 2008).

Table 2. Alcohol-related incidents presented by the type of crime

	2000		2004		2008	
	Incidents	People Involved	Incidents	People Involved	Incidents	People Involved
Drinking	7229	9093	8839	9611	10008	11641
Manufacturing	632	951	427	578	572	915
Possessing and Selling	749	998	696	1211	1805	1927
Total	8610	11042	9962	11400	12385	14483

Table 2 describes the number of alcohol-related incidents and individuals convicted for such incidents by the type of crime in the years 2000, 2004 and 2008. It can be seen that the increases occurred in the number of incidents of drinking and individuals convicted whereas there were reductions in the other types of alcohol offences - manufacturing, possessing and selling - between the years of 2000 and 2008. However, in the latest data available for the year, 2002, there are roughly double the numbers in 2008 in both alcohol-related incidents and individuals convicted for a variety of crimes. This may relate to the growth of the general population (to 26.4 million) and the growth of resident foreigners (to 5.6 million).

Table 3 demonstrates the levels of apprehension alcohol use among Saudis and non-Saudis by gender and age (Ministry of Interior Statistical Book, 2000; 2004; 2008).

Table 3. Alcohol crimes by nationality, gender and age

	Year	Saudi	Non-Saudi	Male	Female	Adult	Minor	Total
Drinking	2000	7891	1202	9001	92	9070	23	9093
	2004	8562	1049	9583	28	4272	5339	9611
	2008	8600	3041	11503	138	10687	954	11641
Manufacturing	2000	208	743	910	41	940	11	951
	2004	134	444	486	92	400	178	578
	2008	325	563	811	104	817	98	915
Possessing and Selling	2000	451	547	892	20	981	17	998
	2004	409	802	1123	88	801	410	1211
	2008	827	1100	1835	92	1705	222	1927

* Minor is under 18 years old.

Table 3 reveals significant differences between male and female alcohol consumption, manufacturing, possessing and selling. It might be argued that drinking alcohol, but not manufacturing, possessing and selling, increased by about 103 percent from 2000 to 2004. It also appears that up until the year 2000, adults were more likely to drink alcohol than minors, this changed quite dramatically by 2008. By 2008 drinking, manufacturing, possessing and selling alcohol increased remarkably by 406 drinkers each year since 2004. Finally, the table shows that apprehended Saudi drinkers are more numerous than apprehended non-Saudi drinkers; there are more than three times as many. Nonetheless, the existence of convicted non-Saudi drinkers may be regarded as confirming their role in the spread of alcohol in Saudi society since the 1980s, as stated in some of the Ministry of Interior Statistical Books.

Despite the prohibition of alcohol in Islamic and Saudi law, the stern punishments and the social stigma of drinking alcohol, the consumption, selling, manufacturing and possession of alcohol has increased dramatically. Consequently, the Saudi government has adopted multiple strategies including prevention and treatment to combat the issue.

Alcohol treatment in Saudi Arabia

In 1987 the Ministry of Health established the first of two hospitals for addiction, both named Al-Amal, which means 'hope' in Arabic, and located in the capital, Riyadh City and in western Saudi Arabia in Dammam City. In 1990 a third hospital was opened in the country's second largest city, Jeddah, which is located in the eastern region. Then in late-1995 the Ministry of Health enlarged the role of the Psychological Health Hospital in Qaseem to treat addicted people by providing similar treatment programmes to those in the other hospitals. All hospitals now, except the Jeddah hospital, are like Qaseem in being combined with psychiatric hospitals and are named Al-Amal Medical United.

The hospitals have different maximum capacities. The main hospital in Riyadh can host about 270 patients. The Dammam and Jeddah hospitals are similar in size with about 260 beds in each. Qaseem is the smallest hospital and can treat only about 110 addicted patients. All these facilities are for both alcoholic and drug addicted patients.

Alcohol treatment is similar to that for other types of

illicit drugs. There is usually award for alcoholic patients who are admitted for in-patient treatment which normally lasts about a month. The first stage of treatment is a week in the withdrawal ward. At this stage, medical treatment is provided. The second stage separates the patients into alcoholic, heroin and other types of drug wards. This is the longest period of treatment and lasts for more than two weeks and involves medical, psychological and social interventions. Besides these treatments, there are other support therapies like acupuncture, occupational therapy, biofeedback and methadone treatment. The last stage of treatment is in a separate ward for rehabilitation. This stage is primarily for convalescence with advanced social, psychological and educational therapies. Rehabilitation takes one week or longer.

Besides the internal wards, there are out-patient clinics that provide other services like individual and group support that may include daily meetings for recently discharged patients who wish to join such meetings. The same integrated model of treatment is available in all the hospitals and is administered by nurses, doctors, psychiatrists, psychologists, social workers and addiction counsellors.

Patients can refer themselves or can be referred to the hospitals by their families or by other institutions like the Religious Enforcement Council and the Bureau of Drug Prevention and Control. The Bureau, which is linked to the Ministry of the Interior, has a special ward in these hospitals controlled by police enforcement officers. These officers are allocated for patients who have five or more admissions and/or have criminal records besides drinking alcohol or using drugs. Patients can be admitted or transferred into the maximum security wards by the court, the police, or the Bureau of Drug Prevention and Control. Such patients would have a history of having more than four admissions at any of the four hospitals. They could also be recommended by their families or a high level of authority of the government, like the Ministry of Interior or the Regional Emirate. They may then have been transferred into the secure wards due to a variety of reasons, though predominantly exceeding four admissions being the most common. Sometimes (hospital staff claim) the presence of the Bureau in the hospitals negatively affects the treatment by reducing the authority of the therapists. Most of the therapy staff disagreed with the strategy operated by the Bureau which allows it to give a stiff penalty to patients who enter hospital more than four times. They claim that this affects their own effectiveness and sometimes turns the patients away from entering the hospitals and seeking medical services privately or abroad.

Generally, alcohol treatment in Saudi Arabia is not as progressive as maybe thought of. The hospitals individually struggle to apply useful programs. There is no strategy for testing the programs, no effective communication and sharing of experiences between the four hospitals. The Al-Amal hospitals are still hesitating to adopt some ‘proven’ Western treatment programs like Half-way-Houses and Alcoholics Anonymous (AA). Another problem is the shortage of available professionals who specialise in addiction and rehabilitation therapy. However, alcohol treatments affect alcoholics in Saudi Arabia in many ways; a) the patients can stay sober from any beverages during their stay at the hospital, b) the patients can learn from the treatment programmes some key concepts such as the craving and ways of dealing with it, and relapse and its negative consequences, c) the patient can get some support from the out-patients programme after being discharged.

Previous Studies

As literature with topic of alcoholics' characteristics, there are a few studies have been conducted in the field of alcohol in Saudi Arabia and all these studies obtained their samples from the Al-Amal hospitals providing some information about alcoholics' characteristics in Saudi Arabia.

The most recent study is a PhD. thesis by Al-Dakhil (2002). This study aimed to explore the demographic characteristics of hospitalised Saudi drinkers. Their reasons for drinking were the study's main concern. The study was carried out in the four branches of the Al-Amal hospitals. The study found that the number of alcoholics was increasing, and that there was little family involvement in treatment programmes, and poor intervention with clients and the clients' families who were coping with alcohol-related problems. The author concluded with a strong recommendation for conducting alcohol epidemiological studies in the future.

A cross-sectional study was conducted in Al-Amal Hospital in Riyadh by Al-Nahedy (1999). The main tool was a questionnaire designed to gather the history of the patient's substance abuse: age at starting substance abuse, people involved at the start of abuse, reactions of the patient and his family, and number of previous admissions. The subjects were 180 male substance abusers aged 20 or older. The nature of the substance abused was verified by the treating physician. Alcohol was used by about one-fourth of the total sample. The two main results were; a) Age, unemployment, peer pressure, family and social stresses were factors that showed statistically significant associations with repeat admissions, b) the most significant predictors of a patient's relapse were unemployment and social stresses. The study recommends more studies to document factors leading to the initiation and continuation of substance abuse and to help treatment and rehabilitative measures.

As a sociological study, Al-Ryias (1995) attempted to explore the social factors related to the relapse patients of substance abusers in Saudi Arabia. The study surveyed 399 relapsed subjects in three Al-Amal hospitals as well as 100 cues patients who stayed sober for three months or more as a control group. Alcoholics or alcohol patients totalled as much as one-third of the participants. By comparing the demographical data of relapsed and un-relapsed alcoholics, relapsed alcoholics tended to be younger, of low education, low income, unmarried, unemployed, and living in urban areas. Among alcoholics subjects the author also found that having alcohol user/abuser as a relative was higher among relapsed participants.

The oldest study of alcohol in Saudi Arabia is also a PhD thesis written by Al-Angari (1988). The study was also carried out in the Al-Amal hospitals where only two branches were running at that time and the total sample was 83 alcoholic patients. The researcher attempted to investigate whether there was a relationship between the Michigan Alcoholism Screening Test (MAST) and the Minnesota Multiphasic Personality Inventory, and the interaction between the MMPI and some personal characteristics of alcoholic patients. A justification of the goal of testing the relationship between the MMPI (which is a scale designed to assess a number of the major patterns of personality and emotional disorders) and the MAST (which is a scale designed as a screening test for assessing alcohol abuse) was absent from the thesis. Although patients' characteristics were one of the study targets, the study did not scan many such characteristics; just age, marital status, educational level and occupation.

Methodology and Design:

The Study Problem

Addressing a problem or phenomenon within a society

considered to be uncovering it and a way towards its solution. Alcohol, in Saudi society, is studied from different perspectives, (e.g. health, medical, social, psychological). However, research gives little attention to the characteristics due to the study field and the special interest and direction of the study. According to this, there is little known about Saudi alcoholics and their personal and demographical characteristics. This study focuses on the characteristics themselves with some other related aspects highlighting any common themes among alcoholics. By concentrating on the main characteristics of the subjects, the study will form a clear profile of Saudi alcoholics who are hospitalized at Al-Amal hospital.

Method and Key Instruments

This study used the quantitative approach as a main method. The quantitative data collected by the main researcher used multiple instruments. The questionnaire was designed for this study and contained three parts (i.e. personal information, alcohol consumption and treatment attempts).

The Alcohol Use Disorders Identification Test (AUDIT) was chosen as a validated tool with a reliability of .86. It is particularly designed for health care practitioners and a range of health settings. It was developed by the World Health Organization (WHO) specifically to detect and identify heavy drinking as well as alcohol dependence. The scale contains ten items about recent alcohol use, alcohol dependence symptoms and alcohol-related problems. It takes 5 minutes to complete the ten questions that were divided into three subscales with three questions on the amount of frequency of drinking, three questions on alcohol dependence and four questions on problems caused by alcohol. The Responses to each question are scored from 0-4 and scores range from 0-40. A total score of 8 or more indicate hazardous or harmful alcohol use. The AUDIT is a very widely used instrument and was translated and adopted into more than 16 languages since its first publication (Babor et al., 2001) including Arabic language and Saudi cultural specifically (Al-Dakhil, 2002).

The Subjects

Al-Amal hospital in Saudi Arabia is the only location where alcoholism is officially and publicly treated in Saudi Arabia and where alcoholics can publicly regard themselves as such. Therefore, for practical purposes, the population of alcoholics and, indeed, alcohol users and abusers more generally, that is available for study in Saudi Arabia is limited to these people. The research was thereby tracked towards groups receiving alcohol treatment. However, issues remained in regards to exactly which groups to study, how to investigate them and how many people to approach.

The subjects in this research were all male alcohol-related patients who were hospitalised for treatment at Al-Amal Hospital that located in Riyadh city, Saudi Arabia during the period of January to July 2010. The sample was totalled 120 patients of alcohol-consuming subjects with different drinking patterns who participated in the study. The sample was divided into two equally sized samples (n = 60). The questionnaire and the AUDIT were administered to these two samples after being randomly selected.

Female patients amount only to 1-10 % of all patients and more exaggerated secrecy would have applied if trying to access their ward even for the purpose of scientific research. It should be stressed here that Al-Amal hospital was the sole realistic source of a Saudi sample with which to study the relation to alcoholism. The principal researcher early on sought official permissions from the hospital, signed ethical forms and

latterly obtained permission from all participants in all samples agreeing to take part in this study.

All participants (N = 120) were selected from the ward as alcoholic patients based on their blood test results, which was taken when they were first admitted. Also, all of them came to the hospital voluntarily as they considered themselves alcoholics.

Ethical considerations were taken into account through these strategies; a) getting a formal approval from the medical and ethical committee at the hospital, b) giving a short presentation to the patients explaining the study and the right of the patients to accept or reject taking part in the study, and c) considering anonymity during the study stages.

Study Limitations

There are four basic limitations of this study which are; a) sampling: the sample was picked from Al-Amal hospitals in Riyadh while there are three other hospitals located in different regions in Saudi Arabia, b) sample size: the sample size consider to be small (N= 120) which minimize the accuracy of the finds; c) the subjects: the subjects were limited to male only while there are female alcoholics at Al-Amal hospitals or maybe at other hospitals or agencies, and similarly a limitation subjected to consideration of non-Saudi in the cultural context of Saudi Arabia.

Findings

Socio-demographic data analysis

The alcoholic patients were spread fairly evenly in terms of age from 20 upwards, but the average ranged between 32-36 years with mean age around 31 years. The largest group were 'never married', only a minority were married and there were roughly equal numbers who were currently and formerly married. The massive majority of the sample started drinking alcohol at early age (20 years old), and have low levels of education (lower than college). Thirty-seven percent had never had a job and many of those who were employed were in temporary posts. Worldwide studies have found that heavy drinkers tend to delay marriage (Martino et al., 2004), are less likely to get married (Power et al., 1999; Horwitz and White, 1991), to stay married (Cacas et al., 1999; Power and Estaugh, 1990), and also find it difficult to find and hold onto jobs (Temple et al., 1991). In this respect, the present study's findings also replicate earlier Saudi studies, findings by Al-Anazi (1999), Al-Angari (1988), Al-Dakhil (2002), Al-Damigh (1997), as well as some Western studies such as Claussen and Aasland (1993) and Colsher and Wallace (1990).

Most of the sample lived with others (74%) particularly their parental families or with their wives and children.

Table 4. Parametric data of age, smoking cigarettes, drinking coffee and age of first drink

Parametric data	In-patients		Out-patients		T-test	
	Mean	SD	Mean	SD	Value	Significant
Age	36.43	7.07	31.95	6.21	3.69	0.00
Number of cigarettes	35.80	9.81	37.11	8.17	-0.80	0.43
Number of cups of coffee	2.41	1.21	3.21	0.99	-3.96	0.00
Age of first drink	21.50	4.53	19.13	2.15	3.65	0.00

Table 4 shows almost all of the participants of the study smoked nearly 36 cigarettes a day and drank as

many as two cups of coffee daily. It has been found that consuming alcohol encourages a smoking habit and vice versa (Bien & Burge, 1990; Ragonese et al., 2003) and this study proved to be the case among the current sample. This result, when attached with alcoholic problems, may constitute an additional health hazard.

Table 5. Most consumed of drink cross-tabulated with the two samples

Type of drink	In-patients	Out-patients
Arag	32	40
Cologne	24	2
Others	4	18
Total	60	60

Chi-square value= 28.41 and associated significant= 0.00

In terms of type of drink, table 5 illustrates that Arag (60%) and Cologne (22%) are the most common types of alcohol that are consumed and this may be because Cologne is available to all. There has been growing evidence that the transition from the initial drink following abstinence (lapse) to excessive drinking (relapse) is influenced by an individual's perception of and reaction to, the first drink (Cummings et al., 1986; Marlatt and Gordon, 1990; Marlatt, 1998). In this particular result, health risks should be raised here due to the association with these two types of drinks. This is seen especially with Cologne, which is a perfume and considered by health professionals as a harmful drink (Chou et al., 1998). It has been proven that these types of drink could lead to faster intoxication if they are not diluted with water, soft drinks or juice (Rutherford, 1997). Alcohol treatment in Saudi Arabia should take this matter seriously and educate patients about this health hazard**.**

Table 6. Using illegal drugs besides alcohol cross-tabulated with the two samples

Using other drugs	In-patients	Out-patients
Non	49	27
Hashish	4	17
Stimulants	7	16
Total	60	60

Chi-square value= 17.94 and associated significant= 0.00

The use of other illicit drugs is also prevalent among Saudi alcoholics. According to table 6, stimulants are the drugs most used by the patients (19%) and hashish is the second (17.5%). The majority of the Saudi alcoholics (81%) had no family history of alcohol use.

Safety is the primary consideration when choosing whom to drink with and a location to drink in Saudi society in order to avoid arrest by police or others like the Religious Enforcement Council. Therefore, a unique feature of drinking alcohol in Saudi Arabia is that drinking mostly takes place in a hidden place. Most of sample were drinking with company (62%), while drinking alone was lower (38%), which itself can be a sign of addiction. The majority of alcoholic patients drank outside their own homes (76%). Private places, outside the city and at home were the places usually chosen to imbibe. These results are similar to those in the study of Al-Dakhil (2002).

The highest proportion of Saudi alcoholics felt that they do not have a drinking problem (55%). The othe 45% knowing they had a drinking problem have known for a while or just recently started realizing their problem.

The most common reasons for drinking were to seek pleasure (27%) and relaxation (23%). However, some alcoholics gave different reasons such as to release anxiety (11%) and to forget about problems (10%).

Although to forget about problems was low among the subjects, Cutter and O'Farrell (1984) found a strong association between drinking alone and drinking in order to forget problems. Also, to enhance sexual ability (8%) contradicts another Saudi study (e.g., Al-Qahtani, 1990). It should be mentioned here that psycho-social problems can interact with drinking in three ways.

(1) Psycho-social problems may occur before drinking and alcohol may make them worse given consumption is illegal in Saudi.
(2) Psycho-social problems may be present after drinking as a consequence of alcohol.
(3) Psycho-social problems may be latent before drinking but alcohol brings them to the surface.

All three processes may well be amplified in Saudi culture which implies a need for more studies to investigate the reasons behind drinking alcohol in Saudi Arabia.

In terms of feelings when drinking alcohol, both happy and relaxed were the most common (55%) feelings. These two feelings are the most likely reasons for drinking among Saudi alcoholics. It is worthwhile to state here that alcohol-related behaviours may be influenced by the outcome expectancies from alcohol use (Duka et al., 1998; Townshend and Duka, 2002).

Table 7. Number of admissions cross-tabulated with the two samples

Number of admissions	In-patients	Out-patients
1-4 times	20	8
5-7 times	26	27
More than 7 times	14	25
Total	60	60

Chi-square value= 8.26 and associated significant= 0.02

Alcoholics tend to have relapses, some participants having more than four admissions (44%) at Al-Amal hospitals as shown in table 7. There is strong evidence that approximately 90% of alcoholics are more likely to experience at least one relapse over the 4-year period following treatment (Polich et al., 1991). The study's result is similar to that found by Al-Nahedy (1999), Al-Ryias (1995) and is also in line with most worldwide studies that proposed craving for alcohol as a significant factor for causing relapses (Field and Duka 2002; Duka et al., 1999).

Table 8. Believe in craving cross-tabulated with the two samples

Belief in craving	In-patients	Out-patients
Yes	41	60
No	19	0
Total	60	60

Chi-square corrected value= 20.26 and associated significant= 0.00

Belief in craving alcohol has significantly higher rates among Saudi alcoholics. Table 8 demonstrates that 84% of the subjects believed that craving was a factor of relapse. A large body of international research has documented the role of alcohol outcome expectancies in the development, maintenance and treatment of alcoholic problems (Goldman et al., 1999). For example, Marlatt and Gordon (1995) suggested that cognitive factors such as expectancies or beliefs can induce craving and relapse, emphasizing that craving and self efficacy are reciprocally related (May et al., 2004; Walton et al., 2003; Kallmen et al., 2003). It has also been shown that expectancies can be influenced by alcohol-related interventions (Connors et al., 1993) and can predict post-treatment use levels (Jones and McMahon, 1994).

Comparisons of the variables discussed among in-patients and out-patients, t-test showed that in-patients

are more likely to be older and started drinking alcohol younger than the other group; while out-patients tend to drink a higher number of cups of coffee than the in-patient's group which may refer to the availability of coffee. On the other issue, Chi-square tests found statistically significant differences between the two samples in terms of type of drink, place of drinking, having a drinking problem, feelings when drinking, using other drugs, number of admissions and belief in craving as a factor of relapse.

Generally, almost all participants showed noteworthy connections between consuming alcohol, a smoking habit, drinking coffee and belief in craving as a factor of relapse. Some laboratory studies have proved the interaction between smoking and craving (Cepeda-Benito and Tiffany, 1996; Sayette and Hufford, 1994; Sayette et al., 1994). The interrelationships between alcohol, cigarettes and coffee have also been indicated by numerous studies. For instance, most, but not all, studies show that heavy coffee and alcohol users are less likely to succeed in giving up smoking (Lima et al., 1990; Kaprio and Koshenvuo, 1998; Carmody et al. 1985; Istvan and Matarazzo, 1984; Pedersen and Floderus-Myrhed, 1984; Freidman et al., 1979; Caggiula et al., 1981; Kannel, 1996).

AUDIT analysis

By looking at the AUDIT results from the cases individually, it appears that with no exception, all the patients scored 8 points or above which clearly indicates alcoholism according to the scale protocol as described earlier. The subjects' points range from 8 up to 28 points with a total mean 28.81 with a standard deviation of 6.46 for both samples. Chart number 1 classified the scores on the scale based on its three domains (i.e. hazardous alcohol use, harmful alcohol use, and dependence symptoms).

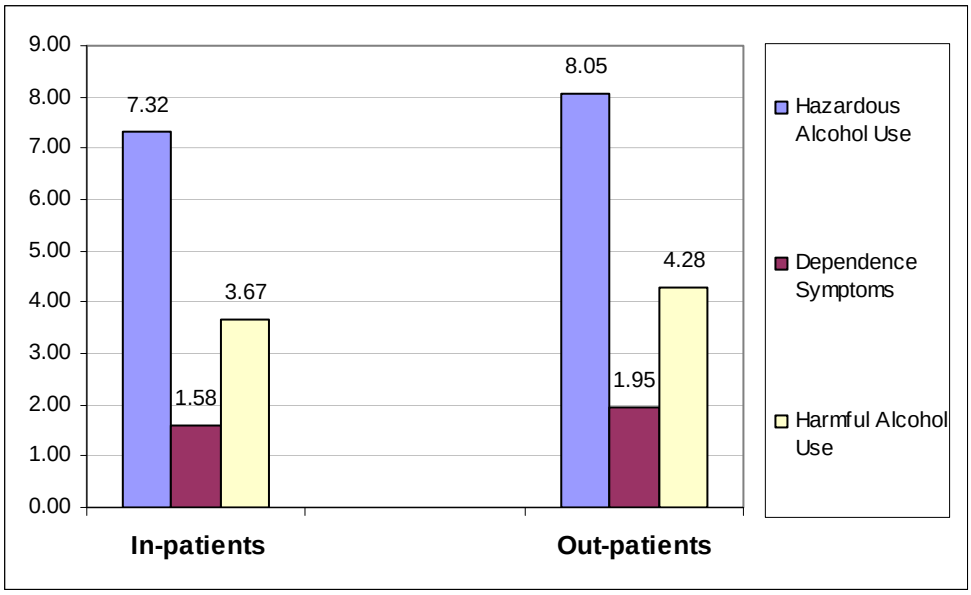

Figure 1: Means of the Three Domains of Audit for the Two Samples

Figure number 1 illustrates that hazardous alcohol use (i.e., questions 1, 2 and 3) is the highest domain.

Harmful alcohol use (i.e., questions 4, 5 and 6) ranked as the second highest followed by dependence symptoms (i.e., questions 7, 8, 9 and 10). The out-patient's group scored a bit higher than the in-patient's group in all three domains.

Table 9. Testing the three domains of the AUDIT by t-test

AUDIT domains	Value	Significant
Hazardous alcohol use	-3.13	0.00
Dependence symptoms	-1.14	0.25
Harmful alcohol use	-1.22	0.23

An independent-sample t-test was conducted to compare the three domains of the AUDIT for in-patients and out-patients. It appears from table number 9 that the first domain 'hazardous alcohol use' has a statically significant difference in the mean scores for out-patients (M= 8.05; SD= 1.10) and in-patients [M= 7.32; SD= 1.44; t(118)= -3.13, p< .001]. There was no significant difference in scores for in-patients (M= 1.58; SD= 1.57) and out-patients [M= 1.95; SD= 1.93; t(118)= -1.14, p> .001] in the dependence symptoms. Similarly, the harmful alcohol use domain has no significant difference in scores for in-patients (M= 3.67; SD= 2.35) and out-patients [M= 4.28; SD= 3.15; t(118) = -1.22, p> .001]. In these two particular domains the scores of significant value were above the required cut-off .05.

Comparing alcoholic respondents with their level of alcoholism

Since all the participants were technically alcoholics but with AUDIT scores ranging from 8 up to 28, it is worthwhile to look at the distribution for different sub-groups. Table number 10 divides both samples into areas both lower and higher than the median (Median= 12) of the AUDIT making a comparison with nine different variables (i.e., age, smoking, drinking coffee, age of first drink, type of alcohol consumed, having a drinking problem, using other drugs, number of admissions and belief in craving).

Table 10. Nine different variables cross-tabulated with the median of AUDIT

Age	**< = 12**		**> 12**	
	N	**%**	**N**	**%**
30 and under	25	37	18	34
31-40	32	47	17	33
41 and over	11	16	17	33
Chi-square value= 4.97; degree of freedom (df)= 2.00; and associated significant= 0.08				
Smoking				
30 < cigarettes a day	27	40	17	33
30-40	35	51	30	57
More than 40	6	9	5	10
Chi-square value= 0.63; degree of freedom (df)= 2.00; and associated significant= 0.73				
Drinking coffee				
1 cup of coffee a day	15	22	10	19
2-3	30	44	18	35

More than 3	23	34	24	46
Chi-square value= 1.92; degree of freedom (df)= 2.00; and associated significant= 0.38				
Age of first drink				
20 and under	49	72	32	54
21-30	17	25	17	29
31 and over	2	3	3	17
Chi-square value= 1.66; degree of freedom (df)= 2.00; and associated significant= 0.44				
Type of drink				
Arag	46	67	26	50
Cologne	14	21	12	23
Other	8	12	14	27
Total	68		52	
Chi-square value= 5.31; degree of freedom (df)= 2.00; and associated significant= 0.07				
Have drinking problem				
Yes	33	27	21	17
No	35	73	31	83
Chi-square value= 0.79; degree of freedom (df)= 1.00; and associated significant= 0.37				
Using other drugs				
Non	45	66	31	59
Hashish	15	22	6	12
Stimulants	8	12	15	29
Chi-square value= 6.55; degree of freedom (df)= 2.00; and associated significant= 0.04				
Number of admissions				
1-4 times	16	24	12	23
5-7 times	35	51	18	35
More than 7 times	17	25	22	42
Total	68		52	
Chi-square value= 4.61; degree of freedom (df)= 2.00; and associated significant= 0.10				
Belief in craving				
Yes	59	87	42	81
No	9	13	10	19
Chi-square corrected value= 0.79; degree of freedom (df)= 1.00; and associated significant= 0.37				

Chi-square tests indicated no significant differences in the variables of age, smoking, drinking coffee, age of first drink, type of drink, have a drinking problem, number of admissions and belief in craving. On the other hand, the test illustrated only a statically significant difference in using other drugs variable where the significant level was .04. The result, therefore, suggests that there is a difference in alcoholism levels across the different groups of using other drugs (i.e. alcohol alone, alcohol and hashish, alcohol and stimulants). Those who

consumed alcohol with a low level were more likely to use alcohol only, but if they were to combine a drug, there choice would be 'hashish.' A high level of alcoholism, by contrast, was higher when using stimulants compared with low level of alcoholism. This shows a correlation between people who have more of a drinking problem and the likeliness to also use illegal drugs and drug abuse.

Recommendations

a) Recommendations for policy makers

1. Review alcohol treatment policy to give more consideration to some common themes within alcoholism, especially relapses. Counting admissions and applying punishment may turn the patients away from seeking treatment.

2. Alcohol educational programmes should be concentrated on adolescents and youths, since drinking starts at an early age among the sample of the study.

3. Study strategies to create a broader awareness throughout society of the hazard of alcohol consumption and its related consequences, for example drinking dangerous beverages like Cologne and its possible effects causing liver damage.

b) Recommendations for alcohol treatment

1. Develop a new clear plan for alcohol treatment that could include a description of the treatment program, therapies provided, eligibility for treatment, length of stay and its requirements, admission and discharge procedures and so on. The plan should consider heavy drinkers and their high possibilities of relapse.
2. All staff at Al-Amal hospitals should be trained to reach the highest standard; professionals need to able to develop and adapt measurements and therapies for craving and treating alcohol and other illicit drugs. Social Workers and other professional should be trained on this protocol of treatment.
3. Alcohol treatment at Al-Amal hospitals should develop a treatment program to help combined dependency (e.g., stimulants and hashish) might need special treatment or intervention.

c) Recommendations for future research

1. More research in the field of alcohol craving is necessary to investigate the exposure of other factors like emotional, motivational and cognitive processes, as well as measuring other the possible lines between craving and other drugs.

Social Work Support

a) Treatment Perspective

Intervention to properly provide treatment should be based on fully understanding the clients' needs, problems and the environment surrounding them. All of these factors should be dealt with within the framework of culture. These factors are of significant importance for the success of the treatment being provided. In order to provide the treatment and/ or fill in the gaps of the treatment, the social workers can engage in accomplishing tasks as part of the whole treatment procedure.

The family of the patient plays in important role during the treatment of their drinking problem. The real reason behind such a problem needs to be investigated by the social workers involved. Then, an effort should be made to encourage the participation of the family during the treatment process. Wives could be educated by female social workers as to how to handle their husbands drinking and also how to encourage them to enter and participate in appropriate treatment procedures. Or at the very least, limit the amount of alcohol that they consume.

Moreover, working in alcohol treatment social workers should take into consideration the factor that some children and wives can be the victims of abuse and violence as a result of alcohol abusers. Hence, exploring cases of violence and abuse is an important role that social workers play, providing them with the assistance they need including referring to an appropriate resource or counselling.

Social workers who work in alcoholic treatment need to be mindful of the situation the family is in by working with them to help address other problems they may be encountering. As a preventative measure, a program should be started by social workers to co-operate and communicate with other departments and agencies. These could include family/ marriage counselling and family planning to help identify and prevent any instability within the family.

b) Prevention Perspective

One of the main goals of the social work profession is prevention. Along with treatment, therefore, a leadership role should be assumed by social workers in order to tackle the problem of drinking by implementing alcohol education campaigns. In other words, social workers should take the initiative to step in, assist and encourage the participation of other medical stakeholders, not only participate in these interventions themselves.

Social workers need to be knowledgeable about targeted populations, alcohol problems, alcoholism and other agencies interested in the prevention of alcohol. Furthermore, social workers require refined interpersonal communication skills to inform the community of the issues and impact of alcoholism in society. In the area of alcohol prevention, valuable information can be provided from the first drinking experience. Social workers, as part of their professional duties, should educate the public on the potential dangers of becoming alcoholics through the co-operation of others. An example of this could be in the collaboration of social workers and school principals. Together they could provide students and their parents with presentations and lectures about alcohol and dependency.

In order for alcohol education to be effective, educational materials need to be suitable for all parties, parents, children and teachers. All parties involved would need to understand the problems of alcoholism and are able to recognise the issues associated with the condition. It is necessary to note that a number of the wives and parents are illiterate so the educational material will have to meet their literacy levels. Also, simple methods could be used by social workers to pass on the message to children of a young age.

As drinking alcohol is illegal in Saudi, the ultimate goal for those being treated is total abstinence. However, total abstinence should not be the only treatment option that the patient has access to. If the patient is not achieving success through traditional treatment, an option that is highly recommended encourages the patient to modify behaviours to assist in ‘breaking’ the drinking pattern activity.

Drinking and smoking both have their own health risks. Combining that consumption of both smoking and drinking can bring even greater risks. Therefore, social workers involved in treatment should assist patients in learning about the health risks involved and to help them quit both if at all possible.

c) Cultural Perspective:

Given the complexity of problems regarding alcohol and the distinct characteristics of drinking alcohol in the society of Saudi, the programme for treating clients should be developed to have a full understanding of the

patient in their environment. A person cannot simply stop drinking even though it is legally, religiously and socially unacceptable in the society in which they are a part of. This may have something to do with the person's personality and the environment that they are surrounded by. Therefore, through recommendation, social workers involved in treatment of patients should understand and view the whole situation that the person is in. From this understanding the effectiveness of all the stages of treatment can be increased.

Given alcohol is religiously and socially illegal in Saudi society; it is most likely to link a social stigma to alcoholics. Given the strong effects of this social stigma some individuals may avoid seeking medical intervention or treatment. Therefore, social workers who work in the treatment process should develop ways to provide more privacy for patients and their families. For example, methods of treatment like group therapy would be culturally inappropriate in Saudi society because people feel very uncomfortable discussing their personal problems when in the company of others. Therefore, the assumption can be made that more individualised treatment needs to be put forward with a holistic approach to care of the patient. All medical stakeholders would need to be engaged to maximise the efficacy of the intervention.

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خصائص مدمني الكحول في المجتمع السعودي

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ملخص

تهدف هذه الدراسة الكمية إلى الاطلاع على خصائص مدمني الكحول في المملكة العربية السعودية. وقد استخدمت الدراسة أداة الاستبيان لجمع بيانات ديموغرافية عن مدمني الكحول، بالإضافة إلى مقياس "اختبار تحديد اضطرابات استعمال الكحول" (AUDIT)، لمحاولة تحديد مستوى الكحول بين المدمنين. خلصت الدراسة إلى أن جميع المبحوثين على مستوى عال من إدمان الكحول، بالإضافة إلى الوصول إلى بعض النتائج العامة ذات العلاقة، وبعض السمات الأخرى مثل شرب السجائر، وتكرار حالات الانتكاسة، وكذلك بعض الخصائص الديموغرافية الأخرى. قدمت الدراسة بعض التوصيات المتعلقة بالدراسات المستقبلية وبعض التوصيات الأخرى، كما قدمت إطاراً نظرياً عن دور الخدمة الاجتماعية مع مشكلة إدمان الكحول في المجتمع.

الكلمات الدالة: مدمني الكحول، المجتمع السعودي، الخصائص الشخصية، شرب الكحول.

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