Alcoholism and Domestic Violence in Saudi Society

by

Abdulaziz A. Albrithen

Thesis submitted in accordance with the requirements of the University of Liverpool for the degree of Doctor of Philosophy in Social Work

THE UNIVERSITY
of LIVERPOOL

September 2006

Abstract

Domestic violence is a common social problem throughout the western world, resulting in a great many deaths and physical and psychological injuries every year. Previous studies show that alcohol use and intoxication, by both the perpetrators and victims, are frequently implicated in violent events. Although the association or correlation between alcohol and domestic violence is still open to discussion in all countries, its investigation has never previously been attempted in Saudi Arabia where alcohol is not allowed and domestic violence is not yet officially acknowledged. This, therefore, is the first investigation into the association in Saudi Arabia between alcohol (ab)use and domestic violence.

Western explorations into the extent and causes of domestic violence have taken many different approaches. For example, some researchers have undertaken surveys of violence in communities while others have interviewed the victims of violence. Others have tested individual subjects on their interpersonal aggression, while yet others have inspected police records and/or hospital data. Following a review of international research, this thesis then explains why, in Saudi Arabia, it was decided that surveying alcoholic men and interviewing women married to alcoholic men, plus comparison groups, would be the best way to begin exploring the connections between alcohol and domestic violence.

This present study is based on interviews with 144 male alcoholic patients who had sought treatment at Al-Amal hospitals in Riyadh, Jeddah, Dammam, and Qaseem, 25 women married to alcoholic men, 25 women married to drug user men, and 25 women married to ‘ordinary’ men. These surveys were complemented by narrative biographical interviews with four alcoholic patients and three focus groups with a total of 18 alcoholic patients. The study, therefore, gathered quantitative and qualitative evidence. Alcoholism among the alcoholic patients was measured using an adapted version of the Michigan Alcoholism Screening Test (MAST), and marital conflict by an adapted Conflict Tactics Scales (CTS).

The results suggest that alcoholism has a highly significant relationship with domestic violence in Saudi Arabia, and that the specific circumstances - prohibition, illegality and social stigma - that currently prevail in Saudi society could well be exacerbating the effects of alcohol (ab)use within families. The study has found high levels and frequencies of aggression committed by alcoholic men particularly those who consumed alcohol heavily and the violent incidents were more likely to occur at the time of drinking or intoxication. The violence was against numerous family members including sisters, brothers, children, parents, and in few cases grandparents, but the married woman was far and away the most likely victim. The women married to alcoholic men were experiencing many types of violence - verbal, psychological, physical and sexual. The alcoholics and their families were enduring economic difficulties, poor quality family lives, neglected duties and obligations, high levels of guilt feelings, and sexual difficulties. There were obstacles inhibiting women married to alcoholics from leaving their husbands. The husbands themselves ran constant risks of being arrested and imprisoned.

The thesis concludes with suggestions for further research, and for changes in policy and practice in Saudi Arabia vis-à-vis alcohol and domestic violence.

Contents

Abstract …….…….. ii
Table of contents ……..……..…. iii
List of tables and figures ……..…….……..…… v
Acknowledgments ……..……..…. vii

Chapter one
Introduction ……..…… 1

Section one: Alcohol in Saudi Arabia ……..……... 3
Increased alcohol in Saudi Arabia ……..... 3
Alcohol treatment ……..... 7
Alcohol studies ……..…... 9
Religious and legal issues ……..…… 11
Sociological issues ……..…….. 13

Section two: Family life in Saudi society ……..…… 15
Social issues ……..…. 17
Education issues ……..…….. 22
Economic issues ……..…….. 23

Section three: Domestic violence ……..…… 25
Historical background ……..…. 26
Theoretical explanations ……..……. 29
Domestic violence in Saudi Arabia: religious and legal issues ……..…….. 33

Conclusions ……..……..…….. 36

Chapter two: Previous studies of alcohol abuse and domestic violence ……..……. 39
Introduction ……..……. 39
Victim and treatment programme samples ……..…. 40
Experimental and quasi-experimental studies ……..…... 49
General population studies ……..……. 52
Summary ……..……. 59

Chapter three: Research design and methods ……..…….. 62
Introduction ……..…… 62
Aims and objectives ……..……. 62
Conceptual framework ……..……. 63
Main methods ……..…... 64
Key instruments ……..…… 65
The subjects ……..…….. 71
Testing and adapting the measurements ……..…….. 75
Data collection and analysis ……..……...…. 79
Difficulties ……..…… 80
Conclusion ……..…… 81

Chapter four: The three samples of married women ……..…… 82
Closed questions ……..……..…….. 82
Open questions ……..…….. 88
CTS results ……..……..…….. 96
Summary ……..……..…….. 99

Chapter five: Alcoholic patients and women married to alcoholics ……..……..……..…. 101
Demographical data ……..……..…… 101
Alcoholic patients comparison ……..……..……..……..…….. 104
MAST ……..……..…….. 116
Comparing alcoholic patients with women married to alcoholics ……..…... 118

Alcohol and aggression …… 120
Discussion …… 131

Chapter six: Narrative interviews with alcoholic patients …… 134
Never married patient, Riyadh region …… 134
Currently married patient, Jeddah region …… 138
Separated patient, Dammam region …… 141
Divorced patient, Qaseem region …… 145
Conclusions …… 148

Chapter seven: Focus groups with alcoholic patients …… 150
Never married patients …… 151
Married patients …… 155
'Other' patients …… 161
Discussion …… 165

Chapter eight: Conclusions …… 168
Main findings …… 168
Reviewing the study's original questions …… 177
Recommendations …… 181
Recommendations for future research …… 182
Recommendations for policy makers …… 183
Recommendations for alcohol and violence treatments …… 184
End note …… 181

Appendices
Appendix 1: Michigan Alcoholism Screening Test …… 185
Appendix 2: Conflict Tactics Scales …… 186
Appendix 3: Questionnaire for alcoholic patients …… 188
Appendix 4: Tables and figures of alcoholic patients sample…… 195
Appendix 5: Semi-structured interview with 'ordinary' women…… 207
Appendix 6: Semi-structured interview with women married to drug users …… 211
Appendix 7: Semi-structured interview with women married to alcoholics…… 215
Appendix 8: Tables and figures of 'ordinary' women sample…… 219
Appendix 9: Tables and figures of the sample of women married to drug users…… 223
Appendix 10: Tables and figures of the sample of women married to alcoholics…… 227

References …… 231
Bibliography …… 249

List of Tables and Figures

Table 1.1: Alcohol-related incidents discovered by the police in selected years ……... 4
Table 1.2: Alcohol-related incidents presented by the type of crime …….. 5
Table 1.3: Alcohol crimes by nationality, gender and age …….. 6
Table 3.1: Number of Admitted Alcohol-Related and Drug-Related Patients in three Al-Amal Hospitals between 1991-199…...…… 72
Table 3.2: Number of Alcohol Related Incidents Discovered by Police ……... 72
Table 3.3: Total number of respondents included in and excluded from the study ……... 73
Table 4.1: Respondents' husbands' experiences of being arrested …… 83
Table 4.2: Respondents' who had suffered seriously due to violent acts …….. 83
Table 4.3: Respondents' calling for help due to violent acts ……. 84
Table 4.4: Respondents' who had felt scared to tell others about violent acts …….. 84
Table 4.5: Respondents' answers on getting married if they had known about their husbands' Behaviour ……..…… 85
Table 4.6: Respondents' attitudes towards their married lives …….. 86
Table 4.7: Respondents' descriptions of their marriage situation …….. 86
Table 4.8: Respondents' descriptions of their marriage conditions ……... 87
Table 4.9: Means and standard deviations on CTS Scales for enacted and received violence of the three samples ……..……... 97
Figure 4.1: Total means of CTS of the three samples of women ……..……...….. 99
Table 5.1: Respondents' ages cross-tabulated with name of Al-Amal hospitals ……..... 101
Table 5.2: Respondents' marital status cross-tabulated with type of ward ……..… 102
Table 5.3: Educational status of patients and wives ……... 102
Table 5.4: Respondents' ages at first time of drinking cross-tabulated with preferred current drink ……...…….. 102
Table 5.5: Respondents' number of marriages and number of children ……...…….. 103
Table 5.6: Women who had left alcoholic patients on account of their behaviour ……...…….. 103
Table 5.7: Respondents' ages cross-tabulated with their marital status …….. 104
Table 5.8: Respondents' employment status cross-tabulated with their marital status ……... 104
Table 5.9: Respondents' current living arrangements cross-tabulated with their marital status ……. 105
Table 5.10: Respondents' number of family friends cross-tabulated with their marital status ……... 105
Table 5.11: Who the respondents spent most time with cross-tabulated with their marital status ….. 106
Table 5.12: Who respondents' mostly drank with cross-tabulated with their marital status ……... 106
Table 5.13: Respondents' places of drinking cross-tabulated with their marital status ……... 106
Table 5.14: Respondents' feelings when drinking cross-tabulated with their marital status ……... 107
Table 5.15: Respondents' main reasons for drinking cross-tabulated with their marital status …….. 107
Table 5.16: Respondents' thoughts on alcohol's effects cross-tabulated with their marital status …. 108
Table 5.17: Respondents' feelings after drinking but before becoming drunk cross-tabulated with their marital status ……..…… 108
Table 5.18: Respondents' reasons for hospital admission cross-tabulated with their marital status ... 109
Table 5.19: Respondents' main motive behind coming to hospital cross-tabulated with their marital status ……..…… 109
Table 5.20: Respondents' family history of alcohol and other drugs cross-tabulated with their marital status ……..…… 110
Table 5.21: Respondents' families' awareness of them drinking alcohol cross-tabulated with their marital status …… 110
Table 5.22: Respondents' behaviour if someone was bothered cross-tabulated with their marital status ……..……... 110
Table 5.23: Respondents' behaviour with others while drunk cross-tabulated with their marital status ……... 111
Table 5.24: Respondents described by others as aggressive while drunk cross-tabulated with their marital status …… 111
Table 5.25: Respondents who had injured a family member because of a drink problem cross-tabulated with their marital status ……..…… 111
Table 5.26: Respondents who had thrown something aggressively at a family member cross-tabulated with their marital status ……..…… 112
Table 5.27: Respondents who needed sex after drinking cross-tabulated with their marital status … 112
Table 5.28: Respondents' guilty feelings regarding their behaviour after drinking cross-tabulated with their marital status …… 112

Table 5.29: Families' calls for help regarding drinking behaviour and using an implement when family conflict occurred cross-tabulated with their marital status …….…….. 113
Table 5.30: Any bad behaviour to any member of the family while drunk cross-tabulated with their marital status ……..…….…… 113
Table 5.31: Respondents who had ever been arrested and the reasons cross-tabulated with their marital status ……..…….…. 113
Table 5.32: Respondents who had ever been imprisoned due to drinking cross-tabulated with their marital status …… 114
Table 5.33: Respondents who had ever forced others to obey them cross-tabulated with their marital status ……..……. 114
Table 5.34: Respondents' family members who had gone to a hospital as a result of negative behaviour cross-tabulated with their marital status ……..……... 114
Table 5.35: Respondents who had abused other family members cross-tabulated with their marital status ……. 115
Table 5.36: Who respondents mostly had a problem with cross-tabulated with their marital status ... 115
Table 5.37: MAST questions and points …….. 117
Table 5.38: Mean and standard deviation to MAST scale ……... 118
Table 5.40: Attitudes towards married lives …… 118
Table 5.41: Descriptions of marriage situations …….. 118
Table 5.42: Descriptions of marriage condition ……...…….... 119
Table 5.43: Means and standard deviations on CTS Scales for enacted and received violence of the two samples ……..……..... 120
Table 5.44: Respondents' marital status cross-tabulated with average mean of MAST scale …… 121
Table 5.45: Respondents' MAST scale cross-tabulated with their marital status ……... 121
Table 5.46: Respondents' ages cross-tabulated with MAST scale …….. 121
Table 5.47: Respondents' types of admission cross-tabulated with MAST scale ……... 122
Table 5.48: Respondents' reasons for hospital admission cross-tabulated with MAST scale …...…. 122
Table 5.49: Respondents' educational status cross-tabulated with MAST scale ……...…. 122
Table 5.50: Respondents' preferred current drink cross-tabulated with MAST scale ……...…. 122
Table 5.51: Respondents' places of drinking cross-tabulated with MAST scale …… 123
Table 5.52: Respondents' MAST scale by age and marital status ……...……... 124
Table 5.53: Respondents' behaviour with others while drunk cross-tabulated with MAST scale ….. 125
Table 5.54: Who respondents mostly had a problem with cross-tabulated with MAST scale …… 125
Table 5.55: Respondents' behaviour if someone was bothered cross-tabulated with MAST scale … 125
Table 5.56: Respondents' described by others as aggressive while drunk cross-tabulated with MAST scale …….. 125
Table 5.57: Respondents' types of violence against other family members cross-tabulated with MAST scale …….. 126
Table 5.58: Respondents who had ever forced others to obey them cross-tabulated with MAST scale ……..... 126
Table 5.59: Families' calls for help regarding drinking behaviour and using an implement when family conflict occurred cross-tabulated with MAST scale ……..……. 127
Table 5.60: Respondents' guilty feelings regarding their behaviour after drinking cross-tabulated with MAST scale ……...…….. 127
Table 5.61: Respondents types of violence against other family members by marital status and MAST scale ……. 128
Table 5.62: Currently married patients' means and standard deviations to MAST and CTS scales ... 130

Acknowledgements

I would like to acknowledge the support and guidance of Professor Ken Roberts who was always an accessible supervisor and perpetually encouraged me to seek experience in teaching and publishing. Further, I thank Professors Barry Goldson (advisor), Chris Jones and Cindy Fazey, Dr. Steve Miles, Dr. Karen Evans and Mr Abdullah Al-Nasser (Saudi Cultural Attaché) for their invaluable comments and continuous encouragement. I am very grateful for insight and assistance generously provided by my fellow student Julie Aldcroft. Deep appreciation is also expressed for the efforts given by the participants taking part in this study and the Al-Amal hospital staff. I extend particular thanks to social workers Kamilia Abu Rashed and Salma Madany who conducted the female interviews at Al-Amal hospital in Dammam, as well as Miteb Al-Numer and Saad Al-Shamary for their help in collecting data. Lastly, my heartfelt thanks to all of my family members, friends and colleagues who always cheered me on.

Chapter One
Introduction

For over two hundred years, many people have regarded alcohol as a cause of poverty and crime (Halvor et al., 2006). For this if for no other reason, alcohol is an emotional and bitterly contentious topic. Evidence of alcohol's negative, and yet compelling, associations can be seen through the American consciousness via the temperance movement of 1873-1900 and prohibition during the 1920s until 1933. Yet alcohol has enjoyed equally close associations with merriment and conviviality. Domestic violence is an old phenomenon in all societies, but was raised into a public issue in the West by second wave feminism in the 1970s. Since then 'domestic violence' has become part of our common vernacular and is seen as abuse of women in the domestic sphere. Domestic violence and alcohol abuse are both social problems, and they have other interesting characteristics in common. For instance, they are both prone to be 'hidden', and they are both often blamed by the abusers for their own problematic conduct.

Since the 1970s a huge volume of worldwide research has uncovered links between alcohol abuse and domestic violence (e.g., Gorad, 1971; Virkunnen, 1974; Gayford, 1975; Mayfield, 1976; Byles, 1978; Leonard et al., 1985; Livingston, 1986). Some facts are now well established and indicate that high percentages of alcohol abusers are violent (Livingston, 1986), and high (in some studies) percentages of domestic violence cases involve alcohol (Byles, 1978). We should note, however, that nearly all of this 'worldwide' research has been in Western countries. The relation of alcohol abuse to domestic violence is in fact very complicated due to the many possible combinations of cause and effect. This makes research in this area complex and challenging. It has become increasingly evident that simple assertions, either that alcohol is a main cause of violence, or that it is far less important than other causes of violence, cannot be treated as universally valid. Certainly, not all alcohol users are abusive to their family members. Nor does all violence within families involve alcohol. Alcohol is neither a necessary nor a sufficient cause of family violence. Yet even if family violence can have other causes, alcohol is on that list. Furthermore, there is growing evidence to suggest that alcohol abuse in its varying forms often contributes to violent behaviour (see, for examples; Fagan et al., 1988; Murdoch et al., 1990; Bushman and Cooper, 1990; Gondolf and Foster, 1991; Leonard and Blane,

1992; Taylor and Chermack, 1993; Pan et al., 1994; Ito et al., 1996; Chermack and Giancola, 1997; Brown et al., 1999; Wells at al., 2000; Leonard, 2001; Brecklin, 2002; Testa et al., 2003; Murphy et al., 2005; Leonard, 2005).

Because alcohol may not be the direct cause of domestic violence, it is likely that the links between the two phenomena are complex. On the one hand, the two could have the same 'third' cause, like the perpetrators' earlier experience of childhood abuse or violence. Also, we know that many victims of violence, though certainly not all, are themselves alcohol abusers (Straus and Gelles, 1990). In looking carefully at the consumption of alcohol and violence it may become evident that alcohol is sometimes used by perpetrators as an excuse (see MacAndrew and Edgerton, 1969). It also seems possible that alcohol sometimes subdues violent tendencies.

Saudi Arabia has developed and changed dramatically since oil was discovered in the late-1930s and has its own problem of alcoholism (as it is described locally). Even though alcohol is illegal under Saudi law, and prohibited by Islam, which is the Saudi religion, there are many people (though precise estimates are impossible at present) who use and/or abuse alcohol (Ministry of Interior Statistical Books, 1980, 1990, 1995, 1999, 2002).

In Saudi Arabia there has been no previous research into the possible link between alcohol and domestic violence despite the presence of a research centre at the Ministry of Interior in Riyadh for crime, and an Academy for Security Sciences in Riyadh that has published many research theses since before the 1990s. Meanwhile, researchers in other countries started studying the worldwide phenomena of alcohol and its effects on family life before the 1970s (e.g., Wolfgang, 1956). So this present study is exploratory in being the first to examine the alcohol-domestic violence link in Saudi Arabia. However, the study is able to build upon the existing worldwide literature, and to examine the applicability in a rather different culture of existing methods and their findings. While the associations between alcohol and domestic violence are well-established issues for debate and research elsewhere, their investigation has never previously been attempted in Saudi Arabia where alcohol is not allowed and domestic violence is not yet officially recognised. This means that the

investigation reported here has needed to navigate in a very distinctive socio-cultural context.

Working as a social worker for three years at Al-Amal hospital in Riyadh gave me a good insight into alcohol and its effects on personal and social life. As far back as I can remember, many Saudi families have severed their relationships with members who used alcohol. Some other factors, like Saudis' acute sensitivity to violence, led me to look closely at possible links between "alcoholism" and domestic violence. Having the opportunity to study in the UK under a governmental scholarship focused my attention and enhanced my motivation to research this phenomenon using scientific methods and tools.

As already mentioned, this study of the relationship between alcoholism and domestic violence in Saudi Arabia is the very first of its kind. The investigation has sought to establish if the association between alcohol and domestic violence appears to be basically the same in Saudi Arabia, where alcohol is prohibited, as it is in Western societies where alcohol is allowed and, in many ways, encouraged. The exploratory character of this research needs to be stressed. In Saudi Arabia there had been hardly any previous research into either alcohol use and abuse or domestic violence. The research reported here has been guided by, and largely built upon, foundations laid by previous research in other countries, but the enquiry was not designed to test hypotheses. Rather, the literature was used as a source of indicators about which groups to study, which fieldwork methods to use, and the kinds of questions to ask. One aim was to discover whether any Saudi specificities need to be taken into account in any future enquiries – specificities about the use of particular research methods in Saudi culture, and alcohol use and domestic violence themselves. However, the primary aim was simply to begin building a body of social science knowledge about alcohol and domestic violence in Saudi Arabia

The remainder of this chapter contains three sections; alcohol in Saudi Arabia, family life in Saudi society, and domestic violence.

Section One: Alcohol in Saudi Arabia

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 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, but 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-Nahedh (1999) and Al-Najar (1998) these factors are:

a) The growth of the economy that has been faster than formerly since the 1980s.
b) The increasing number of people who travel to other countries where alcohol is legal.
c) The global revolution during 1990s, particularly those aspects associated with the internet, movies, and TV satellites.
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.

The Ministry of Interior's Statistical Books (1980, 1990, 1995, 1999, 2002) record the increasing number of alcohol 'offences' as shown in the following two tables.

Table 1.1: *Alcohol-related incidents discovered by the police in selected years*

Year	Number of Incidents
1983	3023
1988	4627
1990	5063
1995	4999
1999	5309
2000	8610
2001	9792
2002	9886

The above table shows the significantly increased number of incidents since the 1980s, 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 (1999, 2002).

Table 1.2: *Alcohol-related incidents presented by the type of crime*

	1995		**1999**		**2002**	
	Incidents	People Involved	Incidents	People Involved	Incidents	People Involved
Drinking	4318	5093	4786	5611	8378	11047
Manufacturing	232	551	127	278	272	515
Possessing and Selling	449	698	396	653	1236	1921
Total	4999	6342	5309	6542	9886	13483

The above table describes the number of alcohol-related incidents and individuals convicted for such incidents by the type of crime in the years 1995, 1999 and 2002. It can be seen that increases occurred in the number of incidents of drinking and individuals convicted whereas there were reductions in the other types of alcohol offences - manufacturing, and possessing and selling - between the years of 1995 and 1999. However, in the latest available year, 2002, there are roughly double the numbers in 1999 in both alcohol-related incidents and individuals convicted for all the type 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).

The next table demonstrates the levels of apprehended alcohol use among Saudis and non-Saudis by gender and age (Ministry of Interior Statistical Book, 1995, 1999, 2002).

Table 1.3: *Alcohol crimes by nationality, gender and age*

	Year	Saudi	Non-Saudi	Male	Female	Adult	Minor	Total
Drinking	1995	4146	947	5074	19	5090	3	5093
	1999	4762	849	5603	8	2272	3339	5611
	2002	8678	2369	11003	44	10593	454	11047
Manufacturing	1995	108	443	510	41	550	1	551
	1999	34	244	254	24	184	94	278
	2002	128	387	488	27	495	20	515
Possessing and Selling	1995	251	447	678	20	695	3	698
	1999	209	444	639	14	343	310	653
	2002	833	1088	1879	42	1864	57	1921

* Minor is under 18 years old.

The above table reveals significant differences between male and female alcohol drinking, manufacturing, possessing and selling. It might be argued that drinking alcohol, but not manufacturing and possessing and selling, increased by about 130 drinkers each year from 1995 until 1999. It also appears that whereas up until 1995 adults were more likely to drink alcohol than minors, this had changed quite dramatically by 1999. By 2002 drinking, manufacturing, and possessing and selling alcohol had increased remarkably by 1812 drinkers each year from 1999. 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.

Also, according to hospital records, the number of known ‘alcoholics’ has increased since the 1980s. In 1988 there were only 83 alcoholics in the Al-Amal hospitals in Riyadh and Dammam whereas more than 83 alcoholic patients were admitted to the Riyadh hospital alone in 1992. In 1999, after opening the Jeddah hospital, the number decreased in Riyadh to just 47 patients, but the total number of alcoholics at all the Al-Amal hospitals in Saudi Arabia in 2001 was 148.

Despite the prohibition of alcohol in Islamic and Saudi law, which will be discussed later, the stern punishments, and the social stigma of drinking alcohol as well as being addicted to it, alcohol drinking (if not convictions for manufacturing, and possessing

and selling) has increased dramatically. Consequently, the Saudi government has adopted multiple strategies including prevention and treatment.

Alcohol treatment

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 capacities of these hospitals are not the same. The main hospital in Riyadh can hold more than 280 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 50 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 a ward 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 a 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 treatment activities like individual and group support, and 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, for patients who have five or more admissions and/or have criminal records besides drinking alcohol or using drugs. Patients can be entered or transferred into the secure wards by the court, the police, or the Bureau of Drug Prevention and Control due to having more than four admissions at any of the four hospitals, recommendations from their family or maybe by recommendation from any high level of authority of the government like the Ministry of Interior or the Regional Emirate. Therefore the patients may have come to treatment ‘voluntarily’ and then transferred into the secure wards due to any reason, mostly exceeding four times of admission. Sometimes (hospital staff claim) the presence of the Bureau in the hospitals affects the treatment negatively through reducing the authority of the therapists. Most of the therapy staff disagree 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 free treatment.

Alcoholism tends to be defined in Saudi society as an ‘addiction’. Professionally, at Al-Amal hospitals, the term alcoholism is most likely, but not always, to be defined, operationalised and diagnosed according to the DSM-IV (1998) criteria which are:

1- Increased tolerance for alcohol marked by an increased consumption of alcohol to achieve intoxication or desired effect or a diminished effect with continued use of the same amount of alcohol.
2- Existence of withdrawal as manifested by either the characteristic withdrawal syndrome for alcohol, or consumption of alcohol to relieve or avoid withdrawal symptoms.
3- Large amounts of alcohol are consumed or over a longer period than was intended, demonstrating lack of control.

4- Persistent desire or unsuccessful efforts to cut down or control alcohol use.
5- A great deal of time is spent in activities necessary to obtain alcohol, suggesting a preoccupation with alcohol.
6- Important social, occupational or recreational activities are either given up or reduced because of alcohol use.
7- The individual continues to use alcohol despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by alcohol.

Three or more of the seven criteria, through observation or documentation, occurring any time in the same 12-month period are required for a diagnosis of alcohol dependence. If three or more of these criteria are met, then the clinician will specify whether the person is physically dependent by noting if items 1 and/or 2 are present.

Generally, alcohol treatment in Saudi Arabia is not as progressive as may be thought. The hospitals individually struggle to apply useful programmes. There is no strategy for testing the programmes and no effective communication and sharing of experiences between the four hospitals. The Al-Amal hospitals are still hesitating to adopt some 'proven' Western treatment programmes like Half-way-Houses and Alcoholics Anonymous (AA). Another problem is the shortage of professionals who specialise in addiction and rehabilitation therapy.

Alcohol studies

A few psychological and sociological studies (e.g., Al-Dakhil, 2002; Al-Angari, 1988) have been conducted in the field of alcohol in Saudi Arabia and all these studies obtained their samples from the Al-Amal hospitals. Most investigated only the reasons that led the people to drink alcohol. It is rare to find an experimental or quasi-experimental study or even a study with its sample from any other place than the Al-Amal hospitals. The lack, and the weakness, of Saudi alcohol studies may be due to reasons such as:

a) The exaggeration of secrecy about alcohol and its use taken by the Ministry of Interior.
b) The social stigma of drinking alcohol and being addicted to it.
c) The extreme sensitivity to publishing studies or even statistics.
d) The lack of scientists who specialise in the field.

e) Negligence by the Ministry of Health towards the field.
f) Neglect by the government towards supporting any scientific research into the topic.

The studies reviewed below are limited to studying alcohol solely and their samples are restricted to Saudi society. The earliest study of alcohol in Saudi Arabia was published in the late-1980s. This and another study will be discussed below. Unfortunately, all the studies have been dissertations that have been geared to gaining a degree rather than publication in Saudi scientific or medical journals.

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. Al-Dakhil claims in his study that the Michigan Alcoholism Screening Test (MAST) (see Appendix 1) would not have been useful for his sample because some patients drank alcohol only once a month. This was despite such patients almost always being addicted to alcohol and having long histories with it, which somewhat undermines his claim. The researcher also argued that some of the MAST questions would not apply in Saudi culture, like; 'Do you ever feel guilty about your drinking?' even though the scale that he used, the Alcohol Use Disorders Identification Test (AUDIT), which is a scale developed to screen alcoholics, contained a similar question: 'How often during the last year have you had a feeling of guilt or remorse after drinking?' Also, he criticised the Michigan scale for its questions; 'Does your wife, husband, parent, or other near relative ever worry or complain about your drinking?' and; 'Has your wife, husband, or another family member ever gone to anyone for help about your drinking?' even though question number ten in the AUDIT was, 'Has a relative or friend or doctor or another health worker been concerned about your drinking or suggested that you cut down?'. Al-Dakhil's 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.

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 when only two hospitals were open 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 objective 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 an analysis of patients' characteristics was one of the aims, the study did not scan many such characteristics; just age, marital status, educational level and occupation. One major limitation is that the study failed to adapt the two scales (MAST and MMPI). The MMPI had been translated into Arabic by three Egyptian psychologists whose culture would be very different. The MAST was translated by the researcher, but never adapted to Saudi culture, and this can be seen in questions one and six where the author translated the phrase, 'a normal drinker', as 'legal and acceptable habit'. By that phrase the MAST aims to measure and to determine the individual's perceptions and the individual's perceptions of others who are subject to dependency and addiction. The study found interaction at the 0.05 level of significance between the MMPI profile and family relations. Groups with poor family relations had high scores on four clinical MMPI scales whereas groups with medium and strong family relations had normal scores. The author proposed further work involving adapting the MMPI and the MAST to Saudi culture.

Religious and legal issues

Islam is the main and official religion in Saudi Arabia, so most Saudi laws have Islamic sources. The Holy Qur'an, which is the first, the foremost, the most reliable, and the highest source of Islamic law, contains more than one indication of alcohol's prohibition. For instance;

> "They ask you concerning alcohol and gambling. Say: In them is a great sin, and some benefits for men, but the sin is far greater than the benefit" (Qur'an 2:219).

The objectives of Islamic divine laws are the protection of faith in God who is the creator, sustainer and carer of humanity and humans' intact lives without abortion, suicide or homicide, their safe property 'ownership', their sober minds without intoxicants, and their lineage without sex outside of marriage. Consequently, Islam prohibits all kinds of intoxicant beverages including any type of drink that contains even a small unit of alcohol. Not only is drinking alcohol prohibited, but also making it, selling it, keeping it, dealing in it, smuggling it, or even growing grapes for the sole purpose of sale to a winery are prohibited in all Islamic sources (Eied, 1984).

However, the decisive step entailing strict prohibition comes in the verse:

> "O you who believe! Intoxicants, and gambling, and sacrificing to idols, and divining arrows, are an abomination of Satan's handiwork. So avoid them in order that you may be successful. Satan only wants to excite enmity and hatred between you with intoxicants and gambling, and hinder you from the remembrance of God and from prayer. So will you not then abstain?" (Qur'an 5:90-91).

Alongside the clear prohibition, there are two types of punishment for those who consume alcohol. The first is related to the relationship between humans and God without mediation, which is one of Islam's principles. According to this relationship, God will punish those who disobey imperatives and prohibitions. Second is the punishment that can and should be applied by other humans through the authority of the courts and police. This punishment is usually limited to flogging - between 40 and 80 lashes (Al-Muateg, 1985; Eied, 1984).

Saudi law provides that punishment for alcohol offences should consist of 40 to 80 lashes but other punishments like imprisonment may be added by a judge depending on circumstances such as the drinker's age, intention, crime history, drinking history and other certain cases (Zufair, 1995). However, alcohol dealing, manufacturing and smuggling have more severe penalties and can even earn capital punishment. Generally, sentences in Saudi Arabia are issued by the courts and executed by police officers.

In order to protect society from such a 'sin' as alcohol, the Saudi government has taken steps that include establishing the Customs Control, the Border and Coastal Guards, the Religious Enforcement Council, the Bureau of Drug Control and more

recently the National Committee of Drug Prevention. Nowadays, there are more activities in schools and universities regarding protection and prevention. Also, today there is more talk about alcohol and its related problems within Saudi society. Accordingly, in the near future more statistics about alcohol and alcoholism in Saudi Arabia should become available, which may or may not lead to a decline in alcohol use and the related problems.

Regarding alcohol treatment as a part of the government's strategy, as mentioned previously, the Saudi government has established special hospital units for alcohol and other types of addiction. The hospitals are located in four parts of the Saudi continent and provide the free-of-charge therapies outlined above.

Sociological issues

Saudi society is a Muslim society in that Islam is the official religion and most characteristics of most people's lives reflect this. In general, people's attitudes towards alcohol are characterised by one or more of three perspectives; the need for and the reality of prohibition, stigma, and certain stereotypes of users.

The fact of, and the need for, prohibition play a major role in people's attitudes towards drinking alcohol or smuggling, manufacturing and selling the substance. The exact numbers of people who drink alcohol regularly and irregularly are not known, and people generally never talk about alcohol or their own drinking (if any) even if the drinking is abroad. Some people who enjoy alcohol but are not addicted to it seek illegal ways to buy alcohol, spending much of their income on this. Others take a 'legal' way and travel at weekends to some of the nearest countries where alcohol can be sold and consumed legally or semi-legally. A few people who cannot travel or buy expensive alcohol make their own liquor or may buy a cheaper substitute like Cologne.

Prohibition gives drinking alcohol special significance. Students and workers can be fired if they are found drunk many times at school, university or work. Also, a man who applies for a job can be rejected if he is a known drinker. Al-Muateg (1985) gives two legal examples. First, a person who drinks alcohol can be rejected as a witness at a court due to lack of trust. Second, a married woman can apply for divorce

at a court, if she wishes, due to her husband drinking. Therefore, alcohol drinkers usually conceal their habit except from those with whom they drink.

Social stigma is linked to prohibition. People who drink alcohol are normally concerned about other people considering them bad Muslims and, at the same time the punishment if they are caught. Due to these consequences, they try very hard to keep their drinking secret. Moreover, families who have a member who drinks alcohol will usually do their best to keep this a secret, thereby avoiding the social stigma that could affect the whole family. Contact with known alcohol users is usually avoided. For example, men may forbid the marriage of a daughter if the suitor's father is known to be an alcoholic or an alcohol drinker.

Because social relationships are highly important in Saudi society, social stigma has fundamental negative consequences. Individuals, families, relatives and tribes pay much attention to social stigma that, understandably, is not easy to remove. Consuming alcohol and its negative results, like being jailed, lead to serious social stigma.

Common stereotypes of drinkers are based on Saudi religious beliefs, and sometimes follow Saudi social class and age divisions. For example, religious people see alcohol as a huge sacrilege that could lead to loss of the brain, then killing or violating others. Most adolescents depend for their knowledge of alcohol on reading about its effects or watching movies. Some may play the role of being drunk with their friends not for fun, but to show that they are really grown-up. Adults usually know that alcohol can make a person happy and relaxed, but going further and trying that experience will depend on some other factor such as personal character, travelling abroad with friends and/or a weakening of religious beliefs. Most women, old religious men and conservative people, see alcohol as a sin and criticise drinkers as dissolute or even non-Muslim.

In sum, stereotypes can be divided into two general categories. The first is the need to fight alcohol as a clearly forbidden drink and without any further negotiation on the matter, which probably reflects the views of the majority of the population in Saudi

Arabia. The second is talking secretly about alcohol and taking pride in knowledge of its effects and knowing all the brand names.

Section Two: Family Life in Saudi Society

Family life in modern Saudi society has changed in two major stages. The first change occurred as a result of the oil revolution from the late 1970s and into the 1980s. The second stage was by the global communications revolution that happened through media developments in the 1990s.

With regard to these changes, family life in Saudi society, and the most recent events, will be discussed in more detail later. Many sources have discussed Saudi life after the establishment of the country (1925-1932) and up to 1980, before the second stage (e.g., Al-Rashid, 1976; Ibrahim and Cole, 1978; Eilts, 1971a; 1971b; Hopwood, 1972; Rugh, 1973). Also, there are a great many books that have described Saudi cultural life after the discovery of oil and during the 1980s when urbanisation, modernisation, and industrialisation accelerated (e.g., Niblock, 1982; Mordechai, 1988; Altorki, 1986; Huyette, 1985; Bahry, 1982; Al-Farsy, 1982). A few books and articles, but none from a sociological perspective, discuss the new stage that the society has faced since the 1990s (see; Arebi, 1994; Boudy, 1999; Doumato, 2002; El-Sanabary, 1994; Prokop, 2003; Roy, 1992; Al-Rasheed and Vitalis, 2004; Yamani, 2005; Hamdan, 2005). Therefore, concerning subjectivity and personal bias, this particular section requires discussion without references due to:

a) Most of the references that cover Saudi life were drafted to reflect a positive image of the society.
b) Most of the references are out of date while social life has been changed dramatically.
c) The lack of official literature on life within the country.

Saudi Arabia is about as diverse a country as it is possible to be; its people, geography and climate are greatly varied. The northern region is inhabited by Bedouins with special customs and the climate is extremely hot in the summer whilst it is very dry and cold in the winter. The northern region contains the industrial city of Yanbu which is located in the north-west. The southern region is more rural with special

customs, and the climate is damp and cold during the summer with beautiful natural features unlike all other regions. Oil is located in the eastern region which has a more modern and open society than elsewhere on the Arabic 'Persian' gulf and contains the second industrial city of Jubail. Here people are considered particularly friendly which, if so, may reflect the pleasant dry climate and modernity, and mixed ethnicities that were brought by oil companies in the early stage of the country's development. The western region is also relatively modern and open as a result of exposure to multiple cultures. Jeddah, for example, is a large and important Red Sea port city. Also, of great significance is the location of Mecca and Medina, the most holy cities in Islam. Foreigners often choose to settle in these places whose cultures and customs have mixed for centuries. The climate in the holy cities is extremely arid all the time whereas in the coastal cities of the Red Sea the climate is warm in the winter, but hot and humid during the long summer season. The central region is similar except for the capital of Riyadh where the central government is located. People in the middle region tend to be more religious, conservative and reactionary. Here, the climate is very arid in the summer with just three months of dry cold weather in winter. Riyadh's population is approximately four million, and it is important due to the fact that all commerce is based there regardless of other regions' and cities' appeal and despite its pollution problems and second-rate transportation system.

Generally, the climate in Saudi Arabia is harsh, dry desert with great extremes of temperature. An exception to the rule is in the Sarawat mountain range that lies east of the Red Sea and runs eastwards into southern Saudi Arabia and Yemen. The terrain is mostly uninhabited, sandy desert.

There are some common customs throughout Saudi society. To the Western mind, some of them could be considered negative and others positive. Conceivably, a negative custom may be the enthusiastic predisposition toward all things related to family, tribe, clan, and religion. Another is the existence of mediation or 'intercession' within almost all Saudi institutions. This plays a major role in creating disguised unemployment, furthering social discrimination and spreading bribery. Still another is the exaggerated sensitivity towards anything related to the family, particularly females. Also, respecting others' opinions as well as handling successful dialogues and conversation can be distinguished as common themes among Saudi

habits. Lastly is the lack of attention given to encumbrances which prevent Saudi Arabia progressing and developing. Examples of positive customs are the sympathy and the cooperation among Saudi people especially among family members; the generosity shown towards foreigners; and finally the inclination towards the emotional rather than the logical. This may also be considered negative at times.

In Saudi Arabia there are many subcultures that have formed via internal and external forces acting upon the society. The internal features that developed did so through simple cultural transfer between Saudi provinces; the external features were formed as a result of mass immigration, industrialisation and resultant multiculturalism, particularly in big religious cities.

Generally, customs and culture in Saudi family life can be divided into three main subject areas: social, educational and economic.

Social issues

Social life inside Saudi families differs from place to place within the country. For instance, families in big cities like Riyadh and Jeddah tend to be different to those living in smaller cities. Generally, Saudi families tend to be large with not less than two children, and often have grandparents. The feature of live-in grandparents seems to be slowly dying out although this depends on their relationships with their sons and daughters. Most Saudi families rely heavily upon the housemaid to take care of cleaning, cooking and possibly raising children. Some rich families have many housemaids in addition to a family driver. Both housemaids and family drivers are usually brought from abroad, in particular from poor countries in eastern Asia.

Housemaids exist in many houses but particularly in the homes of middle and upper income families. Poorer homes are significantly less likely to employ this live-in assistance. Practices began to change during the economic growth of the 1980s when the normal family unit began to change from large and extended to small and nuclear. Nevertheless, the employment of housemaids remains a very common Saudi family custom. The housemaids usually make some £80-150 a month in addition to housing, food, health care and an annual flight home. Because housemaids work inside the family home, they often know more about the running of the home and family

dynamics than even other family members; they are, however, precluded from participating in any family affairs. Generally, some privacy is assured with their own rooms and their formal duties are determined by the maternal figure in the home.

As is the case elsewhere, relationships inside the family depend on an individual's status and personality characteristics. Parents have the highest status in the family. The father figure is usually a strong and formal person who economically provides for the family. The mother has unlimited support inside the house, and her image usually is friendly, sympathetic and hardworking. Children usually find their mother more approachable than their father even on subjects normally related to the father such as money. Generally, all family members are unconditionally respectful of their parents and grandparents. Parental respect usually increases as the age of the children increases. Additionally, all family members are expected to pay attention to the children in the family. The relationships between the boys and girls in the family are usually dependent on their early education before going to school, the family size, their personality characteristics as well as their parental relationships. Nevertheless, girls usually have close relationships with one another and show respect to other members.

In the past, families officially, and usually did, eat at least two meals, lunch and dinner, together or in groups separated by gender. Nowadays, most families eat only lunch together but do so as an entire family unit while at other times restaurants have become common sites for Saudi social life. Boys often go out with their peers to eat at restaurants, coffee shops, cabarets and other venues. Young couples also like to have dinner in restaurants. All these activities usually occur during weekend days, which are Thursday and Friday.

Women spend most of their time at home, and they are required by Islam to wear the veil 'headscarf, *hijab*' when they are in the presence of other males, while other items of dress are likely to be added according to cultural norms particularly when females go outside their homes. Few women disobey some cultural demands and ask for flexibility like permission to drive cars as men can but women are still forbidden to do. Despite this, women in Saudi society are gradually getting more and more freedom. Recently, a few women are gaining access to professions other than teaching

and medicine which have been the only restricted jobs for females. Also, women's segregation has started to be part of a public dialogue and has become an important issue.

There are some old social customs soon to become extinct such as having many children, males in particular. In the past, people in villages and farms preferred sons, for men tended to be the family earners and supporters. Today, the custom of having more than one child still exists, but for different reasons and mostly as a custom. Also, in the past fathers usually named the first male child after the child's grandfather; if the first child was female, she would receive the grandmother's name. In recent years, several new names have been created by the newest generation. Both men and women retain their family names throughout their lives without regard for marriage, thus there is no Saudi equivalent to a woman's maiden name.

Marriage in Saudi Arabia is the only way of legally having sex. In small cities and communities people get married at an early age such as 22. Normally, men usually do not see women. Therefore, if a man wants to get married, he will usually ask his mother or sister to find an appropriate woman. Some boys know their relatives' female children, so they do not need recommendations. After discussing this issue with the entire family, the mother or sister will usually call the woman first to get her unofficial acceptance. After receiving the agreement, the man takes his father and goes to the girl's father to request an engagement. At this time, the girl and the boy can see each other and then make their final decision. If they agree, they enter an engagement period of a couple of months. During this time, the boy calls his fiancée on the phone to get to know her more and to make plans for their future life. When they sign the marriage contract, they can see each other as much as they want and may go out for dinner or shopping. These stages differ from one community to another. People in big cities, for example, have far greater flexibility in observing these customs than people in small towns. The general requirements for marriage are all indicators of solvency:

a) A man's job and house or apartment ownership
b) Giving a dowry for the fiancée, usually £5,000-15,000
c) Giving a gold gift usually from the husband's mother to the fiancée

Although Islam is only the official religion in Saudi society, there are some customs which oppose Islamic principles. For instance, it is rare to find a man who is marrying for the first time a woman who has been divorced. Also and as an inequality example, it is rare to see a man marrying an older woman, but it is not unusual to find an older groom with a young bride. Thus, when women pass their 27th birthday, it is hard for them to be married. Furthermore, some families are closed to the possibility of marriage outside of their tribe. Other families do not belong to a tribe, clan or kin group and therefore members cannot become engaged except to those who are in a similar non-tribal situation. Unfairly, non-tribal families are also seen as 'lower' in something akin to the caste system in India. On the matter of attire, there are some customs that have a very high value but do not have any relationship with Islam such as the wearing of the modern turban by adult Saudi males.

Marriage becomes more and more difficult for new generations. For instance, being independent as a couple in a house or an apartment is a new tradition that has formed since the development of oil and has made social life more complex and difficult to navigate. Additionally, celibacy is another of the major problems facing Saudi society since families do not accept non-Saudis as husbands for their daughters, and many girls have not been married even though they have graduated from college and are old enough to be married. Furthermore, because of the costly requirements of marriage as well as other factors that have not yet been researched or publicly presented, men often take the opportunity to travel abroad and avoid marriage. Consequently, age at marriage has become more advanced and it is not unknown for marriages to occur when men are in their thirties. This delay in marriage may present or create some unexpected results such as prostitution, homosexuality and lesbianism.

Whilst Islam permits men to have not only more than one wife but as many as four wives at the same time, this is not as common as in previous times. Social and economic changes make polygamy harder. Also, the changing status of women which ensures they are more outspoken and more aware of their rights makes polygamy less attractive for men who prefer to avoid problems created among the families. Another factor affecting polygamy is the sheer economic cost of operating two or more

households with housemaids, family drivers and so on. This proves difficult for many men.

Divorce is the final resort in family problems and almost always lies in the husbands' hands. The final divorce between husband and wife can be after the third divorce or three divorces at one time according to the Islamic (Shariah) law. After that, they cannot marry each other again unless the wife gets divorced from a subsequent husband. Women can apply for a divorce in court. However, women usually do this when the husband does not want to end the marriage and this usually happens only under unusual circumstances such as when the husband is addicted to alcohol or drugs, and has failed to take social and economic care and support the family. Unexpectedly, divorce is seen as a common social problem in Saudi society and has not been studied seriously.

Divorce is not an easy decision and is difficult for both husbands and wives. Throughout the entire society, divorce makes a negative impression. For instance, a woman, unlike a man who is divorced, will face difficultly in getting married again and that difficulty is based on how many times she has been divorced. Whilst both men and women face difficulties, a woman faces greater difficulty with the level of stigma attached to divorce. Similar to divorce, childless couples are socially excluded or harshly treated, especially by their families, relatives and friends, because fertility is still a valued norm in society.

There are some other socially sensitive issues. Among husbands who are middle age or younger, there is a common habit of spending nights outside the house with friends. Married women do not have this freedom and often feel isolated within the home. Thus, boys have greater autonomy and opportunities to have what are considered 'unacceptable' relationships with women, and occasionally even with housemaids employed by the family. Similar opportunities may also arise for the females in the family if there is limited control from the family, but especially with limited maternal control.

In the last two decades many studies have been carried out in Saudi society in different fields and on multiple subjects such as juvenile delinquency, crime, and drug

addiction, which have indicated that family relationships are a social factor that may be the cause of problems (Al-Khalidi, 1983; Al-Turki, 1989; Al-Aubaidi, 1990; Al-Rayias, 1995).

Education issues

Saudi Arabia is generally considered an educated society. Certainly, education has a high status in most Saudi homes where families teach their children basic knowledge such as the alphabet and Islamic principles before sending them to kindergarten at the age of five or six. The elementary schools accept pupils aged seven without the requirement of having attended or completed kindergarten. Elementary or primary schools have six grades; middle or intermediate schools have three grades and are different from the high or secondary schools that also have three grades with three specialist fields, science, arts, plus a specialisation in a religious subject. University education extends over four years or more depending on the university and the subjects studied. Almost all teachers at all levels are Saudis.

Saudi families care more about the education of males than females. For example, female literacy is estimated to be at 50 per cent while male literacy is at 72 per cent according to a recent census. This is expected to change in the not too distant future as more jobs become accessible to women. Despite recent developments in Saudi Arabia, however, opportunities for women to work and participate in some sectors of society are still limited, in particular in rural areas where there is a predominance of traditional values and norms and where there is greater emphasis on restricting and regulating the behaviour of women. Although both in terms of quality and quantity, families and the society give greater chances of employment and education to boys, girls are usually more successful than boys at school. Furthermore, women appear to be more positively disposed towards education and work than men with occupations available for women recently emerging in the fields of female education, female banks, health services, social services and the mass media.

Financially, families support their children mostly from kindergarten through to elementary and middle school with some families continuing assistance until university level. Saudi education, either inside the family or at school, is based entirely on instruction and dictation rather than interaction.

The bachelor degree is the lowest and most common degree offered to Saudi university students. There are, however, other educational opportunities and levels involving vocational training and art education in institutions that have lower status than universities. Saudis tend to prefer jobs that do not require physical work, and most university educated people have a preference for the positions of teacher, manager or director.

There are two additional noteworthy characteristics of education in Saudi Arabia. First, education of all types and levels is separate for males and females. Second, all state education is free of charge. Nevertheless, many families, especially the more affluent, prefer the recently introduced private fee-paying schools. This change has occurred since the county faced an educational crisis in the 1990s (see Hamdan, 2005). The government's schools are mostly in very bad condition due to lack of attention and neglect of future needs. The Ministry of Education, along with the entire Saudi government, has faced recurrent financial difficulties which can be a result of mismanagement.

Economic issues

Family income in Saudi society is related to social class. The lower classes usually receive an income not more than £800 per month. The middle class income range, which encompasses the majority of the Saudi population, is from £800-£3000 per month. The higher classes have unlimited incomes not lower than £3000.

Due to the authority of males in Saudi families, men usually take on the official role of 'breadwinner'. Nevertheless, modern families also share this responsibility between men and women. This change has occurred because of women's demand to be allowed to make more significant contributions, and as modern Saudi women have been influenced by media images of western women. Most married men and women share authority and responsibility in order to improve their economic condition. In the past, men preferred to marry women who did not work at all. Nowadays, however, some men seek women who work, especially in teaching which has three attractive characteristics. It is a traditional job for women, has a good salary, and there is a long summer vacation. Consequently, Saudi society is currently in conflict between being

modern and being conservative and limiting opportunities for women to participate in all of the society's sectors. A good example of this is the law which was introduced after the Gulf war of the 1990s which denied women the right to drive. This particular topic has caused great debate inside Saudi society.

Although the economic conditions in Saudi Arabian families are good for most, many express a desire for more. For example, Saudi families would be unlikely to relinquish some customs such as the housemaid, the family driver and the habit of travelling during summer vacations. Saudi Arabia and the Arabic Gulf countries are the only countries that have housemaids in almost every home and, compared to its population, Saudi Arabia has the highest number of housemaids in the world. This is remarkable especially considering the low number of working women. Still, there is the exception of extremely poor families among the Saudi population who appear to face significant social exclusion. However, evidence of poverty induced exclusion is anecdotal and has yet to emerge as a research issue.

Almost every male in a Saudi family has his own vehicle if he is nineteen or older. Even though one seldom finds a family that specifies a certain budget for each member, boys and girls clearly have expensive wants and needs. Boys, for instance, may be divided into two groups, conservative and modern. The latter wear western clothes as their symbol of modernity. Girls mostly prefer the modern, following the trends in hairstyles and fashions for summer weddings and other special occasions. Likewise, children incur high costs for families with regard to necessities of life such as food, clothing and suitable health care, which cannot be found at government hospitals by most Saudi families. All these social and economic factors have affected Saudi society in a number of ways which have merged to form new patterns of social interaction within many Saudi families. An example of this is the dichotomy between the old and the new ways which presents itself as a conflict within and among conservative families on the one hand, and as an economic challenge for families aspiring to change on the other.

The educational difficulties that Saudi society has faced since the 1990s have influenced Saudi families in various ways. Formerly, families looked for convenient primary schools for their children. Recently, however, families have begun to look for

middle and high schools with both high educational standards and good facilities. Further, families have begun to think about the details of participation in higher education. Overwhelmingly, youth who gain places at Saudi universities do so despite poor preparation and with little consideration given to the subjects to be studied. The reason for this is that studying at university is simply believed to be a requirement to complete one's education. Also, educational standards are mostly associated with quantity not quality; that is, the larger the student body, the more impressive the education. However, university graduation has now become a prerequisite for most types of employment that Saudis will consider.

The economic lives of individual families have been affected by many factors, but mostly they are affected by changes at play in the whole of Saudi society. There are four types of labour which have posed problems for the Saudi economy: housemaids, private drivers (mostly for women), nurses at hospitals, and manual labourers such as plumbers, electricians, bricklayers, carpenters and waiters. Unfortunately, this has created a problem that neither the Saudi people nor the Saudi government have taken upon themselves to study seriously, namely, disguised unemployment. Unregulated immigration by workers presents some social problems like discrimination. Unemployment is likely to result in a new series of social problems such as loss of identity, the emergence of extreme ideologies, as well as political problems like terrorism. Due to these and other problems, it is fair to say that social and political life in Saudi Arabia need to be improved in the area of equality, but as gradually and as painlessly as possible.

Section Three: Domestic Violence

Internationally, violence against women has been identified as a serious problem on account of its extent, and this has led to the coining of additional concepts such as 'marital violence' 'spouse abuse' and 'battered wives' (Thomas and Pierson, 1995). All these concepts refer to violence that occurs between couples who are married or cohabiting. Borkowski et al (1983) state that acts of violence such as physical, sexual, emotional, and mental abuse of women mostly involve more than one type of violence.

This section focuses on violence against married women and is divided into three subsections; a) historical background, b) theoretical explanations, c) legal and religious issues in Saudi Arabia.

Historical background

Intra-family violence has ancient and deep roots. The first recorded sanctioning of this appears in The Laws of Hammurabi written in Babylon in 2000 BC. The ancient Roman law gave men power over their spouses. Church doctrine affirmed men's 'right' to dominate women. St Paul wrote:

> 'Wives, be subject to your husbands, as to the Lord…. As the Church is subject to Christ, so let wives also be subject in everything to their husbands' (Ephesians 5: 22-24).

The Christian church approved the right of the husband to expect obedience from his spouse, and the wedding covenant may still contain the words 'love, honour, and obey'. Priests used to preach from the pulpit encouraging a man to beat his wife, and those who elected to interpret the Bible literally used these justifications and so, ultimately, abuse and domestic violence became social and legal norms (Colossians 3: 18,I ; Peter 3: 1). In the late 1400s Friar Cherubino of Sienna supported wife beating in his Rules of Marriage:

> 'take up a stick and beat [your wife] soundly, for it is better to punish the body and correct the soul than to damage the soul and spare the body … then readily beat her, not in rage, but out of charity and concern for her soul, so that the beating will rebound to your merit and her good' (Davis, 1995: 780).

An English jurist and misogynist, Lord Hale, who burned women at the stake as witches, set the tradition of non-recognition of marital rape during the 1500s. He wrote that, when women married, they:

> 'gave themselves to their husbands … the husband cannot be guilty of a rape committed by himself upon his lawful wife, for by their mutual matrimonial consent an [sic] contract with wife hath given herself in this kind unto her husband, which she cannot retract' (Lemon, 1996: 453).

In England during the 1800s Caroline Norton, Frances Power Cobbe and John Stuart Mill were much to the fore in the movement for reform and generated debate on the

prevalence of violence against married women in areas like Liverpool's so-called 'Kicking District' where working class women were regularly maimed or kicked to death by their spouses. Frances Power Cobbe (1878) collected evidence of abuse and presented it in her pamphlet, 'Wife Torture in England' (Radford and Russell, 1992). In it, she delineated four main incitements to violence, although she saw the ultimate cause of all such violence as residing in the inequality of the sexes:

> 'The notion that a man's wife is his property, in the sense in which a horse is his property… is the fatal root of incalculable evil and misery' (Smith, 1989: 4).

The early English common law gave the man the right to beat his wife as long as the weapon he used was a rod no thicker than his thumb, and this led to the expression *rule of thumb.* However, in 1895 women were granted the right to use conviction for assault as sufficient ground for divorce.

A US judicial decision in 1864 approved a man's right to beat his wife. The court ruled:

> 'that the state should not interfere with domestic chastisement unless some permanent injury be inflicted or there be an excess of violence. Otherwise, the law will not invade the domestic forum or go behind the curtain, preferring instead to leave the parties to themselves, as the best mode of inducing them to make the matter up and live together as man and wife should' (Davis, 1995: 780-781).

The origin of domestic violence has no exact date; it occurs throughout most of recorded history. For example, violence toward married women occurred in 1395 when Margaret Neffiled was refused permission by an ecclesiastical court to separate from her husband who had attacked her with a knife on several occasions (Smith, 1989). However, during the period 1770-1845 early feminists such as Frances Cobbe and Mary Wolstencraft fought for women's rights to divorce and to obtain legal separation from violent husbands, which led to the Matrimonial Causes Act of 1878 (Clark, 1988).

Socio-historical accounts trace the roots of male violence against females to the patriarchal structure of the family. Men are seen as heads of households who are entitled to control women through any necessary means. Not only this, but also men

as husbands could violate their wives or punish them for failing to live up to 'marital demands'. Because of their position within the family, men received strong ideological and institutional support both within the family itself and throughout society (Dobash and Dobash, 1992, 1980). For example, British law prior to the 19th century gave men rights over their wives' property and daily affairs and allowed them to, 'give his wife a severe beating with whips and clubs for some offences' (Hecker, 1910: 46).

In Russia in the 16th century, during the reign of Ivan the Terrible, the state church sanctioned the oppression of women by initiating a household ordinance that spelled out when and how men could assault their wives (Martin, 1977). Napoleon Bonaparte, who wanted women to receive equal protection, legislated unique laws (at that time) protecting women who were victims of their husbands' assaults. These laws meant, at that time, that the only occasions when women were deemed equals was when their husbands were punished under the penal code (Davidson, 1978).

After the 19th century, men's legal rights of chastisement began to erode and 'woman battering' disappeared from the agenda of social problems between 1920 and 1970, due largely to the non-existence of an influential women's movement (Freeman, 1979). However, by the mid-1970s the women's refuge movement in the US and elsewhere had succeeded in alerting the public to the plight of women who were experiencing domestic violence. Also, during the 1970s feminists placed domestic violence on the political agenda with the establishment of the Women's Aid movement in 1975 (Maynard, 1993). Thus, since the 1970s domestic violence has received considerable public attention (May, 1978; Marsden, 1978).

In the UK, after three pieces of legislation, The Domestic Violence and Matrimonial Proceedings Act 1976, The Housing Act 1977, and The Domestic Proceedings and Magistrates Courts Act 1978, a Select Committee of Parliament was established. Thereafter, the problem did not become a governmental issue again until the Women's National Commission considered it within the more general context of violence against women (Smith, 1989).

Research on domestic violence clearly shows similarities in patterns of events at the time violence occurs (Pahl, 1985; Wilson, 1983; Binney et al., 1981; Dobash and Dobash, 1980). In the past, researchers focused on characteristics of victims rather than the perpetrators of violence (Hotaling and Sugarman, 1990). Some actually criticised research that focused on the characteristics of perpetrators because of its limited sensitivity regarding cultural and social norms (Stosny, 1995; Tolman and Bennett, 1990; Adams, 1988).

Theoretical explanations

Domestic violence is not a single behaviour and cannot be explained by any single theory. Indeed, in social science a multitude of theories attempt to explain human behaviour. In the field of criminology, for example, there are more than fifteen different theories (Vold et al., 2002). Social science theories predict behaviour in its various forms within a variety of situations.

Although theoretical paradigms vary from one to another in their key concepts, backgrounds and hypotheses, a number of theories note the influence of alcohol on aggression. However, there are other explanations; strain theory, cycle of violence, sub-cultural models and social learning theory all have explanations to offer. Social conditioning, social structural models and resources theory all explain violence against women in much the same way as orthodox feminist theory. Rational choice theory does not interpret family violence any differently than deterrence theory. However, here we will focus on, but not confine ourselves exclusively to, alcohol-related theories.

The ‘de-inhibition model’ gives a plausible account of the association between alcohol and violence. This model challenges the pure pharmacology approach which says that alcohol directly causes domestic violence. Theoretically, the de-inhibition model explains how pharmaceuticals can weaken brain centres which are important in maintaining control over behaviour (Bushman and Cooper, 1990). Supporting this model empirically there are many studies that report a strong association between heavy alcohol consumption and aggression (Van Hightower and Gorton, 1998; Gondolf, 1995; Bushman, 1993; Collins and Messerschmidt, 1993; Bushman and Cooper 1990; Leonard and Jacob, 1987; Coleman and Straus, 1983; Hamilton and

Collins, 1981; Pernanen, 1976). However, this model fails to explain the behaviour of people who are heavy consumers of alcohol but are never violent.

Reduced information processing is said to set the stage for enhanced aggressive behaviour in situations that provoke an instantaneous impulse to behave aggressively. The negative results of aggression such as loss of self-respect and negative relationships are not immediately felt at the time of high-intensity conflict. Alcohol-induced deficits in information processing switch the focus away from weak inhibition and towards the rich, immediately salient, hints of aggression which increase the likelihood of aggressive behaviour occurring. However, pre-existing individual differences in anti-social and aggressive attributes may contribute to both alcoholism and domestic violence. Also, the model does not give enough weight to the fact that only some alcoholics appear to be at high risk of committing violent acts (Murphy and O'Farrell, 1996).

The 'disease model' of alcoholism which implies powerlessness and requires total abstinence for a cure suggests that when alcoholism ends, violence will also end (Bennett et al., 1994; Collins et al., 1997). Therefore, violence can be seen as a consequence of alcoholism due to the anaesthetising effects of alcohol on the brain. Some researchers argue, therefore, that if alcoholism is controlled, violence will also be controlled (Conner and Ackerly, 1994). The two problems are said to be 'separate but similar' (Engelmann, 1992: 6). A common theme in the literature is that alcohol misuse and violence are problems that generally co-exist (Collins et al, 1997; Leonard, 1993; Spieker, 1983; Harner, 1987; Young, 1994). Although this model gives a similar explanation to that of de-inhibition, it focuses on the long-term effects of alcohol on the brain as medically described in the disease model.

The 'expectancy model' stipulates that it is not the pharmacological properties of alcohol that facilitate aggression, but rather the mere knowledge that one has consumed alcohol. This model rests on the assumption that if a person has prior beliefs that alcohol will lead to aggressive behaviour, the outcome is likely to be a self-fulfilling prophecy (Coleman and Straus, 1983). Some experimental studies that have investigated alcohol and aggression among college students, and which have measured aggression using the Taylor Aggression Paradigm, have found placebo

beverages having the same effects on aggression (Pihl at al., 1981; Lang et al, 1975). In this particular model individual differences in beliefs about alcohol and its effects need to be taken into account (Chermack and Taylor, 1995; Dermen and George 1989; Leonard and Senchak 1993). In addition, individual experiences are said to play a major role in such expectations.

The 'indirect effects model' claims that alcohol influences aggressive behaviour through its relationships with difficulties such as erosion of marital intimacy and satisfaction, marital stress associated with financial and work problems, plus legal and other conflicts and problems. It describes how alcohol detrimentally affects certain physiological and/or psychological processes thereby leading to aggressive behaviour (Leonard and Quigley, 1999). This model predicts greater marital distress among families of violent rather than non-violent alcoholics. However, there is an important question regarding the degree to which the general stress that alcoholic conjugality creates in marriages may account for the observed aggression.

'Alcohol myopia' is a state of short-sightedness wherein the immediate aspects of experience have a disproportionate influence on behaviour and emotion, a state in which we can see the tree but miss the forest altogether. It attempts to explain a complex condition which occurs under circumstances of intoxication. Due to intoxication, a wide range of emotional and interpersonal experiences are said to arise. Two major studies have found strong support for myopia theory. According to these studies, intoxicated behaviour is different from sober behaviour only in the immediate high level responses to conflict situations (Steele and Josephs, 1990; Steels and Southwick, 1985).

The 'tension reduction theory (TRT)' suggests that a person drinks alcohol in order to reduce tension and anxiety including anxiety about the person's own behaviour. Because people drink alcohol in response to stressful life situations which also cause anxiety, depression, emotional distress and other psychological and physiological problems, the TRT suggests that people sometimes drink alcohol to try to reduce stress or relieve tension, and thereby decrease control over their antisocial impulses. The relationship is viewed as one where not only does alcohol reduce anxiety but anxiety is also the primary motive for drinking. At the same time, the amount of

aggression produced is positively related the strength of the anxiety which motivated the drinking. Thus, the relationship depends of pre-drinking anxiety as a motive for drinking (Graham, 1980). In some cases regular drinkers may experience positive results such as enhanced sexual response which lead to the reinforcement of the motive for drinking. Goldman et al (1987) found support for this approach; that alcohol's influence can be counted as an incentive due to its capacity to positively affect emotions (Leonard and Blane, 1999).

'Psycho-analytic theory' suggests that personality types can explain tendencies to violence or aggression either towards others or towards the self. Some personality factors that are considered important are said to arise from exposure to aggression in childhood, and include escaping from personal responsibility, ego dysfunctions, responses to frustration and longing for power. One aspect of this theory concerns alcohol's alleged anaesthetising effect on the super-ego (Lee and Weinstein, 1997).

'Social learning theory' identifies a different source of violence in the families of both perpetrators and victims. For example, experiences of or witnessing violence at home during childhood are said to be good predictors of aggressive behaviour and the inter-generational transmission of violence (Lee and Weinstein, 1997). Under this theory, husband-to-wife violence is said to be a result of past exposure to, and the consequent reinforcement of, violent behaviour. The standard application of social learning theory to domestic violence demonstrates that when there is either non-punishment or acquiescence in family violence, aggressive behaviour becomes normalised. Consequently, while learning aggressive behaviour and alcohol drinking from one's parents may be typical, it may also have the effect of teaching a child to ignore 'normal' social rules.

'Deterrence theory' suggests that violence can be reduced by imposing effective and intimidating sentences on offenders (Sherman et al., 1992). According to this theory, deterrence operates on two levels: specific and general. Specific deterrence applies to individuals who perpetrate violent acts. When offenders are certain to be caught and punished, levels of recidivism (repeat offending) are predicted to drop because the individual will have already experienced the full cost. General deterrence applies to would-be offenders in society. When the offender is punished, the punishment serves

as an example to would-be offenders by demonstrating society's commitment to make sure that penalties are levied against any offender (Akers and Sellers, 2004). Thus, rational choice and the judicial system can be part of this explanation. The arrest of an abusing partner serves as a deterrent because the knowledge of the offender's arrest will instil negative reactions to violence in the offender's family (William and Hawkins, 1989). However, some researchers have found that individuals who repeatedly abuse their partners account for the majority of domestic violence arrests.

Some 'feminist theories' specifically argue for the use of the term 'wife abuse' instead of domestic violence and such theoretical positions consider that patriarchy leads to social, economic and political imbalances between males and females both inside and outside the home. According to this theory, violence occurs where male domination is apparent whether in religion, economics, politics or intimate social relationships, and these patriarchal patterns are replicated in family dynamics. Assaults on women are seen as an asymmetrical type of violence directed solely at women by men who attempt to maintain coercive control over women (Buzawa and Buzawa, 1996). Such feminist theories ultimately summarise domestic violence as aggression against women due to a patriarchal system.

The wealth of theories that are available suggests that domestic violence has multiple causes, some of which involve alcohol, albeit in various ways, and that many episodes of violence may well be over-determined.

Domestic violence in Saudi Arabia: religious and legal issues

As noted above, Saudi Arabia is considered a Muslim society since most Saudi people take Islam as their religion and most characteristics of the Saudi family reflect this. Thus, it is necessary to understand Islamic teaching on marriage. In Saudi society marriage entails certain obligations and duties from both the husband and the wife. There are some rights for both husbands and wives such as the couple's right to enjoy daily married life equally, the couple's right to enjoy respect and good deeds by each other, the couple's right to be protected by each other, to defend their love and cordiality, and the right to be tolerated by one another.

Islamic law forbids forcing women to marry anyone without their consent. Women have the full right to their marriage gift, ‘dower, *Mahar*’, which is presented to the woman by her husband. The Mahar concept is a gift symbolising love and affection. The conjugal contract or document states that the woman’s ownership does not transfer to her father or husband. Subsequently, the objectives of marriage are exchanging benefits with honour and appreciation between men and women who must behave physically, verbally, emotionally and sexually towards one another in order to continue the life-cycle. The Qur'an, which is the main holy book of Islam, indicates that women have rights similar to those of men, and gives some examples of the proper relationships between women and men in marriage. For instance:

> "And among His signs is this: That He created mates for you from yourselves that you may find rest, peace of mind in them, and He ordained between you love and mercy. Lo, herein indeed are signs for people who reflect" (Qur'an 30:2 1).

Islam regards men as stronger than women, however. Therefore, men are given the responsibility to be leaders of their families. Taking account of the physiological and psychological make-up of women and men, both have equal rights and claims on one another. Authority and responsibility in the home are divided between husband and wife. Islamic law also assures the right of women to be educated. Also, Islam does not forbid women seeking employment whenever there is a need for it. Women in Saudi Arabia usually work in the education and health fields even though Islam does not prevent a woman with exceptional talent working in any field, and it gives women the right of election to political office. Thus women have full rights to participate in public affairs. Nevertheless, even in modern times, as in the most ‘developed countries’, it is rare to find women in high positions.

Married women in Islam can share their lives with men in the wider society, and alongside perpetuating human life they are also regarded as being essential for society’s emotional well-being and spiritual harmony. Men are expected to pay attention to their wives’ opinions about anything that is related to the whole family, and everything should be worked-out through discussions without aversion or discrimination. Among the most impressive verses in the Qur'an about the relationships between husbands and wives is the following.

> "...But consort with them in kindness, for if you hate them it may happen that you hate a thing wherein God has placed much good" (Qur'an 4: l9).

Economically, men have the responsibility for supporting women and children. Men are the ‘breadwinners’. Yet although women are considered to be primarily housewives, they have the right to their own money and wealth separate from their husbands and fathers. Originally, Islam restored to women the right of inheritance.

Just as men have the right to end a marriage, so women have the right to end a marriage through the courts or even without a court hearing if there is an agreement. The Qur'an states about divorce:

> "When you divorce women, and they reach their prescribed term, then retain them in kindness and retain them not for injury so that you transgress (the limits)" (Qur'an 2:231, see also Qur'an 2:229 and 33:49).

Domestic violence by men as husbands or fathers in Saudi society occurs only through ignoring or misunderstanding Islamic guidelines. For example, the concept of leadership, the right of women to education and work, and men’s economic responsibility, would not lead men to degrade a woman’s status.

Parents in Islam have great importance. Islam clearly forbids behaving aggressively towards them. Children are expected to display respect even when merely speaking. Islam demands kindness and humility towards parents, including grandparents, of both sexes. As God says;

> "If one of them or both of them attain old age in your life, say not to them a word of disrespect, nor shout at them but address them in terms of honour. And lower to them the wing of submission and humility through mercy, and say: 'My Lord! Bestow on them Your Mercy as they did bring me up when I was young'" (Qur'an 17:23-24).

Islam demands that children be protected. After safeguarding the lineage through procreation, Islam bestows certain rights on children which follow naturally from the parent-child relationship, and certain prohibitions protect children’s rights. For example, children have a right to safe lives. The father does not have the right to take

the life of the child. Whatever the motive, Islam absolutely prohibits any savage act, not just premeditated murder but any form of oppression towards others.

It is fair to say that domestic violence exists everywhere whatever the community and whatever the religion. As human beings are similar in nature, so their behaviour can lead to similar results even if the details are different. It has been commonly found that when domestic violence occurs, two other categories of action are apparent. First, behaving aggressively, which is most likely to be by men as husbands or fathers. Second, hiding the fact of domestic violence, which includes both men and, sadly, some women (Dobash and Dobash, 1980; Wilson, 1983; Edwards 1989; Hague and Malos, 1993).

In Saudi society, when a woman is abused she can call the police or she can apply directly to the court. The police deal with crimes while the courts deal with spousal conflicts and divorces. Conjugal conflict, either with criminal incident or without, transfers the matter to the court and a judge will then start investigations with both sides and with witnesses. Nowadays, big cities in Saudi have established centres that 'treat' social and marital problems informally and peaceably, but up to now no law or official demand requires the referral of cases to these centres.

Overall, Saudi society has a problem of domestic violence even though people believe that wife abuse and family violence are wrong Islamically and ethically. Islam does not consent to wife abuse or to any act of violence towards any member of the family.

Conclusions

Alcohol in Saudi Arabia has a very deep history which began long before the advent of Islam in the 7th century AD. The prohibition of alcohol in Saudi law limits the consumption of alcohol on the one hand, but on the other leaves the area concealed from the public eye. Together, social, political and religious perspectives make people hyper-sensitive towards alcohol or anything that might be related to it. Even though the country now witnesses the 21st century's progress, there are still no reliable figures on the number of people who either consume alcohol or are addicted to it. Maybe research in this field has not reached a satisfactory level due partly to its association with other taboo subjects such as violence in the home.

The conventional ‘right’ of men to physically assault their wives started a long time ago. After the violence began, it grew and eventually become commonplace. Yet this was not publicly acknowledged, particularly if there was also involvement with an ancient commodity like alcohol. Then, outside Saudi Arabia, feminism’s ‘second wave’ (1960-) ensured that domestic violence became an international research topic. Perhaps domestic violence in Saudi Arabia can be observed publicly through evidence presented at police stations, courts and elsewhere; nevertheless, it has not been brought to the fore as a research issue or addressed by local media. Indeed, the first time the issue of Saudi Arabian domestic violence was presented publicly was in a non-Saudi publication, *The Guardian,* which published an article about a Saudi female TV presenter who was beaten by her husband in July 2004 (MacAskill, 2004). This case then disappeared from the public domain. Exposing aggression in Saudi families is still virtually impossible unless it is discovered covertly by linkage with other problems in social life.

Alcoholism is a condition that influences human behaviour and can lead to psychological and physical changes in individuals; nevertheless, it is not easy to establish that there is a causal relationship between consuming alcohol and family violence that can be attributed to particular socio-psychological or physiological processes. These processes may involve alcohol as a disinhibitor of social control, or as an instigator of violence, or as a rationalisation for violence, or alcohol’s interference with brain functioning, or alcohol’s destruction of the normal growth and development of the individual and the family system. Therefore, researching that link has challenged researchers. For instance, researchers in the field of domestic violence argue that violence can occur both when alcohol is present and absent. Drinking alcohol by abusers, drinking alcohol by victims, alcohol intoxication of abusers and alcohol intoxication of victims are four variables that should all be taken into account in studies of alcohol and domestic violence (Flanzer, 1993). To sum up, when trying to prove a causal association between alcohol and violence, researchers must show that the causal variable occurs before the dependent variable and produces a real variation in the dependent variable and not as a by-product of other variables. This has proved to be incredibly difficult.

Nonetheless, a relationship between alcohol and domestic violence has been discovered worldwide (see chapter two), but, as we have seen, there is considerable variety in the theoretical perspectives which seek to explain the relationship. The purpose of reviewing the theories is to assess the ways in which violence might arise. Various theories have been presented with none exclusive of the others. Possibly, all of the theories can account for one or more aspects of the link between alcohol and violence. Should this be the case, attempting to pit one theory against another will prove futile. An understanding of the causes of violence has clear relevance for the way in which abuse is regarded and also has important implications for the allocation of resources to investigate the association between alcohol and domestic violence (Flanzer, 1993).

Theoretically and empirically, the influence of alcohol on the likelihood of violence is mediated by social, cultural, political and personal factors, which raises important issues for this study conducted in Saudi Arabia. This study will begin the social scientific exploration of links between alcohol and domestic violence in Saudi Arabia where, due to the unique nature of Saudi society, there is a dearth of research in both areas. The study can be classed as one based on a treatment programme as the samples were selected from individuals undergoing treatment for alcohol-related and other problems. Other samples involved in this study comprised married women, many of whom were self-described victims of domestic violence. The main sample, ‘alcoholic patients’, and the three other samples, the three groups of married women, together aim to explore the associations between alcohol and domestic violence taking account of variables such as the length of time and degree to which drinking has occurred, their links to violent incidents, and the types of violence that took place.

Chapter Two
Previous Studies of Alcohol Abuse and Domestic Violence

Introduction

This literature review is indicative rather than exhaustive. There have been thousands of studies of alcohol – its users and its effects. There is also a formidable literature on violence – domestic and otherwise. The literature on domestic violence was overviewed briefly in the previous chapter. Most of the alcohol literature is being deliberately set aside so that we can focus below on research that has explored links between alcohol and domestic violence. To repeat, the studies reviewed here are indicative rather than exhaustive. The aim is not to identify gaps in knowledge for the findings in later chapters to fill, or to derive hypotheses to test. Rather, the literature has been used to identify different ways of exploring the alcohol-domestic violence relationship, and findings that might be expected (though not confidently for the context is so different) in Saudi Arabia.

Previous research on this topic can be grouped into three types of study. The first group – which elevated alcohol and domestic violence into a public issue – comprises studies of women seeking assistance (e.g., O'Farrell et al., 1999) and, sometimes, their male partners (e.g., Kahler et al., 2003). These studies have typically found that high proportions of the male partners of women seeking refuge (e.g., Van Hasselt et al., 1985), or other kinds of assistance (e.g., Murphy and O'Farrell, 1997), are alcohol abusers (heavy drinkers if not alcoholics) (e.g., O'Farrell et al., 2000), and that the incidents of violence that provoked the women into seeking assistance often occurred when the perpetrators were drunk (e.g., Hutchison, 2003). Interestingly, these studies also find that many of the women victims have alcohol problems (e.g., Dougherty et al., 1996), and many of the studies find that either one or both partners have drug related problems as well (e.g., Bennett et al., 1994). Studies of men seeking or receiving treatment for alcohol problems (e.g., Fals-Stewart, 2003) or violent behaviour (e.g., Abracen et al., 2000) typically find a considerable overlap between these two groups. Of course, none of the above studies prove that alcohol is the causal factor. This has been addressed in the second group of studies - experimental and quasi-experimental studies (i.e., Dougherty et al., 1996; Hoaken and Pihl, 2000; Bailey, 1991; Van Hasselt et al., 1985; Leonard and Roberts, 1998) which have typically found that alcohol consumption does indeed lead to increased

violent/aggressive behaviour. The exceptions can usually be attributed to the character of the experiments or the groups that were studied. Third, there are studies of the general population (i.e., Kantor and Straus, 1987; O'Leary and Schumacher, 2003; Micheli and Formigoni, 2004; Lackie and Man, 1997; Leonard and Quigley, 1999; Leonard and Senchak, 1993; Quigley and Leonard, 2000; Leonard and Senchak, 1996; Heyman et al., 1995; Rossow, 1996; Norstrom, 1998; Graham and Wells, 2002; Chenet et al., 1998; Cunradi et al., 1999; Markowitz, 1999; Marshal, 2003). Here the evidence is less clear-cut. Although these studies usually find a relationship between alcohol use and violent behaviour, they also find that alcohol is not a factor in many violent incidents, and that alcohol consumption does not invariably (or even usually) lead to violence.

The relevant studies have been conducted in many countries, but mostly Western countries where alcohol is readily available (and very widely used), and where nowadays there is a presumption favouring gender equality in all spheres of life. Few of the studies have explored inter-societal/inter-cultural differences (e.g., Cunradi et al., 1999). So we might formulate hypotheses, but we really know nothing about the relationship between alcohol and domestic violence in societies where alcohol is prohibited, where men are still expected to be the real heads of their households/families, and where feminist movements have not elevated domestic violence into a public issue.

Victim and treatment programme samples

A specimen study of a type that has been repeated in many places interviewed 80 females at an urban domestic violence shelter in the USA. The residents were mostly young African-American and Latino women with their children. Many of the adult residents admitted to having their own alcohol or drug problems, and more than 60% reported having another family member with alcohol problems. A total of 52.5% of these women reported having a problem with both alcohol and drugs. As many as 63.8% had another family member with a drug problem and 66.3% with an alcohol problem (Martin et al., 1997). This study revealed how domestic violence can be strongly associated with both alcohol and other drug misuse.

A typical US study of domestic abuse by male alcohol and drug abusers questioned 63 married, cohabitating, or divorced couples. There were three groups: 44% were alcoholics, 14 % were drug addicts (primarily heroin and cocaine), and 42% were dually addicted. All had been hospitalised for addiction and had been abusing alcohol or drugs for 15 years. Half of the sample was white, just under a half were African-American, and 5% were Latino. One important result indicates that domestic violence has a stronger relationship with drug use, particularly cocaine, than with alcohol use (Bennett et al., 1994). Perhaps surprisingly, neither quantity nor frequency of alcohol use, nor the severity of alcohol dependence, was positively associated with an increase in female abuse by the male alcoholics. Rather, the more frequently a man drank, the less he abused his partner. This result replicates some other studies' findings such as Kantor and Straus (1989), and Roberts (1988).

A study entitled 'substance use and abused women's utilisation of the police' aimed to identify the factors that were impelling women to call the police to incidents of domestic violence. A total of 646 cases were considered, in 62.2% of which the abused women themselves had called the police, while 13.8% of the calls were made by neighbours, and 5.5% by a child. The study considered both alcohol and other drugs, and the results indicated that women were significantly more likely to call the police when male partners used both alcohol and other drugs, and when they were frequently drunk. However, it was offender drunkenness rather than the mere quantity or frequency of alcohol consumption that was responsible for a significant escalation effect on police utilisation by victims (Hutchison, 2003).

A longitudinal diary study examined the incidence of partner physical aggression on each day when alcohol was consumed. The samples comprised male and female intimate partners who had reported at least one act of male-to-family physical aggression during the last 12 months. The study actually contained two different samples, both located in the northeastern United States. One sample consisted of men entering a 12-week domestic violence outpatient treatment programme along with their female partners. The other sample was recruited from domestically violent male patients entering a 12-week outpatient alcoholism treatment programme with their female partners. Altogether there were 137 couples. The likelihood of partner physical aggression on days of male partners' alcohol consumption during a period of 15

months was tested for men entering the domestic violence treatment programme and the alcoholism treatment programme. For men entering the domestic violence treatment programme, the odds of any male-to-female physical aggression were more than 8 times higher on days when men drank than on days when no alcohol was consumed. The odds of severe male-to-female physical aggression were more than 11 times higher on days of men's drinking than on days of no drinking. These findings are said to support a proximal effect model of alcohol use and partner violence (Fals-Stewart, 2003).

Kahler, McCrady and Epstein (2003) examined sources of psychological and relationship distress among 96 non-alcoholic women with alcoholic male partners seeking joint outpatient alcohol treatment. Participant couples were controlled according to whether the men had current alcohol problems (assessed by the Michigan Alcoholism Screening Test 'MAST'), had consumed alcohol in the past 60 days, were married or had been living in a stable relationship for at least 6 months, did not meet criteria for severe psycho-active substance dependence, were not psychotic, and did not show signs of gross organic brain dysfunction, while the female partners had to be willing to participate, have no current problems with alcohol (scores of < 5 on the MAST or reported only past problems on the MAST) or other psychoactive substances (assessed through a structured clinical interview), and not be psychotic (assessed by the Psychoticism and Paranoia scales of the SCL-90R).
The results indicated:

a) Psychological distress among the women was strongly associated with lower satisfaction with the marital relationship, the presence of domestic violence, the frequency of male partner's drinking, lower perceived social support from family, and more frequent attempts to cope with the partner's drinking. Controlling for psychological distress, greater marital satisfaction was associated most strongly with greater attempts to reinforce positively the partner's abstinence, and making less effort to detach from the partner's drinking.

b) Unexpectedly, both severity and frequency of the alcoholic partner's drinking showed only weak associations with female partner distress that did not reach any significance level.

The findings in this study highlight the connection between psychological and relationship distress, and potential relations between alcohol related coping behaviours and both psychological and relationship distress. It should be mentioned that the male participants in the study, all of whom were actively seeking treatment, probably restricted the range of alcohol problem severity in the sample. Findings from some other studies that have included spouses of alcoholics who were not actively drinking have also showed a strong correlation between partner drinking and spousal distress (see Moos et al, 1982; Kogan and Jackson 1965).

Stith et al (1991) questionnaired 68 men from male violence treatment programmes and 170 who were on treatment programmes for alcoholism. Both groups were in ongoing relationships with partners. The study used the Conflict Tactics Scales (CTS) to measure violence frequency and other scales to measure to other variables, and employed multivariate analysis. Also, the study used the MAST to measure alcohol use and its problems and found that all members of both groups scored above the cut-off score of 5 (which is an indicator of alcoholism and having serious problems with alcohol). The investigators found very few differences between the men on any of the variables which indicates the close connection between alcohol use and family violence. However, this study used a rather small sample and did not have a control group of men who were not in any treatment programme. These two points limit the study's relevance to the wider population of either all alcoholic men or all men who violate their married partners.

A study entitled 'alcohol and drug abuse in sexual and nonsexual violent offenders' was conducted in the Ontario region of Canada. The study contained three different groups: 72 sexual offenders against adults (rapists), 34 sexual offenders against children (molesters), and 24 as a non-violent comparison group. The total sample of 130 were all either being assessed or treated at a treatment centre. Measuring alcohol use by MAST demonstrated that the most severe alcohol abusers were sexual offenders and that most sexual offenders were also severe alcohol abusers. Non-sexual offenders were significantly more likely to have histories of other forms of substance abuse (Abracen et al., 2000).

A study by Kyriacou et al (1999) evaluated the associations between some selected socio-economic risk factors and acute injury from domestic violence against women. The sample was 26 Hispanic and 20 white female patients aged 16 to 65 with acute injuries sustained from physical violence by intimate male partners. Cases were included in the research if they demonstrated or reported physical aggression by their male partners. To enhance comparability, the researchers used several controls to match each case; education level, employment status, history of drug abuse, and history of alcohol abuse by the male partner. A history of alcohol abuse by the male partner was the strongest predictor of acute injury from domestic violence as reported by the female partner (odds ratio 12.9). Interestingly, the remaining predictor variables were weakly associated or even not associated at all with domestic violence. To stress the importance of alcohol, the investigators demonstrated that the male partners were usually intoxicated by alcohol at the time of the violence. Of the socio-economic variables tested in this research, history of alcohol abuse by the male partner (as reported by the female partners) was far and away the strongest predictor of harm from domestic violence. This study placed great significance on the effect of alcohol on domestic violence.

Communication problems between couples were addressed in a study by Murphy and O'Farrell (1997). Their subjects were 60 aggressive couples and 30 non-aggressive couples according to the presence or absence of self-reported husband-to-wife physical aggression in the previous 12 months. The two samples totalled 90 couples, all with currently abstinent but basically alcoholic husbands who were entering counselling. The husbands and their wives both completed a 10-minute problem discussion session while both were sober. The conditions for recruitment to the study were that the husbands met criteria for alcohol abuse or alcohol dependence, the wives had also abused alcohol but had been abstinent for at least 6 months, and the spouses were separated and unwilling to recommence reconciliation treatment. The study used multiple scales, but the major one was the Marital Interaction Coding System. As hypothesised, the study confirmed that husband-to-wife marital aggression was correlated with problematic communication among the couples, but with higher levels of physical aggression among the aggressive group. The study assessed communication during a sober interaction period and different findings were obtained during intoxicated states in the home on the one hand, and after long-term

sobriety. Overall, this study supports Jacob and Leonard's (1988) finding that alcoholics have distinct patterns of marital communication. Also similar results have been recorded in community samples (see Burman et al., 1992; 1993; Cordova et al., 1993) which have found that aggressive and non-aggressive married alcoholics differ in their ability to end negative communication cycles.

Incidents of domestic violence were examined in another study which collected data about alcohol abuse treatment and recovery experiences, marital and employment profiles, and responses on the CTS. The main aim of this study was to determine whether patients who entered an employee assistance programme and received treatment perpetrated less domestic violence after than before the treatment. The respondents were 80 married, cohabiting or divorced alcoholic males whose self-reports of levels of domestic violence were compared before and after alcoholism treatment. The sample, which was selected from three metropolitan area employee assistance programmes in Chicago, comprised inpatients and outpatients who had been involved in the programmes six months prior to the interviews (Madien, 1996). The study found that 94% of the respondents had engaged in behaviour ranging from verbal intimidation to severe physical aggression prior to the treatment programmes. The programmes in the three areas adhered to a disease model that treated alcohol abuse as a chronic disease and the aim of the treatment was to stop the patients drinking immediately and to change their lifestyles, which was actually likely to take a long time because lifestyles involve diet, sleep, and other behaviours and habits that are affected by abusing alcohol. So a realistic model of alcohol effects will be similar to a boat's waves in so far as, when the boat has gone, or when a patient stops drinking, the 'waves' will stay for a while. Consideration of this was missed by the researchers because their study concentrated on the extent to which violence was curtailed during the 6 months immediately following intervention, and could assess only whether selected factors during 'early' recovery contributed to reducing domestic violence.

A subsequent study conducted by O'Farrell et al (1999) aimed to determine whether reductions in violence were still evident during the second year following behavioural marital therapy (BMT) among a sample of 75 couples who provided data at entry and at 1 and 2 years after completing the BMT. The CTS and MAST were among the

measurements that were used to assess alcohol use and its impact on spouses' violence. The study's conclusions were as follows:

a) Frequency of violence was correlated with the number of days the alcoholic drank.
b) Remitted alcoholics no longer exhibited high levels of family violence.
c) Relapsed alcoholics exhibited greater violence than remitted alcoholics.

One problem with this study is that it focused on one particular treatment (BMT), and any changes in violence cannot reliably be attributed to this treatment because no control group was used.

An Australian study considered whether physical aggression between family members could be regarded as learned aggressive behaviour. The sample comprised 36 male clients who attended counselling therapy and who had histories of domestic violence. The study had as its focus numerous measures of child maltreatment (physical abuse, psychological maltreatment, sexual abuse, neglect and witnessing family violence). Like other enquiries reported above, this investigation used MAST which indicated that more than half the sample were alcoholics or candidates for alcoholism. This study revealed relationships between abusing alcohol currently and the level of child maltreatment by the perpetrator such as physical abuse, psychological maltreatment, sexual abuse, neglect, and witnessing family violence. It also revealed a relationship between levels of physical and psychological conjugal abuse perpetrated by the men and their own experiences of child maltreatment, and also between child maltreatment, low family cohesion and adaptability. Alcohol abuse was significantly associated with frequency of physical conjugal abuse. Overall, the study challenged explanations of domestic violence based on elementary learning theory (Bevan and Higgins, 2002).

A study conducted in Zimbabwe by Rusakaniko et al (1997) aimed to determine the prevalence of domestic violence against married women and the factors involved. The subjects were 350 women; approximately one third had been physically abused (50 of whom were abused while pregnant), about one fifth had been sexually abused, and 46 had been both physically and sexually abused. Alcohol was involved as a significant factor in the physical and sexual assaults on nearly all the violated women.

Unfortunately, the study did not relate levels of alcohol consumption to the types and frequency of violence.

The objective of a study conducted among the Navajo Indians by Kunitz et al (1998) was to find the relative importance of various forms of abuse, conduct disorder, and alcohol dependence as risk factors for being a perpetrator and/or victim of domestic violence. The study interviewed 204 males and 148 females who were on an alcohol treatment programme, plus two control groups; alcohol dependents who were not on the programme (374 men, 60 women) and non-alcohol dependents (157 men, 143 women). The groups were matched for key characteristics. The findings indicated that experience of physical abuse was a significant risk factor for alcohol dependence as well as for domestic violence independent of the effects of alcohol abuse. On the other hand, the effects of sexual abuse with regard to both domestic violence and alcohol dependence did not appear to be significant. Alcohol dependence was a risk factor for family violence, and the more severe the alcoholism, the more likely was violence to have occurred. This matches the evidence from many other studies such as Widom et al (1995) and Martin (1993).

Murphy and O'Farrell (1994) assessed factors associated with marital aggression among male alcoholics. Five variables were involved in the study; consuming alcohol (amounts and frequency), antisocial and other aggressive behaviours, family drinking histories, and beliefs about alcohol. The sample comprised 107 couples who had been married for at least one year, and where the husband consumed alcohol previously but had recently become abstinent following treatment. The couples were all separated and all were unwilling to attempt reconciliation by attending a counselling for alcoholics marriage project. On MAST the husbands all scored more than 7 (which indicates that they had been very heavy drinkers), and through CTS the couples were divided into aggressive and non-aggressive groups. The results showed that aggressive men were more likely than non-aggressive men to have been arrested and to have had work problems some time in the past; verbal aggression levels were much higher for the physically aggressive group and the prevalence and frequency of marital aggression by the alcoholic men were similar to the levels found among men seeking outpatient marital therapy (O'Leary et al., 1992). Another important finding was that aggressive alcoholics and their wives endorsed most strongly the belief that

alcohol caused problems in their relationships. However, a history of alcohol-related work problems was not significantly associated with marital aggression.

The following year O'Farrell and Murphy (1995) conducted a further study that used MAST with a sample of 88 couples. This study's main objective was to assess marital violence before and after alcoholism treatment. The researchers assessed the frequency of marital violence of male alcoholics and their wives a year before entering behavioural marital therapy and a year after completing the therapy programme. The MAST showed that the husbands were serious, chronic alcoholics. The CTS showed that the frequency of violent behaviour decreased significantly for both husband-to-wife violence, from nearly seven violent acts before to one after the behavioural marital therapy programme, and wife-to-husband violence from 10 violent acts before to three after the programme. Violence after the programme was significantly associated with the alcoholics' drinking outcome status. After treatment, remitted alcoholics no longer had elevated marital violence levels whereas relapsed alcoholics did. This study tends to support the conclusion that entering a treatment programme for alcohol leads to a major change in human behaviour.

In a later study O'Farrell et al (2000) measured verbal aggression among male alcoholic patients and their wives in the year before and two years after alcoholism treatment. Here a control group was introduced. The entire alcoholic sample of 88 provided drinking data at all assessment points and questionnaires on verbal aggression at a one-year follow-up; then 75 of the 88 couples completed the verbal aggression questionnaire at the second year follow-up. The MAST showed that husbands in the alcoholic sample had been heavy drinkers and seriously addicted. From the CTS the researchers selected six items that measured the frequency of verbally aggressive behaviour reported by married women (1) yelled, insulted, or swore at the partner, (2) sulked or refused to talk about an issue, (3) stomped out of the room or house or yard, (4) did or said something to spite the partner, (5) threatened to hit or throw something at partner, (6) actually threw something (but not at the partner), or smashed, hit or kicked some object. The study concluded that:

a) Relapsed alcoholics and their wives showed higher levels of verbal aggression in the two years after the treatment programme than both

couples with remitted alcoholic husbands and demographically similar non-alcoholic controls.

b) Compared with the year before entering the treatment programme, alcoholic men and their wives showed significant and extensive reductions in verbal aggression.

These results are consistent with earlier results on physical violence (i.e., O'Farrell and Murphy, 1995; O'Farrell et al., 1999).

A recent study conducted by Schumacher and her colleagues (2003) used the same two scales (MAST and CTC). Eligible participants for the study were married or cohabiting men entering treatment at one of seven alcohol treatment facilities in the north-eastern United States (a total of 1496). All the participating clinics were outpatient facilities offering twelve-step treatment, but none of the clinics also offered in-house treatment for intimate partner violence. All the participants, according to treatment records, met the criteria for alcohol abuse or dependence, 39% also met the criteria for co-morbid drug abuse/dependence, and 64% had sought treatment as a result of a criminal justice related referral. Drug and alcohol diagnoses were based on standard intake and assessment procedures at each of the seven alcohol treatment facilities, and were obtained from client treatment records. The MAST was used to assess the lifetime severity of the men's alcohol problems. The scale showed no significant association with whether or not a client reported a pre-treatment year history of intimate partner violence. The violence subscale of the CTS was used to assess the frequency of male-perpetrated relationship violence. Here the results were that:

1) 134 reported perpetrating one or more acts of severe violence (e.g., hitting, kicking, beating up) in the year before treatment.
2) 658 (44%) of the men seeking treatment reported perpetrating one or more acts of partner physical violence during the pre-treatment year.
3) Of the men who reported pre-treatment year physical violence, 80% reported engaging in only mild to moderate violence (e.g., throwing something at the partner, pushing, slapping).

Experimental and quasi-experimental studies

Determining the effects of a range of alcohol ‘doses’ on the aggressive responses of women was an aim of Dougherty et al’s (1996) study. Dougherty and his colleagues studied 10 women who were not alcoholics or drugs users, nor did they have family histories as such. This study used interviews, ten follow-up sessions, and the Point Subtraction Aggression Paradigm which employs a response panel containing push buttons indicating two levels: non-aggressive and aggressive. The most important finding was that aggressive responses were increased by the administration of a placebo. However, the study found a small subset of individuals whose greatest increases in aggression occurred after consuming alcohol doses.

An investigation by Hoaken and Pihl (2000) which involved 54 male and 60 female participants, aged 18–30, aimed to test possible gender differences in the manifestation of alcohol-induced aggression. The subjects were divided into four groups; sober males (n = 27), males who had consumed alcohol (n = 27), sober females (n = 30), and females who had consumed alcohol (n = 30). All the participants engaged in a competitive aggression game either sober or intoxicated, having all scored lower than 5 on a short form of the MAST which indicates that they were neither addicted to, nor dependent on, alcohol. Heavy smokers and heavy coffee drinkers were excluded from this study, and the women were tested for their menstrual cycle and not being pregnant at the time. The study involved two days of testing and a battery of pencil-and-paper and experimental tests, including a short form of the Revised Wechsler Adult Intelligence Scale including the information, block design and vocabulary sub-tests which allowed intelligence quotients (IQs) to be calculated. The findings demonstrated that intoxicated males were more aggressive than their sober peers. However, under high provocation, whether sober or intoxicated, the females manifested aggression comparable to the intoxicated males. This study suggests:

a) Women can be as aggressive as men based on a laboratory measure of aggression. This result accords with the findings of the International Social Science Survey of Australia (ISSSA) that used CTS to conclude that males and females reported approximately equal rates of being assaulted by their partners in three ways: slapped, shaken or scratched the other; hit with the fist or with something held in the hand; and thrown or kicked (Heady and

Vaus, 1999). However, this finding conflicts with other investigators' results (such as Eron and Huesmann, 1989). On the other hand, some other studies have recorded similar findings to Heady and Vaus, but when levels of violence have been distinguished by gender they have found that it is males who commit the more severe forms of violence (Roscoe and Callahan, 1985).

b) Alcohol intoxication does not seem to be an important determining factor, but this result cannot be generalised because the study did not focus on consuming alcohol heavily; rather this was avoided completely by excluding alcoholics from the enquiry. Furthermore, it is rejected by several investigators including Fals-Stewart (2003) and Kyriacou et al (1999), both of whom have demonstrated that male partners tend to be intoxicated by alcohol at the time of violence.
c) Finally, the result concluded that women manifested considerable direct aggression when highly provoked, therefore, the researchers called into question whether women, if they show any aggression at all, will do so in an indirect manner rather than direct.

Bailey (1991) conducted an experiment on the effects of alcohol on the aggressive behaviour of 290 university students with various predispositions towards aggression. This study used the Buss-Durkee Hostility Inventory to separate subjects with self-reported high, moderate, and low aggressive tendencies. The students were then randomly given either a high dose of alcohol or a low dose, or a placebo. The sample then viewed a videotape of a confederate being seated before a task board and receiving electric shocks. Each participant was then asked to work with a partner on a series of reaction trials. The intoxicated group selected higher levels of shock than the non-intoxicated group under low provocation conditions. The highly intoxicated high and moderate aggressors (according to the hostility inventory) were inclined to increase their shock settings more rapidly as a function of the opponent's provocation than highly intoxicated low aggressors. Although the findings may not be generalisable, it is interesting to note that consuming alcohol increased physical aggression.

An evaluation of alcohol use and psycho-social adjustment among abused wives and their husbands was conducted by Van Hasselt et al (1985). This investigation used standardised measures of alcohol use through the MAST, a quantity-frequency index, an impairment index, and a physical abuse questionnaire which tapped the magnitude and frequency of physical abuse between married or cohabiting couples. The couples who were recruited to this study were 26 who were physically abusive, 26 who were maritally discordant but non-violent, and 15 who were satisfactorily married. These groups were matched for characteristics such as the ages of the husbands and wives, education levels, years living together, and number of children. The study found that the highest scores on the MAST were recorded by physically abusive males (based on their self-reports) as well as on the wives' reports of their husbands' drinking. This enquiry partly replicated other studies such as Collins and Schlenger (1988), Levy and Brekke (1990), Miller and Potter-Efron (1990), Tolman and Bennett (1990), and Flanzer (1990).

Leonard and Roberts (1998) compared the marital interactions of 60 aggressive with 75 non-aggressive men and their wives under a baseline condition, and then after the husband had received nothing, a placebo, or alcohol. The research's procedure required videotaping these sessions, and their coding by research assistants who were unaware of the participants' status and condition. The CTS was used to recruit the two groups. Interviews were conducted after the videoed sessions. The researchers hypothesised that the administration of alcohol and possibly the placebo would exacerbate negative interactions, particularly among aggressive husbands, but the findings did not support this hypothesis. The findings revealed an exacerbation of negative interactions in both groups, aggressive and non-aggressive. One of the primary findings of this study was that the administration of alcohol was associated with behavioural changes. Alcohol, but not the placebo, led to increased negativity by both husbands and wives.

General population studies

A now largely discredited theory is about the 'drunken bum'. This theory asserts that domestic violence is perpetrated primarily by men in blue-collar jobs and that alcohol is the major cause of their violence. In a study designed to test this theory telephone interviews were conducted with males from a nationally representative sample of

5,159 USA households. Even though the theory received some support from this study's evidence, other findings demonstrate that alcohol abuse is neither a necessary nor a sufficient cause of domestic violence. Their findings did not lead the researchers to believe that alcoholism and domestic violence were closely related. In 76% of violent domestic relationships that were reported, alcohol was not involved. In only 14% of the violent incidents reported was the man drinking at the time. However, there was an interesting response to a question about whether the men could imagine that they would ever approve of a man slapping his wife; blue-collar job status, drinking, and approval of violence were all inter-related. These researchers concluded that their findings strongly suggest that theories of alcohol as a major facilitator of violence are unsatisfactory. They propose that other factors such as culture, social level and ideology, and individual factors, need to be taken into account (Kantor and Straus, 1987). According to these investigators, some findings lend support to the 'drunken bum' theory while others cast doubt on this explanation of domestic violence.

Another study examined whether the association between alcohol and male-to-female intimate partner violence is most meaningfully described as a linear relationship, a threshold effect, or both. The links between any self-reported physical abuse and alcohol use by married men were examined. Men in two nationally representative 1985 samples, the National Family Violence Survey (NFVS) and the National Survey of Families and Households (NSFH), were divided into similar drinking groups based on quantity and frequency of alcohol consumption using a seven-point scale for the frequency with which they consumed alcoholic beverages such as beer, wine and spirits. The total in the samples amounted to 2375 adult English- or Spanish-speaking persons aged 19 years or older. In the NSFH, respondents were asked to report the number of times they had consumed any alcohol in the last 30 days, and the average amount. The investigators thereby developed a classification system based on the average number of alcoholic beverages they consumed on a drinking day (0, 1, 2, 3, 4, or 5 or more) and how frequently (never, <1 day/month, 1–3 days/month, 1–2 days/week, 3–4 days/week, 5–6 days/week, daily). Analysis of the association between intimate partner violence and drinking category revealed that although linear associations between the drinking classification scores and intimate partner violence were significant in both samples, the associations were weak. Only heavy drinkers

and binge drinkers were responsible for significant Chi-squares. Overall, the results revealed both linear and threshold effects, and suggested that drinking patterns may be more important than incremental increases in quantity or frequency in making alcohol a risk factor for intimate partner violence (O'Leary and Schumacher, 2003). Even though this study was conducted with a large sample, the influence of cultural factors (English- versus Spanish-speaking, for example) was not investigated.

A study conducted in Brazil by Micheli and Formigoni (2004) surveyed 6,417 students who were attending public schools in the city of Barueri. This study aimed to assess the prevalence of alcohol and drug use among students and to evaluate the influence of alcohol and drug use on family life, school achievement and personal behaviour. A Brazilian version of a drug use screening inventory was used in this study in classrooms where the teachers were absent. Alcohol consumption in the previous month was much higher among boys than girls, and analysis of the findings detected that family problems, the presence of anti-social behaviour, and poor relationships with those with whom they lived were significantly associated with both alcohol and drug use by the students. Again this study implies that alcohol and drug use can be factors provoking aggression.

Eighty-six male undergraduate university students in Quebec took part in a study conducted by Lackie and Man (1997). This questionnaire study examined the relationships between sexual coercion and other variables such as alcohol use, sex role stereotyping, fraternity affiliation, participation in athletics, hostility towards women, aggressive drive, aggressive attitude, and masculinity. Multiple regression analysis identified some of these variables as the best predictors of sexual coercion but alcohol was not among these variables. However, we must bear in mind the small size of the sample that was picked from the university population aged 18-24, and that few of the respondents could be described as heavy drinkers.

A study in the USA aimed to examine the relationship between husband and wife drinking, and whether their most serious conflicts involved verbal and physical aggression. The study was based on a sample of 366 couples who participated in the Buffalo Newly-Wed Study (BNS) which was conducted by Leonard and Quigley (1999) at the Research Institute on Addictions in Buffalo (New York). The BNS was

a three-wave longitudinal study of newly-wed couples with assessments at the time of marriage, the first anniversary, and the third anniversary. The researchers used interviews as their main tool, and administered scales of alcohol dependence and marital violence. The study found that wife drinking considered in isolation was not significantly associated with verbal or physical aggression. However, after controlling for husband drinking, the association between wife drinking and verbal/physical events was significant (OR = 0.15). However, wife drinking was more common in verbal than in physical assaults, while husband drinking was by far the better predictor of physical violence.

Alcohol and premarital aggression among newly-wed couples was also investigated by Leonard and Senchak (1993) who examined the relationship between husbands' and wives' alcohol use and premarital aggression by comparing the results from several aggression scales. The study also evaluated a social learning model of alcohol and aggression that posited a moderating role for alcohol on aggressive motivations. The study used an Alcohol Effects Questionnaire (AEQ), and a Permissiveness in Respect to Aggression While Intoxicated Scale. Heavy alcohol consumption and its frequency were assessed. The sample totalling 607 white and black couples entering their first year of marriage was picked from a courthouse list after applying for marriage licences. The study indicated:

1- A significant relationship between husbands who were heavy alcohol drinkers and premarital aggression.
2- Significant interaction between husbands' heavy alcohol drinking and marital dissatisfaction.
3- Significant interaction between husbands' heavy alcohol drinking and husbands' hostility.
4- Significant interaction between husbands' heavy alcohol drinking and husbands' beliefs in alcohol as an excuse for aggression.

Overall, the results suggest that alcohol use and premarital aggression were associated even in the absence of 'alcohol as an excuse' beliefs, but the presence of appropriate beliefs was strengthening the association as predicted by the social learning model.

Quigley and Leonard (2000) examined the relationships between husbands' violence, marital conflict, and couples' alcohol use in the first year of marriage, then three years

after marriage. Newly-wed couples were recruited at the time of marriage, then surveyed one year after marriage, and again two years later. The sample comprised 567 couples who completed the CTS and the Alcohol Dependence Scale (ADS). The main findings were:

1) Violence in the first year predicted subsequent marital violence.
2) Husbands' and wives' drinking patterns in the first year of marriage interacted to predict violence in later years.
3) The most violence in subsequent years occurred in couples where the husbands were drinking heavily and the wives were not.
4) When no violence occurred in the first year but there was frequent use of verbal aggression, violence often occurred in subsequent years.

The social interaction model looks at marital behaviour in the context of prior verbally aggressive or coercive conflict behaviour such as hostility, gender role and power beliefs that existed before the relationships between couples. The model proposes that using alcohol is related to marital aggression through its association with hostile dispositions and possibly by influencing marital conflict styles. One study attempted to examine this model by giving a prospective prediction of husbands' marital aggression within newly-wed couples. The study subjects were 541 couples who were in their first marriage and who completed a premarital interview concerning husband-to-wife marital aggression during their first year of marriage. The study used numerous scales to measure and compare multiple independent variables related to spouses' violence, spouses' alcohol consumption, spouses' hostility, and wives' histories of family violence. Without addressing whether episodes of violence occurred in the presence of verbal aggression, the study concluded that couples whose relationships were characterised by verbal aggression and heavy drinking by the husbands experienced higher violence than other couples (Leonard and Senchak, 1996).

The CTS and MAST were used by Heyman et al (1995) to measure the association between alcohol consumption and marital aggression in a community sample of 272 couples in a longitudinal study of four waves; pre-marriage, 6, 18, and 30 months after marriage. Couples were recruited through media announcements of a study designed to contribute to knowledge of marriage and the family. They received $40

for each complete assessment session. Through the MAST the researchers found concurrent effects on husbands' problem drinking;

a) Heavy drinking disinhibited aggressive men.
b) A highly significant effect for drink volume at 18 months among husbands with aggressive personalities.

Another important finding from this study was that husbands' problem-drinking status at pre-marriage significantly predicted the continuance of serious husband-to-wife aggression, which supported the findings of Leonard and Senchak (1993). However, even men who were non-problem drinkers were at higher risk of continued aggression. Finally, the study indicated that the relationship between alcohol and marital aggression changed over time.

Rossow (1996) undertook a survey of 2,711 Norwegian adults and questioned them about whether they had taken part in a fight while influenced by alcohol, and whether they had been injured by an intoxicated person during the past year. Semi-structured interviews were used for assessing various aspects of alcohol consumption and its consequences. Alcohol-related violence, alcohol consumption, and drinking patterns were some of the study's variables. Among the 2,385 people who reported consuming alcohol during the last year, only 71 (3%) reported having taken part in fights whilst under its influence. However, this percentage was higher for men than for women, and highest of all among the younger men. Also, the study found that among all the subjects (2,711) just 66 (2.4%) reported injuries inflicted by an intoxicated person during the past year. The possibility of having been involved in alcohol-related violence was found to increase with increased alcohol consumption by the victims.

A study conducted in Sweden aimed to analyse the relationship between homicide and assault rates, and various indicators of alcohol consumption. The investigators used time series data for 1956-1994 on assault rates (police reports of assaults) and homicide rates (number of homicidal acts per 100,000 inhabitants). Alcohol consumption was measured through sales figures. The study concluded that the homicide rate was significantly linked to consumption of spirits in particular, and especially in private (usually domestic) contexts. Also, the assault rate was found to be significantly related to consumption of beers and spirits in bars and restaurants (Norstrom, 1998).

A Canadian study conducted by Graham and Wells (2002) aimed to assess differences in the nature of physical aggression experienced by men and women. The study involved a random sample of 1,753 Ontario adults aged 18-60. Interviewers asked respondents whether they had ever been personally involved in an incident of physical aggression with other adults and how many times they had been involved in such an incident in the past 12 months. The study found that men were significantly more likely than women to state that they had been involved in acts of physical aggression, and that they had been drinking prior to the incidents. However, drinking by both the subjects and the opponents was higher for both man-only and mixed-gender incidents reported by male subjects, and lower for woman-only and mixed-gender incidents reported by female subjects. Man-only incidents were 5.3 times more likely than woman-only incidents to embrace a foe who had been drinking. In essence, the evidence mirrors other studies' findings such as Greenfield and Henneberg (2000), Bushman (1997) and Streifel (1997) that indicate alcohol consumption more often precedes aggression, assault, and other criminal acts by males than by females.

A study in Moscow examined the association between accidental, violent and alcohol-related adult mortality in the Russian capital. The data were from official records of deaths in Moscow from 1994 to 1995, and separated alcohol-related and other deaths, and accidental and violent deaths. The study concluded that high levels of alcohol consumption were involved in most violent and accidental deaths across all social strata (Chenet et al., 1998).

Alcohol related problems and intimate partner violence in the USA were examined by Cunradi et al (1999). This study aimed to assess the prevalence of alcohol-related problems and their contribution to risks of intimate partner violence among a sample of 1,440 white, black and Hispanic couples. The CTS was used to measure male-to-female and female-to-male partner violence. The study demonstrated a significant positive association between female alcohol-related problems and intimate partner violence for white and black couples. Therefore, alcohol-related problems were important predictors of intimate partner violence. However, the researchers found that after controlling for socio-demographic and psycho-social co-variates, male alcohol related problems were no longer significantly associated with an increased risk of

male-to-female partner violence among white or Hispanic couples, which contradicts some previous studies like Leonard at el (1985). Female alcohol-related problems predicted female-to-male partner violence, but not male-to-female partner violence among white couples. In contrast, male and female alcohol-related problems among black couples were strong predictors of intimate partner violence.

One UK study drew its data on domestic violence from the 1985 National Family Violence Survey of 1,541 married or cohabiting individuals, and the 1986 and 1987 follow-ups. Measuring alcohol availability by outlet density, the researcher estimated that increasing the availability of alcohol did not significantly affect the rate of domestic violence. On the other hand, it was estimated that increasing the price of alcohol by raising taxes could decrease the rate of such violence by 3.1% to 3.5% (Markowitz, 1999). The importance of this study lies in showing that with increasing alcohol availability the rate of domestic violence would remain the same (and this may apply in other cultures or countries where alcohol is illegal or especially sensitive, as in Saudi Arabia).

One recent paper has reviewed 60 studies which tested the effects of alcohol use on marital functioning. The 60 studies were reviewed for testing the associations between alcohol use and three aspects of marital functioning (satisfaction, interaction, and violence). This review suggests that there is overwhelming evidence to conclude that marital alcohol use is maladaptive, and that heavy and problematic alcohol use is associated with low levels of spousal satisfaction, high levels of maladaptive marital interaction, and high levels of marital violence. The reviewed evidence supports the hypothesis that marital alcohol use is usually maladaptive and is incompatible with a reverse hypothesis that sees alcohol use as adaptive, temporarily relieving stresses that cause marital dysfunction thereby stabilising the marital relationship and preventing dissolution. However, the reviewer reports that a small subset of studies have found that light drinking patterns improve adaptive spousal functioning. The researcher, however, argues that more research is needed to identify the conditions under which adaptive effects occur (Marshal, 2003).

Summary

Some studies have compared the negative behaviours between alcoholics and non-alcoholics, and some of them have found a higher rate of negative behaviour among alcoholic and maritally distressed couples than among non-alcoholic not distressed couples. A common theme in a group of the previous studies is that alcohol misuse and violence are concurrent problems that generally co-exist. Evidence of this comes from research in many countries, treatment samples, and laboratory studies that have used a variety of measures and blood tests. With the exception of the studies of Kantor and Straus (1987), Hoaken and Pihl (2000), and Leonard and Quigley (1999) that provide only tentative support for a link between husband drinking and husband violence, and the study by Bennett et al (1994) that found alcohol is not an immediate antecedent of violence, the majority of studies reviewed above have stated that consuming alcohol in some way affects human behaviour to engender domestic violence.

However, the findings of the studies vary from one to another due to; 1) The field that the studies relate to such as sociology (e.g., Norstrom, 1998), social work (e.g., Bennett et al., 1994), psychology (e.g., Micheli et al., 2004), psychiatry (e.g., Marshal, 2003), public health (e.g., Cunradi et al., 1999), or the medical field (e.g., Bailey, 1991), and reflect the specific problem that is concentrated on. 2) The differences in definitions of interpersonal violence, and variations in consequence in what was asked about and what was left out. 3) The differences in sample size, and type of responses; for instance, some picked their samples from alcoholism treatment programmes (e.g., Bevan and Higgins, 2000), while others were picked from domestic violence treatment centres (e.g., Kahler et al., 2003). 4) The differences in the tools, methods, and strategies and techniques of collecting data and their implications for what and how the participants remembered and responded to certain events.

The association between alcohol and domestic violence has been well-established in Western cultures, whereas it has never previously been investigated in Saudi Arabia. The subjects in the present study can be considered to be a treatment programme sample using the only possible source since in Saudi Arabia alcoholics can seek treatment only at Al-Amal hospitals. However, as an explanatory study, the investigation reported has needed to navigate in the very distinctive socio-cultural context of Saudi society where alcohol is illegal and domestic violence is not yet

officially acknowledged. These characteristics make this study unique and different from all the above studies.

Chapter Three
Research Design and Methods

Introduction

It was not difficult to choose between the three main types of alcohol and domestic violence research distinguished in chapter two. Alcohol is illegal in Saudi Arabia. This ruled out an experimental study and also, in practice, a survey of the general population with questions about alcohol consumption. The research was thereby tracked towards groups receiving treatment. However, issues remained as regards exactly which groups to study, how to investigate them, and how many people to interview.

The role of the social sciences is discovering, describing and explaining things in order to answer questions such as why, how and when certain phenomena happen. The aims may always be similar but the methods used in social science are numerous. Exploratory research usually aims to break into a new topic like a social problem that has arisen unexpectedly. Addressing a new problem would be one of the best reasons for conducting exploratory research and, at the beginning of such research, questions cannot be formulated precisely. Testing hypotheses, concepts and theories empirically through suitable methods will extend knowledge in already charted areas: this is the natural scientist's way of knowledge building. Combining different approaches such as quantitative and qualitative has a long history in the social sciences but debates continue on the possibility of integrating them within various labels such as rationalistic, naturalistic, functionalist, interpretive, positivist and constructivist.

In this chapter the methods chosen for this particular study will be discussed and justified.

Aims and objectives

The present study has one main question and three subsequent questions. The main question is:

- *Does alcoholism have a relationship or correlation with domestic violence in Saudi society?*

The three subsequent questions are; if alcoholism is associated with domestic violence:

a) *Do men who drink especially heavily have a greater tendency to perpetrate domestic violence than others?*
b) *Does drinking usually occur at the time of violent incidents?*
c) *What types of violence are married women and families in Saudi facing or witnessing?*

Conceptual framework

Alcoholism has been defined as a chronic disease that affects the central nervous system. Alcoholism can also be characterised as a social, psychological, and physical problem. As a consequence, alcoholism can result not only in body damage, but also in social and psychological difficulties (Thomas and Pierson, 1995). The terms alcoholism, alcohol dependency, and alcohol abuse have overlapping meanings. Alcoholism is a physical or mental condition that affects drinkers (Dearling, 1993). However, in the social work dictionary, Barker (2003) distinguishes alcoholism as physical or psychological dependence on the consumption of alcohol that can lead to impairment socially, mentally, or physically, from alcohol abuse when consuming alcohol in such a way as to damage the well-being of the user or those with whom the consumer comes into contact. Therefore, alcohol abuse may lead to accidents, becoming physically assertive, less productive, or to physical deterioration.

This study investigates alcoholic patients who were hospitalised at Al-Amal hospitals, which are the only locations 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. Also, partly because of these constraints on research methods, this study does not concentrate on the intoxication condition of the user or the ‘disinhibition hypothesis’ due to the difficulty of obtaining accurate data on the quantity of alcohol consumed by the perpetrator of domestic violence and whether or not he was intoxicated immediately prior to the violent episode. The study, rather, focuses on the long-term effects of alcohol but also gives attention, albeit limited, to intoxicated behaviour investigated through one of its sub-questions addressed to both husbands and wives. Also, since the sample of women married to drug users is a control group, the analysis covers stimulants and depressants. Stimulants are drugs that excite the

central nervous system such as caffeine, cocaine and amphetamines. Depressants are drugs that inhibit or depress the central nervous system such as alcohol, barbiturates, other sleeping pills, benzodizepines, chloral hydrate, and other sedatives. However, classifying drugs in this manner is complicated because each drug may have different effects depending on the dosage and the neuro-transmitters affected by that drug.

Domestic violence is the use of intentional emotional, psychological, physical and/or sexual force by a family member or intimate partner to control another. The violent acts can include emotional, verbal and/or physical intimidation such as obstruction of the victim's freedom, maiming, insulting, mocking, shouting, threatening, sexual abuse, slapping, punching, kicking, choking, burning, poking, shooting and/or killing. The victims of domestic violence can be spouses, parents, step-parents, children, siblings, elderly relatives, and/or intimate partners (Peace at Home, 1995). Therefore, the terms family violence, woman abuse, spouse abuse, wife abuse, battered wives and battered women have been used interchangeably to describe the same plethora of domestic violence (Smith, 1989).

This study of alcohol and domestic violence concentrates on married women in particular though other possible victims of family violence are also considered such as children, parents, the elderly, sisters, brothers and any other members of the alcoholics' families.

Main methods

The old saying, "No one of us is as strong as all of us", identifies the methodology of triangulation which means the use of more than one method, more than one data source, more than one tool, more than one theory and/or more than one observer (Denzin, 1989). So this study used the two main types of methods:

a) Quantitative, by using the social survey method, and a structured questionnaire as a tool with the groups that were studied. Within this quantitative method there were two existing scale measures; the Michigan Alcoholism Screening Test (MAST) to identify the level of alcohol consumption and alcohol problems, and the Conflict Tactics Scales (CTS) which was used as an instrument to measure the type of violence (if any) used by alcoholics against others.

b) Qualitative, by using narrative 'biographical' interviews and focus groups with alcoholics, and semi-structured interviews with samples of three groups of women; women married to alcoholic patients, women married to drug addicted patients, and women married to 'ordinary' or 'normal' patients.

Key instruments

As mentioned previously, the MAST is a scale for alcohol abuse and the CTS is a scale for partner/spouse aggression. These scales were used simultaneously in five of the studies reviewed in chapter two (Heyman et al, 1995; Murphy and O'Farrell, 1994; O'Farrell and Murphy, 1995; O'Farrell et al, 2000; Schumacher et al, 2003). These scales were selected for this study because both had been used frequently in studies which had established links between alcohol use and domestic violence, the reliability and validity of both scales was well-established (in North America), both could be readily adapted for use in Saudi Arabia, and both were suitable for use with the groups to be studied in this investigation.

MAST consists of 25 questions to be answered 'yes' or 'no' with different weightings for the various questions (see Appendix 1). 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 presence of legal difficulties (Kinney and Leaton, 1991).

The MAST was chosen for this study to assess four aspects of drinking:

(1) Drinking, control of amount, for example:

- Can you stop drinking without a struggle after one or two drinks?
- Are you always able to stop drinking when you want to?

(2) Drinking, time of incidents, for example:

- Have you ever awakened the morning after some drinking the night before and found that you could not remember part of the evening before?
- Do you ever drink before noon?

(3) Drinking problems, for example:

- Have you ever lost a job because of drinking?
- Have you ever been a patient in a psychiatric or mental health clinic or gone to a doctor, social worker, or clergy for help with an emotional problem in which drinking played a part?

(4) Drinking-related behaviour, for example:

- Have you neglected your obligations, your family or your work for two or more days in a row because of drinking?
- Have you ever been arrested, even for a few hours, because of drunk behaviour?

There are more than 30 instruments that measure alcohol use and abuse. These include the Maryland Addictions Questionnaire (O'Donnell et al., 2001), the Alcohol Abuse and Dependence Symptoms (American Psychiatric Association, 1994), the Alcohol Use Disorder Identification Test (Babor et al., 2001), the Alcadd Test (Manson et al., 1992), the Munich Alcoholism Test (Feuerlein et at., 1979), the MacAndrew Alcoholism Scale (MacAndrew, 1981), the Alcohol Use Inventory (Horn et al., 1995), the Alcohol Dependence Scale (Skinner and Horn, 1989), the Alcohol Clinical Index (Skinner and Holt, 1998), the Alcohol Dependence Syndrome (Edwards and Gross, 1976; Skinner and Allen, 1982), the Quantity-Frequency-Variability Index (Cahalan et al, 1969), the Addiction Severity Index (McLellan et al., 1980), the Severity of Alcoholism Dependency Questionnaire (Stockwell et al., 1979), the Impairment Index (Shelton et al., 1969), the Blood Alcohol Concentration (Armor et al., 1978), the Alcohol Urge Questionnaire (Bohn et al., 1995), the Obsessive Compulsive Drinking Scale (Anton et al., 1995), the short form of the Michigan Alcohol Screening Test (Pokorny et al., 1972), and the CAGE (Mayfield et al., 1974). However, most of these tests were designed for use in medical or psychiatric contexts. Others were developed for specific populations like teenagers or pregnant women. Few alcohol instruments are as widely applicable as the MAST.

The MAST is a very widely used instrument designed to measure the extent and severity of alcohol misuse with well-established reliability and validity (Selzer, 1971). Internal reliability coefficients range from .83 to .95, and the test has consistently

been shown to possess good face validity with concurrent validity coefficients ranging from .79 to .90 (Hedlund and Vieweg, 1984). The test takes about 10 minutes to complete. Raw scores can range from 0-53 with the higher scores indicating increased problems with alcohol. When the raw scores have been grouped into a smaller number of bands, scoring ten or more points is suggestive of alcoholism, four points to nine means that the subject at high risk of problem drinking where addiction to alcohol is likely, and three points or less indicates that the subject is unlikely to be an alcoholic. Different questions are given different weights during the grouping of the raw scores. Thus alcoholic responses to questions 9, 20 or 21 are given a 5-point value, questions 3, 5, 10, and 17 are assigned a value of one point, question 7 is given a value of zero, and the rest of the questions are given a 2-point value. Questions 1, 4, 6 and 8 are given a value of 2 points if they are answered ‘no’ (negative response). In this study the MAST was placed at the end of the questionnaire which was administered to the alcoholic patients.

The Conflict Tactics Scales (CTS) has been widely used for more than 30 years with strong evidence of validity and reliability (see Appendix 2). Its internal consistency reliability ranges from .79 to .95 (Straus, 1979; Straus, 2004). There are other measurements of violence such as the Short Marital Adjustment Test (Locke and Wallace, 1959), the Conflict Inventory (Margolin, 1980), the Abusive Behavior Inventory (Shepard and Campbell, 1992), the Physical Abuse Questionnaire (Morrison and Van Hasselt, 1980), the Dyadic Adjustment Scale (Spanier, 1976), the Miller Social Intimacy Scale (Miller and Lefcourt, 1982), the Family Assessment Measure (Skinner et al., 1984), the Marital Interaction Coding System (Weiss, 1993), the Marital Status Inventory (Weiss and Cerreto, 1980), the Spielberger Trail Anger Scale (Spielberger et al., 1979), the Taylor Aggression Paradigm (Tedeschi and Quigley, 1996; Giancola and Chermack, 1998), the Buss-Durkee Hostility Inventory (Buss and Durkee, 1957), the History of Violence Scale (Neidig, 1985), the Marital Stress Scale (Pearlin and Schooler, 1978), the Approval of Marital Violence Scale (Saunders, 1980), the Marlowe-Crowne Social Desirability Scale (Crowne and Marlowe, 1964), the Who Does What Questionnaire (Cowan et al., 1978), the Domestic Violence Inventory (Risk and Needs Assessment, Inc., 2001), the Behavioral Affective Rating Scale (Johnson, 2002), and the Communication Patterns Questionnaire (Christensen and Sullaway, 1984). However, some of these scales are

used to measure specific conditions like marriage adaptation, satisfaction, or risks of divorce. Also, unlike some of the other scales, the CTS can deal with conflict reported by both men and women to measure who was aggressive towards whom, and how often. Furthermore the CTS was developed to measure different types of aggression;

a) Negotiation:
    1- Explained side of argument.
    2- Suggested compromise in an argument.
    3- Showed partner that subject cared.
    4- Said could work out problem.
    5- Agreed to try partner's solution.
    6- Respected partner's solution.

b) Psychological aggression:
    1- Insulted or swore at partner.
    2- Shouted at partner.
    3- Stomped out of room.
    4- Threatened to hit or throw something at partner.
    5- Destroyed something of partner.
    6- Did something to spite partner.
    7- Called partner fat or ugly.
    8- Accused partner of being a lousy lover.

c) Physical assault:
    1- Kicked, bit or punched partner.
    2- Slapped partner.
    3- Beat up partner.
    4- Hit partner with something.
    5- Choked partner.
    6- Slammed partner against wall.
    7- Grabbed partner.
    8- Threw something at partner that could hurt.
    9- Used knife or gun on partner.
    10- Pushed or shoved partner.
    11- Twisted partner's arm or hair.
    12- Burned or scalded partner on purpose.

d) Sexual coercion:

1- Used force to make partner have sex.
2- Used threats to make partner have anal sex.
3- Used force to make partner have anal sex.
4- Insisted on anal sex (no force).
5- Used threats to make partner have sex.
6- Insisted on sex (no force).
7- Insisted on sex without a condom (no force).

e) Injury:

1- Partner was cut or bleeding.
2- Partner went to doctor for injury.
3- Partner needed to see doctor but didn't.
4- Partner felt pain the next day.
5- Partner had sprain or bruise that could be seen.
6- Partner's private parts were bleeding.

Research on marital conflict and communication has shown that the emotional tone of discussions, whether positive or negative, is strongly linked to marital stability. Therefore, negotiation in the CTS is defined as actions taken to settle a disagreement through discussion, like the cognitive items, while the emotion subscale is meant to measure the extent to which positive affect is communicated by asking about expression of feelings of care and respect for the partner.

.

Because the CTS was built to measure marital violence from both sides, male-to-female and female-to-male, in this study the scale was used with both the alcoholic patients and the three groups of married women (see below). The CTS is the most widely used violence scale to assess the frequency of male and female perpetrated verbal aggression, overall violence and severe violence. No other scale is available which separates types of violence with such high validity and reliability.

The CTS takes 15 minutes to complete. There are 78 questions each with 7 answer categories (never, once, twice, 3-5 times, 6-10 times, 11-20 times, more than 20 times) for the frequencies with which respondents and their intimate partners engaged in the behaviours during the last 12 months. Straus (1995) has suggested scoring the frequency of violent acts using middle of yearly frequency ranges for each CTS

response category as: never = 0; once = 1; twice = 2; 3-5 times = 4; 6-10 times = 8; 11-20 times = 15; more than 20 times = 25.

The questionnaire used with alcoholic patients (Appendix 3) contained six parts; 1) personal data, 2) state of marriage, 3) alcohol consumption, 4) general behaviour, 5) legal status, and 6) family and relatives. Using a questionnaire was judged to be the best way to approach alcohol-related patients to discover the actual relationships in their families and any other problems related to alcohol misuse.

Narrative interview is classified among the qualitative research methods to be considered a form of unstructured, in-depth interview with specific features (Jovchelovitch and Bauer, 2000). The narrative interviews were conducted by the researcher after the main fieldwork for the purpose of gaining insights into the biographies and social lives of alcoholics in Saudi society. Since up to now there have been no studies of alcohol in Saudi Arabia, the narrative interviews were considered essential to embellish what was written in the first chapter of this thesis about social life in Saudi society. It was also believed that this material would be useful to professionals who work in preventive, ameliorative and rehabilitative roles in Saudi Arabia, and to policy makers who need to understand alcoholism properly when contemplating legislative matters. Additionally, since there are extreme sensitivities surroundings social life and its problems in Saudi society, it was considered timely to generate case study material to help to bring the issues of both alcoholism and domestic violence towards the fore of social scientific research, to elevate them into social and public health issues, and to spread awareness of these matters across Saudi society as a whole.

The four narrative interviewees agreed to take part in the study after being randomly picked. The participants represent the three main groups of patients - never married, currently married, and separated or divorced - and each case also represents one hospital and region of Saudi Arabia - Riyadh, Jeddah, Dammam and Qaseem. Each interview lasted for about an hour with only writing key words during the interview in order to give the attention to the interviewees. The whole details and analyses were written shortly after each session which took more than one hour.

Focus groups were also used in this research for the purpose of understanding behaviours and customs, and gaining insights from the subjects (Bloor et al., 2001). The aim was to draw upon patients' attitudes, feelings, beliefs, experiences and reactions in a way which would not be feasible using quantitative methods. Therefore, the focus groups were created by the researcher after analysing the questionnaires which suggested areas that needed to be further investigated and discussed more deeply.

It is worthwhile mentioning here that several issues were taken into account before conducting the focus groups. First, it was decided to include Saudi alcoholic patients who had never married, were currently married, and others who were divorced or separated, and to have 6 in each group, 18 patients in total. The groups were held in conference rooms at the Al-Amal hospitals in Riyadh, Jeddah and Dammam which are the biggest three hospitals of Al-Amal serving three different regions (Middle, Western and Eastern) of Saudi Arabia. Each session lasted approximately 90 minutes, and refreshments, paper and pens were provided. An agenda for the focus groups was developed that ensured that a mix of open-ended questions, 'why' questions, and 'think back' questions were used, plus end questions to bring closure to parts of each session and to obtain summary comments. Questions that could be answered 'yes' or 'no' were avoided. These procedures are discussed in further detail in chapter 7.

The subjects

The principal subjects in this research were male alcohol-related patients who were hospitalised for treatment at Al-Amal Hospitals that located in the cities of Riyadh, Jeddah, Dammam, and Qaseem. Female patients amount only to 1-10 % of all patients and they are all treated at the Riyadh hospital 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 the Al-Amal hospitals were the sole realistic source of a Saudi sample with which to study the relationship between alcohol and domestic violence. The principal researcher early on sought official permissions from the four hospitals and signed ethical forms and latterly got permissions from all participants in all samples, but the three groups of women were approached initially by female social workers.

Table 3.1: *Number of Admitted Alcohol-Related and Drug-Related Patients in three Al-Amal Hospitals between 1991-1993*

Year / Hospital	1991	1992	1993	Total
Riyadh	5638	6290	6281	25961
Dammam	3147	3415	2394	14555
Jeddah	3972	8212	12229	24413
Total	12757	17917	20904	64929

Table 3.1 (Al-Amal Magazine, 1994) shows the number of admissions in Al-Amal hospitals with the exception of the Qaseem hospital which was established after 1993. These numbers include alcoholics and drug addicts. It should be mentioned here that Al-Amal hospitals allow patients to enter the hospital as many times as they wish until they complete their treatment programmes, which in most cases last 30-45 days.

Table 3.2: *Number of Alcohol Related Incidents Discovered by Police*

Year	Number of incidents
1983	3023
1988	4627
1990	5063
1995	4999
1999	5309
2000	8610
2001	9792
2002	9886

Table 3.2 (Ministry of Interior Statistical Book, 2002) shows the number of alcohol related incidents discovered by the Saudi police. We know that not all these cases were admitted to Al-Amal hospitals. How do we know this? We know, for example, that a person with a death penalty will not be admitted. On the other hand, a patient who is admitted to one of the three hospitals more than once will be included in the figures more than once.

Regarding the approximate number of alcohol inpatients who were available, we need to consider the time of data collection which was during a three month period, and the numbers in the above tables are for whole years. Considering the capacity of the

hospitals, this meant that there would be around 50 patients at each hospital of the Al-Amal hospitals during the three months. It seemed likely that 15- 20% of these would not be available for the study due to their poor condition, physically or psychologically, or not agreeing to take part. Considering all these circumstances and based on the time of collecting the data, the populations and respondents in this study of alcoholic patients were as follows:

Table 3.3: *Total number of respondents included in and excluded from the study*

Hospital	Total Patients	Excluded Owing to Incomplete Questionnaire	Excluded Owing to Refusal to Participate	Final Number of Respondents
Riyadh	66	11	3	52
Jeddah	51	11	2	38
Dammam	41	8	4	29
Qaseem	35	6	4	25
Total	193	36	13	144

Of the 193 alcoholic hospitalised patients, 180 agreed to take part in the study. Of these 36 patients did not complete their questionnaires. Therefore, 144 questionnaires were used in the final analysis. Also, the population of the study can be categorised into voluntary patients (112) and involuntary patients (32) from the secure wards - more details in Appendix 4. All alcoholic patients (144) were assessed by MAST to distinguish truly alcoholic from non-alcoholic patients. In addition, among those who took part in the study, only married patients (42) were measured by the CTS to discover the levels and types of violence used (if any had happened).

The study also involved three samples of married women; 25 women married to alcoholic patients, 25 women married to drug user patients, and 25 women married to ‘ordinary’ patients (i.e. women married to ‘ordinary patients, not alcoholics or drug users, who were picked randomly from the general hospital to represent the general population). A general hospital in Saudi Arabia is a place to find participants presenting no overt signs of violence or alcohol use whatsoever. Women married to alcoholic patients were the main group, while the other married women were used as control and comparison groups in order to see if there were any differences between them in terms of the aggression that they had experienced. Since domestic violence

had not previously been investigated in Saudi society, it was valuable and worthwhile to use control groups.

The sizes of the samples are reasonable and realistic considering that some patients came to the hospitals secretly and therefore did not wish their families to be approached. Also, not all alcoholic patients were married, and not all married women wished or could be accepted to take part in the study.

The three groups of married women were selected randomly, but then screened to be similar in the following characteristics:

a- Length of marriage to be between 3 and 15 years.
b- Education status had to be neither under secondary nor above college.
c- Economic condition based on the family income.
d- All groups to be from Dammam City where the third hospital of Al-Amal is located.
e- All to have one child or more.
f- All to be living with their husbands, not separately.
g- All to be normal in health, physically and psychologically.
h- Married women and their parents to be similar in education and economic backgrounds.
i- Married women whose husbands used or were addicted to both alcohol and drugs were excluded.

The interviews included questions on the relationships between the women and their husbands, and covered subjects like child abuse, sex abuse, and other violence. Also, all women were measured by the CTS to discover the levels and types of violence (if any) that they had experienced.

The semi-structured interviews with the three groups of married women (Appendices 5, 6 and 7) took 40-90 minutes and worked well. The questionnaires used with married women contained some closed questions like, “Have you ever suffered because of his drinking?” and some open questions like, “How would you describe your husband’s behaviour before and after drinking?” with separate spaces for writing down his behaviour before and after drinking. The interviews were conducted by

female social workers at the hospital. The principal researcher taught them how to conduct and gather the information. He drew-up guidelines for the interviews, and organised training and practice sessions. It is more ethical to rely on female social workers to conduct such interviews since the topic includes social and sensitive issues like sexual and family relationships.

The female social workers arranged times and places for the interviews at Al-Amal hospital in Dammam. The women mostly came to the hospital regularly to visit their husbands. Female social workers were considered better than any other persons for conducting the interviews with married women because of the socially sensitive subjects that were covered. These included physical, psychological, and sexual aggression. It is worthwhile here acknowledging the special difficulties that arise when relying on others to do qualitative fieldwork. The person who is going to analyse the study's material can anticipate special problems. One of these is the long time that must be spent analysing materials that are collected by others. In any case, transcribing talk into text is never easy because not all spoken words can be written down, especially in a different language, like in this study. Also, the training requirements (for the female social workers in this case) were more complex than with a purely quantitative study. Thus, great attention was given to training the fieldworkers during the piloting of the project. The training for the semi-structured interviews helped the social workers to handle the interviews and obtain the target data. They showed skills that were needed for this type of interview which were asking questions exactly as worded, and probing incomplete answers in a non-directive way, that is, in a way that did not increase the likelihood of one particular answer over others, and recording answers with discretion. They practiced the advice given about compromises that were required when representing transient speech as written text. It worthwhile to state here that some participants (60%) accepted the use of tape recorders by the female social workers which, when permissions were given by both the participants and the hospital, helped them to write down all necessary details.

Testing and adapting the measurements

The term 'standardised measures' is applied to instruments, scales, inventories, questionnaires or tests that are used to measure people or other phenomena (Bloom et

al., 2003). Standardised measures are pre-tested for their validity, reliability, sensitivity and specificity, but even these need further consideration when applied in a different culture. The misuse of such measurements could lead to false or unreliable findings, and ethical lapses. When applying instruments in other cultures, researchers should always test them to make sure that they fit the purposes of the study. Literal translations may lead to erroneous interpretations (Triandis, 1990). Ethical dilemmas, which may arise from false inferences, have become an issue in many disciplines. Research ethics have been developed in order to provide suitable guidelines for proper conduct (Gillespie, 1995).

Therefore, the MAST and CTS were translated by the researcher into Arabic language and adapted to Saudi culture, after which their face validity was tested by seeking feedback from some practitioners, academics and professionals. The second step was to conduct a pilot study to test them empirically. Unlike the MAST and CTS, developing the questionnaires initially involved writing down all the relevant questions that came to mind. Modifying the questionnaires came next. Such modification included deleting, adding to, re-ordering and checking the wording of each item. Next, the questionnaires were translated into Arabic language and then given to some professional and academic experts in the field of addiction to examine and judge their validity. Its reliability was tested by circulating the questionnaire to a small sample of alcoholic patients (n = 22) at Al-Amal hospital in Riyadh. This sample was monitored by the researcher at the time of filling-in the questionnaire and then interviewed as a group shortly after completion in order to make sure that the questions were clear enough and the time was reasonable. Finally, the questionnaires were retested in the fieldwork during the pilot study that included another 15 alcoholic patients at Al-Amal hospital in Riyadh (completed in early 2004) to ensure that the amendments made the questionnaire more clear and understandable. The samples used for testing and retesting were excluded from the main sample at the time of data collection.

After translation, all the instruments were piloted as is normal in social science (Teijlingen and Hundley, 2004). Piloting can help a researcher to:

1- Identify and avoid any unforeseen problems in the questions' wording which may lead to bias when analysing the data, or to difficulties during the fieldwork.
2- Identify and avoid unethical processes or words.
3- Identify any preparation or training that may be needed either for respondents or fieldworkers.
4- Tap the local culture and its sensitivities.
5- Identify any further questions that may need to be added.
6- Identify superfluous questions that can be erased.
7- Assess the value of open-ended sections of the questionnaire.
8- Assess the fit between the tools and respondents' abilities and time available.

Therefore the pilot test for this study proved very helpful as did the researcher's experience as a social worker at Al-Amal hospital from 1994-1997. The participants in the pilot study totalled 15% of the final actual samples. As a result of the piloting, some changes were made to the instruments. Some questions were erased because of repetition and on the basis of academics' and professionals' feedback. Other questions were re-written to aid the respondents' understanding.

The MAST also required changes due to cultural differences. The question, 'Does your spouse or your parents ever worry or complain about your drinking?' proved unrealistic in Saudi culture where alcohol is prohibited and illegal. So either using or abusing alcohol would not be accepted by married women, parents or anyone else. As a consequence, the question was eliminated.

In the MAST there were some other questions which did not fully apply in Saudi culture, but in these instances it was possible to fine tune the phrasing through appropriate translation. Examples include, 'Do you feel you are a normal drinker?' which was followed by the phrase 'normal drinker means you are not addicted' and 'Do you ever feel bad about your drinking?' ('bad' was replaced by 'guilty'). With the question, 'Do your friends or relatives think that you are a normal drinker?' the phrase 'who know about your drinking' was added after 'friends or relatives' to give the question more clarity and to be more specific about the individual's perceptions of others.

In contrast, other questions that looked strange were accepted after discussing them with alcoholic patients. For example, ‘Have you ever been arrested, even for a few hours, because of drunk behaviour?’ and ‘Have you ever been arrested for drunk driving or driving after drinking?’ After discussing these questions with alcoholic patients in groups and individually in the pilot study, it was concluded that the questions were reasonable and acceptable.

The Arabic version of the CTS required some changes. The scale proved very complicated for both patients and married women and took longer to complete than was expected. So some questions were changed to make their meanings clearer without influencing the scale values. Respondents were asked to circle 1 for one time in the past year, 2 for two times in the past year, 3 for three times in the past year, 4 for four times in the past year, 5 for five times in the past year, 6 for six times or more in the past year, 7 for not in the past year but it did happen before, and 0 for ‘this has never happened’. The reasons for these changes were; a) during the pilot study the original scoring confused the participants and took a very long time, and b) after analysing the pilot study data, it was found that about 92% of the participants circled 1, 2, or 3 of the original categories on all scale’s items, indicating that a more discriminating scoring scheme was needed.

Also, some questions jarred with Saudi culture. The questions, ‘I made my partner have sex without a condom’, and, ‘My partner did this to me’, proved inapplicable in Saudi culture where (officially and largely in practice) there are no sexual relationships between men and women outside of marriage. These questions will work better in some other cultures, like in the Western societies where the scale was built and where condoms are used for sexual disease and pregnancy prevention.

All the changes in both scales were taken into account when coding and analysing the data.

For the semi-structured interviews with married women, the place where the interviews were expected to be held, namely Riyadh, was changed. Travelling to East Saudi Arabia where Dammam is located proved a good alternative because of the

presence of active and helpful female social workers. At Al-Amal hospital in Dammam two female social workers accepted the task of conducting the interviews and were trained for this. The two female social workers did very well in their practice and training. There were no major changes to the interview form, except to add more space for writing answers to the open-ended questions.

The narrative interviews were conducted after the main fieldwork. These interviews were tape-recorded after obtaining permission from the participants as well as the hospitals. This enabled the interviewer to give full attention to everything that was said and to observe the interviewees, thereby gaining some vivid descriptions and details of the participants' biographies, especially how they had been introduced to alcohol, and their subsequent drinking careers.

For the focus groups with alcoholic patients, the researcher made short individual interviews with the individuals to make sure that they would talk and participate effectively. Practising a short session as training was highly useful. First, it suggested that mixing a group in terms of marital status would lead to blocks in the discussions. Therefore, three groups based on marital status were used and these displayed good interaction. Second, the training helped the researcher to moderate the discussion without leading the conversation into predetermined answers. Third, the training demonstrated the need of some equipment such as flipchart and marker, refreshments tape recorder and its requirements which were official permissions from the participants and from the hospitals after filling a form.

Data collection and analysis

The collection of the data from the main sample of patients started on 12 June 2004 and was completed by 22 September 2004. However, the interviews with the married women began earlier and took longer; these interviews were completed on 17 December 2004. Narrative interviews and focus groups were both conducted later in July-August 2005.

The quantitative data was processed and analysed using the Statistical Package for Social Sciences (SPSS for Windows, version 13.0). The SPSS is usually used for statistical analysis, data management (e.g., case selection, file reshaping, creating

derived data) and data documentation which are features of the basic software. It places constraints on internal file structure, data types, data processing and matching files, which together considerably simplify programming. In addition, Command syntax programming has the benefits of reproducibility and handling complex data manipulations as well as straight-forward analysis.

The analysis and interpretation of quantitative data should be presented in a clear, readable and meaningful way. The researcher has tried to analyse the data in different ways using various statistical tools, but some of these were rejected as a result of being useless for the evidence under scrutiny, complex or making no meaningful sense. The inferential statistics presented in this study were the best available given the sample sizes and the aims of the study.

The qualitative information was processed and analysed manually with a little support from the NUD*IST 4 project to NVivo software programme that allows qualitative data to be coded and retrieved. This programme enabled detailed coding of the interview transcripts and the document texts to identify emergent themes and sub-themes related to descriptive and procedural concepts, and then ‘coding on’ to identify the characteristics and dimensions of these concepts.

Difficulties

There were some special difficulties which were overcome.

1- Finding scales that could be rebuilt, translated and adapted to Saudi culture.
2- Finding female social workers who were prepared to conduct the interviews; this resulted in the relocation of the relevant fieldwork from Riyadh to Dammam.
3- Translating while retaining the meaning of sentences and phrases in the American scales, the MAST and the CTS.
4- The process of entering the hospitals and alcohol wards in order to collect information from patients during the testing, the piloting and in the main fieldwork.
5- The lack of previous Saudi studies of alcohol, violence and other family problems.

6- The exaggeration of secrecy about alcohol and violent incidents within Saudi agencies.
7- Reviewing and obtaining Arabic literature from books and articles, and translating them into English.
8- Conducting empirical research in one society while attending courses in another country.
9- The number of women married to alcoholics who were available and willing to be interviewed was fewer than expected, which extended the time needed for collecting data.
10- Talking about individual experiences rather than answering a question intended to apply to all alcoholics in Saudi society was one difficulty faced by the researcher during the focus groups.
11- Analysing the qualitative data took longer than expected as the researcher was relying on others to conduct the qualitative fieldwork.
12- Translating qualitative data into English, and then using content analysis, was the most difficult part of the study.
13- Finding widowed patients (in the event none were included in the study) for the group of 'other' patients in narrative interviews and focus groups.

Conclusion

This chapter began by outlining the aims and objectives of the study and then discussing the two main concepts 'alcoholism' and 'domestic violence'. Second, the main methods and the key instruments were described in detail with their methodological issues. Third, the subjects (the main sample which is alcoholic patients) as well as other samples were noted and explained according to their purposes, ways of selection, sizes and characteristics. This chapter also outlined why, how, when, and where the research took place. Ethical issue, piloting and plans prior to entering the field were highlighted throughout this chapter. Nonetheless, despite the minor problems and difficulties faced during the study phases that listed above, the study design and methods worked well and provided rich data for analysis which is presented in the following chapters.

Chapter Four

The Three Samples of Married Women

This chapter compares women married to 'ordinary' patients, drugs user patients and alcoholic patients. The 25 women married to male 'ordinary' general patients were from a general hospital in the eastern region whereas the two other groups were interviewed at Al-Amal hospital in Dammam. The interviewers were the same as those used with the other samples, but minor changes were made to the interview content due to the subjects' status. The 'ordinary' women interview schedule (see appendix 5) contained nineteen questions in total, all designed to match the study's aims and objectives. Some of the findings from this sample have been placed in Appendix 8.

The 25 women married to patients who abused drugs, but not alcohol, were from the Al-Amal hospital in Dammam. These patients considered themselves and were considered by others to be addicted to drugs. The female social workers who conducted the entire study's interviews used an interview schedule that contained eighteen questions (see Appendix 6) which were mostly similar to those used with the other groups of married women. Violence under the influence of certain drug is not a public issue in Saudi Arabia yet international research indicates consistently that drug users are over-represented among the perpetrators of violence. Some data from this sample can be found in Appendix 9.

The third sample is 25 women married to alcoholic patients, the core sample of women in this study. This sample was also drawn from the Al-Amal hospital in Dammam and was investigated through semi-structured interviews (see Appendix 7). Data from this sample is in Appendix 10.

The interviews contained two groups of questions, closed questions and open questions, plus the Conflict Tactics Scales (CTS) which was used in exactly the same way with all three samples.

Closed questions

Table 4.1: *Respondents' husbands' experiences of being arrested*

Arrested	Women married to 'ordinary' patients		Women married to drug users		Women married to alcoholics	
	N	%	N	%	N	%
Yes	-	0	13	52	11	44
No	25	100	12	48	14	56
Total	25		25		25	

The above question aimed to look at histories of being arrested due to perpetrating any illegal behaviour. As a non-representative sample, none of the 25 'ordinary' women said that their husbands had been arrested. About half the husbands who used illicit drugs had been arrested, and over two-fifths of the alcoholic husbands had been arrested due either to abusing drugs or alcohol, or other criminal problems. This is just one indication (others follow) of how the alcoholics and drug addicts were creating problems for their families. Forty-eight percent of both groups of women reported that their husbands had been in prison. Ninety-two percent of both groups believed that drugs/alcohol were causes of aggression. (These, and some other results from the closed questions to the samples of women are in Appendices 8, 9 and 10).

Table 4.2: *Respondents' who had suffered seriously due to violent acts*

Suffered	Women married to 'ordinary' patients		Women married to drug users		Women married to alcoholics	
	N	%	N	%	N	%
Yes	3	12	23	92	24	96
No	22	88	2	8	1	4
Total	25		25		25	

Following the previous question, all the samples of women were asked whether they had ever suffered seriously because of their husbands' behaviour. This query aimed to explore possible reasons that in some way or another could lead to violence within Saudi families. The vast majority of the 'ordinary' women (88%) said that they had never suffered seriously, which clearly indicates a low level of seriously troubled relationships between Saudi spouses. Out of 25 women married to drug users, 23 said that they had suffered seriously because of their addicted husbands. The large majority (92%) who had suffered seriously indicates a strong relationship between abusing drugs by husbands and problems that may lead to violence. Out of the 25 women married to alcoholics, 24 said that they had suffered seriously because of their husbands' addiction. Again, the high proportion (96%) who claimed to have suffered

seriously suggests a strong relationship of some description between alcohol abuse and domestic problems that may lead to violence.

Table 4.3: *Respondents' calling for help due to violent acts*

Called for help	Women married to 'ordinary' patients		Women married to drug users		Women married to alcoholics	
	N	%	N	%	N	%
Yes	-	0	16	64	14	56
No	25	100	9	36	11	44
Total	25		25		25	

The subjects were questioned on whether they had ever called for help because of their husbands' behaviour. The table above shows that all the 'ordinary' women (100%) responded 'no' while more than half (64%) of women married to drug users had called for help. Similarly, more than half (56%) of the women married to alcoholics had called for help. These results are further evidence of the difficulties that these women faced, and the frequency of their calls for help may be regarded as surprising given the sensitivity surrounding social and married life in Saudi Arabia. The predicaments of the women who had never called for help (36-44%) are illustrated in the statements given under the open questions where some of the subjects explained that they could not leave their husbands because they did not have any other places to live or because of the children.

Table 4.4: *Respondents' who had felt scared to tell others about violent acts*

Felt scared	Women married to 'ordinary' patients		Women married to drug users		Women married to alcoholics	
	N	%	N	%	N	%
Yes	1	4	17	68	18	72
No	24	96	8	32	7	28
Total	25		25		25	

A further question explored the women's status by focusing on those who had suffered from their husbands' behaviour. The women were asked if they had ever felt too scared to tell other people about this. This question may indicate hidden problems within marriages in Saudi Arabia where social and family life are extremely sensitive issues. The table above shows that as many as 24 'ordinary' women (96%) had never felt too scared to tell other people about their husbands' behaviour. This high number is consistent with the finding that only three women had suffered seriously because of their husbands' behaviour, and the woman who had felt too scared on one or more

occasions was expectedly one of these three. Looking at women married to drug users in contrast shows that as many as 17 women (68%) had felt too scared to tell other people about their husbands' behaviour. The answers of the women married to alcoholics show that as many as 18 (72%) had felt too scared to tell other people. These high numbers, more than two-thirds of women married to drug users and women married to alcoholics, are consistent with the fact that nearly all these women had suffered seriously because of their husbands' behaviour whereas only around two-thirds had called for help.

Table 4.5: *Respondents' answers on getting married if they had known about their husbands' behaviour*

Being married	Women married to 'ordinary' patients		Women married to drug users		Women married to alcoholics	
	N	%	N	%	N	%
Yes	20	80	3	12	1	4
No	5	20	22	88	24	96
Total	25		25		25	

The women were questioned as to whether, if they had known about their husbands' behaviour beforehand, would they still have married them. As shown in the above table, the majority of the 'ordinary' women said 'yes' but 5 out of these 25 women (20%) said 'no'. The 'ordinary' women were not all enjoying satisfying married lives. Although they themselves had not been victims of domestic violence, 40% believed that this problem was prevalent in Saudi Arabia (see Appendix 8). Maybe this shows that the problems of domestic violence in Saudi Arabia need more investigation and greater publicity. Unlike 'ordinary' women, only a minority of women married to drug users (12%) said 'yes', they would still have married their husbands even if they had known about his addiction. The three exceptional women who answered positively were different from the rest of the respondents in other respects, especially in their answers to some of the open-ended questions (see below). As reported in the same table, the majority of women married to alcoholics (96%) said 'no', the highest proportion among the three samples. These findings from women married to alcoholics and women married to drug users both suggest a high probability of suffering from being abused.

Table 4.6: *Respondents' attitudes towards their married lives*

Attitude	Women married to 'ordinary' patients		Women married to drug users		Women married to alcoholics	
	N	%	N	%	N	%
Happy	15	60	4	16	3	12
Satisfying	5	20	1	4	4	16
Sad	5	20	20	80	18	72
Total	25		25		25	

Another group of closed questions investigated the conjugal lives of the three samples. There were three questions concentrating on personal attitudes, marriage situations and the condition of the marriages. First, the women were asked to describe their attitudes towards married life. From the above table, it appears that the majority (60%) of the 'ordinary' women had a happy attitude towards their marriages, while another fifth described their married lives as satisfying. A further fifth opted for the 'sad' answer. Women married to drug users tended to have sad attitudes towards their marriages with 80% responding this way (n = 20). However, four women described their lives as happy. Only one woman professed a 'neutral', just 'satisfied', attitude toward her married life. Another high percentage, 72% (n = 18), of women married to alcoholics had a sad attitude towards their marriages which is a slightly lower percentage than for women married to drug users. Only three women described their married lives as happy, which is not surprising given the results already reported. Four women married to alcoholics expressed a 'satisfied' attitude toward married life with their husbands.

Table 4.7: *Respondents' descriptions of their marriage situation*

Marriage situation	Women married to 'ordinary' patients		Women married to drug users		Women married to alcoholics	
	N	%	N	%	N	%
Living without any problem	7	28	1	4	3	12
Living with some problems	14	56	5	20	5	20
Living with too many problems	4	16	19	76	17	68
Total	25		25		25	

Living with some problems, with too many problems, or without problems has become a standard way of assessing the quality of marital relationships (Corcoran and Fischer, 2000). This question revealed many problems between the women and their husbands. From the marriage situation question, it appears that the majority of 'ordinary' women (18 women) were living with some or too many problems. Only just over a quarter (n = 7) said that life with their husbands was free of any problem.

However, the choice 'living together with too many problems between wife and husband' received the majority of the women married to drug users' answers (76%). Thus, 19 women were living with too many problems, while five women stated that they were living with some problems, and only one woman said that she was living with her husband without any problems. Interestingly, the woman who stated that she was living without any problems was herself using an illegal drug but she did not regard herself as an addict. Women married to alcoholics were also most likely (68%) to pick the choice, living together with too many problems between wife and husband. Living with some problems was the second highest answer among this sample - five women selected it – while just three women stated that they are living without any problem.

Table 4.8: *Respondents' descriptions of their marriage conditions*

Marriage condition	Women married to 'ordinary' patients		Women married to drug users		Women married to alcoholics	
	N	%	N	%	N	%
Spouses love each other	17	68	13	52	8	32
Husband loves only	3	12	3	12	9	36
Wife loves only	3	12	3	12	1	4
Spouses hate each other	2	8	6	24	7	28
Total	25		25		25	

The above table offers another description of the marriages, using love as an indicator, which is another way of assessing spousal relationships. A good majority, 68%, of the 'ordinary' women, described themselves as exchanging love with their husbands. It appears from this evidence that minor problems amid moderate and stable conditions are quite common in marriages in Saudi society. Three women stated that their husbands loved them but they did not love their husbands. Another three women described their marriage condition as loving their husbands while their husbands did not love them. There were just two cases where it was said that the spouses hated each other.

More than half, 52%, of women married to drug users responded that they were sharing reciprocal love with their husbands. Another 24% said that they and their husbands hated each other, while 12% stated that they loved their husbands but the husbands did not love them, and similarly 12% stated that their husbands loved them but they did not love their husbands. Considering the previous results, particularly the question on drugs and aggression where 23 of the subjects responded positively, and

the ‘ever suffered seriously’ question where 23 women claimed to have done so, the majority who were said to love each other in the above table (13 women) may be regarded as unexpected. It appears to show that some women married to drug abusers are able to give and exchange love even though they are treated badly. Only six women stated that they hated their husbands. Nevertheless, it is worthwhile calculating here that more than one third, 36% of the participants, either hated or had loveless bonds (at least on one side) with their husbands.

Over one-third (36%) of women married to alcoholics stated that their husbands loved them but they did not love their husbands. Eight women (32%) responded that they were sharing reciprocal love with their husbands. Another 28% said that they and their husbands hated each other, while only one woman stated that she loved her husband but the husband did not love her. Considering the previous results, particularly the questions on alcohol and aggression and the question on ‘ever suffered’ where almost all the subjects responded positively, it is surprising that only 16 women did not love or hated their alcoholic husbands.

Open questions

A closed question followed up by an open question found that as many as 21 women married to alcoholics and 18 women married to drug users responded ‘yes’ when asked, ‘Have you or anyone in the family been injured or abused by your husband?’ These results imply the high risk of living with a husband who abuses alcohol or drugs. Women who responded positively were asked to give details. Some women married to drug users stated that their husbands had many times created problems without reason. The husbands had tried to promote themselves and to disdain their wives. Some of them mentioned that their husbands had treated them aggressively and two of the subjects stated that their husbands had hit them heavily while they were pregnant. One woman said that her husband was ‘in no doubt that she was cheating on him so one day he took the kids to a hospital to make sure that they were related to him and not to anybody else’. Not only this, she said, but also while under the influence of drugs he had ‘solicited’ their eldest daughter (aged 14).

Several women married to alcoholics had experienced psychological aggression because of their husband’s drinking. Some listed other victims like children and a few

stated that they were forced to drink alcohol with their husbands. Also, a few said that their husbands' behaviour was similar to their fathers-in-laws', so the husbands' mothers were similarly facing aggression which indicates a possibility of violence transmission (cycle of violence) in homes where the husbands abuse alcohol. Most women described their hard situations with their husbands as painful for the entire families. Some women said that they could not leave their husbands because of the children yet the children were suffering because their father was either treating them badly or perpetrating domestic violence while they watched and the neighbours heard.

Fourteen answers of women married to alcoholics illustrated connections with economic difficulties. According to these answers, the alcoholic husbands became pleasant only when they did not have money to purchase alcohol so they behaved nicely in order to get money from their working spouses. The negative answers in general indicate a relationship between a weak economic condition and consuming alcohol heavily. On this matter, there were two groups of women. One group did not have jobs, and they described their bad situations in characteristic ways. For example, two women said that they hated their husbands because of their consuming alcohol heavily and failing to support their families economically. Not only this, some women said that they cheated on their husbands in order to bring in money for their families. One said, 'He spent the money that I brought from prostitution on alcohol, so he deserves it!' The other group of women who had jobs described their frustrations rather differently, often in terms of being assaulted. For instance, one woman mentioned that she had experienced two miscarriages due to physical assaults by her husband when he had asked for the money that she earned as a teacher. Another woman had lost her hearing because of a heavy blow on the ear. Women who had jobs had two options; 1) obey the husbands' demands and give them the money to spend on alcohol and face the negative economic consequences, or 2) reject the husbands' demands with the negative consequence of facing physical aggression and domestic violence.

Most aggressive acts committed by alcoholic husbands were twisted hair, slapped on the face, beaten up or grabbed.

There were some common themes in the answers; a) the problems were almost always linked temporally to abusing alcohol, b) the victim was almost always the woman, c)

the problems happened while the husband was drunk, and d) the problems occurred for reasons like taking care of the house and children, or money.

Inflicting minor and serious injuries, unacceptable jealousy, cursing without reason, and insults were among the negative acts of drug user husbands. Most women married to drug users who gave details demonstrated three things about their husbands; a) behaving generally aggressively to them, b) behaving aggressively with the children only when 'under the influence of drug', and c) neglecting obligations in general. Also, dangerous implements such as guns and sharp tools like knives were sometimes used by husbands towards women who were struggling to improve their conditions without complaining except to their very close friends or families who would encourage them to get treatment for their husbands and protect the children.

'Ordinary' women in contrast responded 'no' when asked the same question indicating that no severe violence had ever been perpetrated. However, the women were asked what they would do if their husbands did abuse them. On this question, most 'ordinary' women were in one of two almost equal-sized groups; a) start peaceful negotiations with him, b) protect herself and defeat him, possibly aggressively, and then call her family to force him not to do it in the future, and if it occurred again, take the final action of leaving his house and returning to their own families' homes. There were additional, less frequent answers to this question. Two interviewees said that they would request divorce. One woman stated that, if abuse happened, she would leave him until he recognised his fault. Another said that she would be patient and tolerate the pain. Some other single answers were passive or purely protective such as trying to calm him down, asking him for a temporary separation, closing the door in between to protect the children, and finally doing nothing. Looking closely at the most common responses, the few and the singular responses shows that there was only one really decisive response (ultimately leaving the home) but only 34% of the Saudi women felt able and willing to protect themselves in this way from being abused.

The husband's behaviour before and after using drugs or consuming alcohol was one of the open-ended questions. In response, most women married to drug users explained how, under normal conditions, their husbands were 'calm, considerate,

kind, affectionate and friendly'. The husbands were said to be 'positive, friendly and respectful towards their wives and children' in most cases, for most of the time. A few women said that their husbands were amusing and liked to take trips or picnics, especially with the kids. Most women stated that the effect of the drugs on mental/physical functioning, being 'stoned', continued for no longer than two or three days after which the husband would become aggressive, and the women feared most of all the withdrawal symptoms that appeared after a period of being quiet. Most women said that their husbands without drugs were 'romantic' or 'showed love' and 'felt sorry about their previous aggression'. Before using drugs, four women mentioned that their husbands were quiet, cared about the family and the house, and shared spousal duties. However, two women stated that their husbands were lying and aggressive before using drugs. After using drugs most respondents said that their husbands became 'lazy, highly nervous, inactive, careless and beastly'. Some stated that their husbands displayed unacceptable jealousy which almost always led to arguments and then to verbal and physical aggression. Also, some women complained about their husbands' totally negative addicted behaviour. One said, 'When my husband takes a drug he becomes reclusive at home and if we ask him to do something he becomes nervous and bestial like a wild animal'. Insults and swearing, and using threats such as quasi-physical assault, were the most likely forms of behaviour of addicted husbands. One woman labelled her husband as a 'devil' when under the influence of drugs and another said, 'He sleeps most of the day and the rest of the day is as sluggish as a dead body'. In a few cases, however, being unsocial, depressed and uncommunicative were the social, psychological and physical characteristics of husbands after using drugs. Some other behavioural tendencies, however, were not linked to violence - neglecting obligations, and skipping jobs, for examples.

Women married to alcoholics on the other hand, produced answers that fell into three broad groups. Eight women explained that their problems had a historical background of family violence and alcohol abuse. Most of these women knew about their husbands' problem before marriage, sometimes because the future husbands were friends of their own fathers as members of drinking groups, and one of these women mentioned that she was forced to marry her husband. These answers illustrate a very strong relationship between alcohol and domestic violence. 'Bold, insolent, filthy,

selfish and nervous' were common descriptions of the husbands after drinking alcohol. 'Cooperative, romantic, helpful, social, respectful, quiet and a good husband and father' were the common positive characteristics of alcoholics before drinking. Other women spoke of a cold or absent relationship with their husbands. Quiet or absent husbands were common characteristics of alcoholics before drinking alcohol. After drinking alcohol, however, they could be completely different. Five women stated that their husbands while drunk were just normal. One woman said, 'Although he never hits me after being drunk, I hear bad words towards me due to his nervous condition'. Another woman was frustrated because of his jealousness. Three women who described their husbands as extremely quiet persons were satisfied with their drunken behaviour when they became talkative, and on this matter one woman said, 'I like my husband when drunk because he is usually much more fun'. Unlike these women, one woman complained about her nervous husband and she stated that she liked him to be drunk because then he became a very quiet person. Nonetheless, the majority of the women (n = 19) feared various types of violation including verbal, psychological, physical, and in few cases sexual aggression. Without any exception from these 19 women, the interview details demonstrate that husbands neglected most, if not all, of their duties both as fathers and husbands. Two women stated that they had self-learned to be seamstresses so as to support their families economically 'like with power and water bills', while the husbands neglected their families and sometimes took household goods 'like the radio and TV' to sell in order to buy alcohol.

Contrastingly, 'ordinary' women were asked about their husbands' general behaviour in front of others. They were given two separate opportunities to give details of their husbands' behaviour; one describing their behaviour in front of others, and the other their behaviour inside the house. Only one woman gave a negative description of her husband's behaviour in front of others and she referred to a psychological sickness. She claimed that her husband tried to present a false personality and if anyone queried these characteristics he would become angry and might even fight. Three other women described their husbands' behaviour as normal, but with lack of attention and love towards them. Also, these women said that their husbands tried to avoid any embarrassment of being under a woman's control, so they exaggerated by showing the power of their masculinity. However, the majority (n = 21) of the women gave

positive descriptions of their husbands in front of others. Mostly, they described their husbands as ‘respectful, understanding, cooperative, sympathetic, humble, pleasant, quiet, social and generous’.

Inside the house, however, five ‘ordinary’ women described their husbands’ behaviour negatively, mostly in terms of anger and shouting. Two women stated that their husbands spent most of their time outside and disliked staying at home. They went on to explain that if the husbands stayed at home they would be in foul moods. These wives were happier being alone because, if their husbands stayed in, they would be masterful and try in different ways to complain about things and create problems with the women. Two women complained because their husbands showed no respect, lack of understanding, poor discussion, or miserly tendencies. Only one woman out of these seven regarded her husband’s behaviour as a psychological sickness. The majority of the subjects, 20 women, described their husbands as ‘respectful, quiet and cooperative’ but only two saw their husbands as romantic. A few women made critical comments such as: ‘My husband is a feeble person who allows his family to interfere in our own issues’, and two said that the husbands spent most of the time with friends and these women claimed that this was common among Saudi males.

Questions about the husbands’ sexual behaviour before and after taking drugs aimed to discover whether there was any evidence of sexual coercion. Most of the women married to drug users stated that their husbands were quite normal without the influence of drugs and enjoyed ‘natural sex’. The husbands who enjoyed ‘natural sex’ were described as ‘not selfish, romantic and warm-hearted’ by the women. A few women (20%) mentioned that their husbands insisted on having ‘unnatural sex’, but some of these were never free of the influence of drugs so they were always aggressive and had difficulty in performing ‘sex as normal’. One woman said that she had not had sex with her husband for ten years because of his lack of sexual appetite. Responses to the above question found that sexual behaviour under the influence of drugs was much different than before. Most women married to drug users (88%) replied that their husbands became inactive sexually, so even when they tried hard to have sex they always failed. One woman said, ‘My husband and I usually spend all the night trying, but he fails, and in the end he questions my femininity’. Another

woman explained that her husband had a sexual appetite but that he did not have the ability to do it, and if he tried hard he would start but never complete the act successfully. More than half of the women said that sexual failure made their husbands exhausted, and also mad and more aggressive towards them and careless about the woman's feelings. A few women reported having 'normal sex' but said that it took a long time and was painful, but to avoid their husbands' anger they apparently said nothing. Sadly one woman said that her husband threatened her and used force to have 'unnatural sex' and that she obeyed in order to protect herself from being injured or killed.

The same question was addressed to women married to alcoholics where most of the subjects stated that their husbands were quite normal before becoming drunk and that they both enjoyed 'natural sex'. Those husbands who enjoyed 'natural sex' were described as 'not selfish, romantic and warm-hearted' by the women. However, a third of the women (n = 8) mentioned that their husbands insisted on having 'unnatural sex' and one of these women accepted it involuntarily. One woman said that she totally hated sex in general because of the sexual assault that she experienced from her husband. Sexual behaviour while drunk was said to be much different than before. The majority of women married to alcoholics (96%) replied that orgasm took a long time. One woman said, 'It takes mostly two hours', while another said, 'It takes all night which causes pain all night and on the following day'. Eight women explained that their husbands asked for 'unnatural sex' which would lead to one of two consequences, namely, a) obeying and facing sexual assault, b) rejecting and facing physical aggression. Some women (20%) stated that their husbands had sexual relationships with other women, typically the housemaid, or with men. Women who did not enjoy sex amounted to 80% of this sample. They said that this was due to their husbands' aggression and selfishness during the sexual act, the long time that sex took, the pain and frustration that they experienced, and the inconvenience of the smell of alcohol. There were three distinct reactions regarding sexual relationships. Two women said that while their husbands were drunk there was no sex at all. Two stated that their husbands' sexual behaviour was as normal, and the third reaction is illustrated by one woman who said, 'Because my husband demands anal and oral sex, I never enjoy sex with him. I would rather enjoy it with someone else'.

When questioned about whether they had considered leaving the husbands because of the above problems, 44 % of the women married to drug users said ‘yes’ while 56% answered ‘no’. Those who answered ‘yes’ were asked in a subsequent open-ended question to describe how many times, what kind of problems, and how they had come back (if they had actually left). Some of the women stated that they had separated more than five times and the main problems were: a) assault, b) suspicion, and c) using drugs. Also, they mentioned that they came back again either after the husbands’ treatment at a hospital or after mediation concerning the children, mostly from the woman’s family.

On the above question (about leaving their husbands), five of the women married to alcoholics said ‘yes’ while 20 answered ‘no’. Those who answered ‘yes’ were asked in a subsequent open question to describe how many times, what kind of problems, and how they had come back (if they had actually left). Three women stated that they had separated only inside the house; in one case the separation had lasted months and in the other two cases it had lasted for several years. Two women had genuinely separated as many as three times. The main problems triggering these separations were said to be, a) consuming alcohol, b) assault, and c) having affairs with others. They explained that they came back again either after the husbands’ treatment at a hospital or after mediation concerning the children, mostly from the couples’ families. Some women, about 50% of those who had never left their husbands, stated that they had not left because of their kids. Others (24%) stated that they did not have the option of a close-by family. For instance, two women described themselves as parentless. Another two women mentioned that their families were far away and one of them said, ‘I never left him not because I love him, but because my family lives abroad’.

‘Ordinary’ women, in contrast, rarely mentioned any history of divorce or otherwise leaving a husband because of problems with him. Only two had left their husbands, on just one occasion in each case. The reasons differed between the two cases. The first woman stated that she could not tolerate his ignorance and absence from the house which completely changed from life in the first year of their marriage. She returned to him after consultations with her sisters and friends who had mostly faced similar situations. The woman who described this explained her response in terms of her own

lack of experience and her misunderstanding of the facts of married life. As she sarcastically stated; ‘I did not know that marriage is like a barrel where the asphalt pitch is covered by honey’. The other woman had left her husband mainly because of his family interfering. Both women had returned to their husbands after mediation, reconciliation, and because of their children.

CTS results

The Conflict Tactics Scales (CTS), as mentioned earlier, is designed to measure conjugal acts by both genders, wives and husbands (Straus and Gelles, 1990; Straus et al., 1996). The subscales are listed in the table below. Also, as mentioned earlier in the methodology chapter, the frequency of how often the acts had happened was scored from one to five, six recorded six times or more during the past 12 months, while seven indicated not during the last 12 months but that the act had happened previously. Zero means the act had never happened which distinguishes it from an unanswered question or missing data. So scoring one through seven indicates a behaviour problem in a particular area of the psychological, physical, sexual, and injury scales. A positive answer from one side in the negotiation scale indicates a positive act, but positive answers from both sides indicate a high level of verbal conflict. Positive answers on all the other sub-scales indicate unambiguously negative acts.

The negotiation sub-scale contains emotional and cognitive items, while the acts on the other sub-scales can be divided into minor and severe. For instance, in the case of the physical assault scale, the items used to indicate severe assault are more severe in the sense that they pose a greater risk of injury that would require medical attention. The overall score, however, measures the entire set of 12 items. The disadvantage of using the terms minor and severe is that the former might be interpreted as falsely suggesting that something is not a serious problem for either the victim or the wider society.

Category seven, as noted above, indicates that the act did happen before but not in the past year and in previous research it has been used in two ways: (a) when scores for the previous year only are desired (the usual use of the CTS) and category seven is scored zero, and (b) to obtain a long-term prevalence measure of physical assault, that

is, even if not in the last year, did an assault ever occur? Respondents who answer one through seven are then scored as 1 (yes). This latter practice was adopted in scoring the scales in this particular study.

In this study, the CTS has been used for the first time in Saudi society and some of the participants, the 'ordinary' women, were a quasi-random group rather than selected because they were known to be either violent or victimised. Most studies that have used the CTS have been experimental studies that drew their participants from domestic violence treatment programmes. This exploratory study shows that the CTS works well in Saudi Arabia, and has done so with a quasi-representative sample of 'ordinary' women as well as with treatment groups – the alcoholic patients and women married to alcoholics and drug users.

Comparisons between the three samples of women based on the CTS are summarised in the table below as enacted, received and total means with standard deviations, for all five scales. Full details of scale results from the three samples of women are in Appendices 8, 9 and 10.

Table 4.9: *Means and standard deviations on CTS Scales for enacted and received violence of the three samples*

Group of Women	Women married to 'ordinary' patients			Women married to drug users			Women married to alcoholics		
Scales & Subscales	Enacted	Received	Total	Enacted	Received	Total	Enacted	Received	Total
Negotiation									
(mean)	9.08	3.08	12.16	25.52	21.44	46.96	18.44	17.44	35.88
(SD)	5.28	2.61	6.64	10.34	9.79	19.27	9.37	10.50	18.43
Psychological Aggression									
(mean)	0.88	1.76	2.64	17.76	23.72	41.48	15.68	14.40	30.08
(SD)	1.09	1.71	2.25	10.09	12.69	20.00	11.57	10.19	19.99
Physical Assault									
(mean)	0.00	0.04	0.04	6.12	20.76	26.88	3.76	15.40	19.16
(SD)	0.00	0.20	0.20	7.49	16.23	21.08	4.48	13.53	16.12
Sexual Coercion									
(mean)	0.00	0.00	0.00	0.40	10.96	11.36	0.56	9.36	9.92
(SD)	0.00	0.00	0.00	1.12	11.47	11.60	1.36	9.09	8.77
Injury									
(mean)	0.00	0.00	0.00	1.48	7.96	9.44	0.28	5.16	5.44
(SD)	0.00	0.00	0.00	2.83	8.76	9.08	0.84	5.54	5.98

* Since the participants were screened to be between 3-15 years in length of marriage, the category 7 in this table is scored as 0 in order to look at violent acts during the last 12 months only.

Negotiation in the CTS is defined as actions taken to settle a disagreement through discussion, or when a positive affect is communicated by asking about or expressing

feelings of care and respect for the partner. Therefore, higher enacted negotiation means higher motivation to work-out a marital problem, but high total (enacted and received) negotiation scores mean more verbal conflict within the couples. It appears that verbal aggression is quite common among Saudi couples in general. However, women whose husbands abuse drugs were the most likely to enact and receive this kind of aggression, while alcoholics' wives ranked second. There is not much difference between enacted and received verbal aggression in the samples of women married to drug users and women married to alcoholics. In fact, women in all three groups were slightly more likely to enact than to receive, which may be considered as evidence of their higher motivation to negotiate and resolve marital problems than their husbands.

Psychological aggression has the second highest total means. However, women enact less than they receive, except with women married to alcoholics where their enacted aggression is a little higher (m = 15.68) than their received aggression (m = 14.40).

Physical assault has the third highest scores among the five scales with the highest mean for the women married to drug users. Women married to drug users and women married to alcoholics received very high physical aggression compared with what they enacted and what the 'ordinary' women received.

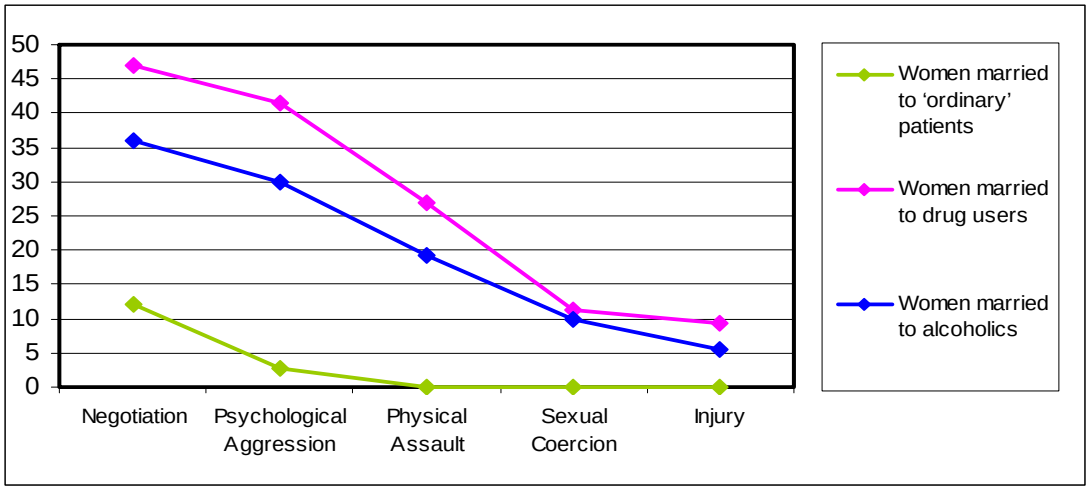
Sexual coercion shows the fourth highest score. Women married to drug users and women married to alcoholics received similar levels of sexual offence while this type of aggression was far less likely to occur among ordinary couples. Comparing women's enacted and received sexual aggression, it clearly appears that Saudi women are far less likely than their husbands to be perpetrators.

The injury scale has the lowest mean among the five scales with the lowest possible result among the 'ordinary' women (m = 0.00), higher among the women married to alcoholics (m = 5.44) and about double this level for women married to drug users (m = 9.44).

With the exception of enacted psychological aggression by women married to alcoholics, on all the sub-scales for all the samples, women were more likely to be

victims than perpetrators. Overall, the findings from the CTS strongly suggest that; a) Saudi women whose husbands abuse drugs experience particularly high levels of violence, and b) Saudi women are less likely than their husbands to perpetrate physical and sexual aggression, and inflict injuries. The following figure re-presents and summarises the five sub-scales described above and highlights that Saudi couples where the husband abuses drugs have higher marital conflict scores than the other groups.

Figure 4.1: *Total means of CTS of the three samples of women*



Summary

Among women married to drug users and alcoholics, there was widespread belief in the effects of using and abusing drugs/alcohol on domestic violence. Seriously suffering due to using drugs/alcohol and violent acts, calling for help and feeling scared to tell others about the husbands' violent acts, all show high percentages in these two samples. Respondents' answers on getting married if they had known about their husbands' behaviour, the women' attitudes towards married life, living with too many problems as a description of the marriage situation, and loveless relationships were all far more common among women married to alcoholics and drug users than among the 'ordinary' women.

The interview evidence from the Saudi women contains another interesting finding. Cheating with other women was reported most frequently by women married to alcoholics. Regarding violence at home, the data from both women married to drug

users and alcoholics reveals significant violence, but not equally. More than two-thirds of the women married to drug users had been violated but even more, nearly all (21 out of 25), of women married to alcoholics had been violated by their alcoholic husbands. Unlike the ‘ordinary’ women, the violations in the two other samples involved many different types of violence including verbal, psychological, physical and sexual aggression, mostly in the condition of being drunk or under the influence of drugs.

Sexual relationships among women married to alcoholics and drug users demonstrate some different and some common features. Lack of sexual desire, lack of appetite, was a common remark by women married to drug users, especially while their husbands were under the influence of drugs. Long sexual intercourse and hard orgasm or climax were common among alcoholics, especially while the husbands were drunk, which could be regarded as sexual coercion, liable to affect relationships between spouses as well as the women’s attitudes towards married life. Another common complaint among these two samples was about the husbands seeking ‘unnatural’ or otherwise unacceptable sex, which could also be classed as sexual coercion.

From the CTS, it can definitely be said that Saudi women face all types of aggression, usually more frequently and more intensely than they perpetrate such acts. Also, there is much more aggression among Saudi spouses where the husband uses drugs or, albeit to a somewhat lesser extent, alcohol. The marriages of the ‘ordinary’ women were not problem-free, but none had to cope with imprisoned husbands, violence in the home, or feeling too scared to seek any outside help.

This chapter’s information on the state of the marriages was supplied by the women, but as we shall see in the next chapter, the alcoholic husbands were not in denial.

Chapter Five
Alcoholic Patients and Women Married to Alcoholics

This chapter makes a series of comparisons preceded by some general information about the sample of alcoholic patients. The chapter then compares three groups of alcoholic patients based on marital status. The next section analyses the results from the Michigan Alcoholism Screening Test (MAST) whilst the third section compares married patients only (n = 42) with women married to alcoholics' answers to identical questions and to the CTS. The chapter then explores in greater depth than hitherto the core issue of the research. It compares the alcoholic respondents according to their levels of alcoholism as indicated on the MAST scale. This section starts by asking who were the heaviest drinkers/most serious alcoholics, what alcohol did they consume and where did they consume the alcohol. The following section explores alcohol's associations with domestic violence; is alcohol best regarded as a cause, or could the relationship be purely correlational and spurious?

Demographical data

This section introduces the sample of alcoholics (some further information about these respondents is placed in Appendix 4).

Table 5.1: *Respondents' ages cross-tabulated with name of Al-Amal hospitals*

Age	Riyadh	Jeddah	Dammam	Qaseem	Total	%
30 and under	23	15	13	4	55	38
31-40	11	16	9	13	49	34
41 and over	18	7	7	8	40	28
Total	52	38	29	25	144	100

With regard to the respondents' ages, only a minority (38%) were under age 30, probably at least partly because alcohol addiction tends to take a long time to develop, and as we shall see below, the older respondents had usually started drinking alcohol much earlier in their lives. Riyadh hospital had the largest number of alcoholic patients overall and the highest number aged 30 and under (23 patients) and it also had more than other hospitals who were aged 41 and over, while Qaseem hospital had the lowest number in total (25), even lower than Dammam hospital. Jeddah hospital contained the largest number of patients (16) aged between 30 and 40 and was the second largest hospital after Riyadh.

Table 5.2: *Respondents' marital status cross-tabulated with type of ward*

Marital status	Voluntary	Involuntary	Total	%
Never married	44	18	62	43
Currently married	34	8	42	29
Other	34	6	40	28
Total	112	32	144	100

In terms of marital status, the largest group (43%) among the patients were those who had never married. Majorities in all the marital status groups were in voluntary wards (n= 112). Patients who were currently married totalled just 42 and only 8 of these were in involuntary wards. The other patients (40) were all either divorced, separated or widowed, and only 6 of these had been admitted to involuntary wards.

Table 5.3: *Educational status of alcoholics and women married to alcoholics*

Educational status	Alcoholic patients	Women married to alcoholics
Illiterate	3	0
High school and under	74	8
College or higher	27	34
Vocational, art and others	40	0
Total	144	42

With respect to educational status, there were only 3 illiterate patients but roughly a half of the respondents (51%) had just secondary school education or less. Just 27 patients (19%) possessed a college degree. Vocational training, art or some other type of post-secondary education was the highest level achieved by 28% of the alcoholic patients. Among the respondents who were married (n= 42), 34 had wives who had achieved college or higher while only 8 had high school or under as their ultimate educational level. Therefore, it can be said that women married to alcoholics had been more likely to continue their education and were generally better-educated and qualified than their husbands.

Table 5.4: *Respondents' ages at first time of drinking cross-tabulated with preferred current drink*

Age	Arag	Beer	Wine	Cologne	Hard Spirit	Total	%
20 and under	60	7	8	17	6	98	68
21-30	25	3	2	7	2	39	27
30 and over	2	1	1	2	1	7	5
Total	87	11	11	26	9	144	100

* Arag is a type of vodka.

Although the patients were spread quite evenly throughout age groups from under-30 upwards, for more than a half (68%) their first time of drinking alcohol was when they were teenagers and for about a quarter their first time of drinking was between the ages of 21 and 30, while only 7 patients indicated that their first time of drinking was when they were aged 30 or older. With respect to their preferred current drinks, more than half (87 patients) preferred Arag (a locally produced spirit) – by far the most common drink among the alcoholics who were hospitalised at Al-Amal hospitals. Less than a quarter (26 patients) drank Cologne (a perfume that may be classified as a type of cognac) while fewer used other types of alcoholic drink like beer, wines and other spirits.

Table 5.5: *Respondents' number of marriages and number of children*

	Number of marriages	Number of children
None	62	20
One	51	8
Two	15	19
Three	6	18
Four	7	9
Five and more	3	8
Total	144	82

Some of the patients had never married (43%, n=62) but there were 82 (57%) who were either currently married or other (e.g., divorced, separated or widowed) and among these the highest percentage (35%, n=51) had only married once. Among the patients who were either currently married or other, 20 indicated having no children, 19 had two, and 18 had three.

Table 5.6: *Women who had left alcoholic patients on account of their behaviour*

Women left	Number	%
Never	37	44
One time	17	21
Two times	7	9
Three times	6	7
Four times	4	5
Five times	3	4
More than five times	8	10
Total	82	100

Excluding patients who had never married (43%), there were 82 (57%) among the total population who were either currently married or divorced, separated or widowed. The above table shows that less than half (44%) of married or formerly married patients had never been left by their wives: 21% said that their wives had left them once during their marriages due to bad behaviour committed by the husbands, while 8 wives had left their husbands on 5 or more occasions. Leaving twice was the third highest frequency (9%) while leaving 3, 4 and 5 times had the lowest frequencies. Basically, the above table shows a high incidence of marital instability among the alcoholics.

Alcoholic patients comparison

This section compares alcoholic patients based on their marital status (i.e. patients who had never married, were currently married, and others who were divorced, separated or widowed).

Table 5.7: *Respondents' ages cross-tabulated with their marital status*

Age	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
30 and under	45	72	5	12	5	13	55	38
31-40	11	18	18	43	20	49	49	34
41 and over	6	10	19	45	15	38	40	28
Total	62		42		40		144	100

Most of the patients who had never married were under age 30. However, currently married patients (n = 42) divided almost equally between the two groups of age 31-40 and 41 and over. Those who classified themselves as 'other' (40 cases) were similar in age to the currently married group.

Table 5.8: *Respondents' employment status cross-tabulated with their marital status*

Employment status	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Never had a job	42	67	4	10	7	18	53	37
Have a temporary job	6	10	21	49	17	42	44	31
Less than a year in full time job	6	10	6	14	4	10	16	11
1-5 years in full time job	4	6	4	10	4	10	12	8
6-10 years in full time job	3	5	2	5	2	5	7	5
11-15 years in full time job	1	2	3	7	2	5	6	4
More than 15 years in full time job	-	0	2	5	4	10	6	4
Total	62		42		40		144	100

Alcoholic patients who had never had a job were mostly never married which is to be expected since most were aged under 30. Roughly half of the currently married patients and the 'other' alcoholics who were employed had temporary jobs, while nearly all the rest had permanent jobs which they had occupied for varying lengths of time.

Table 5.9: *Respondents' current living arrangements cross-tabulated with their marital status*

Patients living	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Alone	17	27	-	0	2	5	19	13
With wife and children	-	0	42	100	-	0	42	29
With family	33	54	-	0	29	72	62	43
With friends	12	19	-	0	9	23	21	15
Total	62		42		40		144	100

Approximately a half of the never married respondents lived with their (parental) families. The rest lived either alone or with friends. All the married patients were living with their wives and children. Those in the 'other' category were mostly living with their (parental) families while nine lived with friends.

Table 5.10: *Respondents' number of friends among their families cross-tabulated with their marital status*

Number of friends	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
None	57	92	16	38	25	62	98	68
One	3	5	16	38	10	25	29	20
Two	2	3	6	14	2	5	10	7
More than two	-	0	2	5	2	5	4	3
All of them	-	0	2	5	1	3	3	2
Total	62		42		40		144	100

Many alcoholic patients had no friends among their families, and having no such friends was most likely among those who had never married (58%). Perhaps more surprising, more than one third (16 out of 42 cases) of the currently married patients had no friends among their families. Over a half of the 'other' patients had no friends and another quarter had only one. Overall, few of the Saudi alcoholics reported having more than two friends among their families.

Table 5.11: *Who the respondents spent most time with cross-tabulated with their marital status*

Who spent most time with	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Alone	40	65	4	10	10	25	54	38
Wife	-	0	20	48	-	0	20	14
Other member of family	2	3	6	14	8	20	16	11
Whole family	2	3	3	7	4	10	9	6
Friends	18	29	9	21	18	45	45	31
Total	62		42		40		144	100

Most never married patients, about two-thirds, spent most of their time alone and just under a third spent it with friends. Less than half of the currently married patients mostly spent their time with their wives. 'Other' patients were most likely to spend time with friends and otherwise alone. Spending time with friends was the second ranked choice for all the Saudi alcoholics (31%) but overall the top answer (by 38%) was mostly spending time alone.

Table 5.12: *Who respondents' mostly drank with cross-tabulated with their marital status*

Drinking with	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Alone	26	42	18	43	16	40	60	42
Friend	26	42	20	47	22	55	68	47
Family member	4	6	-	0	-	0	4	3
Girls	6	10	4	10	2	5	12	8
Total	62		42		40		144	100

'With a friend' has the highest proportion (47%) of answers in the above table (on who the patients usually drank with), and this applied whatever the alcoholics' marital status except that as many of the never married patients usually drank alone. Four currently married patients unexpectedly stated 'drinking with girls'. Drinking with a family member was indicated only by four patients who were all never married.

Table 5.13: *Respondents' places of drinking cross-tabulated with their marital status*

Place of drinking	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Home	6	10	15	36	12	30	33	23
Others houses	12	19	1	2	1	3	14	10
Private place	6	10	18	42	18	44	42	29
Outside the city	27	43	4	10	4	10	35	24
Elsewhere	11	18	4	10	5	13	20	14
Total	62		42		40		144	100

A private place (e.g., resort, farm or special house or apartment) was the place where the largest number of alcoholics usually drank (29%), The main exceptions here were the never married patients who usually drank outside the city. Currently married patients and 'other' patients usually drank in private places and in their homes as well. Drinking at others people's houses was mostly by never married patients.

Table 5.14: *Respondents' feelings when drinking cross-tabulated with their marital status*

Feeling when drinking	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Happy	20	32	6	14	9	22	35	24
Relax	11	18	30	72	23	57	64	45
Bad	23	37	3	7	3	8	29	20
Do not know	8	13	3	7	5	13	16	11
Total	62		42		40		144	100

About a third of the never married patients had bad feelings when drinking alcohol. Another third felt happy, and the rest were split between feeling relaxed and not knowing about their feelings. Currently married patients, on the other hand, mostly had relaxed feelings when they drank alcohol. The 'other' patients were similar in stating relaxation as their most common feeling.

Table 5.15: *Respondents' main reasons for drinking cross-tabulated with their marital status*

Reason for drinking	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
To feel happy	12	20	10	24	10	25	32	21
To relax	2	3	13	31	12	29	27	19
To behave normally	-	0	2	5	5	13	7	5
To release anxiety	6	10	2	5	6	15	14	10
To forget problems	7	11	5	12	5	13	17	12
To enhance my sexual ability	2	3	9	21	-	0	11	8
To respond to friend's pressure	10	16	1	2	2	5	13	9
Only for the sake of drink	11	18	-	0	-	0	11	8
To pass the time	12	19	-	0	-	0	12	8
Total	62		42		40		144	100

The Saudi alcoholics were more likely to drink to feel happy than for any other reason. Relaxation was the next most common reason among currently married and 'other' patients. To behave normally was the least common reason among the general alcoholic population - just two cases among the currently married and five 'other' patients stated this as a reason for drinking. Escaping anxiety was the reason given by 10%, mostly never married and 'other' patients. Another 12% of the total sample

drank to forget problems. Some currently married patients (9) used alcohol to enhance their sexual ability. To feel happy, to relax, to behave normally, to release anxiety, to forget problems, and to enhance sexual ability can all be described by the 'expectancy model' and the 'tension reduction theory' (TRT) (see chapter 1, section 3). Twelve never married patients gave 'passing the time' as their reason. Never married patients were more likely than others to drink alcohol due to pressure from friends.

Table 5.16: *Respondents' thoughts on alcohol's effects cross-tabulated with their marital status*

Thoughts on alcohol's effect	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Quiet	13	21	18	43	17	42	48	33
Active	13	21	3	7	2	5	18	13
Forget problem	9	15	4	10	1	3	14	10
Concentrate	3	5	-	0	-	0	3	2
Happy	15	32	6	14	5	12	26	18
Making trouble	1	2	-	0	3	8	4	3
Normal	4	6	7	17	4	10	15	10
Anxious	3	5	3	7	3	8	9	6
Addicted	1	2	1	2	5	12	7	5
Total	62		42		40		144	100

The data above shows that becoming quiet was the effect of drinking named by a third of the respondents (33%), and currently married and 'other' patients had higher numbers giving this answer than never married patients. However, the effects of becoming active and happy were mentioned a lot more frequently by those who had never married. There were some answers which were most common among 'other' patients compared with the two other groups which were making trouble and becoming addicted. Anxiety was mentioned by 6% of the total sample. One response which was found among never married patients only was concentrating (three cases in total).

Table 5.17: *Respondents' feelings after drinking and before becoming drunk cross-tabulated with their marital status*

Feeling after drinking compared with before becoming drunk	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
More aggressive	11	18	11	26	11	27	33	23
Normal	26	42	18	43	17	42	61	43
More friendly	17	27	9	21	9	23	35	24
Do not know	8	13	4	10	3	8	15	10
Total	62		42		40		144	100

In the above table the main difference is that the never married respondents were less likely than the other two groups to report becoming more aggressive after drinking, and more likely to report becoming more friendly. Nonetheless, in general there were only minor differences among the three groups.

Table 5.18: *Respondents' reasons for hospital admission cross-tabulated with their marital status*

Reasons for admission	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Drinking and family problems	48	78	17	40	21	52	86	60
Drinking problem	5	8	15	36	14	35	34	24
Family problem	7	11	10	24	5	13	22	15
Criminal problem	2	3	-	0	-	0	2	1
Total	62		42		40		144	100

The highest proportions in all three groups said that they had been admitted to hospital because of both drinking and family problems. Just drinking was the second highest reason among currently married and 'other' patients. A family problem only as a reason of hospital admission was most common among the currently married.

Table 5.19: *Respondents' main motive behind coming to hospital cross-tabulated with their marital status*

Main motive	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Stop drinking	13	21	25	60	25	62	63	45
Satisfy wife	-	0	12	26	-	0	12	8
Satisfy others	18	29	1	2	3	8	22	15
Regain health	16	26	-	0	4	10	20	14
Solve social problems	8	13	1	2	3	8	12	8
Brought by authority	7	11	3	7	5	12	15	10
Total	62		42		40		144	100

Never married patients were less likely than the other two groups to be in hospital for the purpose of quitting alcohol. Married patients often explained their admission in terms of satisfying their wives, the never married to satisfy other people (probably their families) and also to regain their health. 'Brought by authority' was the fourth most common reason overall (10%) and was most likely to be stated by never married and 'other' patients.

Table 5.20: *Respondents' family history of alcohol and other drugs cross-tabulated with their marital status*

Family history	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
No history	27	44	35	83	33	82	95	66
Alcohol	13	21	5	12	5	13	23	16
Drugs	12	19	2	5	2	5	16	11
Alcohol and drugs	10	16	-	0	-	0	10	7
Total	62		42		40		144	100

As far as family histories of alcohol and drugs are concerned, having no history was the situation for the majority of the subjects (65%), but the never married patients had the higher numbers and proportions with all the other types of histories - alcohol alone, drugs alone, and alcohol and drugs together.

Table 5.21: *Respondents' families' awareness of them drinking alcohol cross-tabulated with their marital status*

Who is aware with the family?	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
No-one	19	31	2	5	1	3	22	15
Wife	-	0	10	24	11	27	21	15
Parents	2	3	1	2	1	3	4	3
Brothers and sisters	8	13	1	2	1	3	10	7
Whole family	33	53	28	67	26	64	87	60
Total	62		42		40		144	100

From the table above, it can be seen that 60% of the alcoholics said that their whole families knew about their drinking and there was not much difference between the three groups in this respect. 'No one knows' ranked as the second highest answer by never married patients whereas 'just the wife knows' was in second place among 'other' patients as well as the currently married. From the table above it can be concluded that it is difficult to keep drinking alcohol secret within Saudi families.

Table 5.22: *Respondents' behaviour if someone was bothered cross-tabulated with their marital status*

Behaviour when bothered	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Normal	17	27	18	43	17	42	52	36
Aggressive	12	19	10	24	9	23	31	22
Ignore	33	54	14	33	14	35	61	42
Total	62		42		40		144	100

Many of the Saudi alcoholics (42%) said that they ignored others who were bothered by their drinking. Claims of normal behaviour were least common among the never married patients. Aggression as a reaction to others being bothered was least common

among the alcoholics who had never married. Generally there were few differences between the groups' answers.

Table 5.23: *Respondents' behaviour with others while drunk cross-tabulated with their marital status*

Behaviour when drunk	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Friendly	13	21	12	29	11	27	36	25
Normal	12	19	13	31	10	25	35	24
Aggressive	10	16	9	21	9	23	28	19
Do not know	27	44	8	19	10	25	45	32
Total	62		42		40		144	100

According to the subjects' responses, behaviour with others while drunk showed no major differences between the three groups. Most of those who answered claimed to behave normally or that they became friendly. However, the table below shows that a half of all three groups acknowledged that other people regarded them as aggressive when they were drunk.

Table 5.24: *Respondents described by others as aggressive while drunk cross-tabulated with their marital status*

Described as aggressive	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Yes	31	50	21	50	20	50	72	50
No	31	50	21	50	20	50	72	50
Total	62		42		40		144	100

Table 5.25: *Respondents who had injured a family member because of a drink problem cross-tabulated with their marital status*

Who was injured	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
No-one	45	72	25	59	22	54	92	63
Wife	-	0	11	26	10	25	21	15
Children	1	2	2	5	1	3	4	3
Mother	2	3	-	0	-	0	2	1
Father	1	2	-	0	-	0	1	1
Sister	6	10	2	5	3	8	11	8
Brother	7	11	2	5	4	10	13	9
Total	62		42		40		144	100

Around a third of all three groups admitted injuring someone during drunken spells. In the cases of currently married and other patients, wives were the most likely persons to have been injured whereas brothers and sisters had been targeted by the never married. This pattern is replicated in the following table, which records whether the alcoholics had ever thrown an object at anyone, and who the targets had been.

Table 5.26: *Respondents who had thrown something aggressively at a family member cross-tabulated with their marital status*

Thrown at	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Never	46	74	24	56	19	47	89	61
Wife	-	0	12	29	12	30	24	17
Children	4	6	2	5	2	5	8	6
Mother	1	2	-	0	-	0	1	1
Sister	6	10	2	5	4	10	12	8
Brother	5	8	2	5	3	8	10	7
Total	62		42		40		144	100

Table 5.27: *Respondents who needed sex after drinking cross-tabulated with their marital status*

Need sex	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Always	24	39	11	26	10	25	45	31
Sometimes	33	53	18	43	24	60	75	52
Never	5	8	13	31	6	15	24	17
Total	62		42		40		144	100

Just over a third of the never married, and somewhat less than a third in the other two groups, reported always needing sex after drinking. Only 17% of the whole sample said that this was never the case. Interestingly, this answer was least common among the never married.

Table 5.28: *Respondents' guilty feelings regarding their behaviour after drinking cross-tabulated with their marital status*

Feeling guilty	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Always	34	55	8	19	13	33	55	38
Sometimes	20	32	31	74	24	59	75	52
Never	8	13	3	7	3	8	14	10
Total	62		42		40		144	100

The majority felt guilty after drinking alcohol at least 'sometimes', and the main difference here was that the never married were the most likely to report always feeling guilty.

Table 5.29: ***F****amilies' calls for help regarding drinking behaviour and using an implement when family conflict occurred cross-tabulated with their marital status*

	Never married		Currently married		Other			
Family calling for help	**N**	**%**	**N**	**%**	**N**	**%**	**Total**	**%**
Yes	47	76	2	5	6	15	55	38
No	15	24	40	95	34	85	89	62
Total	62		42		40		144	100
Using an implement								
Yes	8	13	10	24	9	23	27	19
No	54	87	32	76	31	77	117	81
Total	62		42		40		144	100

Never married patients were the most likely to report that their families had called for help about their drinking. This had been relatively rare among both of the other two groups. However, using an implement when family conflict occurred had been exceptional by the never married, but was reported by around a quarter of the other two groups.

Table 5.30: *Any bad behaviour to any member of the family while drunk cross-tabulated with their marital status*

	Never married		Currently married		Other			
To whom behaved badly	**N**	**%**	**N**	**%**	**N**	**%**	**Total**	**%**
No-one	43	69	24	58	19	47	86	60
Wife	-	0	14	33	10	25	24	17
Children	3	5	1	2	2	5	6	4
Mother	2	3	-	0	-	0	2	1
Father	1	2	-	0	-	0	1	1
Sister	6	10	1	2	3	8	10	7
Brother	3	5	2	5	4	10	9	6
Grand mother or father	4	6	-	0	2	5	6	4
Total	62		42		40		144	100

Although the majority of the total sample said that they had never committed any bad behaviour, 40% admitted doing so while they were drunk with wives being the most likely victims of bad behaviour committed by currently married and 'other' patients. The bad behaviour of never married patients had been more widely targeted within their families.

Table 5.31: *Respondents who had ever been arrested and the reasons cross-tabulated with their marital status*

	Never married		Currently married		Other			
Arrested and the reasons	**N**	**%**	**N**	**%**	**N**	**%**	**Total**	**%**
Never	16	26	19	45	13	33	48	33
Drinking alcohol	22	35	21	51	17	42	60	42
Family problem	19	31	1	2	8	20	28	19
Fighting while drunk	5	8	1	2	2	5	8	6
Total	62		42		40		144	100

Two-thirds of the patients had been arrested – slightly more among the never married and the 'other' group than among married respondents. The usual reason for the arrests was drinking, but the never married group's arrests were more likely than the other groups' arrests to have been for other reasons, especially family problems.

Table 5.32: *Respondents who had ever been imprisoned due to drinking cross-tabulated with their marital status*

Imprisoned due to drinking	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Never	37	60	30	71	26	64	93	65
Once	6	10	3	7	1	3	10	7
Twice	15	24	5	12	3	8	23	16
Three times	4	6	4	10	4	10	12	8
Four times and more	-	0	-	0	6	15	6	4
Total	62		42		40		144	100

Overall 35% of the participants had been imprisoned with little difference between the three groups. However, the 'other' group was the most likely to have been imprisoned on four or more occasions.

Table 5.33: *Respondents who had ever forced others to obey them cross-tabulated with their marital status*

Force others	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Never	39	63	25	60	23	57	87	60
Sometimes	13	21	16	38	16	40	45	31
Many times	6	10	1	2	1	3	8	6
Always	4	6	-	0	-	0	4	3
Total	62		42		40		144	100

Investigating coercive behaviour directly, the majority of the patients (60%) said that they had never forced others to obey them. The main difference between the three groups was that the never married patients were more likely than the others to admit to having been coercive 'many times' or 'always' when they were drunk.

Table 5.34: *Respondents' family members who had gone to a hospital as a result of negative behaviour cross-tabulated with their marital status*

Ever gone to hospital	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
Never	48	77	32	77	32	79	112	77
Wife	-	0	7	17	3	8	10	7
Children	1	2	1	2	1	3	3	2
Mother	2	3	-	0	-	0	2	1
Father	1	2	-	0	-	0	1	1
Sister	5	8	1	2	2	5	8	6
Brother	5	8	1	2	2	5	8	6
Total	62		42		40		144	100

Most of the subjects (77%) said that they had never perpetrated heavy violence towards any family member that led to them going to a hospital. However, among those who had, there were seven currently married and three 'other' patients whose violence had resulted in the wife's hospitalisation, reflecting a high severity of domestic violence targeted towards wives compared with other family members. Although parents and children rarely received heavy violent acts that led to them going to a hospital, when this happened it was most likely to be by the never married. Brothers and sisters (8 cases each) had also been hospitalised, mostly by never married alcoholics.

Table 5.35: *Respondents who had abused other family members cross-tabulated with their marital status*

Who was abused	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
No-one	51	82	27	64	23	57	101	70
Wife	-	0	12	29	8	20	20	14
Mother	1	2	-	0	-	0	1	1
Father	2	3	-	0	-	0	2	1
Sister	3	5	1	2	2	5	6	4
Brother	5	8	2	5	7	18	14	10
Total	62		42		40		144	100

Using the negative term 'abuse', the above table shows that 70 percent of the subjects said that they had never abused any other member of their families. However, the positive responses indicate that wives had been the most likely victims of their alcoholic husbands. Brothers were the next most likely victims (10%) followed by sisters (4%), and both of them were abused mostly by never married and 'other' patients. Abusing a father or a mother had rarely happened, and when this did occur it was by never married patients.

Table 5.36: *Who respondents mostly had a problem with cross-tabulated with their marital status*

Problem with	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
No-one	33	53	23	55	19	47	75	52
Wife	-	0	12	29	10	24	22	15
Children	3	5	1	2	1	3	5	3
Mother	5	8	1	2	2	5	8	6
Sister	8	13	2	5	3	8	13	9
Father	6	10	1	2	1	3	8	6
Brother	7	11	2	5	4	10	13	9
Total	62		42		40		144	100

The table above shows around a half of never married, currently married, and ‘other’ patients did not have a family problem (or so they said). The Saudi wife was the person most likely to be considered a problem by her alcoholic husband; about one quarter of currently married and ‘other’ patients identified the wife as the person who they had a problem with. Brothers and sisters were the next most likely persons who alcoholics had problems with, mostly never married alcoholics. The table also shows that parents were the third most named persons while children were the least likely to be named.

MAST

By looking at the MAST results for the cases individually, it appears that with no exception all the patients scored above 12 points which clearly indicates alcoholism. According to the MAST protocol (see, Selzer, 1971), any score above 10 points is considered ‘alcoholism’ (see Appendix 1). The table below lists the measure’s questions and their points.

Table 5.37: *MAST questions and points*

N	Questions	Yes	No	Points
1	Do you feel you are a normal drinker 'normal drinker means you are not addicted'?	42	102	204
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 before?	56	88	112
3	Can you stop drinking without a struggle after one or two drinks?	86	58	116
4	Do you ever felt guilty regarding to your drinking?	132	12	132
5	Do your friends or relatives who know about your drink think that you are a normal drinker 'normal drinker means you are not addicted'?	11	133	133
6	Do you ever try to limit your drinking to certain times of the day or to certain places?	45	99	0
7	Are you always able to stop drinking when you want to?	77	67	134
8	Have you ever attended a meeting of Alcoholics Anonymous (AA)?	44	100	220
9	Have you gotten into fights while drinking?	32	112	32
10	Has drinking ever created problems with you and your spouse or family?	32	112	64
11	Has your spouse or other family member ever gone to anyone for help about your drinking?	26	118	52
12	Have you ever lost friends or relatives because of your drinking?	42	102	84
13	Have you ever gotten into trouble at work because of drinking?	28	116	56
14	Have you ever lost a job because of drinking?	22	122	44
15	Have you neglected your obligations, your family or your work for 2 or more days in a row because of drinking?	138	6	276
16	Do you ever drink before noon?	17	127	17
17	Have you ever been told you have liver trouble or cirrhosis?	5	139	10
18	Have you ever had Delirium Tremens (DT's), severe shakes, heard voices, or seen things that weren't there after heavy drinking?	12	132	24
19	Have you ever gone to anyone for help about your drinking?	62	82	310
20	Have you ever been in a hospital because of your drinking?	52	92	260
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?	50	94	100
22	Have you ever been seen at a psychiatric or mental health clinic or gone to a doctor, social worker, or clergy for help with an emotional problem in which drinking had played a part?	50	94	100
23	Have you ever been arrested, even for a few hours, because of drunk behaviour?	60	84	120
24	Have you ever been arrested for drunk driving or driving after drinking?	17	127	34

* N = 144, appendix 1 describes coding the questions' points.

Questions 17 and 18 have high negative answers indicating low percentages having liver trouble or cirrhosis (3.4%) or ever having Delirium Tremens (DTs), severe shakes, hearing voices, or seeing things that were not there, after heavy drinking. These two items scored two points for positive answers according the scale's structure. Also, questions 16 and 24 have similar low positive results (17 cases) that may relate to cultural factors where alcohol is not always available due to its prohibition and drinking secretly is more common than driving after drink. Item 16 is coded as one point for a positive answer while item 24 is coded as two points for the same answer. In contrast, question 5 has high negative responses, but its point is coded as a negative answer. A few questions get five points, some rank one and others code two points.

Table 5.38: *Mean and standard deviation to MAST scale*

	Mean	SD
MAST	18.29	5.28

* N = 144.

The table above summarises the mean and standard deviation of the participants. The mean is somewhat lower than in most western studies of treatment samples (e.g., Heyman et al, 1995; Murphy and O'Farrell, 1994; O'Farrell and Murphy, 1995; O'Farrell et al, 2000; Schumacher et al, 2003). There are several possible reasons for this: a) socio-cultural factors like attending AA meetings being uncommon among Saudi alcoholics, b) one of the scale items was completely eliminated in this study as described in the methodology chapter, making the total points 52 rather than 53, and c) it is possible that in Saudi Arabia people who are just moderately alcoholic are more likely to end-up in treatment than their peers in western countries.

Comparing alcoholic patients with women married to alcoholics

This section deals with similar questions which were addressed to both the alcoholics and women married to alcoholics.

Table 5.40: *Attitudes towards married lives*

Attitude	Alcoholics		Women married to alcoholics	
	N	%	N	%
Happy	7	17	3	12
Satisfying	30	71	4	16
Sad	5	12	18	72
Total	42	100	25	100

The majority of the husbands (71%) expressed satisfied attitudes towards their marriages while about the same percentage of women (72%) indicated sadness.

Table 5.41: *Descriptions of marriage situations*

Marriage situation	Alcoholics		Women married to alcoholics	
	N	%	N	%
Living without any problem	8	19	3	12
Living with some problems	14	33	5	20
Living with too many problems	20	48	17	68
Total	42	100	25	100

The above table reveals many problems between the Saudi couples where the husband abused alcohol. The choice, living together with too many problems between wife and husband, received the largest number of the husbands' (48%) and the women' (68%) answers, indicating no peaceful life for these couples. Living with some problems was the second highest choice of both husbands (33%) and women (20%). The least frequent choice of both was the clear positive situation of living without any problems; husbands 19%, and women 12%.

Table 5.42: *Descriptions of marriage condition*

Marriage condition	Alcoholics		Women married to alcoholics	
	N	%	N	%
Spouses love each other	7	17	8	32
Husband loves only	10	24	9	36
Wife loves only	6	14	1	4
Spouses hate each other	19	45	7	28
Total	42	100	25	100

Making a comparison by 'love', sharing reciprocal hate has the largest number of endorsements from the husbands (45%). Unexpectedly, only 28% of the women gave this answer. The largest group of the women believed that their husbands loved them but they did not reciprocate (36%) whereas only 14% of the husbands had this kind of feeling (that the partner felt unreciprocated love). Women married to alcoholics were the more optimistic about sharing reciprocal love with their husbands: 32% felt this way compared with only 17% of the husbands. Irrespective of these differences, both sides ultimately showed lack of love in their marriages.

Table 5.43: *Means and standard deviations on CTS Scales for enacted and received violence of the two samples*

Samples	**Alcoholics Sample**			**Women married to alcoholics**		
Scales & Subscales	Enacted	Received	Total	Enacted	Received	Total
Negotiation						
(mean)	17.12	22.93	40.05	18.44	17.44	35.88
(SD)	10.51	11.59	22.1	9.37	10.50	18.43
Psychological Aggression						
(mean)	18.19	18.33	36.52	15.68	14.40	30.08
(SD)	12.49	13.57	26.06	11.57	10.19	19.99
Physical Assault						
(mean)	15.90	2.19	18.09	3.76	15.40	19.16
(SD)	13.98	2.73	16.71	4.48	13.53	16.12
Sexual Coercion						
(mean)	8.67	0.88	9.55	0.56	9.36	9.92
(SD)	7.82	1.73	9.55	1.36	9.09	8.77
Injury						
(mean)	3.36	0.38	3.74	0.28	5.16	5.44
(SD)	4.75	1.32	6.07	0.84	5.54	5.98

* Since the participants were screened to be between 3-15 years in length of marriage, the category 7 in this table is scored as 0 in order to look at violent acts during the last 12 months only.

Do alcoholics and women married to alcoholics agree on the different types and levels of conflict in their relationships? Table 5.43 allows us to compare the frequencies of different types of conflict that husbands claimed to perpetrate and wives to receive, and vice-versa. There are 10 comparisons to be made in Table 5.43, and in five of these there are only minor differences between the parties' corresponding scores for how much was enacted and received. However, women claimed to enact less verbal negotiation and psychological aggression than the husbands reported receiving, while the women reported enacting more physical aggression than the husbands said they received. Husbands reported enacting less sexual coercion and inflicting fewer injuries than the women said that they received. These differences have to be set against the agreement between the two parties on the relative frequency of different types of conflict, and on the alcoholics and the women agreeing that the women were the most likely to enact negotiation and psychological aggression while the men were the most likely to commit physical and sexual assaults and inflict injuries. The disagreements display no consistent pattern: neither party appears particularly prone either to 'blame the other' or to engage in unwarranted self-criticism.

Alcohol and aggression

All the participants were technically alcoholic but with MAST scores ranging from 12 points up to 30. So it is worthwhile to look at the distributions for different sub-groups. The tables below divide the subjects into lower, close to, and above the mean (m=18.29) MAST groups: those who scored less than 17, 17-19, and over 19.

Table 5.44: *Respondents' marital status and average mean of MAST scale*

	N	Minimum point	Maximum point	Mean	SD
Never married	62	12	20	14.06	1.89
Currently married	42	17	30	23.57	5.22
Other	40	15	25	19.55	1.80

Those who recorded higher than the mean MAST scores were the most likely to be currently married. The next highest scorers were the 'other' patients while never married patients had the lowest scores (Tables 5.44 and 5.45). With regard to age, patients aged under 30 scored lower than both of the other age groups (31-40, and older). The oldest group recorded much higher levels of alcoholism than the other groups: 77% scored 19 or higher on the MAST scale (Table 5.46).

Table 5.45: *Respondents' MAST scale cross-tabulated with their marital status*

Marital status	Never married		Currently married		Other		Total	%
	N	%	N	%	N	%		
< 17	32	52	2	5	9	23	43	30
17 – 19	26	42	19	45	16	39	61	42
> 19	4	6	21	50	15	38	40	28
Total	62		42		40		144	100

Table 5.46: *Respondents' ages cross-tabulated with MAST scale*

Age	30 and under		31 – 40		41 and over		Total	%
	N	%	N	%	N	%		
< 17	23	42	11	22	4	10	38	26
17 – 19	21	38	20	41	5	13	46	32
> 19	11	20	18	37	31	77	60	42
Total	55		49		40		144	100

Unsurprisingly, the patients who had been admitted to the hospitals involuntarily had the highest MAST scores (Table 5.47), and they had also been more likely than those admitted voluntarily to have gone to the hospitals solely on account of drinking problems rather than a family problem, or a criminal problem, or a combination of all these kinds of problems (Table 5.48).

Table 5.47: *Respondents' types of admission cross-tabulated with MAST scale*

Type of admission	Voluntary		Involuntary		Total	%
	N	%	N	%		
< 17	42	37	1	3	43	30
17 – 19	38	34	15	47	53	37
> 19	32	29	16	50	48	33
Total	112		32		144	100

Table 5.48: *Respondents' reasons for hospital admission cross-tabulated with MAST scale*

Reasons for admission	Drinking and family problems		Drinking problem		Family problem		Criminal problem		Total	%
	N	%	N	%	N	%	N	%		
< 17	26	30	1	3	19	86	-	0	46	32
17 – 19	39	46	8	24	2	9	2	100	51	35
> 19	21	24	25	73	1	5	-	0	47	33
Total	86		34		22		2		144	100

The better-educated subjects were the least likely to be in the higher MAST groups. The most serious alcoholics had usually either not completed, or had not gone beyond high school, or had proceeded to some kind of vocational school rather than continuing their academic education beyond secondary level (Table 5.49).

Table 5.49: *Respondents' educational status cross-tabulated with MAST scale*

Educational status	Illiterate		High school and under		College or higher		Vocational, art and others		Total	%
	N	%	N	%	N	%	N	%		
< 17	-	0	28	38	18	66	13	33	59	41
17 – 19	3	100	12	16	5	19	12	30	32	22
> 19	-	0	34	46	4	15	15	37	53	37
Total	3		74		27		40		144	100

Arag (a locally produced vodka) was the drink of choice of most of the more serious alcoholics. Those who usually drank beer, wine, Cologne (a perfume), and even hard spirits were less likely to be in the 19-plus MAST group (Table 5.50).

Table 5.50: *Respondents' preferred current drink cross-tabulated with MAST scale*

Type of drink	Arag		Beer		Wine		Cologne		Hard spirit		Total	%
	N	%	N	%	N	%	N	%	N	%		
< 17	19	22	11	100	9	82	1	4	6	67	46	32
17 – 19	30	34	-	0	1	9	19	73	1	11	51	35
> 19	38	44	-	0	1	9	6	23	2	22	47	33
Total	87		11		11		26		9		144	100

The respondents who usually drank at home and ‘elsewhere’ (secretly but ‘in the open’, that is, not in any enclosed premises) were the most serious alcoholics. Some who usually drank at places outside the city, in friends’ houses, and in private premises (illegal ‘clubs’) were sometimes serious alcoholics, but they were more likely to record MAST scores in the lower ranges (Table 5.51).

Table 5.51: *Respondents’ places of drinking cross-tabulated with MAST scale*

Place of drinking	Home		Others houses		Private place		Outside the city		Elsewhere		Total	%
	N	%	N	%	N	%	N	%	N	%		
< 17	4	12	3	21	18	43	10	29	5	25	40	28
17 – 19	12	36	8	58	14	33	16	45	5	25	55	38
> 19	17	52	3	21	10	24	9	26	10	50	49	34
Total	33		14		42		35		20		144	100

From the above we can form a profile of the really serious Saudi alcoholic. He is most likely to be older rather than younger, without higher-level education, married, inclined to drink Arag either at home or ‘elsewhere’ (as defined above), and to have been admitted to hospital solely on account of his drinking problem.

Now age and marital status were related within this sample, so the question arises as to whether it was age per se, or the changes in marital status that tended to occur with age, that were related causally to changes (increases) in levels of drinking. The evidence in Table 5.52 suggests that both age and marital status were independently associated with levels of drinking. This evidence is consistent with the view that people who use alcohol regularly will tend to increase their consumption as their drinking careers progress and as their metabolisms adjust to successively higher levels of alcohol intake. However, becoming married was also (independently of age) boosting alcohol consumption. We should remember here that this research was based on a treatment sample. Any Saudi alcoholics who eliminated or curbed their consumption of alcohol following marriage would not have appeared among the respondents. However, unless marriage had been a ‘cure’, the evidence from this research suggests that it was tending to aggravate any existing alcoholic condition. This could be due to the tensions that arise within marriages. Or, equally and possibly even more plausibly, in Saudi Arabia marriage usually gives male drinkers their own homes, where they are the ‘masters’, and where they can drink privately (except from

family members), whereas they would have been less likely to have this freedom while living in the dwellings of their parents.

Table 5.52: *Respondents' MAST scale by age and marital status*

	30 and under						31 – 40						41 and over					
	Never Married		Currently married		Other		Never married		Currently married		Other		Never married		Currently married		Other	
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
<18.29	41	87	1	33	3	60	8	67	2	10	2	13	2	67	3	17	5	26
>18.29	6	13	2	67	2	40	4	33	19	90	14	87	1	33	15	83	14	74
Total	47		3		5		12		21		16		3		18		19	

We have seen that, on their own admission, the alcoholic respondents often behaved aggressively towards others, particular towards other family members and, among these, particularly towards women to whom they are married. We have also seen in chapter 4 that the women married to alcoholics and drug users were much more likely to be victims of their husbands' aggression (and to be far less satisfied with their marriages) than the control group of 'ordinary' women. This evidence is highly persuasive, but not entirely sufficient to indict alcohol as the cause. Here we disaggregate the sample of alcoholics and investigate whether aggression and violence were related to MAST scores. Were the heaviest drinkers/most seriously alcoholic the most aggressive and violent?

Tables 5.53 – 5.60 (below) show that, on their own admission, this was generally the case. Respondents in the highest scoring MAST group were the most likely to describe their own behaviour when drunk as aggressive, to say that they had problems with other people on account of their drinking, that they responded aggressively if and when someone bothered them about their drinking, to state that they were described by others as aggressive when drunk, to admit that they had behaved badly and abused another family member when drunk, to have thrown something at another family member, to have injured another family member, to have caused a family member to be hospitalised, to have forced others to obey them, and to have acted when drunk in ways that led to their families calling for outside help. The higher MAST scorers were no more likely than the other alcoholic respondents to report feeling guilty about their drinking, and were no more likely to admit using implements to attack another family member. Overall, however, the consistency of the above evidence is impressive.

There were high levels of domestic violence among the entire sample of alcoholics, and these levels were highest of all among the most serious alcoholics.

Table 5.53: *Respondents' behaviour with others while drunk cross-tabulated with MAST scale*

Behaviour when drunk	Friendly		Normal		Aggressive		Do not know		Total	%
	N	%	N	%	N	%	N	%		
< 17	14	39	14	40	2	7	11	24	41	28
17 – 19	14	39	11	31	14	50	18	40	57	40
> 19	8	22	10	29	12	43	16	36	46	32
Total	36		35		28		45		144	100

Table 5.54: *Who respondents mostly had a problem with cross-tabulated with MAST scale*

Problem with	< 17		17 – 19		> 19		Total	%
	N	%	N	%	N	%		
No-one	29	66	24	48	22	44	75	52
Wife	3	7	10	20	9	18	22	15
Children	1	2	2	4	2	4	5	3
Mother	3	7	2	4	3	6	8	6
Father	5	11	4	8	4	8	13	9
Sister	2	5	2	4	4	8	8	6
Brother	1	2	6	12	6	12	13	9
Total	44		50		50		144	100

Table 5.55: *Respondents' behaviour if someone was bothered cross-tabulated with MAST scale*

Behaviour when bothered	Normal		Aggressive		Ignore		Total	%
	N	%	N	%	N	%		
< 17	29	56	2	6	10	16	41	28
17 – 19	12	23	8	26	33	54	53	37
> 19	11	21	21	68	18	30	50	35
Total	52		31		61		144	100

Table 5.56: *Respondents' described by others as aggressive while drunk cross-tabulated with MAST scale*

Described as aggressive	Yes		No		Total	%
	N	%	N	%		
< 17	11	15	26	36	37	26
17 – 19	28	39	30	42	58	40
> 19	33	46	16	22	49	34
Total	72		72		144	100

Table 5.57: *Respondents' types of violence against other family members cross-tabulated with MAST scale*

To whom behaved badly	< 17		17 - 19		> 19		Total	%
	N	%	N	%	N	%		
No-one	32	72	31	60	23	49	86	60
Wife	2	4	10	20	12	25	24	17
Children	-	0	2	4	4	8	6	4
Mother	2	4	-	0	-	0	2	1
Father	1	2	-	0	-	0	1	1
Sister	4	9	3	6	3	6	10	7
Brother	3	7	3	6	3	6	9	6
Grand mother and father	1	2	2	4	3	6	6	4
Total	45		51		48		144	100
Who was abused	**< 17**		**17 – 19**		**> 19**		**Total**	**%**
	N	**%**	**N**	**%**	**N**	**%**		
No-one	33	81	37	68	31	64	101	70
Wife	-	0	9	17	11	22	20	14
Mother	1	2	-	0	-	0	1	1
Father	1	2	1	2	-	0	2	1
Sister	2	5	2	4	2	4	6	4
Brother	4	10	5	9	5	10	14	10
Total	41		54		49		144	100
Thrown at	**< 17**		**17 - 19**		**> 19**		**Total**	**%**
	N	**%**	**N**	**%**	**N**	**%**		
Never	34	89	33	58	22	46	89	61
Wife	2	5	11	19	11	22	24	17
Children	-	0	3	5	5	10	8	6
Mother	-	0	-	0	1	2	1	1
Sister	1	3	6	11	5	10	12	8
Brother	1	3	4	7	5	10	10	7
Total	38		57		49		144	100
Who was injured	**< 17**		**17 - 19**		**> 19**		**Total**	**%**
	N	**%**	**N**	**%**	**N**	**%**		
No-one	36	86	38	66	18	41	92	63
Wife	1	2	9	16	11	24	21	15
Children	-	0	-	0	4	9	4	3
Mother	-	0	-	0	2	4	2	1
Father	-	0	1	2	-	0	1	1
Sister	3	7	4	7	4	9	11	8
Brother	2	5	5	9	6	13	13	9
Total	42		57		45		144	100
Ever gone to hospital	**< 17**		**17 - 19**		**> 19**		**Total**	**%**
	N	**%**	**N**	**%**	**N**	**%**		
Never	38	88	40	74	34	73	112	77
Wife	-	0	4	7	6	13	10	7
Children	-	0	1	2	2	4	3	2
Mother	-	0	1	2	1	2	2	1
Father	-	0	1	2	-	0	1	1
Sister	3	7	3	6	2	4	8	6
Brother	2	5	4	7	2	4	8	6
Total	43		54		47		144	100

Table 5.58: *Respondents who had ever forced others to obey them cross-tabulated with MAST scale*

Force others	Never		Sometimes		Many times		Always		Total	%
	N	%	N	%	N	%	N	%		
< 17	34	39	12	27	2	25	-	0	48	33
17 – 19	28	32	20	44	2	25	1	25	51	36
> 19	25	29	13	29	4	50	3	75	45	31
Total	87		45		8		4		144	100

Table 5.59: *Families' calls for help regarding drinking behaviour and using an implement when family conflict occurred cross-tabulated with MAST scale*

	Family calling for help						Using an implement					
	Yes		No				Yes		No			
	N	%	N	%	Total	%	N		%		Total	%
< 17	10	18	35	39	45	31	10	37	42	36	52	36
17 – 19	22	40	29	33	51	36	8	30	38	32	46	32
> 19	23	42	25	28	48	33	9	33	37	32	46	32
Total	55		89		**144**	**100**	27		117		**144**	**100**

Table 5.60: *Respondents' guilty feelings regarding their behaviour after drinking cross-tabulated with MAST scale*

Feeling guilty	Always		Sometimes		Never		Total	%
	N	%	N	%	N	%		
< 17	18	33	25	33.3	4	29	47	32.3
17 – 19	19	34	25	33.3	4	29	48	33.3
> 19	18	33	25	33.3	6	42	49	34.3
Total	55		75		14		144	100

We have just seen that the patients with the higher MAST scores were more aggressive and violent than those with lower MAST scores. We also saw earlier that the older and married or formerly married respondents were more seriously alcoholic than the never married group. We saw earlier that the married respondents and those in the 'other' marital status group reported more aggression than the never married. The reason why the older and married (currently or formerly) groups displayed higher aggression appears to have a clear explanation – they were the more seriously alcoholic. However, we must entertain the possibility that a change in marital status (becoming married) was the cause of both increased alcoholism and increased aggression, and that the relationship between the latter two variables was purely a correlation. In order to test this possibility we now proceed to compare answers to the aggression questions by MAST scores within martial status groups. Here, in order to maintain satisfactory numbers in as many columns as possible, the patients are divided into just two MAST groups according to whether they scored above or below the mean. The following table (Tables 5.61) compares their answers to the questions about whether they had a problem with any other family member on account of their drinking, whether they had abused another family member while drunk, inflicted an injury, thrown something, caused a family member to visit a hospital, and admitted to behaving badly while drunk. Married respondents only are also compared on their enacted CTS scores (Table 5.62).

Table 5.61: *Respondents types of violence against other family members by marital status and MAST scale*

	Never married				Currently married				Other			
	<18.29		>18.29		< 18.29		>18.29		<18.29		>18.29	
Problem with	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No-one	18	63	15	46	14	87	9	35	12	64	7	32
Wife	-	0	-	0	2	13	10	37	4	21	6	29
Children	1	3	2	6	-	0	1	4	1	5	-	0
Mother	1	3	4	12	-	0	1	4	-	0	2	10
Father	2	7	4	12	-	0	1	4	-	0	1	5
Sister	4	14	4	12	-	0	2	8	1	5	2	10
Brother	3	10	4	12	-	0	2	8	1	5	3	14
Total	29		33		16		26		19		21	

	Never married				Currently married				Other			
	<18.29		>18.29		< 18.29		>18.29		<18.29		>18.29	
Who was abused	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No-one	25	81	26	85	10	91	17	56	13	65	10	54
Wife	-	0	-	0	1	9	11	35	3	15	5	23
Mother	-	0	1	3	-	0	-	0	-	0	-	0
Father	1	3	1	3	-	0	-	0	-	0	-	0
Sister	2	6	1	3	-	0	1	3	1	5	1	5
Brother	3	10	2	6	-	0	2	6	3	15	4	18
Total	31		31		11		31		20		20	

	Never married				Currently married				Other			
	<18.29		>18.29		< 18.29		>18.29		<18.29		>18.29	
Who was injured	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No-one	40	94	5	26	20	95	5	23	12	56	10	53
Wife	-	0	-	0	1	5	10	47	5	24	5	26
Children	-	0	1	5	-	0	2	10	-	0	1	5
Mother	1	2	1	5	-	0	-	0	-	0	-	0
Father	-	0	1	5	-	0	-	0	-	0	-	0
Sister	1	2	5	26	-	0	2	10	2	10	1	5
Brother	1	2	6	33	-	0	2	10	2	10	2	11
Total	43		19		21		21		21		19	

	Never married				Currently married				Other			
	<18.29		>18.29		< 18.29		>18.29		<18.29		>18.29	
Thrown at	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No-one	36	81	10	55	20	91	4	20	10	50	9	45
Wife	-	0	-	0	2	9	10	50	6	30	6	30
Children	2	5	2	11	-	0	2	10	1	5	1	5
Mother	-	0	1	6	-	0	-	0	-	0	-	0
Sister	3	7	3	17	-	0	2	10	2	10	2	10
Brother	3	7	2	11	-	0	2	10	1	5	2	10
Total	44		18		22		20		20		20	

	Never married				Currently married				Other			
	<18.29		>18.29		< 18.29		>18.29		<18.29		>18.29	
Ever gone to hospital	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No-one	35	87	13	58	10	100	22	69	14	77	18	81
Wife	-	0	-	0	-	0	7	22	1	5	2	9
Children	1	3	-	0	-	0	1	3	1	6	-	0
Mother	1	3	1	5	-	0	-	0	-	0	-	0
Father	-	0	1	5	-	0	-	0	-	0	-	0
Sister	2	4	3	14	-	0	1	3	1	6	1	5
Brother	1	3	4	18	-	0	1	3	1	6	1	5
Total	40		22		6		36		18		22	

	Never married				Currently married				Other			
	<18.29		>18.29		< 18.29		>18.29		<18.29		>18.29	
To whom behaved badly	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
No-one	32	83	11	46	18	90	6	27	10	53	9	42
Wife	-	0	-	0	2	10	12	54	4	21	6	28
Children	1	3	2	8	-	0	1	5	1	5	1	5
Mother	1	3	1	4	-	0	-	0	-	0	-	0

Father	-	0	1	4		-	0	-	0		-	0	-	0
Sister	2	5	4	17		-	0	1	5		1	5	2	10
Brother	1	3	2	8		-	0	2	9		2	11	2	10
Grand mother and father	1	3	3	13		-	0	-	0		1	5	1	5
Total	38		24			20		22			19		21	

With the full sample of alcoholics, it is possible to make 18 comparisons within the three marital status groups - between the high and low MAST scorers on the six aggression questions. In all but four cases, that is, on 14 of the 18 comparisons, the higher MAST scorers prove to be the more aggressive. Three of the exceptions are within the ‘other’ group. In these instances the ‘exceptional’ results could well have been due to women leaving their husbands before aggression became serious. There is just one question on which the never married respondents with high MAST scores indicated no more aggression than those with lower MAST scores. Within the currently married group, in contrast, on every single question, without any exception, those with the higher MAST scores were the more aggressive. The consistency of these results within the currently married group is impressive. What this means is that marriage was not having a calming affect on the alcoholics. Rather, it was placing married women and other family members in double jeopardy. Marriage increased the risks of the males drinking heavily (becoming seriously alcoholic) and, as a result of their heavier drinking, behaving aggressively within their families.

It is possible to compare family conflict as measured on the CTS only within the currently married group (the CTS was not administered to any other respondents). What we see here (Table 5.62) is that the respondents with the higher MAST scores were also the highest scorers on most of the CTS sub-scales – those measuring psychological aggression, physical assaults, sexual coercion, and inflicting injuries. On each of these sub-scales the high MAST scorers recorded CTS scores between two and five rimes as high as the comparison group. On the negotiation sub-scale (negotiation can be regarded as constructive behaviour) there was little difference between the results from the high and low MAST scorers.

Table 5.62: *Currently married patients' means and standard deviations to MAST and CTS scales*

	< 18.29		**> 19.29**	
	Mean	SD	Mean	SD
Negotiation	16.81	11.98	17.24	8.88
Psychological aggression	11.76	11.33	24.62	10.23
Physical assault	5.86	9.21	25.86	10.14
Sexual coercion	3.38	4.43	13.71	6.83
Injury	1.81	3.75	4.90	5.21

With full sample of patients it is possible in Tables 5.61 to compare the levels of aggression recorded by members of the different marital status groups who had similar MAST scores. Here the findings are not clear-cut. Within each of the MAST groups, comparisons are possible on six questions. With the lower MAST scorers, the 'other' marital status group turns out to be the most aggressive on five of the six comparisons, and the never married group on the other one. There is no case, within the lower MAST group, where the currently married respondents are the most aggressive. It seems possible, therefore, that when men are not seriously alcoholic already, and do not become so following marriage, marriage does not have a significant aggravating effect.

Within the higher scoring MAST group, the results are rather different, though not entirely clear-cut. 'Other' respondents have the highest aggression scores on three of the six comparisons, married respondents on two, and the never married on just one. Within the higher scoring MAST group, the never married respondents prove the least aggressive on five out of the six comparisons, and 'other' respondents on the remaining indicator. The currently married respondents were never the least aggressive of the three marital status groups.

Now it is possible that their aggressive behaviour (when indicated) was the reason why some of those concerned had become 'other' in terms of marital status (wives had left them). It is equally possible that some of the married respondents who were behaving aggressively were destined to move from the currently married into the 'other' group before long. What is most striking about these findings is that the never married high MAST scorers were nearly always (except on one indicator) the least aggressive, while the married or 'other' groups (who had been married previously) were the most aggressive on all but one of the six indicators. The earlier double jeopardy thus becomes a triple jeopardy. Marriage was leading to levels and types of

drinking behaviour which led to higher MAST scores, which in themselves increased the risks of aggression, and within marriages high MAST scorers were behaving more aggressively than people with similar levels of alcoholism who had never married.

Discussion

From the first section, Saudi alcoholics seem unlikely to marry young, and if they do marry later on, they seem unlikely to stay married (even unhappily married). The lives of those who had married appeared far from stable; 41 married women out of 82 had left their alcoholic husbands at least once. Most of the alcoholics had a rather low level of education which had surely affected their careers. As for preferred current drinks, Arag was the favourite followed by 'Cologne'.

The second section found few differences between the three marital status groups (never married, currently married and 'other') on most of the variables. There were few positive findings on employment, social and personal matters. Relationships between alcoholics and their families were generally weak and in many cases very poor, indicating almost no relationship at all in some instances. Common themes among the three groups were a) having no friends within their families, b) drinking alone or with friends, c) feeling normal or more friendly after drinking compared with before becoming drunk, d) citing drinking and family problems as reasons for admission to the hospitals, e) not having family histories of alcohol and other drugs, f) ignoring others who bothered them, g) being described as aggressive, h) needing sex after drinking alcohol, i) feeling guilty after drinking, j) not using an implement when a family conflict occurred, k) running high risks of being arrested and imprisoned due to consuming alcohol, and l) not forcing others to obey them.

Never married alcoholics were often living alone and spending time alone. They liked to drink outside the city or at friends' houses. Their feeling when drunk was sometimes bad while others felt happy. Their reasons for drinking were various permutations of to feel happy, to pass the time, for the sake of the drink, and in response to friends' pressure. Views on alcohol's effects were divided between becoming happy, quiet and active. Their main motives behind coming to hospital were to satisfy others and to regain health. Usually their whole families were aware of their drinking.

Married alcoholics, on the other hand, were living with women and children as well as spending their spare time with them. They liked to drink in private places or in their own homes. Their usual feeling when drinking was relaxed, and their reasons for drinking were to relax and to feel happy. Most thought that alcohol's effect was to make them quiet. Their main motive behind coming to hospital was to stop drinking alcohol since their whole families were aware of their drinking. Currently married patients usually felt that they behaved normally or became friendly when drunk.

In contrast, the 'other' patients (divorced, separated or widowed) were mostly living with their (parental) families but they liked to spend most their spare time with friends. They also liked to drink at private places or at home. Their usual feeling when drunk was relaxed and their main reasons for seeking alcohol were to feel happy and relaxed. They thought that alcohol's effect was to make them quiet. Their main motive behind coming to the hospitals was to stop drinking. Usually their whole families knew about their drinking. This group of patients spread their answers regarding their behaviour when drunk between friendly, normal, aggressive and 'do not know'.

As for violence, it can be said that currently married and 'other' patients behaved more aggressively towards their wives than any other family members, and were more aggressive at home than the never married group. Minor violence was being perpetrated by at least a third and up to a half of currently married and 'other' patients. Severe violence, on the other hand, scaled from a quarter up to a third, mostly committed by never married patients and most often towards family members like sisters and brothers and, in a few cases, children also. The targets within Saudi families extended further to parents and grandparents. However, parents and grandparents were the least likely people to be victimised which can be explained by Islamic instructions. There is no strong evidence in this research of a relationship between alcoholism and other types of crime outside the family (just 1% of all the alcoholic respondents).

The third section demonstrated that all the subjects were indeed alcoholics according to the MAST scale. Two questions had higher than usual (in MAST studies) positive

responses among the Saudi alcoholics. These were neglecting social or employment obligations because of alcohol and feeling guilty regarding drinking alcohol.

The fourth section compared married alcoholics and women married to alcoholics. These comparisons showed low positive feelings and perceptions among alcoholics towards their married lives, while women had even lower positives and both parties expressed a lack of love. All this indicates high possibilities of unsuccessful or unstable marriages among Saudi alcoholics. The comparison of the CTS results demonstrates high levels and frequencies of domestic violence in Saudi couples where the husbands abuse alcohol. Domestic violence could involve different types of violence such as verbal, psychological, physical and sexual.

All the patients in this study were technically alcoholics (according to the MAST scale), but they were experiencing different degrees or levels of this condition. The previous section of this chapter has shown that the highest MAST scorers (the most seriously alcoholic) differed from other patients in additional ways – their preferred drink (usually Arag), and where they usually drank alcohol (at home or outside any premises). The most seriously alcoholic also tended to be older, were less well-educated, and were more likely to be currently or formerly married. Their admissions to the hospitals were more likely to have been involuntary, and solely on account of drink problems. The evidence analysed and presented in the fifth section is wholly consistent with the view that alcohol(ism) is an independent cause of domestic violence. It has proved impossible to make the relationship disappear whatever controls (for age and marital status) have been introduced.

However, in Saudi Arabia marriage itself (when the husband is alcoholic) appears to increase the incidence of aggression. Among the patients in this study, marriage was leading to heavier drinking and higher MAST scores. Then, among the more seriously alcoholic respondents, the context of marriage was increasingly the likelihood of them behaving aggressively at home. All family members, but married women particularly, were at risk of victimisation.

Chapter Six
Narrative Interviews with Alcoholic Patients

The previous chapters have presented a great deal of information about the family lives of alcoholics in Saudi Arabia, but have said nothing about how the alcoholics had reached their current predicaments. Structured questionnaires were considered unsuitable for exploring such matters. Rather, a complementary approach was adopted – a limited number (n = 4) of biographical interviews with patients who were in the Al-Amal hospitals at the time. The aim in these interviews was not to test any theories but simply to generate insights in what, to repeat, was always conceived as an exploratory, and in Saudi Arabia, a highly innovative investigation.

The biographical, narrative, interpretive interview is used to generate detailed accounts of subjects' lives. Simply, it means encouraging and stimulating subjects to tell a story about significant events in their lives. The subjects here were four in total, each representing one group of the patients based on marital status - never married, currently married, separated, and divorced. Also each represents one hospital of Al-Amal and one region of Saudi Arabia - Riyadh, Jeddah, Dammam and Qaseem. The participants were asked to give details about their lives starting from the past then emerging into their current lives and future hopes and expectations.

Never married patient, Riyadh region

As far back as this patient remembered, his life was in a small village not far away from the capital, Riyadh, but visiting the capital was infrequent and was considered almost like an amusing dream. The subject was the second oldest of three brothers and four sisters. Gathering with 'gangs' in certain places in the town after school was an experience that changed his life at an early age, which was during primary school. In the gang he learned many things, particularly negative behaviour such as bothering others, destroying things and then smoking cigarettes. The family did not give enough care, as he claimed, even though his school grades showed signs of slow learning, poor attention, lack of preparation, and troubles and tumults. Family neglect created a huge gap between his life at home and at school which should be complemented and supported. Incidents suggested that his neglect of schoolwork could be seen through his personal behaviour and activities. For example, at school he used to gather with his gang when and wherever possible. Their activities included playing truant and

singing songs, writing on walls and destroying things. Daily, and immediately after school, and when just at the school gate, he regularly fought with others in his group where no control was imposed by the school.

In middle school he had a new gang and learned other things matched by his age, then 13. For instance, he had a bicycle that allowed him to go far not only from his home but also outside the town, which he called a ‘desert trip’. Some of his activities during a desert trip were smoking trashed cigarettes collected from the ground, with burned hands indicating youth and bravery as a smoker. Life at home during this period seemed to be neglected by parents who had a low education level, and relationships among the whole family were not that strong, especially between the oldest brother and the interviewee.

After restudying two years at the middle school failing in the second and third year, he moved into the following professional level which was at a secondary high school where the course was three years long. However, he never passed this level. After finishing the first year successfully he spent two academic years in the second level without making any progress. Due to the stress experienced at this time he acquired new friends who introduced him alcohol; spirits that were easily stolen from general stores. Because of his age at the high school, he guided some younger friends to break rules and to sniff glue while decorating the school (which was encouraged by the school administration). Nothing changed in his family life. His father was working and gathering in the evening with some of his friends. The mother was quiet and doing her ‘duty’ as a mother which was taking care of the house and serving food, sometimes for the whole family and at other times twice based on gender. The weak communication inside the family, especially between himself and other members, was said to have led him to ‘escape’ from home and pursue his personal interests.

When the interviewee had spent two academic years in the second level of the high school, he gave up and left the public education system, and turned towards the capital, Riyadh, to join vocational training as an option for those who did not do well in the public schools. Vocational training institutions were then publicly known as centres of juvenile delinquency. In Riyadh he was ‘released’ from all family control, if there was any, and rented an apartment with a few friends at the institution. Soon he

started using alcohol regularly as well as engaging in other negative activities such as pederasty (sodomy), smoking hashish, and stealing cars and stunt driving. The pederasty was common among adolescents, mostly juvenile delinquents, who were seeking sexual vent as an alternative to looking for prostitutes who were not easy to find and required money. At vocational training he received a salary which was enough for his rent, food, alcohol, cigarettes, hashish and sometimes drugs, mostly amphetamines.

After finishing vocational training he moved back to his hometown and spent five months without getting a job. Due to lax family control and economic difficulty, as hinted, he decided to move back again to the capital where there was more personal freedom and a better chance of finding a job. In the capital he found a job at a small factory in an industrial area. At the beginning, he lived inside the factory where cultures intermingled. It was in a poor residential area with a general lack of safety. At work he established new mixed cultural friendships and the group gathered at night in the same area to smoke hashish and drink cognac that was locally made. There was not much communication with his family. When he reached age 30 he reduced his smoking hashish, but on the other hand he increased his alcohol consumption. He changed his job from time to time, but all were much the same in their character, salaries and places. He never thought of going back to his hometown or of getting married, but he would work two jobs sometimes to pay for weekends with prostitutes.

The problem of alcohol was officially recognised at the age 35 when he was caught by the police with some others at the place where they used to gather, drink and use illicit drugs. He was admitted to Al-Amal hospital and then got a term of three months jail. Later, he started thinking of quitting alcohol but realised that he was dependent. During this period he made two decisions: the first was to quit alcohol totally with support from the medical team at Al-Amal hospital, and the second was to seek marriage.

When interviewed as a 44 year old man, he had been admitted to Al-Amal hospital again. Actually he had been admitted 11 times and had relapsed on each occasion. He had tried very hard through joining Alcoholics Anonymous as well as outpatient programmes, but struggling was an accurate description of his current condition. He

had been to prison five times. So far, he had reached three conclusions. First, all habits are difficult to break, but dependency is the most difficult to recover from due to the chemical element involved. Second, because alcohol had destroyed his economic condition, it would be very difficult to find a partner for marriage. Who would accept someone who had been jailed so many times, who was separated from his own family, and addicted? Third, due to his long absence from his family, he had attended neither his brother's nor his sister's wedding, nor met their spouses, and therefore the time had gone to go back to his family and start a good relationship, and the stigma of addiction would not be easily removed.

Currently he was suffering seriously from alcohol dependency, as he explained; 'I cannot sleep at night without spending hours thinking about my terrible history and sometimes it comes to my mind that this is not just dependency, it is demons.' Therefore, he had visited a religious leader to discuss this issue with him. Recently, he had stayed at the hospital even when the treatment programme had finished because he felt frightened to face society. Sometimes he argued with the medical staff when a discharge decision was being made. However, as a patient at Al-Amal hospital he regarded himself as a motivated and cooperative person whether with the medical team or with other patients. He participated in all medical and non-medical recreation activities. Unlike some other patients, he believed that a job was not the most important thing for protecting oneself from relapse. This required changing ones whole way of life, including but not only the type of job. This change was not easy and required long-term planning. It had to start with making a plan and practising personal conduct before venturing into real life where many challenges would be present.

The most fundamental conditions for success were said to be missing from his own life. These were, a) changing the place where he lived so no old friends could reach him, b) abandoning the bad friends and establishing new more positive friendships, c) looking for a job that must be legal and fit with his personal interests, d) finding a good way to go back to his family, especially his parents, and make good to them before they died, and e) looking for a partner and establishing a new family with children which would be easier after taking the previous four steps. In the meantime he 'had to be patient and remain self-confident'.

Currently married patient, Jeddah region

The interviewee had started his life within a small family of father, separated mother and two sisters who lived with the mother at a small house provided by some relatives and some support from social benefits. In his early life, he was admitted to the agency of juvenile delinquency ‘juvenile delinquency home’, although he did not remember what the reason was. His life developed in the home where he learned smoking cigarettes in the fifth level of the elementary school when 11 years old. He used to see his mother and two sisters sometimes on weekend days (which are Thursday and Friday in Saudi Arabia), but he was never visited by his father who had started a new family with a young wife. He discovered later from the sisters that the parents had divorced. Although he did not know the reality of the conflict, he knew that his father was an aggressive man.

After finishing the final level his uncle signed his graduation from the home and drove him to the house where his own family lived, together with his mother and his two sisters. The house was very small and not comfortable so he tried to spend most of his time outside playing with the neighbours. The uncle visited them once a week and spent the time mostly with the mother. The mother took care of everything in the house, doing shopping and buying for their needs. One day he was dragged-off by two foreign labourers who were selling pigeons. In the next street, they raped him. As he said, ‘Living with juvenile delinquents, there were plenty of sexual stories, but being copulated created a hate in my heart’. In risky areas such as where their house was located, he needed someone to look after him and his family, as he noted, but that was not recognised by anybody, even his mother. He tried to make himself stronger for two reasons which were facing dangerous people like the two labourers and forgetting the history that would shame him.

He recognised his need to be protected at the middle school where there was no control by the school at all. Not only this, but also at home where no-one looked after him, especially over school matters. The mother was concerned about money, buying food and paying bills. The two sisters did well at school and at home as well, but the interviewee could not finish the intermediate school so he left without a certificate

and started his own business at the vegetables market that was within walking distance from the house.

At the market, he started his first career where old Saudi and foreign labourers did better business than others. His negative experience with the foreign labourers was in his mind, but gradually he found it unavoidable to communicate with them. After a few months he became very well known and popular there and everyone liked to work or do business with him. As a young man who was active and had many skills, some of the labourers encouraged him to look for another job working for them as a drug dealer including selling and manufacturing alcohol. At first he hesitated to accept the offer, but later on he started to think about it and asked about the job. He was looking for money, and because of this, along with encouragement like being given packets of cigarettes and food, he accepted the offer. At that time, he was only sixteen years old.

At the time of starting the new job, his sisters got married consecutively and later on his mother followed. The marriages made him feel terribly lonely and he began drinking alcohol. As he stated, ‘My life with alcohol started at the age of eighteen’. Shortly before he began the new job, he made a decision to continue his education through evening school, but when he started the job, and received a large amount of money, he no longer attended school. In the new job his task focused on making local liquor at an unoccupied house in a very rough old area. He was taught how to make, how to sell and to whom to sell, and as he made very quick progress he started to think of having his own business. Without quitting this job, he gradually started his own liquor business until he became a ‘professional’ who knew how to make and test a good type of liquor. He also began drinking excessively.

At that stage of life, the weak relationships with his family, the mother and two sisters, as well as the relative, the uncle, came to an end when the police discovered his illegal business and arrested him. After being jailed, he came back to society with no family and no qualification or money. He went to the vegetable market, but he could not recognise anyone and after giving up he worked as a bus driver. ‘I worked as a bus driver but alcohol and its business was in my mind and I needed some money to start that business’. The poor family who rented his old family house had moved, and the house, which was not in good condition, was to be let which led him to make

a decision to take it as a factory for the liquor business. A few months of alcohol manufacture made a lot of income.

At the age of twenty-seven he purchased a small house and decorated it for use as a brothel. Although he received lots of money, he spent much more until he realised that there is no ‘blessing’ in illegal and prohibited work. Subsequently he stopped manufacturing, but still consumed alcohol and worked as a taxi driver inside the city of Jeddah as well as making short journeys to other cities in the region. Of that time he said; ‘I started to pray and not to cheat others, making an effort to be a good Muslim’. As he tried to stop drinking, he heard about Al-Amal hospital, but he never recognised that he needed to go there. However, after several unsuccessful attempts to quit alcohol he came to the belief that he needed help to get over it. At Al-Amal hospital, he believed that he learned many things about addiction and its characteristics and negative consequences. He spent most of his time at the mosque inside the hospital and every time he was discharged, his taxi car was parked and ready to start work.

Seven years of his life were spent between Al-Amal hospital and outside working as a taxi driver. In his own words, ‘These seven years were a waste of time with no real recovery or happiness or even normal life’. At the age of thirty-six he heard about a rehabilitation centre for alcohol and drug addiction in Cairo, Egypt, and he went there after saving plenty of money. After spending a few months there he went back to Al-Amal hospital with good motivation and experience of alcohol and drug treatment.

His first admission after Egypt was at Al-Amal hospital in Riyadh. He chose that hospital because he did not want to see people who knew him in Jeddah. When he exaggerated in expressing an Islamic point of view, other patients strongly criticised him as a drinker, smoker, and as a singer playing on a musical instrument. In Riyadh hospital he enjoyed his time practising Islam and also had parties at the end of every week which were organised by the hospital staff. There was a special welcome to him from everybody as a really motivated patient, a good singer who played a good tune, a most cooperative person, and he was encouraged to lead others in prayer at the mosque or in the residency wards. Therefore, he spent six months at the hospital as an exceptional inpatient.

After being discharged, he moved back to Jeddah and worked in his previous job, as a taxi driver. One day he drove a poor family to another part of the city, and during his driving he was listening to an Islamic tape and talking with a mother who asked about marriage. The conversation led to the mother offer him marriage to her oldest daughter who had divorced two times. As he said, 'It was a golden opportunity'.

After eighteen months of successful marriage, he gradually discovered some unexpected things about his wife's family, and he decided that family was not suitable for him. He found that his wife was secretly smoking cigarettes and having affairs. For her part, his partner discovered that he had hidden something from her, which was consuming alcohol with others, and she thought that these gatherings might include other women. Consequently, the interviewee returned to alcohol overtly and openly in the house, regularly and with a high level of consumption either to forget problems or to release anxiety.

At the present time, he had experienced eight admissions to the Jeddah hospital where he was interviewed. The incidents suggested that he as usual was an active and motivated patient. However, he believed his latest relapse had a different reason and was due to his family problems. His wife still visited him weekly at the hospital on the visit day, Friday. According to him, she seemed to be optimistic about him recovering and repairing the damage to their relationship, but he was still not sure what to do with no plan for the future unless he could get over and recover from the addiction which, as he said, lay behind every single problem affecting his entire life.

Separated patient, Dammam region

This interviewee began life with no major problems either at home or at school. His family included the parents who loved each other, two other sons and three girls; the interviewee was the oldest. The father worked hard and respected both his job and his duties at home; he was an honest man who loved everybody in the family. The father spent his free time equally divided between friends, family and relatives; he was a sociable person. Both parents were well educated. The mother was much younger than the father who had joined the Aramco company a long time ago so he spoke English fluently and received a good salary which meant that the family lived in good

economic conditions. The parents cared about education, and the father prized those who accomplished at school and did daily homework. Many times the father took his eldest son, the interviewee, to the sea where he joined his colleagues. On reaching the age of ten, the interviewee realised that his father and his friends were drinking alcohol. During these gatherings he usually played with his father's friends' children and sometimes they tried to investigate what the fathers drank. As he was told the drink was juice, one day he asked for a cup and the group laughed and told him, 'It is a juice for older people and those who have already finished school'.

While the respondent was still attending high school the father died of a heart attack after which the eldest son had more freedom to be outside the house, but never neglected his school work. In the western community alcohol was common among members of the younger generation as well as those who had joined the Aramco company early-on and liked its style and modernity. With his friends, the interviewee retained the same social gathering as when his father was alive, and his own involvement with alcohol started at the age of seventeen or eighteen. From time to time, newcomers joined the gathering with new substances like hashish and amphetamines and the interviewee enjoyed hashish and smoked excessively.

After finishing high school successfully the respondent replaced the excesses of hashish by increasing his daily consumption of alcohol; he had more freedom as a college student. The gathering place also moved to a residential apartment and then to a private resort where the men had affairs with women. The alcohol suppliers were two friends who worked at Aramco and obtained the cognac sometimes for free and at other times at very cheap prices. College life, the private resort and cheap alcohol gave the respondent the opportunity to drink as much as he wished and at any time.

By the time of finishing university, alcohol was about to affect his life negatively. The mother knew that her son consumed alcohol, especially at college. Three years after getting a job at one of the companies in the city the interviewee sought marriage. He and his wife, who was a teacher at a female school, rented an apartment in the same district where her family lived. Day after day, alcohol started to affect his social life especially when his partner visited her family during the weekend. Due to his mother's mediation his wife hoped for a better future particularly when she found that

she was pregnant. The interviewee could not stop drinking, however, although he tried very hard to hide his drinking as well as showing care and doing duties at home, as he had promised his mother, his wife and her family.

During the pregnancy he tried very hard to prepare for his future role as a father. He thought that when the baby came the family would be tighter. He had no plan to stop the alcohol because he believed that his wife would understand his situation and his baby's love would assist him to give care and attention to the whole family.

When the baby arrived, his life was stable for a few months only. Soon his wife started complaining about his drinking and his employer warned him officially. These two events came sequentially and the interviewee became determined to confine his drinking to weekends only. Before he could start his plan of reducing alcohol, however, his wife asked for a short temporary leave to spend with her family, and he understood that she was uncomfortable with him. The wife subsequently refused to come back. For the first time he had to sit with his wife's father and oldest brother and discuss the miserable life described by his wife. They all agreed to try to solve the problem on condition that he cooperated, made a clear plan and gave a promise to stop drinking alcohol.

After two months of negotiation, his partner came back for nine months, and the husband behaved as he had promised. He acted positively but he felt that he was under surveillance, being observed by his wife, his mother and his wife's family, who did not hesitate to show that they were watching him closely. Consequently, mixed feelings of anxiety, depression and restriction surrounded his entire life. One day he received a suggestion from his boss to visit a psychiatrist, which he did. Under intense personal pressure, the interviewee increased his drinking and even experimented with heroin, abandoning his promises.

Troubles intensified at home and at work. Eventually his wife contacted her oldest brother and left the apartment after writing a message stating that when he really decided to be a good husband and father, she would return to him, but that would not happen unless he could separate himself from alcohol and his drinking group entirely.

Also, his boss at work helped him to apply for a long leave ‘without salary’ in order to solve the problem of alcohol and suggested Al-Amal hospital.

He went to the hospital where he looked at himself and his history, and found that alcohol was a major part of his life. Yet he still believed that drinking or not drinking was his own business and that nobody had the right to enter his personal life, even his wife. He thought that if he quit alcohol other problems would arise such as anxiety and depression. This was recognised by others including the medical team at Al-Amal hospital, as he emphasised, even though it was his first admission. He spent more than three weeks at the hospital and met other alcoholic patients who had been treated several times and others who had been with Alcoholics Anonymous for a long period of time, which led him to believe that when alcohol became a part of the body it was a waste of time to look for treatment or recovery. As an educated person, he strongly believed that the best way to deal with alcohol dependency was to control drinking by the day, time and the quantity, but in some cases like his it was not practical to quit alcohol totally because this would not be successful in the long-term.

Since his admission, he had been visited by his mother, brother and sisters, but nobody had visited him from his wife’s family, and he had received no visit from his wife herself. He did not want to call his wife since he had broken the promises that he had given to her father and oldest brother.

Looking towards the future, the interviewee was in a position of conflict between two ideas. First, his desire to be close to his son and raise him with a good social and educational pattern, which made him accept that he must quit alcohol and look after his family with the consequence of enjoying a successful social life. Yet, on the other side, he believed that this would leave him suffering from psychological distress, anxiety and depression. The second idea was his strong belief in having freedom. This tended to make him reject the suggestion that he should quit alcohol entirely. It made him believe that he should look for another place to live, emigrate to where he could enjoy the freedom of drinking and gain release from psychological distress. On the other hand, he realised that this would mean losing contact with his mother, brother and sisters, his wife, his son, and his wife’s family.

Divorced patient, Qaseem region

This subject was born on a little farm by a small village in the region of Qaseem. His father was a religious man who married several times, latterly with two wives each having more than six boys and girls. The interviewee was the fourth among his six brothers and four younger sisters. At the age of seven, he was sent to school in the village until the second grade, whereupon the entire family moved to a big city in the region. As his parents were not educated, the mother took care of the house and his father did business at the auction and sometimes traded in antiques beside his part-time job at the mosque. The family's economic condition was weak most of the time. The relationship between the parents was not stable due to many factors such as the economic condition, the relationships between the boys and girls who fought with each other and with the second wife's family members. Overall, the interviewee felt that his father did not treat his children equally, and additionally he believed that his father did not get as close to him as to his brothers.

The interviewee did not pay much attention to school rules and led his friends to leave the lessons and ignore the teachers' demands. He enjoyed athletics and art lessons. However, the athletics lessons were not well organised so some students spent the time gathering in places like the toilet area or in empty study rooms. Therefore, and as a non-athletic person, the respondent learnt various negative behaviours before he moved into the middle school by which time he was two years behind others of his age. Conditions at the middle school were worse, as described, so he learnt more negative behaviour traits as well as practising unaccepted sexual behaviours; unaccepted especially by those who were extremely religious, like his father. For example, he brought some rude photographs to the school and taught others about masturbation and smoked cigarettes with his friends inside the school toilets. Outside school they gathered at farms smoking and sniffing glue, and they tried to encourage younger boys by allowing them to join the group and providing them with cigarettes and teaching them how to catch birds and ride donkeys.

The interviewee spent five years finishing the three middle school grades due to repeating the second and the third grades. Also, in this school he felt discriminated against by a teacher due to his original village community. In the high school, aged

19, he and his friends continued their gathering, but the group replaced glue with a perfume known as cologne that was purchased or stolen from a store.

Life inside his home changed a little based on the members' ages. For example, he ceased to have any contact with his brothers from his father's second wife, while his younger brothers played among themselves. One day his father discovered that he smoked cigarettes and unexpectedly expelled him from the house. He moved to a deserted farm belonging to a relative who had another small old house in the city central area. This situation gave him an opportunity to turn aside from society and to practice whatever he wanted. The father had expelled him not only as a punishment, but mainly to bring him back to the right way based on the father's opinion. The son, on the other hand, took it as an unacceptable punishment that shamed him among his community. As he stated, 'I could have come back as a normal person if my father had behaved towards me properly'.

When he moved to live at the farm, however his problem continued. For instance, his group came to him daily and stayed until midnight and some of them slept at his dwelling during weekends. The gathering included those who failed at school and had simple manual jobs like selling or farming. The interviewee sometimes worked with them, especially with those who delivered fruit and vegetables to big cities, particularly to the capital. Thereby, money was provided for purchasing items like food, alcohol and cigarettes.

He used to visit his family on Fridays during the weekly prayer so that his father would not be present, but he could see only his mother and sisters because his brothers were usually at the mosque.

At the age of twenty-nine, the gathering started to make their own liquor and enjoy drinking as well as smoking hashish and using amphetamines. Also, their incomes increased rapidly when they turned to theft as a way of making money.

When he reached the age of thirty-three, the group broke up and, perhaps surprisingly, he decided to join the Police Institute located in the capital, Riyadh. He was accepted at the Institute and joined the nine month training course. During this training, he

faced difficulties in reaching Wednesdays each week; this is the first day of the weekend when he could look for alcohol. Nevertheless, he finished the training successfully and got a job as a police officer in his home region of Qaseem.

Working as a policeman allowed the interviewee to buy good quality alcohol made locally and sometimes imported alcohol. Also, his income allowed him to improve his life condition so he started to think about marriage. Two of his brothers came to him twice asking him to come back to the house and said that their father did not mind if he smoked cigarettes. He did not dare to tell them that he was not only smoking cigarettes but also smoking hashish and drinking alcohol excessively.

A few months later, his father died at the age of eighty-seven. The interviewee went home to thank those who came to give consolation. Although his father looked like a poor person, he left behind a considerable sum of money of which the interviewee received a share which was good for any future plan, like marriage. Being seen regularly at the family house and helping relatives improved his reputation within the local community. His uncle offered his daughter as a marriage partner and the interviewee accepted, but the marriage failed even before the couple completed their first year. The unsuccessful marriage and his absence from home in order to consume alcohol with a few of his friends outside the city again isolated him socially. After two years of isolation and with minor troubles at work, he applied for a month's leave and went to Riyadh to join the addiction treatment at Al-Amal hospital because there was no Al-Amal hospital in Qaseem at that time. When he came back and restarted work, his oldest brother offered to help find a marriage partner from outside their own social community. He applied more than eight times before acceptance by a family not only from outside the community but also from outside the region; the proposed partner had divorced a long time ago. When they married, he was forty-three and his new partner was thirty-nine.

During the engagement which lasted seven months, his friend suggested going to Al-Amal hospital in Jeddah to avoid the possible stigma of being known by others. They went together for one-and-a-half months and formed a good impression about the treatment, but they both relapsed and consumed alcohol excessively again. The interviewee lapsed from abstinence a few months after getting married. By the second

year, his wife could not stand his absences and ignorance so she asked him several times for a divorce, but he rejected this. Since her family was far away, she separated from him inside the house on many occasions and requested help from his oldest brother who was much respected. One day, she called his oldest brother asking for help because her husband had beat her unconscious, and the oldest brother came with his wife. Following this she applied to the court for a divorce which was granted. After this divorce, the oldest brother and the whole family realised that something was still very wrong in the interviewee's life so he decided to enter Al-Amal hospital in Qaseem and seek treatment.

At the Qaseem hospital, as an admitted patient (by his family, that is, the oldest brother), he did not have much motivation towards the treatment, and he did not have any future plan since he had divorced twice and the second divorce was through the court. He was ashamed that not only his oldest brother but his entire family knew everything about his problem. As a man of forty-six he was not optimistic about marrying again, so all his thoughts were focused on keeping the job that he was about to lose. Regarding alcohol, he claimed that he could stop at any time he wanted. All he needed, he said, was to restore the trust and love of his family, particularly the oldest brother and his mother who was seriously ill. He looked upon his oldest brother (sixty-five years old) as a father and definitely did not want to lose him or to annoy his mother before she passed away, as his father had.

Conclusions

There are common themes in all the above biographies. All the alcoholics had commenced their drinking careers when they were young, in peer groups that were beyond the gaze of their teachers and families. In addition to alcohol, they had been introduced to tobacco, drugs and a variety of illicit sexual practices. We simply do not know what proportion of all young Saudi males become involved in these practices, but they are unlikely to be just a few isolated cases. All young males are likely to be 'at risk', at least of 'experimenting', unless they are supervised very closely by their families.

Many young drinkers (and drug users) are likely to desist as they establish marriages, families of their own, and occupational careers, but all the interviewees had persisted.

They had become heavy, frequent drinkers (and sometimes drugs users also), and eventually, irrespective of whether they realised it at the time, they became dependent on alcohol. When they were young the interviewees had not wanted to be ‘cured’. They were enjoying their lives – extended adolescences in some cases – and they did not want to change.

However, in the longer-term, problems with their families, in their marriages, and in their jobs had led to their admission to the hospitals. While in hospital they had all (compulsorily) withdrawn from alcohol, but irrespective of their intentions at the time, they had all relapsed, and this applied even to those who had been determined to embark forthwith on successful and respectable lives.

Chapter Seven
Focus Groups with Alcoholic Patients

Some issues can be investigated more effectively via group discussions than in either one-to-one interviews or written questionnaires. In this research it was felt that exploring the ways in which alcohol could be obtained, attitudes towards its availability, views about the consequences of drinking, and attitudes towards the regime at the Al-Amal hospitals, would be best investigated in focus groups that stimulated interaction and exchanges of views among the participants.

A focus group is a research technique specifically designed to gain insights from a small group of subjects. The group interviews featured in this chapter used a set of prompt questions deliberately sequenced and focused to move the discussion towards issues arising from the results of the questionnaire surveys that were reported in chapters 4 and 5.

Based on the three main groups of alcoholic patients - never married, currently married, and ‘other’ who were divorced or separated - the three focus groups totalled eighteen participants and each group represented one of the marital status groups. This phase of the research was conducted at different times and in different Al-Amal hospitals: the never married patients were interviewed in Riyadh, the married patients were interviewed in Jeddah, and the ‘other’ focus group was held in Dammam. The participants were asked by the researcher to give their views and perceptions of alcohol and domestic violence in Saudi society and some related subjects. Here the proceedings of the focus groups have been truncated by judicious editing, but otherwise follow the verbatim talk at each event. A tape recorder was used after getting permission from the groups in order to retrieve and edit their conversations. Some questions will seem to be different from one group to another which is due to; a) the three groups differed in their marital status which sometimes required modifying certain questions, and b) the aim of this qualitative method was to support and clarify some of the quantitative data, but not to compare the three groups systematically based on their opinions or their regions.

Never married patients

To begin I would like to start by asking about alcohol and its availability in this society. Since there are strong rules against drinking, manufacturing and smuggling alcohol as well as strong punishments, how do alcoholics satisfy their need for alcohol?

'Dealers are always in conflict with government institutions and agencies. Every time one is caught, the market creates a new seller and every time a strategy of selling or delivering is annulled, the dealers create a new strategy.' Most of the patients were basically users, but most of them also sold, as non-professionals, to help a friend or to improve their economic conditions. 'Most of the dealers are abusers, but are not necessarily addicted. Alcoholics mostly satisfy their needs from one or more dealers. When dealers are caught they have already disposed of the goods. Alcohol and particularly illicit drugs exhibit seasonal popularity during the year. For example, summer times are known as a quiet market while the pilgrimage season is the peak when most smuggling occurs.'

Do you think if alcohol was legal in Saudi Arabia, alcoholic numbers would be more, less or the same?

'If alcohol was legal in Saudi society the numbers would definitely be much higher. Take the previous example of seasonal drug use when Al-Amal hospitals are full of patients during summer times while poor residents are on pilgrimage.' One participant gave another example: when he had quit alcohol for four months just because he could not find alcohol. He elaborated that if alcohol did not exist, he would still be sober. Another believed that the numbers of addicted people in Sweden had increased after the licensing law was relaxed.

Some people like to have or try something prohibited. Is this the case with most Saudi alcoholics or just some of them?

Three of the group strongly agreed, and the other three tended to agree but were less certain. Generally, the six participants, according to their experience, thought that 'personal curiosity' was important, especially when it was allied with a friend's pressure. One participant stated that he looked at his oldest friends proudly and tried hard to follow them even when they broke the rules. His mimicry started with

smoking cigarettes, then stunt driving, then on to using drugs and alcohol, and ended with addiction to alcohol which he called the final destination.

How would you describe people's behaviour after drinking alcohol?
'Behaviour after drinking alcohol is mostly the opposite to that before drinking. Alcoholics drink in response to body need, craving, and the expected consequence is satiation, but other people's responses are different and can be sadness or it can help to create happiness.' However, some of the group talked about coma and losing control over behaviour as a result of excessive drink. There were arguments between those who spoke in these terms and others who stressed that it depended upon the quantity drunk and the body's capacity. A participant gave an example of when a sad person drank alcohol to release his sadness and to forget his problems but then became even sadder after getting drunk and started crying and talking about personal problems rather than forgetting them. The discussion ultimately ended with agreement that the more alcohol consumed the more behaviour would worsen no matter how a person's condition was before.

The term 'domestic violence' has become widely used internationally; do you think that we are witnessing this in Saudi society? And do you think alcohol has any involvement in this matter either nationally or internationally?
Initially, the group seemed to have no experience of domestic violence in Saudi society, but after considering some incidents like the TV presenter's case that had been reported in local and foreign media, they started to give examples of other cases that involved violence at home. For instance, one stated that a mother and her children applied to the courts for protection from violent acts committed by the mentally ill father. Another example was a drug abuser who threatened his family in order to get money to buy illicit drugs.

The second part of the question prompted negative answers. However, recalling the earlier comments where alcohol had led to mental illness, and noting that alcoholics shared some similar characteristics with drug abusers, the group gradually persuaded each other to give a positive answer, especially when losing control was a consequence of excessive drink.

Some national and international studies indicate a relationship between alcohol and crimes in addition to alcohol and aggression. Do criminals consume alcohol or do alcoholics perpetrate crimes; in other words, which one leads to the other?
There was disagreement within the group. Two participants saw offenders as liable to engage in other forms of negative behaviour including abusing alcohol and drugs. Yet they believed that alcoholics were oppressed by the public and by scientists. One said, 'When something bad happens anywhere, people do not hesitate to involve alcohol and/or drugs'. The rest of the group identified a certain behaviour pattern of alcoholics and gave an example of when an alcoholic could not find a drink and where his behaviour completely changed as a result of the craving. One member turned to the other participants saying; 'If you do not believe in craving and its influence over behaviour, why do you not quit alcohol easily without coming to this uncomfortable place - Al-Amal hospital?'

Now we would like to discuss some issues that have been illustrated by our data or by other local studies. The findings from alcoholic patients at Al-Amal hospitals show a low number of married patients. What is the reason behind that?
'As single patients we see this as a normal result in our society.' The group had a very long discussion about this matter. They believed that they had made mistakes early in adulthood, but they could not stop without help from their families and society. They saw themselves as paying a bill that cost them their whole lives without consideration by others. Since their families did not trust them, other people in the society did not welcome them and other families were reluctant to consider marriage to someone who was addicted. This increased the perception of being addicted and made relapse more likely. One participant sadly said; 'After fourteen months of recovery, I sought marriage and applied to more than ten families and the results were the same - rejection.'

Our data show weak relationships between alcoholics and their families. What it is the best way to improve that condition?
The interviewees completely agreed with this result. One attributed the condition to the early awareness of the family. The breakdown started when the family first become aware that a family member was a drinker. Another described how the breakdown continued as long as drinking persisted. 'The weak relationship continues

since relapse is a characteristic of addiction.' The group concluded; 'Whenever we get discharged from Al-Amal hospitals or whenever we get released from prison, our families as well as the society do not accept us as normal and therefore our destiny is to be addicted and imprisoned either at jails or in Al-Amal hospitals'.

In our study, we found that 40% of alcoholics admitted coercing others while 50% described themselves as aggressive, and 38% always felt guilty regarding their behaviour after drinking. How do you see these percentages compared with normal behaviour among the general population in Saudi society?

The subjects disagreed with these percentages and suggested that they were exaggerated. They argued that alcoholics displayed some aggressive behaviour, like others, but not as much as some people believed. The participants justified their opinion saying that dual abusers were more likely to commit such acts and that the violence was exaggerated publicly and officially. They did not think that alcoholics were more violent than drug abusers. Nonetheless, they thought, based on their experience, that alcoholics might commit acts of aggression in greater numbers than lay people, but lower than drug abusers or dual abusers. The subjects finished their discussion by accepting half the above percentages for alcoholics while a quarter or maybe a third of these proportions would represent the general population in the society.

We also found between a quarter and up to a third of never married alcoholics violated some other family members such as brothers, sisters and in few cases parents and children. What do you say about this?

The interviewees justified this behaviour in terms of losing their minds due to unusual circumstances like strong craving. Other justifications were given when family relationships were at their worst level, which was not unusual among alcoholics who said that the responsibility for this rested with the whole family. Stress was named as another reason for drinking. In conclusion, the six participants agreed that aggression did occur but was not especially towards parents, and with children it was simply not acceptable at any time, even when the children had flouted Islamic and ethical principles.

As a last question, how do you evaluate alcohol treatment at Al-Amal hospital, and are there any efforts to treat aggression either at the hospital or somewhere else?
Firstly the subjects believed that the most effective treatment was in the patient's own hands. However, they also said that the role of Al-Amal hospital was not as effective as they had expected. The main role was said to be isolating patients from alcohol. There were no treatment strategies or therapies. They also complained about the overlaps of the Ministry of Health and the Bureau of Drug Prevention and Control where there was a confusion of health and punishment approaches. They strongly criticised the Bureau and its presence at Al-Amal hospitals. Additionally, they had not seen any family therapy or any other types of therapy dealing with personal behaviour and solving the patients' problems with their families. They stated; 'Most of the patients finish the treatment within the time limit and get out at a time when their family situation is at its worst level.'

Married patients

First, let's start with a question concerning alcohol and its existence in this society. From where do people get or purchase alcohol?
Since people in Saudi society, like other societies, are not equal economically, it was said to be impossible to match one answer to all alcohol drinkers and abusers. The group explained that wealthy people might purchase better quality imported alcohol. All the interviewees knew some brand names such as 'Black Label' even if they had never travelled internationally. However, they also knew, or knew of, users who made their own liquor, and others who bought poor and cheap products made locally. With the exception of locally produced cognac, all kinds of alcohol were said to be expensive, but imports were the most expensive of all. The group believed that it was easy to obtain alcohol, and any difficulty would arise only for a first time buyer or first time maker.

Do you think alcohol should not be illegal in Saudi society?
Without exception, all the participants believed that alcohol should be illegal and they were against its presence in Saudi Arabia. They wanted to eliminate alcohol from the society, and likewise other illicit drugs. Concerning alcohol's availability as a reason for using and misusing it, one participant said; 'If I had the chance to fight smuggling, I would do, and the best treatment for alcohol dependency is never to find it.' He

concluded by likening the smuggling of alcohol and illegal drugs to other ways of killing people.

Why do some people drink alcohol while others do not?
The group gave various reasons. For instance, they said that some people like to try something new and that these people were more likely to drink alcohol than others. Another example was people who faced difficulties in their lives and did not know how to cope. These people were said to be more likely to drink alcohol than others. The availability of alcohol plus personal characteristics were both said to play major roles in leading persons to use or abuse alcohol. The group drew parallels with smoking cigarettes and using drugs. Bringing the discussion back to the reasons for drinking, the responses elicited from the patients indicated that the main reason for drinking was to feel happy which was somehow related to forgetting problems. 'To relax' was also offered as a key reason for drinking.

Can we move to the possible association between alcohol and domestic violence? Which one comes first, alcohol or family violence?
The participants started talking about the association between alcohol and domestic violence as a weak relationship, but in general they confirmed the link although they believed it was a minor link seen only when a person was in a highly intoxicated condition. Therefore, they argued, drinkers who were not addicted but who became intoxicated could be abusive persons. Consequently, the group linked intoxication (rather than alcohol itself or alcoholism) to family violence. In other words, they thought that people who drank alcohol regularly would mostly not become intoxicated and therefore their behaviour would be normal. In contrast, people who drank irregularly would mostly drink to intoxication which could well lead to losing control over behaviour and, as a consequence, violence might occur. Continuing this train of thought, the six participants all thought that drinking by those not familiar with alcohol and who were not alcoholics could well lead to aggression. That said, an intoxicated condition was said to cause aggression no matter who the drinker, whatever the drink, and whenever or wherever the drinking took place.

What is the difference between violence by married alcoholics and violence by others?

There were said to be no differences in the level or frequency of violence, but that there could be a difference over who the violence was directed towards. Non-married alcoholics might attack friends, relatives or other family members. Married alcoholics were said to be most likely to be violent towards their wives or children. Unanimously, the group was against aggression. One member said; ‘A respectful person never commits violence towards women or children and never pulls up others without reason no matter if they are alcoholic or not and married or not.’

Do you think that the family plays a role in creating violence perpetrated by alcoholics to women?

Although there were some disagreements among the group, generally they believed that people in Saudi Arabia entertained false stereotypes with regard to alcohol. People in general, including families and women, were said to know nothing about alcohol and did not know how to deal with alcoholics. In this case, these people in one way or another could create problems regarding alcohol itself and might be prepared to go further until violence was received or delivered. On the other hand, they said that few people knew how to drink alcohol, so they could intoxicate easily and would usually drink alcohol just for the sake of drinking. These people were said to be among the more adventurous who liked to experience new things such as drinking alcohol and were more likely than others to commit violence. The group agreed that, ‘Both people who know nothing about alcohol and people who do not know how to drink, are more likely to create violence because they miss the unique and universal culture of alcohol.’

When alcohol users/abusers stop drinking, does their violence stop or decrease?

Of course, the answer was ‘yes’ since most violence was said to occur under the influence of alcohol, and more precisely during an intoxicated condition. However, the group argued that for those who were naturally aggressive, their violence would remain the same or might decrease only a little when they stopped drinking. This meant that the aggression came first in these cases, but intoxication could make the aggression worse. The violence of some people who were considered alcoholics would be on the same level unless their families, friends and other people surrounding them understood their situation either when they drank alcohol or when they voluntarily quit alcohol whereupon conditions and moods could change, requiring a

new way of life. Regarding those who stopped drinking involuntarily, that is, during imprisonment, it was expected that their condition and their violence would surely worsen. The problem in Saudi society was said to be the sensitivity surrounding subjects such as alcohol and family violence. The group claimed that most people did not realise that most alcoholics wished to stop drinking. 'They know that it is our fault when we drink, but they ignore or forget that every human being has one or more vices, defects, and at the same time everybody needs help to handle difficulties.'

Do you think that if Saudi women drink alcohol, violence can occur?
The subjects thought that this could happen but nobody knew if it was already happening. Women and all related topics are sensitive matters in Saudi society. The group concluded, 'We do know a few Saudi girls who drink alcohol, but we have never heard that they abuse or violate others … If violence was perpetrated by female alcoholics, this would be under intoxication and the violence would be towards other females, not males.' They believed that Saudi males had the greater power in all social situations and relationships.

Now we would like to discuss some points that have been proven by our data or by other studies. Demographic results from alcoholic patients at Al-Amal hospitals in Saudi Arabia and their wives show low levels of economic condition, education and employment. What are the reasons behind these results?
Immediately, the subjects turned towards alcohol. They looked at this as a chain of cause and effect. Consuming alcohol at an early age negatively affected the person's education, and since alcohol was expensive, its consumption for a long time imperilled the family's economic condition, and drinking alcohol daily and frequently caused trouble at work and in some cases losing a job. Another consequence was said to be that low levels of education and lack of qualifications decreased one's chances of obtaining and holding down secure employment.

Some local studies find that alcohol can affect family relationships. How does this happen in Saudi society, noting our data on the high number of married patients who live with too many problems and the high number of women married to alcoholics who have sad attitudes towards their married lives?

Since alcohol is illegal and forbidden in Saudi Arabia, and is not accepted socially and publicly, the group agreed that, even without looking at its negative consequences, consuming alcohol would affect family relationships even if the drinker was the father which gave him a high position and that priority was given to parents by Islam. Anyone in the family who drank alcohol could expect a loss of respect and moral position. Further effects could be seen when a drinker was negligent of his or her obligations or behaved in an inappropriate way. Accordingly, the group argued that alcohol would surely affect family relationships negatively, especially the relationship between married couples because consuming alcohol could be hidden from others, but not from a spouse. Awareness by the woman would lead to a bad relationship with the alcoholic husband.

In our study women and married women in particular faced more violence than any other family members. What is your opinion about this? How would you account for this?

Initially the group hesitated to accept the result, but after some discussion they agreed that wives would be victims of violence perpetrated by males. Their opinion was that women were likely to complain, argue and ask for many things such as money and improvements in their condition, while the males in general did not want to hear any of this. To prove this point they gave two examples. Elderly people were said to complain mostly about their health, and if this improved they would stop complaining. The group said that children mostly asked for amusement, and if given toys their demands would end. Women's demands, complaints and arguments, however, were said to be endless, which in time would lead to male aggression. Wives might face more violence than others because wives were the most likely to ask for things, but in some cases the wives were innocent yet were nevertheless violated by husbands who did not take life seriously and ignored their obligations and duties. In these cases, wives were the only individuals who looked after their families educationally, socially and economically, which meant playing the roles of both mother and father, and this gave them reasonable justification for complaint.

Since there is recognition of the impact of alcohol, do you think that alcohol changes sexual behaviour? And why do only one third of Saudi alcoholics in the sample state that they always need sex after drinking?

Because alcohol and particularly intoxication change human behaviour generally, sexual behaviour will also be changed. The group believed that sexual behaviour would worsen only when the drinker was intoxicated. For instance, they argued that orgasm took longer after drinking alcohol which was seen as not bad, but in an intoxicated condition the orgasm could take a very long time and sexual appetite, 'libido', would be depressed, and this was described in negative terms. In this case, if one partner was not intoxicated, the sexual operation would not be equal and the inequality would mean reducing sexual appetite or losing it completely by the sober side. After an effort to explore the possibility of sexual violence due to inequality, the group flatly disagreed unless there was rape at the beginning of the sexual activity. Answering the second part of the question, and taking guidance from the alcohol culture, the group argued that a certain amount of alcohol was suitable for sex, and that young people and some others would increase their alcohol consumption to reach the point of 'desire', but if they passed that point they would feel sexually undesirable or they could react to the missing arousal and then they would face real difficulty in arriving at orgasm which would ultimately be harmful to both partners. One participant commented that this had happened to him in the early stages of his history with alcohol causing severe harm to his wife, which had resulted in negative psychological reactions towards sex by both of them for a long time.

Here is the last part of the discussion: since the relationship between alcohol and domestic violence is significant nationally and internationally, what is the best way to terminate violence by alcoholics?

The best solution was said to be delivering appropriate treatment programmes to two groups - alcoholics themselves and their families - and for two purposes. First, to teach the families how to behave with alcoholics both during their drinking and if and when they stopped. Second, helping alcoholics to stop drinking voluntarily and without enforcement, and to eliminate some other difficulties that could result from quitting alcohol. The group also advocated contacting people who drank alcohol irregularly, mostly adolescents, and correcting some misconceptions such as intoxication being a necessary aim or outcome. The group argued that dependency was not easy to recover from, and finally that warnings should be given based on Islamic teaching about alcohol and its prohibition.

‘Other’ patients

Starting with the existence of alcohol in Saudi society and according to your experience, from where do people get alcohol and how easy and cheap is it?

‘People buy their liquor from different sources. For instance, here in eastern Saudi Arabia some people purchase alcohol from Aramco because its cognac is good and cheap. Others smuggle alcohol across the border from Bahrain which is only a few miles away and where it is legal to drink. Aramco has had an impact on the region since it settled here in the mid-1990s. To be fair, the company has some positive impacts as well as producing a few negative results such as increasing the use of alcohol in the region.’ Buying alcohol for personal use was considered easy compared with some other regions like central Saudi Arabia, Riyadh, and was not that expensive compared with some other illegal products like heroin. Also, the group said that some people could make their own liquor and a few might prefer using the perfume known as cologne.

Do you think that if alcohol was not prohibited, this would be better or worse?

‘There is no doubt that if alcohol was not prohibited it would be far more prevalent, there would be more cases of addiction, and some other related problems such as crime would increase. Also, we should notice that alcohol affects the economy within families and in society as a whole.’

How does alcohol change human behaviour, noting that alcohol is scientifically classified as an inhibitory drug?

‘Alcohol changes human behaviour in two ways. One is the short-term effects by losing control and intoxication. The other is the long-term effects that mainly concern what is known as addicted behaviour. A common example of a short-term effect is neglecting people, duties at home and a job’s obligations. One common example of a long-term effect is lying, particularly to prove, deny or get something for the purpose of possessing alcohol.’

Can we move to the following queries regarding the possible association between alcohol and domestic violence. Why does one perpetrate this even though it is unacceptable based on law, Islam and social customs?

The group believed that life in Saudi society needed something like alcohol that made a person relax, because the weather, social life and work atmosphere were hard. Taking the three points separately, agreement was reached that the hot weather across the country and humidity, particularly in the eastern and western regions, encouraged people to look for something that would improve their mood. Social life and friendship both required high attention that made a person nervous or worried by having to give high priority to local customs. The atmosphere in most Saudi agencies and institutions was said to be unhealthy for work and achievement. Only a few people were said to be happy or even just satisfied with their jobs or with what they were doing. The group agreed that Saudis regarded employment as a way of obtaining money, nothing else. In other words, in Saudi Arabia jobs were taken to improve economic conditions with little consideration given to personal interests and skills.

Some international studies have found violence perpetrated by people who do not drink alcohol while other studies associate violence with alcoholism. Do you think alcohol has any impact on violence at home?

The interviewees believed that somehow alcohol had an influence on human behaviour which could lead to family violence. Some of the interviewees gave examples of how alcohol was a major reason for divorce. Two of the subjects described how their ex-wives' families had confronted them personally, and through authorities like the courts had made them divorce their wives. Another separated participant stated that his wife's brothers threatened him with divorce and they applied to the police for punishment, giving evidence that he flouted the prohibition of alcohol. As he explained, he had to choose between two options: allowing his wife to leave him or keeping her but facing police troubles for being a drinker. In conclusion, these experiences were expressed as negative results of behaving badly with married women, noting that divorce was harder for women than for men in Saudi society.

Who is the most responsible for domestic violence, men or women, and do you see any involvement of alcohol in this matter noting that a high percentage of married women in Saudi believe alcohol is a factor?

The participants saw men as responsible for most domestic violence. They believed that violence could be committed by non-alcoholics as well as alcoholics, but in both groups males were the most likely to perpetrate violence. The main difference

between the groups was said to be the heavier violence by alcoholics. One divorcee said, ‘There is nothing worse for woman than marrying an alcoholic husband’, and he stated that he and his wife had shared reciprocal love yet had separated seven times before divorcing. Nevertheless, the group gave women some responsibility for failing to give the husbands support in quitting alcohol so that violence would be eliminated. They described addiction as a disease like diabetes. By definition, addiction needed a particular way of life, and this was not generally recognised by families or Saudi society.

Do you think that violence perpetrated by Saudi alcoholics is greater or less than violence perpetrated by alcoholics in western societies?

The interviewees agreed that comparison was not possible because they did not know about violence in the west. However, they thought that since people in Saudi society knew little about alcohol and strongly rejected it, the problem of violence must be worse where it was used more widely. Although this was agreed by the whole group, a reminder was given that rejection came from the Islamic point of view and at the same time Islam also rejected behaving badly with others and strongly called for caring for women. Also, they mentioned a point that may increase violence in Saudi society which relates to family relationships that are wider than those in western societies and involve obligations based on social customs. Another point that received approval was that no Saudi law proscribed violence at home. One participant commented that it was rare to hear about someone being sued due to family violence or anything related to social life. Contrastingly, however, married women in Saudi could seek a court ruling in any Saudi town or city as being oppressed, and they could do this either with or without a solicitor and the courts and judges were free of charge.

What is the difference between violence conducted by alcoholics and violence conducted by non-alcoholics?

‘When a person is unconscious from alcohol intoxication, violent acts can occur no matter what the situation. Due to intoxication’s effects, a person can behave inappropriately both with reason and without reason. However, when violence occurs by non-alcoholics, they definitely mean it and there is a reason behind their behaviour.’ This led to a discussion about types of violence, in which the participants believed that intoxication could make aggression sharper and more severe.

Why would a Saudi woman marry an alcoholic husband?

'No woman would consent to marry an alcoholic person unless her case had some unusual circumstances. For instance, when a woman comes from an extremely poor family while the alcoholic is a very rich man. In such a case, the woman considers the positive side which is money and ignores other things that surely will create under-estimated troubles in future. Another possible example is when the woman and her family do not know about the husband and his problem with alcohol, especially when no clear indications of addiction are present before and during the first years of marriage. An unusual example is when a woman's family has a family history of drugs or alcohol. In this example, a 'normal' man is unlikely to marry a woman when her father is an alcoholic or addicted, so one of her destinies is to marry an alcoholic husband.'

There is a percentage of Saudi women who use/abuse alcohol. Do you see this as common within the society?

'In this region of eastern Saudi Arabia there are many cases compared with some other regions like the southern or northern regions. However, compared with men's percentages, women are less likely to consume alcohol even when they face men's circumstances or their lives are harder. In this region, as well as in the cities of Jeddah and Riyadh; we can roughly say that in every ten drinkers there is one female and among twenty addicted cases there is only one female. Other regions and cities seem to have much lower proportions.'

We come to the last stage of our discussion, Al-Amal hospitals in Saudi Arabia recently introduced a combined approach to addiction and mental health treatment. Has this approach improved the treatment and its effectiveness? And what is the best treatment for alcoholics who behave aggressively?

'Actually the patients are not mixed at Al-Amal hospital. The hospital's name has the term of 'Psychological Health', but addicted patients are separated from those who are mentally ill and the treatment staff are also different. Therefore, there is not much difference compared with past experience, before the combination.' Regarding treating alcoholics who behave aggressively, the interviewees believed that more attention should be given to this phenomenon starting with scientific studies to

research the reasons for aggression. The group argued that, at the time of recovery from alcohol, other behaviours needed to be rehabilitated. Based on this point, they argued that behavioural treatments should be designed side-by-side with addiction treatments.

Discussion

Conclusions can be drawn from the first group of 'never married patients' confirming two reasons for consuming alcohol; personal curiosity and as a response to friends' pressure (see chapter five and six). Also, the group stated that the more alcohol consumed the more behaviour would change for the worse no matter what the individual's condition before, which is an important result from alcoholics when exploring connections between alcohol and violence. In addition to that, the group thought that Saudi society was witnessing an increase in domestic violence. Furthermore, the group agreed that aggression was associated with alcohol, and that between a quarter and a third of alcoholics were aggressive towards some family members, but not usually towards parents or young people. Other results of drinking were said to be losing control over behaviour, intoxication with all its negative consequences, and an association between alcohol and other crimes as highlighted by women married to alcoholics (see chapter four). Also, this focus group confirmed the weak relationships between Saudi alcoholics and their families. The never married group pointed out their difficulty in seeking marriage due to their histories of alcohol use. Finally, they were critical of the treatment programme at Al-Amal hospital and strongly criticised the presence of the Bureau of Drug Prevention and Control.

The second focus group of 'married patients' raised some issues related to consuming alcohol and domestic violence, namely a) relating violence to intoxication, b) confirming the weakness of women's positions in Saudi society, c) confirming three common reasons for drinking among Saudi alcoholics (to feel happy, and relaxed, and in response to friends' pressure), d) verifying the negative impacts of alcohol on sexual behaviour as stated by women married to alcoholics (see chapter four), e) declaring that women, and married women particularly, were the most likely persons to face aggression (as found in chapter five), f) acknowledging that alcohol has a negative influence on Saudi family relationships, g) arguing that drinking alcohol is

confined to a few Saudi women, and finally, h) authenticating the association between alcohol and violence by stating that alcohol consumption increases family violence.

Patients who were divorced or separated comprised the third focus group that confirmed some results reported elsewhere such as the link between alcohol and crime, and the link between alcohol and weak economic conditions. Based on their personal experiences, the group argued that alcohol had an influence on human behaviour through short-term effects via reducing awareness, losing control or intoxication and through long-term effects including denial and blaming others, as well as further addictive behaviours. Also, the group attested to the heavy violence that could be committed by Saudi alcoholics particularly during intoxication and towards women (see chapter four). This group of patients corroborated that Saudi women were unlikely to accept, marry and stay with an alcoholic husband. Moreover, this group noted that consumption of alcohol was by only a few Saudi females and even fewer were addicted to it. Regarding the treatment programme at Al-Amal hospitals, this focus group did not feel confident about its effectiveness and asked for improvements, and for special treatments and therapies for behavioural rehabilitation.

Some points were agreed or contested (sometimes hotly contested) in all the focus groups. First, they all agreed that it was easy to obtain alcohol in Saudi Arabia. Second, they were all, unanimously, against alcohol and supported its prohibition. Third, they agreed that drinking led to grave problems in seeking a bride, then remaining happily married, and in securing and retaining employment. Fourth, they all argued that the hospital treatment for alcoholics was ineffective. Finally, all the groups were diffident about the relationship between alcohol and violence, domestic or otherwise. They are willing to admit, but only reluctantly in some cases, that drinking could lead to violence. However, it was variously claimed that it was intoxication rather than drinking per se, or the inexperience of the drinker, or provocation from others, that were really responsible for any violence. Another argument was that it was only if a person was pre-disposed to violence that alcohol would aggravate this tendency. In any case, the groups felt that levels of violence by alcoholics were exaggerated by the media, public opinion, and even by scientific research. In the structured questionnaires the alcoholics confessed to their own violent

tendencies, whereas in group situations they produced a series of mitigations, justifications and ‘techniques of neutralisation’.

Chapter Eight
Conclusions

This chapter summarises the main results that were presented in detail in previous chapters. In doing so, it notes similarities, where similarities have been found, with the findings in comparable international studies. In other instances Saudi particularities are highlighted, and implications for various parties in Saudi Arabia are extracted. The chapter then returns to, and answers, the research's original main questions. Finally, the chapter draws implications and makes recommendations for future research, for policy makers in Saudi Arabia, and for the treatment of alcoholism and domestic violence in that country.

Main findings

The alcoholic patients were spread fairly evenly in terms of age from 20 upwards, but only a minority were married. The largest group were 'never married', and there were roughly equal numbers who were currently and formerly married. 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, are less likely to get married and to stay married, and also find it difficult to get and hold onto jobs. In this respect, the present study's findings replicate earlier Saudi studies by Al-Angari (1988) and Al-Dakhil (2002).

Most of the Saudi alcoholics lived with their parental families (62%) or with their wives and children (29%). Thirty-eight percent spent most of their spare time alone. Less than half of the married patients (47.5%) indicated that they spent most of their spare time with their wives. Moreover, most of the participants did not have any friends among their family members (68%) which was confirmed in the focus group discussions.

The majority of alcoholic patients drank outside their homes (77%). Yet it was clear that family interactions occurred while the person was intoxicated which could cause some kinds of violence as described by 'alcohol myopia'. Most of the Saudi drinkers were drinking either with friends (47%) or alone (42%), which itself can be a sign of addiction. Private places outside the city, and (by married respondents) at home were the places usually chosen to imbibe. Safety is the primary consideration in choosing a

place to drink in Saudi in order to avoid arrest by the religious enforcement council or the police. Some patients (44%) drank throughout the whole week, which may indicate alcoholism. Weekend days (32%) were the second most common pattern. These results are similar to those in the study by Al-Dakhil (2002).

The most common reasons for drinking were to seek happiness (21%) and to relax (19%). However, some alcoholics gave different reasons such as to forget problems (12%) and to release anxiety (10%) which may lead to violence as described by the 'expectancy model' and the 'tension reduction theory' (TRT) (see chapter 1, section 3). Psycho-social problems can interact with drinking in three ways.

(1) Psycho-social problems may occur before drinking and alcohol may make them worse (especially in Saudi where alcohol is prohibited).
(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, relaxation was the most common (42%) followed by happiness (27%). These two feelings are the most likely reasons for drinking among Saudi alcoholics. Thoughts on alcohol's effects presented the same results: peace and quiet (33%) and happiness (18%) were the two most frequent answers. When asked about their feelings after drinking compared with before becoming drunk, 'normal' was the most likely answer (42%) while 'more aggressive' and 'more friendly' each received 24%. These answers do not contradict those given by the women married to alcoholics. Cultural factors (e.g. honour and respect between the genders, and social customs), and expectations of alcohol's effects (see chapter 1, section 3) may play major roles in increasing aggression towards others.

More than half of the alcoholic patients (60%) had been admitted to the Al-Amal hospitals for the reason of drinking and family problems, while drinking alone was named by 24% and family problems alone by 15%. When asked for their main motive behind coming to the hospital, the majority said it was to stop drinking. However, a

fairly high percentage (27%) thought that they did not have a drinking problem, which also came across in the focus groups.

The majority of the Saudi alcoholics (65%) had no family histories of alcohol use, which does not support the 'learning in the family' theory. The respondents would have known had there been family histories of drinking. Due to the difficulties of keeping drinking alcohol secret within Saudi families, the majority indicated that their entire families were aware of their own drinking (60%) while just 15% stated that no-one knew. The majority who said that there was no family history corresponds with the answers given by the women married to alcoholics.

Concerning self-reported drunken behaviour, the Saudi alcoholics divided between normal (34%), friendly (25%), do not know (22%) and aggressive (19%). Even when someone bothered them the reaction was said to be normal (36%), ignore (42%) or aggressive in just 22% of the cases.

The majority of alcoholic patients stated a need for sex after drinking 'sometimes' (52%) while 31% 'always' needed it. Most of the latter group were never married. Those who were currently married indicated a low sexual appetite, or an inability to perform normally, which was confirmed by their married partners. 'Cheating' and prostitution were hinted at throughout all the samples, suggesting a need for studies in Saudi to track exposure to illicit sex industries and related health issues including sexually transmitted diseases.

Two-thirds of the alcoholics had the experience of being arrested and the most likely reason was drinking alcohol. However, just 35% had been to prison one time or more.

A large number of the married alcoholics (71%) expressed satisfaction with their marriages while about the same percentage of women married to alcoholics (72%) indicated sadness. The women's answers are consistent with Marshall's (2003) conclusions from a review of 60 previous studies, which found overwhelming support for the notion that alcohol use is maladaptive and is associated with marital dissatisfaction. The same conclusion was drawn by Leonard and Senchak (1993) whose findings were reviewed in chapter 2.

There was a similar result among alcoholics (48%) and women married to alcoholics (68%) concerning living with many problems indicating unstable lives among Saudi couples where the husbands abuse alcohol. Many studies indicate a strong relationship between abusing alcohol and marital adjustment problems and some of these studies have emphasised that marital adjustment improves when drinking decreases. However, marital problems among Saudi couples where the husbands abuse alcohol may be aggravated by alcohol itself being prohibited.

Measuring love between the samples of alcoholics and women married to alcoholics confirms the generally weak relationships among the couples. On this matter, 45% of the alcoholics and 28% of the married women indicated that they hated each other. Alcohol use and marital dissolution in Saudi Arabia need more research among both married couples and separated and divorced couples.

When the women married to 'ordinary' partners were asked to give their opinions regarding domestic violence, 40% said that Saudi society was witnessing family violence, and among those who gave positive answers both genders were usually pointed to as being responsible (60%), while men alone were blamed by just 28% (see tables A.8.1. and A.8.2., appendix 8). Domestic violence in Saudi society was also discussed by the alcoholic patients in the focus groups, and their comments give support to the women's answers as stated above. These results may reflect men's position in Saudi society which is high compared with women's status, as was mentioned in the first chapter.

Another query addressed to the women married to 'ordinary' partners was how people could avoid domestic violence (see table A.8.3. appendix 8). Good understanding, conversation, and respecting women received the majority of the answers. Saudi institutions and Saudi society as a whole should be aware of domestic violence and should take initiatives to strike a better balance between the genders. This would avert confrontations as happened when a few women organized driving cars in the capital, Riyadh, in the early-1990s as a protest against social and governmental inequality. They were appealing for permission for women to drive cars as in other similar societies like Kuwait and Bahrain. Nearly a half of the women married to 'ordinary'

partners gave ‘men’s status’ as a reason for family violence. Using drugs (12%) and drinking alcohol (8%) were mentioned far less frequently (see figure A.8.1. appendix 8).

Women married to drug users and women married to alcoholics were asked for their opinions on the relationship between drugs/alcohol and aggression (see tables A.9.1. appendix 9, and A.10.1. appendix 10). There were only two women in each sample who responded negatively (that there was no relationship) while 23 out of each group of 25 women responded positively. So large majorities (92%) of the women who had experienced drugs/alcohol and their effects through their husbands believed that drugs/alcohol made people more aggressive.

These two samples were also questioned about their husbands’ criminal problems (see tables A.9.2., appendix 9, and A.10.2. appendix 10). About a half (48%) of the drug using husbands were said to have criminal records, and likewise 40% of the alcoholic husbands. There were no reported histories of arrest among the ‘ordinary’ couples. The present study’s result is surprisingly similar to some Western studies’ results (see, for instance, Murphy and O’Farrell, 1994). On arrest matters, the two Saudi samples demonstrate a highly significant relationship between domestic violence and a history of arrest, which matches Bennett et al’s (1994) results from 63 male inpatient alcohol and drug addicts and 34 of their female partners. The difference between arrests in Western countries and this study’s result is not the frequency but that the subjects in Saudi Arabia were more likely to have been arrested due to having alcohol or an illicit drug like hashish, but the overall proportion who had been arrested is quite similar to those reported by Bennett et al (1994).

There was not a single positive answer from the women married to ‘ordinary’ partners regarding requesting help because of their husbands’ behaviour. In contrast, more than half of the two other samples had requested help. The majority of women married to ‘ordinary’ partners (80%) would still have married their husbands if they had known all about their husbands’ behaviour beforehand. Yet the majority of women married to drug users (88%) and women married to alcoholics (96%) would not have married their husbands. The interview details demonstrate that men who abused drugs or alcohol neglected most, if not all, of their duties both as fathers and

husbands. Examples of such neglected duties were abundant in the focus groups of alcoholics.

There was a noteworthy connection between domestic violence and money particularly with the husbands who abused alcohol. This result has been replicated in multifarious recent studies which conclude that alcohol use acts as a chronic stressor and has a deleterious influence on marital functioning. The low-income result is supported by Bennett et al (1994) who found that low income is one of the correlates of domestic abuse. The financial problems of the families indicate indirect effects of alcohol as proposed by the indirect model (see chapter 1, section 3).

Feminists will no doubt see that, throughout the three samples of women, there are strong signs of patriarchy. Hence, the relationships recorded between alcohol consumption and domestic violence in Saudi society can easily be linked to feminist theory (see chapter 2). This result fits with the argument that alcohol interacts with males' need for power which elicits aggression (Dobash and Dobash, 1992; 1980).

Women married to drug users and women married to alcoholics mostly appeared to have normal sex with their husbands under the condition of 'no drugs or alcohol'. However, there were some cases of drug users (20%) and alcoholics (32%) insisting on having 'unnatural' or unacceptable sex which led on some occasions to sexual assault. After the husbands took drugs (88%) or alcohol (96%), the women said that their sexual behaviour changed completely and the men themselves spoke of two common consequences; long orgasm and weak appetite. The majority of women married to alcoholics (96%) stated that the husbands' orgasms took a long time to rise and this bothered them. Also, some women complained that their husbands sought 'unnatural' sex, which was not acceptable to women. It has been shown elsewhere that male alcoholics, when compared with non-alcoholic men in cross-sectional studies, have a heightened prevalence of (a) sexual dysfunctions, the most frequent of which are erection difficulties, diminished libido, and retarded ejaculation, and (b) sexual dissatisfaction including disagreements about sex, lowered sexual frequency, and reduced sexual satisfaction (e.g., Jensen, 1984). Sexual dysfunction as a consequence of abusing alcohol may lead to sex offences by the abuser. This was indicated in the CTS sexual coercion sub-scale and sexual dissatisfaction can be

counted as a contributor to the sad attitudes towards married life that were expressed by most of the Saudi women married to alcoholics. According to the interviewers, the women must have been suffering seriously to tell about this despite the modesty that is expected in Saudi Arabia especially about sexual matters.

Some women married to alcoholics (20%) and women married to drug users (44%) had separated from their husbands on at least one occasion. Abusing drugs/alcohol and assault were among the main reasons of leaving a marriage. We must bear in mind that it is not easy for Saudi women to leave a marriage if only for economic reasons (see chapter one, section two).

Generally, there are three major problems facing male alcoholics in Saudi society that can be deduced from the surveys, the narrative interviews and the focus groups, which are;

a) Weak economic conditions.
b) Lack of career prospects where 37% of alcoholic patients had never had a job and 31% had only temporary jobs.
c) Bleak marriage prospects.

There are also three general problems facing women who are married to alcoholics in Saudi, which are;

a) Enduring violence in order to prevent a marriage break-up for economic, children and social stigma reasons.
b) Lack of opportunity to marry again if they get divorced.
c) Facing sexual problems as well as ‘cheating’.

Half of the Saudi alcoholics stated that they were described as aggressive and 38% of their families had called for help about their drinking. However, only 19% of the subjects indicated that they had ever used a weapon when family conflict occurred. Forty percent of the alcoholic patients said that they had sometimes forced others to obey them. Just under a half of the alcoholics (52%) ‘sometimes’ felt guilty regarding their behaviour after drinking while 38% reported feeling guilty ‘always’. A very large percentage of the women married to alcoholics (96%) spoke of suffering because of their husbands’ behaviour. This contrasts with the statements of the

'ordinary' women sample where only 12% responded positively. Women married to alcoholics who had their own paid jobs had to obey the husbands' demands when they asked for money otherwise the women could face physical aggression. The focus groups with divorced and separated patients confirmed this finding and in this context we should note again that married women in Saudi have limited opportunity to leave alcoholic husbands.

Substantial proportions of the alcoholics (though in each less than a half) admitted that someone had been injured (37%), that they had thrown something (39%), behaved badly (40%), and caused someone to go to hospital (23%), and the married woman was the most likely victim. Nonetheless, other family members including sisters, brothers, children, parents, and in a few cases grandparents had been victimised. Small wonder then that 68% of the women married to alcoholics stated that they were living with too many problems. One woman mentioned that she had experienced two abortions due to physical assaults by her alcoholic husband. Similar levels of intimate partner violence have been found in alcohol treatment seeking populations in Western cultures (50% or even higher in the USA, see Murphy and O'Farrell, 1994; O'Farrell and Murphy, 1995). Family norms in Saudi society could make family violence much worse when it occurs due to the masculine power system. Also, alcohol may play a stronger role in provoking violence in Saudi homes if only because, according to the results of this research, this is a place where married alcoholics are likely to do their drinking.

Qualitative information from the women married to alcoholics illustrates the variety of forms of aggressive behaviour that they had experienced - twisted hair, slapped on the face, beaten up, and grabbed. These types of aggression had been more common than in comparable Western studies, possibly due to the weak position of Saudi women as well as unclear laws and most women not knowing their rights. We should note several points here.

a) Saudi females have not been given full rights to participate in reviewing and reforming laws and policies.
b) Saudi courts have not been modernised to deal with problems like woman, child and elder abuse.

c) Social services in Saudi Arabia are remarkably weak and are not authorised to discover and treat domestic violence.
d) Although Islam requires women to be treated kindly, a person who does not obey Islam and drinks alcohol is unlikely to hesitate to break other Islamic demands.

Looking at the Michigan Alcoholism Screening Test (MAST) results, the total mean (M= 18.29) of the Saudi alcoholics is close to that found by Al-Angari (1988) as well as in Western studies of victim and treatment programme samples which have used the same instrument (i.e. Stith et al., 1991; Abracen et al., 2000; Bevan and Higgins, 2002; Murphy and O'Farrell, 1994; O'Farrell and Murphy, 1995; O'Farrell at al., 2000). However, the alcoholics in this study had a wide range of MAST scores. The highest scorers (the most seriously alcoholic) differed from other patients in additional ways – their preferred drink (usually Arag), and where they usually drank alcohol (at home or outside any premises). The most seriously alcoholic also tended to be older, were less well-educated, and were more likely to be currently or formerly married. Their admissions to the hospitals were more likely to have been involuntary, and solely on account of drink problems.

This study clearly shows that older, and married and 'other' alcoholics, were more violent than other groups. Furthermore, among the more seriously alcoholic respondents, the context of marriage was increasing the likelihood of them behaving aggressively at home. This needs more investigation.

The theories that were reviewed in the first chapter (i.e., de-inhibition model, reduced information processing, disease model, expectancy model, indirect effect model, alcohol myopia, tension reduction theory, psycho-analytic theory, social learning theory, deterrence theory, and feminism) matched some of the results as highlighted in the relevant passages, while some other theories proved less helpful in interpreting the data. The cultural specificities of Saudi society may well be the reason when no support was found among the findings for one or more theories. However, rejecting a theory totally would not be justified given that factors such as the particular study, the location of the subjects, and the techniques employed (e.g., questionnaires and interview schedules, sampling, and times of data collection) could be responsible for

this. Therefore, theories that did not prove helpful in this enquiry could well be accepted by another study in a different society, or even within the same society (Saudi Arabia). However, this was an exploratory study, and reviewing these numerous theories is one of its contributions from theoretical and empirical perspectives.

It can be said the methods and tools used in this study worked successfully with all the samples. This includes methods that were used for the first time in an addiction field (focus groups and narrative interviews), and those tools which were adapted to Saudi culture like the MAST and the CTS. The CTS in particular worked very well even with the 'ordinary' women sample, and its results were similar to those recorded in worldwide studies. Unfortunately, a precise comparison between the Saudi sample and the previous studies is not possible since the CTS in this study was scored and coded slightly differently.

Reviewing the study's original questions

This section returns to and answers the study's principal questions.

> *Does alcoholism have a relationship or correlation with domestic violence in Saudi society?*

The evidence presented in previous chapters is wholly consistent with the view that alcoholism is an independent cause of domestic violence. The interviews with women married to alcoholics offer strong illustrations of an association between consuming alcohol and domestic violence. Almost of the all of the women perceived this association. In analysing the data from the sample of alcoholics, it proved impossible to make the relationship disappear whatever controls for age and marital status were introduced.

This result is in line with the association between partner violence and alcohol problems (i.e, abuse and/or dependence) that has been reported consistently in studies of individuals seeking treatment for substance abuse (Brown et al., 1999; Stith et al., 1991), and it has also been reported among violent couples in treatment (Rosenbaum and O'Leary, 1981; Telch and Lindquist, 1984), partners of violent men in the

community (Cunradi et al., 2002; Van Hasselt et al., 1985), pre-marital samples (Leonard and Senchak, 1996; Heyman et al., 1995), a military sample (Pan et al., 1994), and emergency department samples (Grisso et al., 1999; Kyriacou et al., 1999). Also, it has been demonstrated in nationally representative samples (Kantor and Straus, 1989; Coleman and Straus, 1983; Leonard and Blane, 1992) and community samples (Fagan et al., 1988; Mckenry et al., 1995). The relationship has been established both cross-sectionally and longitudinally, even after controlling for pre-marital violence (Leonard and Senchak, 1996; Heyman et al., 1995), and it has been confirmed by both experimental studies and shown in laboratory situations (Bushman and Cooper, 1990; Hull and Bond, 1986). Commonly, alcohol has been credited with adding excessive brutality to already violent situations (Holcomb and Anderson, 1983; Roizen and Schneberk, 1978).

This study's results replicate plenty of previous studies which indicate that maritally violent men are considerably more likely than a wide variety of comparison groups to use and abuse alcohol (Quigley and Leonard, 2000). Domestic violence is generally found to be 5-6 times more prevalent in alcohol treatment samples than in demographically matched nationally representative samples (see, for example, O'Farrell and Murphy, 1995).

On the whole, the Saudi samples of alcoholic husbands and women married to alcoholics confirm that a consistent and positive relationship exists between alcohol consumption and aggressive behaviour in general. This matches the 'drunken bum' theory - not its assertion that domestic violence is engaged in primarily by blue-collar men but rather that alcohol is the major cause of this form of abuse (Kantor and Straus, 1987). The findings reported here are wholly in line with the majority of Western studies (see chapter 2). However, what needs to be considered is the family norms and the position of alcohol in Saudi Arabia that make it different than Western societies. This needs to be taken into account when addressing the problem.

The three subsequent questions are; if alcoholism is associated with domestic violence:

a) *Do men who drink especially heavily have a greater tendency to perpetrate domestic violence than others?*

The results from alcoholic patients suggest a powerful relationship between heavy alcohol consumption and domestic violence. Comparisons of the MAST scores clearly indicate high levels of domestic violence among the entire sample of alcoholics and these levels were highest of all among the most serious alcoholics. Surprisingly, marriage (currently or formerly) was leading to levels and types of drinking behaviour which led to higher MAST scores, which in themselves increased the risks of aggression, and within marriages respondents with high MAST scores were behaving more aggressively than people with similar levels of alcoholism who had never married.

The association between drinking excessively and perpetrating high rates of aggression matches the disinhibition theory described earlier (see chapter 1, section 2), and it also fits with empirical findings that the higher the level of drinking alcohol by men and the larger the amount consumed per occasion, the greater the risk of aggression (see studies reviewed in chapter 2).

Kantor and Straus (1987) investigated whether physical abuse against married women is determined in part by drunkenness, using interview data from a nationally representative sample of 5,159 families. Their findings showed that higher levels of alcohol use were associated with higher rates of domestic violence. In addition to the physiological effects of acute intoxication, alcohol may contribute to marital violence by the neuropharmacologic sequelae of heavy drinking (e.g., hangover, hypoglycaemia, withdrawal, sleep deprivation, cognitive impairment). Leonard and his colleagues suggested that distal influences such as drinking patterns, personality traits, temporally stable couple characteristics, marital discord and partner drinking, in conjunction with proximal factors such as situational cues and acute alcohol influences, produce physical violence when in the context of negative, conflictual interactions among couples (Leonard and Roberts, 1998; Leonard and Senchak, 1996; 1993).

The link between heavy drinking and domestic violence has consistently been confirmed in control group studies of violent men, alcoholic men and abused women, and in epidemiological studies of the general population and women in health-care settings. Collectively, a pattern of drinking large amounts per occasion, drinking to intoxication or heavy episodic drinking has been found to be associated with violence, alcohol-related harm and alcohol-related aggression in samples of adolescents and young adults. To summarise, the findings of this study replicate most Western studies' results (reviewed in chapter 2).

b) Does drinking usually occur at the time of violent incidents?

The women married to alcoholics believed that there was a significant correlation between being drunk and domestic violence by alcoholic husbands. The qualitative data collected in this study firmly supports the view that alcohol consuming husbands become more verbally, psychologically, physically and sexually aggressive. An intoxicated condition was strongly emphasised by Saudi alcoholics who took part in the focus groups, who sometimes justified any aggression as due to losing control as a consequence of heavy drinking. Around 25% of the alcoholics admitted to feeling more aggressive after drinking than before becoming drunk. These results can be explained by alcohol myopia theory especially when the actor is in an intoxicated condition.

Some studies have found that high percentages of 'batterers' were under the influence of alcohol at the time of the incidents (Fals-Stewart, 2003). In addition, Murdoch et al (1990) studied 9,304 criminal cases reported in 26 different investigations in 11 countries and found that about 62% of the violent offenders had committed their offences while drinking or shortly after drinking alcohol. Laboratory studies have also shown that alcohol tends to enhance the level of provocation experienced (Hoaken and Pihl, 2000). However, some heavy drinkers who had engaged in domestic violence had done so only while sober, or while sober and while intoxicated. Therefore, it appears to be the case that chronic alcohol abuse creates a generalised rather than time-specific risk of physical abuse.

c) *What types of violence are married women and families in Saudi facing or witnessing?*

The CTS clearly proves that verbal aggression is the most common problem among Saudi couples where the husbands abuse alcohol. However, women married to alcoholics face all types of violence with a variety of levels for each type. The sub-scales from both samples (currently married alcoholics and women married to alcoholics) demonstrate that the negotiation and psychological scales have similar high scores. The physical, sexual and injury scales have lower overall scores. Taken all together, and according to both the alcoholics themselves and the women married to alcoholics, married women are the main victims of spousal violence except on the psychological aggression scale which is the only negative behaviour enacted by women a little more frequently than by their husbands.

This positive relationship between consuming alcohol and committing domestic violence is supported by plenty of Western studies that used the CTS to measure violence among couples where the husbands drank alcohol (such as Stith et al, 1991; Madien, 1996; O'Farrell et al, 1999; Murphy and O'Farrell, 1994; O'Farrell and Murphy, 1995; O'Farrell et al, 2000; Schumacher et al, 2003; Hoaken and Pihl, 2000; Leonard and Roberts, 1998; Quigley and Leonard, 2000; Heyman et al, 1995; and Cunradi et al, 1999; see chapter 2).

Recommendations

a) Recommendations for future research

Saudi Arabia needs to establish social research centres. These are needed to study, plan, develop, and protect the society's future. Such institutions would undertake priority investigations, including investigations into the topics addressed in this thesis – alcohol use and abuse, drug use and domestic violence. The results would be used in developing policies and, in the case of alcohol, in planning prevention, treatment and rehabilitation programmes. According to the study reported here, further enquiries and actions are need as follows.

1. Epidemiological studies are necessary in the field of alcohol and drug use and abuse as well as all types of domestic violence (i.e. woman abuse, child abuse, elder

abuse). For example, we still do not know the percentages of people in Saudi Arabia who drink socially, who would be classified as alcoholics, who apply for alcohol treatment, and who quit alcohol.

2. Saudi culture desperately needs serious research to develop and adapt measurements and scales for family violence, and alcohol and illicit drugs matters and their consequences. Also, searches for appropriate therapies and treatment programmes are needed to deal with and solve the related social, psychological and health problems.

3. More research is needed to discover why alcoholics increase their drinking following marriage and why married alcoholics are more violent than others.

4. The relationships between alcohol, drug abuse and domestic violence in Saudi Arabia require more research to explore these issues using numerous methods and tools so as to discover what works best under Saudi conditions.

5. Further research is needed from a feminist perspective to look at how the whole socio-cultural and political position of women in Saudi Arabia interacts with their exposure to domestic violence.

b) Recommendations for policy makers

Saudi authorities such as the ministries of health, social affairs and justice and the parliament ‘Majlis Al Shura’ need to re-examine existing legislation. Some Saudi laws and policies have not changed for a long time. As Islam does not oppose progress and modernity, the government should be aware of the possibility of movement and more flexibility and should therefore review legislation and consider changes which will not harm either the society or the government. According to the current study, there are some steps that could be taken quickly to protect the society and particularly women from harmful problems that result from alcohol and drug abuse. These steps would be;

1. Establish health care laws and ethics that assure good quality and equality of health services, and which protect human dignity and privacy.

2. Review the social policy and social justice systems to make sure that social services are provided with appropriate manners and are easy to reach by those who are socio-structurally weak like women, children, the elderly, the disabled and others.

3. Review alcohol treatment policy to make sure that the treatment is accessible to all communities and available to everyone equally. The treatment policy should not allow the Ministry of Interior to operate within Al-Almal hospitals where the residents are patients not criminals. The policy also should protect those of both genders who have seriously suffered from alcohol, drugs and/or domestic violence.

5. Establish civil courts to deal with those who break the law and to protect all individuals from aggressive behaviour like violence at home.

6. Study strategies to create a broader awareness throughout society of the hazard of domestic violence due to alcohol consumption.

c) Recommendations for alcohol and violence treatment

Al-Amal hospitals are the only official agencies that treat addiction and dependency in Saudi Arabia. No statistics are collected about use and recovery. This implies a strange lack of curiosity about the effectiveness of the alcohol treatment and weak support after treatment. The services need to be monitored to see how effective they really are.

Following this study, the following are some suggestions to improve alcohol and domestic violence treatment.

1. Review the treatment programmes from time to time to improve their effectiveness and publish the outcomes.

2. All staff at Al-Amal hospitals should be trained to reach the highest standard as professionals who are able to develop and adapt measurements and therapies for alcohol, drugs and domestic violence problems.

3. More consideration should be given to the association between alcohol and domestic violence in Saudi society, because increased alcohol consumption (which is occurring) is likely to lead to an increase in violence.

4. More active strategies should be introduced to encourage Saudi families to participate in alcohol and violence treatments.

5. Marriage and work are two serious problems facing most Saudi alcoholic patients which need to be taken into account by the staff and therapists.

End note

The findings from this research offer proof of an association in Saudi Arabia between alcoholism and domestic violence. The research has found high levels and frequencies of aggression against numerous family members including married women, sisters, brothers, children, parents, and in few cases grandparents also, but the married woman was far and away the most likely victim. Women married to alcoholics were experiencing many types of violence - verbal, psychological, physical and sexual. The alcoholics and their families were enduring weak economic conditions, poor quality family lives, neglected duties and obligations, high levels of guilt feelings, and sexual difficulties. There were obstacles to inhibit women married to alcoholics from leaving their husbands. The husbands themselves ran constant risks of being arrested and imprisoned.

Could anything be done? In Saudi Arabia there is plenty of scope to improve prevention, treatment and rehabilitation programmes for both addiction and domestic violence, and there is enormous scope for further research to learn how to make interventions truly efficacious. Sadly, at the present time there exists a lack of opportunity to achieve the listed recommendations. To set against the wide and weighty arguments for making changes, those who are involved in ruling positions are mostly either conservative ‘extremists’ who tend to oppose any major change, or utilitarian ‘profiteers’ who are not much concerned about national improvement.

Appendix 1

Michigan Alcoholism Screening Test

Points		Question No.	Yes	No
2	1 *	Do you feel you are a normal drinker?		
2	2	Have you ever awakened the morning after some drinking the night before and found that you could not remember part of the evening before?		
1	3	Does your spouse or your parents 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 bad about your drinking?		
2	6 *	Do your friends or relatives think that you are a normal drinker?		
0	7	Do you ever try to limit your drinking to certain times of the day or to certain places?		
2	8 *	Are you always able to stop drinking when you want to?		
5	9	Have you ever attended a meeting of Alcoholics Anonymous (AA)?		
1	10	Have you gotten into fights while drinking?		
2	11	Has drinking ever created problems with you and your spouse?		
2	12	Has your spouse or other family member ever gone to anyone for help about your drinking?		
2	13	Have you ever lost friends or girlfriends/boyfriends because of your drinking?		
2	14	Have you ever gotten into trouble at work because of drinking?		
2	15	Have you ever lost a job because of drinking?		
2	16	Have you neglected your obligations, your family or your work for 2 or more days in a row because of drinking?		
1	17	Do you ever drink before noon?		
2	18	Have you ever been told you have liver trouble or cirrhosis?		
2	19	Have you ever had Delirium Tremens (DT's), severe shakes, heard voices, or seen things that weren't there after heavy drinking?		
5	20	Have you ever gone to anyone for help about your drinking?		
5	21	Have you ever been in a hospital because of your drinking?		
2	22	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?		
2	23	Have you ever been seen at a psychiatric or mental health clinic or gone to a doctor, social worker, or clergy for help with an emotional problem in which drinking had played a part?		
2	24	Have you ever been arrested, even for a few hours, because of drunk behaviour?		
2	25	Have you ever been arrested for drunk driving or driving after drinking?		

* Negative responses are alcoholic responses.
0-3 points = Normal range, low risk.
4-9 points = High risk for problem drinking. Addiction to alcohol is likely. Contact your doctor for help.
> 10 points = Alcoholism. Contact your doctor for help. You've got problems.

Appendix 2

Conflict Tactics Scales

1. I showed my partner I cared even though we disagreed	**1 2 3 4 5 6 7 0**
2. My partner showed care for me even though we disagreed	**1 2 3 4 5 6 7 0**
3. I explained my side of a disagreement to my partner	**1 2 3 4 5 6 7 0**
4. My partner explained his or her side of a disagreement to me	**1 2 3 4 5 6 7 0**
5. I insulted or swore at my partner	**1 2 3 4 5 6 7 0**
6. My partner did this to me	**1 2 3 4 5 6 7 0**
7. I threw something at my partner that could hurt	**1 2 3 4 5 6 7 0**
8. My partner did this to me	**1 2 3 4 5 6 7 0**
9. I twisted my partner's arm or hair	**1 2 3 4 5 6 7 0**
10. My partner did this to me	**1 2 3 4 5 6 7 0**
11. I had a sprain, bruise, or small cut because of a fight with my partner	**1 2 3 4 5 6 7 0**
12. My partner had a sprain, bruise, or small cut because of a fight with me	**1 2 3 4 5 6 7 0**
13. I showed respect for my partner's feelings about an issue	**1 2 3 4 5 6 7 0**
14. My partner showed respect for my feelings about an issue	**1 2 3 4 5 6 7 0**
15. I made my partner have sex without a condom	**1 2 3 4 5 6 7 0**
16. My partner did this to me	**1 2 3 4 5 6 7 0**
17. I pushed or shoved my partner	**1 2 3 4 5 6 7 0**
18. My partner did this to me	**1 2 3 4 5 6 7 0**
19. I used force (like hitting, holding down, or using a weapon) to make my partner have oral or anal sex	**1 2 3 4 5 6 7 0**
20. My partner did this to me	**1 2 3 4 5 6 7 0**
21. I used a knife or gun on my partner	**1 2 3 4 5 6 7 0**
22. My partner did this to me	**1 2 3 4 5 6 7 0**
23. I passed out from being hit on the head by my partner in a fight	**1 2 3 4 5 6 7 0**
24. My partner passed out from a hit on the head in a fight with me	**1 2 3 4 5 6 7 0**
25. I called my partner fat or ugly	**1 2 3 4 5 6 7 0**
26. My partner called me fat or ugly	**1 2 3 4 5 6 7 0**
27. I punched or hit my partner with something that could hurt	**1 2 3 4 5 6 7 0**
28. My partner did this to me	**1 2 3 4 5 6 7 0**
29. I destroyed something belonging to my partner	**1 2 3 4 5 6 7 0**
30. My partner did this to me	**1 2 3 4 5 6 7 0**
31. I went to a doctor (M.D.) because of a fight with my partner	**1 2 3 4 5 6 7 0**
32. My partner went to a doctor (M.D.) because of a fight with me	**1 2 3 4 5 6 7 0**
33. I choked my partner	**1 2 3 4 5 6 7 0**
34. My partner did this to me	
35. I shouted or yelled at my partner	**1 2 3 4 5 6 7 0**
36. My partner did this to me	**1 2 3 4 5 6 7 0**
37. I slammed my partner against a wall	**1 2 3 4 5 6 7 0**
38. My partner did this to me	**1 2 3 4 5 6 7 0**
39. I said I was sure we could work out a problem	**1 2 3 4 5 6 7 0**
40. My partner was sure we could work it out	**1 2 3 4 5 6 7 0**
41. I needed to see a doctor (M.D.) because of a fight with my partner, but I didn't	**1 2 3 4 5 6 7 0**
42. My partner needed to see a doctor (M.D.) because of a fight	

with me, but didn't	**1 2 3 4 5 6 7 0**
43. I beat up my partner	**1 2 3 4 5 6 7 0**
44. My partner did this to me	**1 2 3 4 5 6 7 0**
45. I grabbed my partner	**1 2 3 4 5 6 7 0**
46. My partner did this to me	**1 2 3 4 5 6 7 0**
47. I used force (like hitting, holding down, or using a weapon) to make my partner have sex with me	**1 2 3 4 5 6 7 0**
48. My partner did this to me	**1 2 3 4 5 6 7 0**
49. I stomped out of the room or house or yard during a disagreement	**1 2 3 4 5 6 7 0**
50. My partner did this to me	**1 2 3 4 5 6 7 0**
51. I insisted on sex when my partner did not want to (but did not use physical force)	**1 2 3 4 5 6 7 0**
52. My partner did this to me	**1 2 3 4 5 6 7 0**
53. I slapped my partner	**1 2 3 4 5 6 7 0**
54. My partner did this to me	**1 2 3 4 5 6 7 0**
55. I had a broken bone from a fight with my partner	**1 2 3 4 5 6 7 0**
56. My partner had a broken bone from a fight with me	**1 2 3 4 5 6 7 0**
57. I used threats to make my partner have oral or anal sex	**1 2 3 4 5 6 7 0**
58. My partner did this to me	**1 2 3 4 5 6 7 0**
59. I suggested a compromise to a disagreement	**1 2 3 4 5 6 7 0**
60. My partner suggested a compromise	**1 2 3 4 5 6 7 0**
61. I burned or scalded my partner on purpose	**1 2 3 4 5 6 7 0**
62. My partner did this to me	**1 2 3 4 5 6 7 0**
63. I insisted my partner have oral or anal sex (but did not use physical force)	**1 2 3 4 5 6 7 0**
64. My partner did this to me	**1 2 3 4 5 6 7 0**
65. I accused my partner of being a lousy lover	**1 2 3 4 5 6 7 0**
66. My partner accused me of this	**1 2 3 4 5 6 7 0**
67. I said or did something to spite my partner	**1 2 3 4 5 6 7 0**
68. My partner said or did this to me	**1 2 3 4 5 6 7 0**
69. I threatened to hit or throw something at my partner	**1 2 3 4 5 6 7 0**
70. My partner did this to me	**1 2 3 4 5 6 7 0**
71. I felt physical pain that still hurt the next day because of a fight with my partner	**1 2 3 4 5 6 7 0**
72. My partner still felt physical pain the next day because of a fight we had	**1 2 3 4 5 6 7 0**
73. I kicked my partner	**1 2 3 4 5 6 7 0**
74. My partner did this to me	**1 2 3 4 5 6 7 0**
75. I used threats to make my partner have sex	**1 2 3 4 5 6 7 0**
76. My partner did this to me	**1 2 3 4 5 6 7 0**
77. I agreed to try a solution to a disagreement my partner suggested	**1 2 3 4 5 6 7 0**
78. My partner agreed to try a solution I suggested	**1 2 3 4 5 6 7 0**

How often did this happen?

1 = Once in the past year
2 = Twice in the past year
3 = 3-5 times in the past year
4 = 6-10 times in the past year
5 = 11-20 times in the past year
6 = More than 20 times in the past year
7 = Not in the past year, but it did
0 = This has never happened

Appendix 3

Questionnaire for Alcoholic Patients

Dear Patient ..,

As way of introduction, I am a Ph.D. student at The University of Liverpool, U.K. conducting a research regarding alcohol consumption and domestic violence. 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 suits 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.

Thank you again for your cooperation.

Researcher: Abdulaziz Albrithen
Department of Sociology, Social Policy,
and Social Work Studies
The University of Liverpool
United Kingdom

A- Personal Data :

1- How old are you? ( )

2- What is your Marital Status?
Never married ( ) Now married ( ) Divorced ( ) Separated ( ) Widowed ( ) Other ( )

3- What is your current educational status?
Illiterate ( ) Can read and write ( ) Elementary ( ) Intermediate ( ) Secondary ( )
Diploma ( ) College ( ) Master degree ( ) Ph.D. degree ( ) Other, Specify ( ) …….

4- From the following list, select those persons who are currently living with you:
Alone ( ) Wife ( ) Children ( ) Mother ( ) Father ( ) Sisters ( ) Brother ( ) Other,
Specify ( ) ……

5- Do you currently have a job? Yes ( ) No ( )

6- How long age was your longest full time job ?
Never had a full time job ( ) Less than a year ( ) 1-5 years ( ) 6-10 years ( ) 11-15 years ( )
More than 15 years ( )

7- What is your mother's education status:
Illiterate ( ) Can read and write ( ) Elementary ( ) Intermediate ( ) Secondary ( ) Diploma ( )
College ( ) Post graduate ( ) Other specify ( ) …….

8- What is your father's education status:
Illiterate ( ) Can read and write ( ) Elementary ( ) Intermediate ( ) Secondary ( ) Diploma ( )
College ( ) Post graduate ( ) Other specify ( ) …….

9- From the following list, select one statement that describe your parents' situation:
My parents are alive and they are living together ( )
My parents are alive but they are divorced ( )
My parents are alive but they are separated ( )
Both my parents are dead ( )
My father is alive but my mother is dead ( )
My mother is alive but my father is dead ( )
Other specify ( ) ……..

B- Marriage Status : (if you are not married skip to Section **C**)

1- What is the total number of your marriages?
One time ( ) Two times ( ) Tree times ( ) Four times ( ) Five times ( ) More than five ( )

2- How old is your wife? ( )

3- How many children do you have?
0 ( ) One ( ) Two ( ) Tree ( ) Four ( ) Five ( ) Six ( ) More than Six ( )

4- Which one of the words best describe your attitude toward life with your husband?
Satisfying ( ) Happy ( ) Sad ( )

5- From the following list, select one statement that best describe your marriage situation:
My wife and I are living together without any problem ( )
My wife and I are living together but with some problems ( )
My wife and I are living together with too many problems ( )
My wife and I are living separately ( )

6- From the following list, select one statement that best describe your marriage condition:
My wife and I love each other ( )

My wife loves me but I don't love her ( )
I love my wife but she doesn't love me ( )
My wife and I hate each other ( )

7- What is your wife's educational status?
Illiterate ( ) Can read and write ( ) Elementary ( ) Intermediate ( ) Secondary ( )
College ( ) Master degree ( ) Ph.D. degree ( ) Other, specify ( ) ……..

C. <u>Alcohol Consumption :</u>

1- What age were you when you had had your first drink? ( )

2- What is your most consumed of drink?
Arag ( ) Beer ( ) Wine ( ) Cologne ( ) Spirits ( )

3- With who do you usually have your drink:
Alone ( ) With a friend ( ) With wife ( ) With other member of family ( ) Others specify ( )

4- Where do you usually have your drink?
At home ( ) At others' home ( ) At a private resort ( ) Outside the city ( ) Other specify ( )

5- In what days of the week do usually drink?
Whole week ( ) Week days ( ) Weekends ( ) Any day ( )

6- Since when did you start feeling that you have a drinking problem?
I don't have a drinking problem ( ) Less than a year ( ) 1-3 years ago ( ) 4-6 years ago ( ) 7-9 years ago ( ) More than 9 years ago ( )

7- What are your main reasons for drinking? **(Tick all that apply)**
To feel happy ( ) To relax ( ) To behave normally ( ) To release anxiety ( ) To forget problems ( ) To enhance my sexual ability ( ) To respond to my friends' pressure ( ) Only for the sake of drink ( ) others, specify ( ) ……..

8- How often do you perform the religious practices?
Always ( ) Most of the time ( ) Seldom ( ) Never ( )

9- Do you think alcohol makes people:
Quiet ( ) Active ( ) Other, specify ( ) ……..

10- Do you think alcohol makes people more potent or virile at sex? Yes ( ) No ( )

11- How do you describe your feelings of drinking?
Happy ( ) Relax ( ) Bad ( ) Do not know ( ) Other specify ( )
……

D. <u>General Behaviours :</u>

1- How do you behave with others while you drunk?
Friendly ( ) Normally ( ) Aggressively ( ) Do not know ( ) Other specify ( ) ……

2- How do you describe yourself after drinking and before being a drunk?
Aggressive ( ) Normal ( ) Friendly ( ) Do not know ( ) Other specify ( ) ……..

3- Have you ever been told that you are aggressive while you drunk? Yes ( ) No ( )

4- Has any member of your family been injured because of problem with you? Yes ( ) No ( )

5- IF you answered YES to the previous question, Please select **(Tick all that apply)**:

Wife ( ) Children ( ) Mother ( ) Sister ( ) Father ( ) Brother ( ) Grand, mo, or fa. ( )
Other, specify ( ) ……

6- Have you ever thrown something aggressively at your wife or any member of your family?
Yes ( ) No ( )

7- IF you answered YES to the previous question, who? **(Tick all that apply)**
Wife ( ) Children ( ) Mother ( ) Sister ( ) Father ( ) Brother ( ) Grand mo, or fa. ( )
Other specify ( ) ……..

8- IF you answered YES to the question 6, please select how often:
Always ( ) Sometimes ( ) Rarely ( )

9- Do you feel that you are in need of sex after drinking?
Always ( ) Sometimes ( ) Never ( )

10- When you feel that you are in need of sex after drinking, does your wife allow you?
Always ( ) Sometimes ( ) Never ( ) I never felt that ( )

11- Do you feel guilty regarding to your behaviour after drinking?
Always ( ) Sometimes ( ) Never ( )

12- Has your wife or any member of your family called for help regarding to your behaviour after drinking? Yes ( ) No ( )

13- Have you ever done any bad behaviour to your wife or any member of your family while you were drunk? Yes ( ) No ( )

14- IF you answered YES to the previous question, Please select one:
Wife ( ) Children ( ) Mother ( ) Sister ( ) Father ( ) Brother ( ) Grand, mo, or fa. ( )
Other, specify ( ) ……

15- IF you answered YES to the question 13, Please select how many times:
Always ( ) Sometimes ( ) Rarely ( )

16- Do you have a certain tool (implement) that you use when you have a conflict with someone or when someone bothers you regarding to your drinking?
Yes ( ) No ( )

17- When you feel that you are in need of sex and your wife doesn't do you force her to allow you?
Never ( ) Sometimes ( ) Many times ( ) Always ( )

18- Have you ever forced others to obey to you?
Never ( ) Sometimes ( ) Many times ( ) Always ( )

E. <u>Legal Status :</u>

1- Is this admission prompted or suggested by criminal justice system (judge, police, religious authority, etc): Yes ( ) No ( )

2- IF answered YES to the previous question, please state the main reason for it:
Drinking alcohol ( ) Family problem ( ) Criminal problem ( ) Others specify ( ) …….

3- Have you ever been arrested? Yes ( ) No ( )

4- IF you answered YES to the question 3, Please state why:
Because of drinking ( ) Because of family problem ( ) Because of fighting while drunk ( )
Other reasons, specify ( ) ……

5- Have you ever been imprisoned due to drinking?
Never ( ) One time ( ) Two times ( ) Tree times ( ) Four times and more ( )

6- Are you presently awaiting charges, trial, or sentence? Yes ( ) No ( )

7- What is the main motive behind your coming to hospital this time:
To stop drinking ( ) To satisfy wife ( ) To satisfy others ( ) To regain my health ( ) I have been brought by authority ( ) Others, specify ( ) …….

8- Has your wife or any member of your family gone to a hospital regarding to your negative behaviours? Yes ( ) No ( )

9- IF you answered YES to the previous question, Please select:
Wife ( ) Children ( ) Mother ( ) Sister ( ) Father ( ) Brother ( ) Grand mo, or fa. ( ) Other specify ( ) ……..

F. <u>The family and its Relations:</u>

1- Does anyone of your family drink alcohol? Yes ( ) No ( )

2- Does anyone of your family use drugs? Yes ( ) No ( )

3- With whom do you spend most of your free time?
Alone ( ) Wife ( ) Other member of family ( ) Whole family ( ) Friends ( ) Others, specify ( ) ……..

4- How many close friends among your family members do you have?
None ( ) One ( ) Two ( ) More than two ( ) All of them ( )

5- During your drinking problem, have you had problem getting along with? **(Tick all that apply)**
Not at all ( ) Wife ( ) Children ( ) Mother ( ) Sister ( ) Father ( ) Brother ( ) Grand mo, or fa ( ) Others, specify ( ) ……

6- IF you answered YES to the previous question, Please state:
Sharp verbal argument ( ) Hands conflict ( ) Slapping ( ) Injuring ( ) Killing ( ) Other, specify ( ) ……. ……..

7- Which one of your family do you usually have a problem with?
None ( ) Wife ( ) Children ( ) Mother ( ) Sister ( ) Father ( ) Brother ( ) Grand mo, or fa. ( ) Others, specify ( ) ……..

8- Whose in the family is aware of your drinking?
None ( ) Wife ( ) Children ( ) Mother ( ) Father ( ) Sister ( ) Brother ( ) All of them ( )

9- What is your family's standpoint on your drinking problem? (Select only one):
They discussed it with me dialectically ( ) They treated me badly ( ) They expelled me from home ( ) Other, specify ( ) ……

10- Has your wife left you regarding to your behaviours? Yes ( ) No ( )

11- IF you answered YES to the previous question, Please state how many times:
One time ( ) Two times ( ) Tree ( ) Four ( ) Five ( ) More than five times ( )

12- Does your wife or any member of your family bother you regarding to your drinking?
Yes ( ) No ( )

13- IF you answered YES to the previous question, Please select:

Wife ( ) Children ( ) Mother ( ) Sister ( ) Father ( ) Brother ( ) Grand mo, or fa. ( ) Other specify ( )

14- If someone bother you, how do you behave?
Normal ( ) Aggressive ( ) Ignore ( ) Other specify ( )……..

15- Has your wife or any other member of your family been abused by you? Yes ( ) No ( )

16- IF you answered YES to the previous question, Please select:
Wife ( ) Children ( ) Mother ( ) Sister ( ) Father ( ) Brother ( ) Grand, mo, or fa. ( ) Other, specify ( ) ……

17- IF you answered YES to the question 15, Please select:
Emotionally ( ) Physically ( ) Sexually ( ) Other, specify ( ) ……

Appendix 4

Tables and Figures of Alcoholic Patients Sample

Table A.4.1: Respondents' ages cross-tabulated with name of Al-Amal hospitals

Age	Riyadh	Jeddah	Dammam	Qaseem	Total	%
30 and under	23	15	13	4	55	38
31-40	11	16	9	13	49	34
41 and over	18	7	7	8	40	28
Total	52	38	29	25	144	100

Table A.4.2: Respondents' marital status cross-tabulated with type of ward

Marital status	Voluntary	Involuntary	Total	%
Never married	44	18	62	43
Currently married	34	8	42	29
Other	34	6	40	28
Total	112	32	144	100

Table A.4.3: Educational status of patients and wives

Educational status	Patients	Wives
Illiterate	3	0
High school and under	74	8
College or higher	27	34
Vocational, art and others	40	0
Total	144	42

Table A.4.4: Respondents' employment status

Employment status	Number	%
Never had a job	53	37
Have a temporary job	44	31
Less than a year in full time job	16	11
1-5 years in full time job	12	8
6-10 years in full time job	7	5
11-15 years in full time job	6	4
More than 15 years in full time job	6	4
Total	144	100

Figure A.4.1: Respondents' current living arrangements

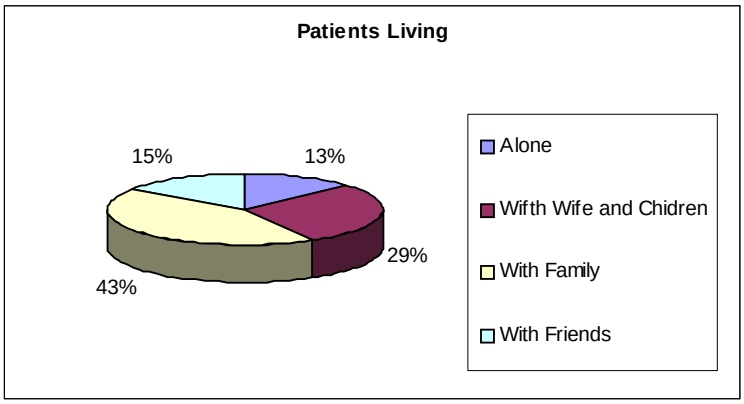


Table A.4.5: Respondents' ages at first time of drinking cross-tabulated with preferred current drink

Age	Arag	Beer	Wine	Cologne	Hard Spirit	Total N	%
20 and under	60	7	8	17	6	98	68
21-30	25	3	2	7	2	39	27
30 and over	2	1	1	2	1	7	5
Total	87	11	11	26	9	144	100

* Arag is a type of vodka.

Table A.4.6: With whom respondents spent most of their time cross-tabulated with number of close friends among their families

Number of family friends Who respondent spends most time with	None	One	Two	More than Two	All of them	Total N	%
Alone	41	10	3	-	-	54	38
Wife	7	9	2	1	1	20	14
Other member of family	8	5	2	1	-	16	11
Whole family	-	3	2	2	2	9	6
Friends	42	2	1	-	-	45	31
Total	98	29	10	4	3	144	100

Table A.4.7: Persons with whom respondents mostly drank cross-tabulated with usual place of drinking

Drinking with	Home	Others houses	Private place	Outside the city	Elsewhere	Total N	%
Alone	26	-	11	17	6	60	42
Friend	4	13	25	16	10	68	47
Other member of family	2	-	1	-	1	4	3
Girls	1	1	5	2	3	12	8
Total	33	14	42	35	20	144	100

Table A.4.8: Respondents' usual days of drinking cross-tabulated with performing religious practices

Religious practice / Days of drinking	Always	Most of the time	Seldom	Never	Total N	%
Whole week	6	20	23	14	63	44
Week days	1	4	5	2	12	8
Weekends	12	13	11	10	46	32
Any day	6	13	2	2	23	16
Total	25	50	41	28	144	100

Table A.4.9: Respondents' main reason for drinking cross-tabulated with feeling when drinking

Feeling when drinking / Reason for drinking	Happy	Relax	Bad	Do not Know	Total N	%
To feel happy	21	6	5	-	32	21
To relax	5	20	2	-	27	19
To behave normally	2	1	3	1	7	5
To release anxiety	3	9	1	1	14	10
To forget problems	4	9	2	2	17	12
To enhance my sexual ability	-	2	7	2	11	8
To respond to friends' pressure	2	7	1	3	13	9
Only for the sake of drink	-	2	5	4	11	8
To pass the time	2	4	3	3	12	8
Total	39	60	29	16	144	100

Table A.4.10: Respondents' thoughts on alcohol's effect cross-tabulated with their thoughts on its sexual effect

Alcohol sexual effect / Thoughts on alcohol's effect	More potent	Less potent	Total N	%
Quiet	7	41	48	33
Active	16	2	18	13
Forget problems	2	12	14	10
Concentrate	2	1	3	2
Happy	14	12	26	18
Trouble maker	1	3	4	3
Normal	9	6	15	10
Anxious	3	6	9	6
Addicted	3	4	7	5
Total	57	87	144	100

Table A.4.11: Respondents' feelings on having a drinking problem

Have drinking problem	Number	%
Do not have a drinking problem	40	27
Less than a year	23	16
1-3 years	21	15
4-6 years	21	15
7-9 years	23	16
More than 9 years	16	11
Total	144	100

Table A.4.12: Respondents' feeling after drinking and before becoming drunk

Feeling after drinking compared with before becoming drunk	Number	%
More aggressive	34	24
Normal	61	42
More friendly	34	24
Do not know	15	10
Total	144	100

Figure A.4.2: Respondents' reasons for hospital admission

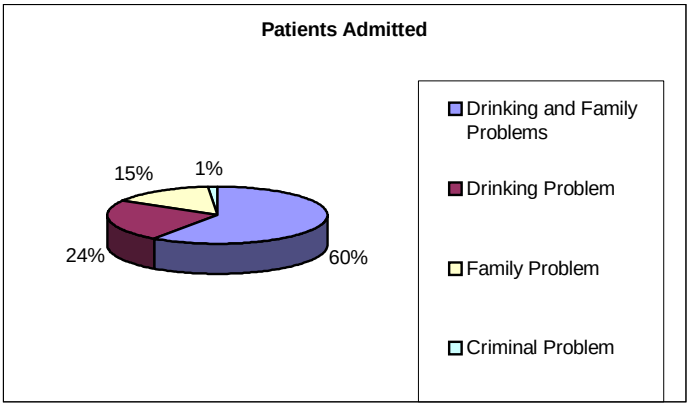


Table A.4.13: Respondents' main motives behind coming to hospital

Main motive	Number	%
Stop drinking	63	45
Satisfy wife	12	8
Satisfy others	22	15
Regain health	20	14
Solve social problems	12	8
Brought by authority	15	10
Total	144	100

Table A.4.14: Respondents' family histories of alcohol and other drugs

Family history of alcohol and drugs	Number	%
No history	94	65
Alcohol	23	16
Drugs	16	11
Alcohol and drugs	11	8
Total	144	100

Table A.4.15: Respondents' families' awareness of them drinking alcohol

Who is aware within the family?	Number	%
No-one	22	15
Wife	21	15
Parents	4	3
Brothers and sisters	10	7
Whole family	87	60
Total	144	100

Table A.4.16: Respondents' families' standpoints on their drinking

Family's standpoint	Number	%
Discussing it calmly	83	58
Treating him badly	29	20
Expelling him from home	22	15
Admitting him to hospital	10	7
Total	144	100

Table A.4.17: Respondents were bothered by most family members' reactions to their drinking

Bothered by a family member drinking	Number	%
Never	44	31
Wife	34	24
Children	6	4
Parents	16	11
Brothers and sisters	28	19
Whole family	16	11
Total	144	100

Table A.4.18: Respondents' behaviour if someone was bothered

Behaviour when bothered	Number	%
Normal	52	36
Aggressive	31	22
Ignore	61	42
Total	144	100

Table A.4.19: Respondents' behaviour with others while drunk

Behaviour when drunk	Number	%
Friendly	36	25
Normal	49	34
Aggressive	28	19
Do not know	31	22
Total	144	100

Table A.4.20: Respondents described by others as aggressive while drunk

Described as aggressive	Number	%
Yes	72	50
No	72	50
Total	144	100

Table A.4.21: Respondents who had injured a most family member because of a problem

Who was injured	Number	%
No-one	92	63
Wife	21	15
Children	4	3
Mother	2	1
Father	1	1
Sister	11	8
Brother	13	9
Total	144	100

Table A.4.22: Respondents who had thrown something aggressively at a most family member

Thrown at	Number	%	How often		
Never	89	61	Always	Sometimes	Rarely
Wife	24	17	4	10	10
Children	8	6	5	1	2
Mother	1	1	-	-	1
Sister	12	8	6	2	4
Brother	10	7	7	1	2
Total	144	100	22	14	19

Table A.4.23: Respondents' need for sex after drinking and wives' tolerance of married patients

Need sex	Number	%	Wife's tolerance		
			Always	Sometimes	Never
Always	45	31	-	2	-
Sometimes	75	52	7	21	5
Never	24	17	-	-	7
Total	144	100	7	23	12

Table A.4.24: Respondents' guilty feelings regarding their behaviour after drinking

Feeling guilty	Number	%
Always	55	38
Sometimes	75	52
Never	14	10
Total	144	100

Table A.4.25: Respondents' families calling for help regarding drinking behaviour and using an implement when family conflict occurred

	Family calling for help		Using an implement	
	Number	%	Number	%
Yes	55	38	27	19
No	89	62	117	81
Total	144	100	144	100

Table A.4.26: Any bad behaviour to any member of the family while drunk

To whom behaved badly	Number	%	How often		
No-one	86	60	Always	Sometimes	Rarely
Wife	24	17	4	10	10
Children	6	4	4	1	1
Mother	2	1	-	-	2
Father	1	1	-	-	1
Sister	10	7	4	3	3
Brother	9	6	3	3	3
Grand mother or father	6	4	1	2	3
Total	144	100	15	16	27

Table A.4.27: Respondents' attitudes towards their married lives

Attitude	Number	%
Happy	7	17
Satisfying	30	71
Sad	5	12
Total	42	100

Table A.4.28: Respondents' descriptions of their marriages situation

Marriage situation	Number	%
Living without any problem	8	19
Living with some problems	14	33
Living with too many problems	20	48
Total	42	100

Table A.4.29: Respondents' descriptions of their marriages condition

Marriage Condition	Number	%
Spouses love each other	7	17
Husband loves only	10	24
Wife loves only	6	14
Spouses hate each other	19	45
Total	42	100

Table A.4.30: Respondents' number of marriages cross-tabulated with number of children

	Number of marriages	Number of children
None	62	20
One	51	8
Two	15	19
Three	6	18
Four	7	9
Five and more	3	8
Total	144	82

Table A.4.31: Respondents whose wives had left them on account of their behaviour

Wife left	Number	%
Never	37	44
One time	17	21
Two times	7	9
Three times	6	7
Four times	4	5
Five times	3	4
More than five times	8	10
Total	82	100

Table A.4.32: Respondents who had ever been arrested and the reasons

Arrests and the reasons	Number	%
Never	48	33
Drinking alcohol	60	42
Family problem	28	19
Fighting while drunk	8	6
Total	144	100

Table A.4.33: Respondents who had ever been imprisoned due to drinking

Imprisoned due to drinking	Number	%
Never	93	65
Once	10	7
Twice	23	16
Three times	12	8
Four times and more	6	4
Total	144	100

Table A.4.34: Respondents who had ever forced others to obey them

Force others	Number	%
Never	87	60
Sometimes	45	31
Many times	8	6
Always	4	3
Total	144	100

Table A.4.35: Respondents' family members who had gone to a hospital as a result of negative behaviour

Ever gone to hospital	Number	%
Never	112	77
Wife	10	7
Children	3	2
Mother	2	1
Father	1	1
Sister	8	6
Brother	8	6
Total	144	100

Table A.4.36: Respondents who had abused other family members and type of abuse

Who was abused	Number	%	Type of abuse		
No-one	101	70	Emotional	Physical	Sexual
Wife	20	14	8	11	1
Mother	1	1	1	-	-
Father	2	1	2	-	-
Sister	6	4	4	2	-
Brother	14	10	6	8	-
Total	144	100	21	21	1

Table A.4.37: Respondents who had a 'getting along' family problem and types of response

Types of problem Getting along with	Sharp verbal	Hands conflict	Slapping	Injuring	Total N	 %
Wife	11	4	7	7	29	31
Mother	7	-	-	1	8	9
Sister	6	1	2	7	16	17
Brother	7	10	3	4	24	26
Father	10	1	-	1	12	13
Wife's family	3	1	-	-	4	4
Total	44	17	12	20	93	100

Table A.4.38: Who respondents mostly had a problem with

Problem with	Number	%
No-one	75	52
Wife	22	15
Children	5	3
Mother	8	6
Sister	13	9
Father	8	6
Brother	13	9
Total	144	100

Table A.4.39: Negotiation frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I showed my wife I cared even though we disagreed	Emotional	18	3	1	0	1	2	14	3	42
My wife showed care for me even though we disagreed	Emotional	7	2	0	0	5	8	16	4	42
I showed respect for my wife's feelings about an issue	Emotional	13	1	1	2	1	3	17	4	42
My wife showed respect for my feelings about an issue	Emotional	3	1	0	1	0	10	21	6	42
I said I was sure we could work out a problem	Emotional	15	3	1	1	3	4	8	7	42
My wife was sure we could work it out	Emotional	4	3	0	1	2	6	19	7	42
I explained my side of a disagreement to my wife	Cognitive	13	2	4	1	3	4	11	4	42
My wife explained her side of a disagreement to me	Cognitive	7	3	1	2	3	3	19	4	42
I suggested a compromise to a disagreement	Cognitive	6	6	4	2	4	3	14	3	42
My wife suggested a compromise to a disagreement	Cognitive	6	2	2	2	2	7	17	4	42
I agreed to try a solution to a disagreement my wife suggested	Cognitive	9	2	1	2	3	8	15	2	42
My wife agreed to try a solution I suggested	Cognitive	6	1	3	5	4	6	15	2	42

Table A.4.40: Psychological aggression frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I insulted or swore at my wife	Minor	9	3	3	3	3	4	15	2	42
My wife did this to me	Minor	20	6	4	1	3	4	3	1	42
I shouted or yelled at my wife	Minor	9	3	1	3	1	1	22	2	42
My wife did this to me	Minor	12	2	1	4	3	6	11	3	42
I stomped out of the room or house or yard during a disagreement	Minor	16	3	4	5	1	1	9	3	42
My wife stomped out of the room or house or yard during a disagreement	Minor	11	2	3	3	4	6	10	3	42
I did or said something to spite my wife	Minor	16	4	3	2	4	2	6	5	42
My wife did or said something to spite to me	Minor	14	3	2	4	7	6	4	2	42
I called my wife fat or ugly	Severe	29	2	1	0	0	0	9	1	42
My wife called me fat or ugly	Severe	20	1	0	2	7	4	5	3	42
I destroyed something belonging to my wife	Severe	26	1	0	0	1	0	13	1	42
My wife did this to me	Severe	19	1	2	5	6	6	2	1	42
I accused my wife of being a lousy lover	Severe	26	3	2	2	1	1	7	0	42
My wife accused me of being lousy lover	Severe	15	3	1	1	1	8	9	4	42
I threatened to hit or throw something at my wife	Severe	20	3	1	2	0	4	11	1	42
My wife did this to me	Severe	21	3	2	1	9	5	1	0	42

Table A.4.41: Physical assault frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I threw something at my wife that could hurt	Minor	16	5	3	0	1	5	12	0	42
My wife did this to me	Minor	30	6	2	0	0	0	4	0	42
I twisted my wife's arm or hair	Minor	18	2	0	4	6	7	5	0	42
My wife did this to me	Minor	40	2	0	0	0	0	0	0	42
I pushed or shoved my wife	Minor	25	4	0	4	0	3	6	0	42
My wife did this to me	Minor	34	7	0	0	0	0	1	0	42
I grabbed my wife	Minor	22	4	6	5	2	2	1	0	42
My wife did this to me	Minor	42	0	0	0	0	0	0	0	42
I slapped my wife	Minor	19	11	5	1	0	0	1	5	42
My wife did this to me	Minor	39	3	0	0	0	0	0	0	42
I used a knife or gun on my wife	Severe	24	12	2	0	0	0	0	4	42
My wife did this to me	Severe	35	5	0	0	0	0	0	2	42
I punched or hit my wife with something that could hurt	Severe	24	6	5	0	3	3	0	1	42
My wife did this to me	Severe	32	7	1	0	0	0	1	1	42
I choked my wife	Severe	28	5	1	2	1	3	2	0	42
My wife did this to me	Severe	41	1	0	0	0	0	0	0	42
I slammed my wife against a wall	Severe	18	4	4	3	1	4	3	5	42
My wife did this to me	Severe	29	10	2	0	0	0	0	1	42
I beat up my wife	Severe	24	7	0	2	7	0	0	2	42
My wife did this to me	Severe	42	0	0	0	0	0	0	0	42
I burned or scalded my wife on purpose	Severe	27	4	1	3	4	0	0	3	42
My wife did this to me	Severe	42	0	0	0	0	0	0	0	42
I kicked my wife	Severe	19	8	2	3	5	2	2	1	42
My wife did this to me	Severe	35	3	1	0	0	0	0	3	42

Table A.4.42: Sexual coercion frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I insisted on sex when my wife did not want to (but did not use physical force)	Minor	19	2	2	1	0	2	11	5	42
My wife did this to me	Minor	34	3	1	1	0	0	2	1	42
I insisted my wife have oral or anal sex (but did not use physical force)	Minor	21	2	3	3	4	3	3	3	42
My wife did this to me	Minor	39	3	0	0	0	0	0	0	42
I used force (like hitting, holding down, or using a weapon) to make my wife have oral or anal sex	Severe	28	4	0	4	4	0	1	1	42
My husband did this to me	Severe	42	0	0	0	0	0	0	0	42
I used force (like hitting, holding down, or using a weapon) to make my wife have sex	Severe	27	2	1	3	4	3	0	2	42
My wife did this to me	Severe	42	0	0	0	0	0	0	0	42
I used threats to make my wife have oral or anal sex	Severe	22	3	3	5	2	6	1	0	42
My wife did this to me	Severe	37	4	1	0	0	0	0	0	42
I used threats to make my wife have sex	Severe	24	2	2	7	0	0	6	1	42
My wife did this to me	Severe	36	2	3	0	0	0	0	1	42

Table A.4.43: Injury frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I had a sprain, bruise, or small cut because of a fight with my wife	Minor	41	0	0	0	1	0	0	0	42
My wife had a sprain, bruise, or small cut because of fight with me	Minor	24	8	4	0	1	0	0	5	42
I felt physical pain that still hurt the next day because of a fight with my wife	Minor	41	0	0	1	0	0	0	0	42
My wife still felt physical pain the next day because of a fight we had	Minor	29	3	0	2	1	0	3	4	42
I passed out from being hit on the head by my wife in a fight	Severe	42	0	0	0	0	0	0	0	42
My wife passed out from being hit on the head in a fight with me	Severe	34	5	0	0	0	1	1	1	42
I went to a doctor because of a fight with my wife	Severe	42	0	0	0	0	0	0	0	42
My wife went to a doctor because of a fight with me	Severe	32	7	0	1	0	1	1	0	42
I needed to see a doctor because of a fight with my wife	Severe	39	2	0	0	0	0	1	0	42
My wife needed to see a doctor because of a fight with me	Severe	23	3	5	4	1	1	2	3	42
I had a broken bone from a fight with my wife	Severe	41	1	0	0	0	0	0	0	42
My wife had a broken bone from a fight with me	Severe	31	7	0	0	0	0	0	4	42

Table A.4.44: Means and standard deviations on CTS scales by 'enacted' and 'received'

Scales	Enacted	Received
Negotiation		
(mean)	17.12	22.93
(SD)	10.51	1159
Psychological aggression		
(mean)	18.19	18.33
(SD)	12.49	13.57
Physical assault		
(mean)	15.90	2.19
(SD)	13.98	2.73
Sexual coercion		
(mean)	8.67	0.88
(SD)	7.82	1.73
Injury		
(mean)	3.36	0.38
(SD)	4.75	1.32

* Since the participants were screened to be between 3-15 years in length of marriage, the category 7 in this table is scored as 0 in order to look at violent acts during the last 12 months only.

Appendix 5

Semi-Structured Interview with 'Ordinary' Women

Dear ..,

As way introduction, I am a Ph.D. student at The University of Liverpool, U.K. conducting a research regarding to the possible negative results of husbands behaviours. This study aims to better understanding those suffering from social life. Understanding this complicated problem and its related issues, and avoiding some other social negative results could be more effective and suitable to Saudi society.

So, allow the female social worker to take some of your time in responding these questions of interview. There are two kinds of questions; the first is the close questions, which can be answered by ‘Yes’ or ‘No’. The second is through interview that will be administrated by female social worker.

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 answer to be based on what are really thinking rather than ideal thinking (what ought to be).

Finally, I would like to remind you that your providing information is confidential, and will not be use for any propose other the scientific research. Therefore, do not write your name, phone number, or any other identify information that would make you in doubt of telling the fact.

Your assistance is greatly appreciated, and thank you so much for your cooperation.
Researcher: Abdulaziz Albrithen,
Department of Sociology, Social Policy,
and Social Work Studies
The University of Liverpool
United Kingdom

Can we begin with some questions about your general views on drugs and alcohol?
1- The term 'Domestic Violence' has become widely used internationally; do you think that we are witnessing that in Saudi society?
Yes ( ) No ( )

2- Who is the most responsible for domestic violence, men or women?
Men ( ) Women ( ) Both ( ) Other specify ( ) …….

3- How can people avoid domestic violence? Pease state points in order:
1-
2-
3-
4-

4- What is the major reason of domestic violence? Please number the choices as important to you:
Drinking alcohol ( )
Using drugs ( )
Men status ( )
Other specify in order……..

5- Have you or any member of your family ever had a problem with alcohol or drug misuse?
Alcohol problem ( ) Drugs problem ( ) None of them ( )

Can we get further and ask about your husband's behaviour?
6- Has he been arrested due to any aggressive behaviour?
Yes ( ) No ( )

7- Have you ever suffered seriously because of any of his an acceptable behaviour?
Yes ( ) No ( )

8- Have you ever called for help because of his behaviour?
Yes ( ) No ( )

9- Have you ever felt scared to tell other people about your husband's behaviour?
Many times ( ) Sometimes ( ) Never ( )

10- If you had known about his behaviour before marring, would you still have married him?
Yes ( ) No ( )

Can we move to the open questions?
11- If your husband abuses you, what would you do?

12- Have you or anyone in the family been injured or abused by him?
Yes ( ) No ( )

13- IF answered **Yes** for question 12, please explain, who was injured or abused, how, and how many times, and so on…..

14- How would you describe your husband's behaviour generally in front of others and inside the house?

In front of others:

Inside the house:

15- Have you ever left him because of problems? Yes ( ) No ( )

16- If **Yes** please describe how many times, what kind of problems, how you came back and so on…...

Can we ask three general questions related to your experience of marriage?
17- Which one of the words best describes your attitude towards life with your husband?
Happy ( ) Satisfying ( ) Sad ( )

18- From the following list, select one statement that best describes your marriage situation:
My husband and I are living together without any problem between us ( )
My husband and I are living together but with some problems between us ( )
My husband and I are living together with too many problems between us ( )

19- From the following list, select one statement that best describes your relationship with your husband:
My husband and I love each other ( )
My husband loves me but I don't love him ( )
I love my husband but he doesn't love me ( )
My husband and I hate each other ( )

Appendix 6

Semi-Structured Interview with Women Married to Drug Users

Dear ..,

As way introduction, I am a Ph.D. student at The University of Liverpool, U.K. conducting a research regarding to drugs and alcohol consumption and the possible negative results. This study aims to better understanding those suffering from addiction so that decreasing alcohol and drugs, improving alcohol and drugs treatment, and avoiding some other social negative result could be more effective and suitable to Saudi society.

So, allow the female social worker to take some of your time in responding these questions of interview. There are two kinds of questions; the first is the close questions, which can be answered by ‘Yes’ or ‘No’. The second is through interview that will be administrated by female social worker.

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 answer to be based on what are really thinking rather than ideal thinking (what ought to be).

Finally, I would like to remind you that your providing information is confidential, and will not be use for any propose other the scientific research.

Your assistance is greatly appreciated, and thank you so much for your cooperation.

Researcher: Abdulaziz Albrithen,
Department of Sociology, Social Policy,
and Social Work Studies
The University of Liverpool
United Kingdom

Can we begin with a question about your general views on drugs?
1- Do you think abusing drugs makes people more aggressive?
Yes ( ) No ( )

Can we get further and ask about your husband behaviours?
2- What type of drugs does your husband use?
( )

3- Has your husband had any criminal problem regarding his using drugs?
Yes ( ) No ( )

4- Has he been arrested due to using drugs?
Yes ( ) No ( )

5- Has he been imprisoned due to using drugs?
Yes ( ) No ( )

6- Have you ever suffered because of his using drugs?
Yes ( ) No ( )

7- Have you ever called for help because of his behaviour while under the influence of drugs?
Yes ( ) No ( )

8- Have you ever felt scared to tell other people about your husband's behaviour?
Many times ( ) Sometimes ( ) Never ( )

9- If you had known about his problems before marriage, would you still have married him?
Yes ( ) No ( )

10- Have you or anyone in the family been injured or abused by him?
Yes ( ) No ( )

11- IF answered **Yes** for question 9, please explain, who was injured or abused, how, and how many times, and so on…..

12- How would you describe your husband's behaviour before and after using drugs?
Before:

After:

13- Describe his sexual behaviour before and after using drugs?
Before:

After:

14- Have you ever left him because of problems? Yes ( ) No ( )

15- If **Yes** please describe how many times, what kind of problems, how you came back and so on…...

16- Which one of the words best describes your attitude toward life with your husband?
Satisfying ( ) Happy ( ) Sad ( )

Can we ask two general questions related to your experience of marriage?
17- From the following list, select one statement that best describe your marriage:
My husband and I are living together without any problem between us ( )
My husband and I are living together but with some problems between us ( )
My husband and I are living together with too many problems between us ( )

18- From the following list, select one statement that best describes your marriage condition:
My husband and I love each other ( )
My husband loves me but I don't love him ( )
I love my husband but he doesn't love me ( )
My husband and I hate each other ( )

Appendix 7

Semi-Structured Interview with Women Married to Alcoholics

Dear ..,

As way introduction, I am a Ph.D. student at The University of Liverpool, U.K. conducting a research regarding to drugs and alcohol consumption and the possible negative results. This study aims to better understanding those suffering from addiction so that decreasing alcohol and drugs, improving alcohol and drugs treatment, and avoiding some other social negative result could be more effective and suitable to Saudi society.

So, allow the female social worker to take some of your time in responding these questions of interview. There are two kinds of questions; the first is the close questions, which can be answered by ‘Yes’ or ‘No’. The second is through interview that will be administrated by female social worker.

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 answer to be based on what are really thinking rather than ideal thinking (what ought to be).

Finally, I would like to remind you that your providing information is confidential, and will not be use for any propose other the scientific research.

Your assistance is greatly appreciated, and thank you so much for your cooperation.

Researcher: Abdulaziz Albrithen,
Department of Sociology, Social Policy,
and Social Work Studies
The University of Liverpool
United Kingdom

Can we begin with a question about your general views on drugs and alcohol?
1- Do you think alcohol makes people more aggressive?
Yes ( ) No ( )

Can we get further and ask about your husband behaviours?
2- Has your husband had any criminal problem regarding to his drinking?
Yes ( ) No ( )

3- Has he been arrested due to drinking?
Yes ( ) No ( )

4- Has he been imprisoned due to drinking?
Yes ( ) No ( )

5- Have you ever suffered because of his drinking?
Yes ( ) No ( )

6- Have you ever called for help because of his behaviour while he was drunk?
Yes ( ) No ( )

7- Have you ever felt scared to tell other people about your husband's behaviour?
Many times ( ) Sometimes ( ) Never ( )

8- If you had known about his problems before marriage, would you still have married him?
Yes ( ) No ( )

9- Have you or anyone in the family been injured or abused by him?
Yes ( ) No ( )

10- IF answered **Yes** for question 8, please explain, who was injured or abused, how, and how many times, and so on…..

11- How would you describe your husband's behaviour before and after drinking?
Before:

After:

12- Describe his sexual behaviour before and after drinking?
Before:

After:

13- Have you ever left him because of problems? Yes ( ) No ( )

14- If **Yes** please describe how many times, what kind of problems, how you came back and so on…...

15- Which one of the words best describes your attitude toward life with your husband?

Satisfying ( ) Happy ( ) Sad ( )

Can we ask two general questions related to your experience of marriage?
16- From the following list, select one statement that best describe your marriage situation:
My husband and I are living together without any problem between us ( )
My husband and I are living together but with some problems between us ( )
My husband and I are living together with too many problems between us ( )

17- From the following list, select one statement that best describes your marriage:
My husband and I love each other ( )
My husband loves me but I don't love him ( )
I love my husband but he doesn't love me ( )
My husband and I hate each other ( )

Appendix 8

Tables and Figures of 'Ordinary' Women Sample

Table A.8.1: Respondents' views on the prevalence of domestic violence

Incidence of domestic violence in Saudi society	Number	%
Yes	10	40
No	15	60
Total	25	100

Table A.8.2: Who is the most responsible for domestic violence

The most responsible	Number	%
Men	7	28
Women	3	12
Both	15	60
Total	25	100

Table A.8.3: Respondents' list of how people can avoid domestic violence

	How people can avoid domestic violence?
1	Good understanding and good conversation
2	Good treatment and good respect to women
3	Truthfulness between couples
4	Raising males to respect females
5	Giving enough attention to the family
6	Reciprocal love and loyalty
7	Avoiding anger
8	Respecting religious demands
9	Discovering violence everywhere in the society

Figure A.8.1: The major reasons of domestic violence

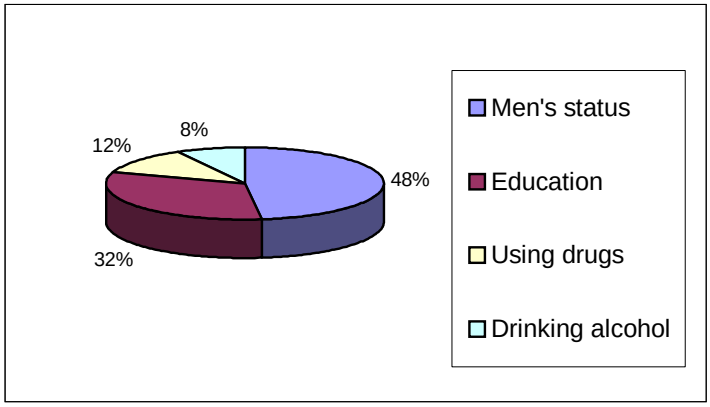


Table A.8.4: Respondents and their families' backgrounds of any alcohol or drugs problems

Alcohol and drugs problem	Number	%
Alcohol problem	-	0
Drugs problem	-	0
None of them	25	100
Both of them	-	0
Total	25	100

Table A.8.5: Negotiation frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I showed my husband I cared even though we disagreed	Emotional	6	1	3	2	2	3	4	4	25
My husband showed care for me even though we disagreed	Emotional	11	2	4	2	2	0	0	4	25
I showed respect for my husband's feelings about an issue	Emotional	8	3	2	1	1	4	2	4	25
My husband showed respect for my feelings about an issue	Emotional	15	2	2	1	0	0	0	5	25
I said I was sure we could work out a problem	Emotional	12	1	2	1	1	2	0	6	25
My husband was sure we could work it out	Emotional	18	3	1	0	0	0	0	3	25
I explained my side of a disagreement to my husband	Cognitive	4	1	1	2	6	2	1	8	25
My husband explained his side of a disagreement to me	Cognitive	10	1	6	4	1	0	0	3	25
I suggested a compromise to a disagreement	Cognitive	8	3	6	2	2	0	0	4	25
My husband suggested a compromise to a disagreement	Cognitive	17	4	1	0	0	0	0	3	25
I agreed to try a solution to a disagreement my husband suggested	Cognitive	13	2	2	2	1	1	0	4	25
My husband agreed to try a solution I suggested	Cognitive	15	4	0	0	0	0	0	6	25

Table A.8.6: Psychological aggression frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I insulted or swore at my husband	Minor	13	3	3	0	0	0	0	6	25
My husband did this to me	Minor	12	3	3	1	0	0	0	6	25
I shouted or yelled at my husband	Minor	18	3	1	0	0	0	0	3	25
My husband did this to me	Minor	18	2	2	0	0	0	0	3	25
I stomped out of the room or house or yard during a disagreement	Minor	19	3	0	0	0	0	0	3	25
My husband stomped out of the room or house or yard during a disagreement	Minor	15	4	3	1	0	0	0	2	25
I did or said something to spite my husband	Minor	19	3	0	0	0	0	0	3	25
My husband did or said something to spite me	Minor	19	2	1	0	0	0	0	3	25
I called my husband fat or ugly	Severe	23	1	0	0	0	0	0	1	25
My husband called me fat or ugly	Severe	19	3	1	0	0	0	0	2	25
I destroyed something belonging to my husband	Severe	24	0	0	0	0	0	0	1	25
My husband did this to me	Severe	19	2	0	0	0	0	0	4	25
I accused my husband of being a lousy lover	Severe	22	1	0	0	0	0	0	2	25
My husband accused me of being lousy lover	Severe	22	1	0	0	0	0	0	2	25
I threatened to hit or throw something at my husband	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	22	1	0	0	0	0	0	2	25

Table A.8.7: Physical assault frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I threw something at my husband that could hurt	Minor	24	0	0	0	0	0	0	1	25
My husband did this to me	Minor	20	1	0	0	0	0	0	4	25
I twisted my husband's arm or hair	Minor	25	0	0	0	0	0	0	0	25
My husband did this to me	Minor	22	0	0	0	0	0	0	3	25
I pushed or shoved my husband	Minor	25	0	0	0	0	0	0	0	25
My husband did this to me	Minor	25	0	0	0	0	0	0	0	25
I grabbed my husband	Minor	25	0	0	0	0	0	0	0	25
My husband did this to me	Minor	24	0	0	0	0	0	0	1	25
I slapped my husband	Minor	25	0	0	0	0	0	0	0	25
My husband did this to me	Minor	25	0	0	0	0	0	0	0	25
I used a knife or gun on my husband	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	25	0	0	0	0	0	0	0	25
I punched or hit my husband with something that could hurt	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	24	0	0	0	0	0	0	1	25
I choked my husband	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	25	0	0	0	0	0	0	0	25
I slammed my husband against a wall	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	25	0	0	0	0	0	0	0	25
I beat up my husband	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	25	0	0	0	0	0	0	0	25
I burned or scalded my husband on purpose	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	25	0	0	0	0	0	0	0	25
I Kicked my husband	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	25	0	0	0	0	0	0	0	25

Table A.8.8: Sexual coercion frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I insisted on sex when my husband did not want to (but did not use physical force)	Minor	25	0	0	0	0	0	0	0	25
My husband did this to me	Minor	20	0	0	0	0	0	0	5	25
I insisted my husband have oral or anal sex (but did not use physical force)	Minor	25	0	0	0	0	0	0	0	25
My husband did this to me	Minor	22	0	0	0	0	0	0	3	25
I used force (like hitting, holding down, or using a weapon) to make my husband have oral or anal sex	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	25	0	0	0	0	0	0	0	25
I used force (like hitting, holding down, or using a weapon) to make my husband have sex	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	25	0	0	0	0	0	0	0	25
I used threats to make my husband have oral or anal sex	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	24	0	0	0	0	0	0	1	25
I used threats to make my husband have sex	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	23	0	0	0	0	0	0	2	25

Table A.8.9: Injury frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I had a sprain, bruise, or small cut because of a fight with my husband	Minor	24	0	0	0	0	0	0	1	25
My husband had a sprain, bruise, or small cut because of fight with me	Minor	25	0	0	0	0	0	0	0	25
I felt physical pain that still hurt the next day because of a fight with my husband	Minor	25	0	0	0	0	0	0	0	25
My husband still felt physical pain the next day because of a fight we had	Minor	25	0	0	0	0	0	0	0	25
I passed out form being hit on the head by my husband in a fight	Severe	23	0	0	0	0	0	0	2	25
My husband passed out from being hit on the head in a fight with me	Severe	25	0	0	0	0	0	0	0	25
I went to a doctor because of a fight with my husband	Severe	25	0	0	0	0	0	0	0	25
My husband went to a doctor because of a fight with me	Severe	25	0	0	0	0	0	0	0	25
I needed to see a doctor because of a fight with my husband, but I did not	Severe	25	0	0	0	0	0	0	0	25
My husband needed to see a doctor because of a fight with me, but did not	Severe	25	0	0	0	0	0	0	0	25
I had a broken bone from a fight with my husband	Severe	25	0	0	0	0	0	0	0	25
My husband had a broken bone from a fight with me	Severe	25	0	0	0	0	0	0	0	25

Table A.8.10: Mean and standard deviation to CTS scales by enacted 'perpetrated' and received 'victimized'

Scales	Enacted	Received
Negotiation		
(mean)	9.08	3.08
(SD)	5.28	2.61
Psychological Aggression		
(mean)	0.88	1.76
(SD)	1.09	1.71
Physical Assault		
(mean)	0.00	0.04
(SD)	0.00	0.20
Sexual Coercion		
(mean)	0.00	0.00
(SD)	0.00	0.00
Injury		
(mean)	0.00	0.00
(SD)	0.00	0.00

* Since the participants were screened to be between 3-15 years in length of marriage, the category 7 in this table is scored as 0 in order to look at violent acts during the last 12 months only.

Appendix 9

Tables and Figures of the Sample of Women Married to Drug Users

Table A.9.1: Respondents' views on the relation between drugs and aggression

Drugs and Aggression	Number	%
Yes	23	92
No	2	8
Total	25	100

Figure A.9.1: Types of drugs used by husbands

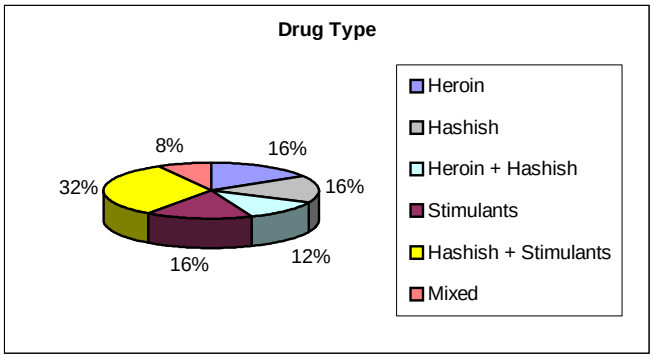


Table A.9.2: Respondents' husbands with criminal problems regarding use of drugs

Criminal Problems	Number	%
Yes	12	48
No	13	52
Total	25	100

Table A.9.3: Respondents' husbands' who had ever been imprisoned due to using drugs

Imprisoned	Number	%
Yes	12	48
No	13	52
Total	25	100

Table A.9.4: Negotiation frequencies of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I showed my husband I cared even though we disagreed	Emotional	7	0	0	0	4	0	8	6	25
My husband showed care for me even though we disagreed	Emotional	8	3	3	4	0	3	2	2	25
I showed respect for my husband's feelings about an issue	Emotional	0	2	0	1	1	4	13	4	25
My husband showed respect for my feelings about an issue	Emotional	1	3	1	4	2	2	7	5	25
I said I was sure we could work out a problem	Emotional	9	1	1	0	0	2	6	6	25
My husband was sure we could work it out	Emotional	12	1	1	0	0	2	3	6	25
I explained my side of a disagreement to my husband	Cognitive	1	1	0	2	3	2	11	5	25
My husband explained his side of a disagreement to me	Cognitive	3	0	1	3	2	4	7	5	25
I suggested a compromise to a disagreement	Cognitive	8	0	2	3	0	3	6	3	25
My husband suggested a compromise to a disagreement	Cognitive	10	1	3	2	0	2	4	3	25
I agreed to try a solution to a disagreement my husband suggested	Cognitive	6	1	1	2	2	5	6	2	25
My husband agreed to try a solution I suggested	Cognitive	8	1	6	2	0	3	1	4	25

Table A.9.5: Psychological aggression frequencies of CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I insulted or swore at my husband	Minor	8	0	3	1	0	2	9	2	25
My husband did this to me	Minor	2	0	0	0	2	0	17	4	25
I shouted or yelled at my husband	Minor	6	1	0	0	0	0	13	5	25
My husband did this to me	Minor	3	1	0	0	1	0	16	4	25
I stomped out of the room or house or yard during a disagreement	Minor	7	1	2	0	0	0	12	3	25
My husband stomped out of the room or house or yard during a disagreement	Minor	10	1	2	0	0	0	8	4	25
I did or said something to spite my husband	Minor	8	1	3	0	0	1	4	8	25
My husband did or said something to spite me	Minor	5	1	0	0	0	3	11	5	25
I called my husband fat or ugly	Severe	19	1	0	1	0	0	2	2	25
My husband called me fat or ugly	Severe	13	0	0	0	0	1	8	3	25
I destroyed something belonging to my husband	Severe	10	0	3	2	0	0	7	3	25
My husband did this to me	Severe	6	1	2	0	2	0	11	3	25
I accused my husband of being a lousy lover	Severe	6	0	1	0	0	0	12	6	25
My husband accused me of being lousy lover	Severe	13	0	0	0	0	1	8	3	25
I threatened to hit or throw something at my husband	Severe	14	0	1	0	0	3	3	4	25
My husband did this to me	Severe	10	0	0	1	0	1	9	4	25

Table A.9.6: Physical assault frequencies of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I threw something at my husband that could hurt	Minor	16	6	0	1	0	0	0	2	25
My husband did this to me	Minor	11	1	4	0	0	0	7	2	25
I twisted my husband's arm or hair	Minor	22	1	0	0	0	0	0	2	25
My husband did this to me	Minor	11	2	0	2	1	0	6	3	25
I pushed or shoved my husband	Minor	11	4	2	0	0	1	6	1	25
My husband did this to me	Minor	7	0	2	0	0	2	12	2	25
I grabbed my husband	Minor	21	0	0	0	0	0	3	1	25
My husband did this to me	Minor	6	0	0	1	2	3	12	1	25
I slapped my husband	Minor	21	1	0	1	0	0	2	0	25
My husband did this to me	Minor	10	2	0	2	0	1	7	3	25
I used a knife or gun on my husband	Severe	21	2	0	0	1	0	1	0	25
My husband did this to me	Severe	20	5	0	0	0	0	0	0	25
I punched or hit my husband with something that could hurt	Severe	18	5	1	0	0	0	0	1	25
My husband did this to me	Severe	13	1	0	2	1	1	4	3	25
I choked my husband	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	11	9	0	0	2	0	2	1	25
I slammed my husband against a wall	Severe	17	2	0	0	1	1	3	1	25
My husband did this to me	Severe	17	0	0	0	0	0	5	3	25
I beat up my husband	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	17	4	0	0	1	0	2	1	25
I burned or scalded my husband on purpose	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	25	0	0	0	0	0	0	0	25
I Kicked my husband	Severe	23	0	0	0	0	0	2	0	25
My husband did this to me	Severe	11	1	1	1	1	1	7	2	25

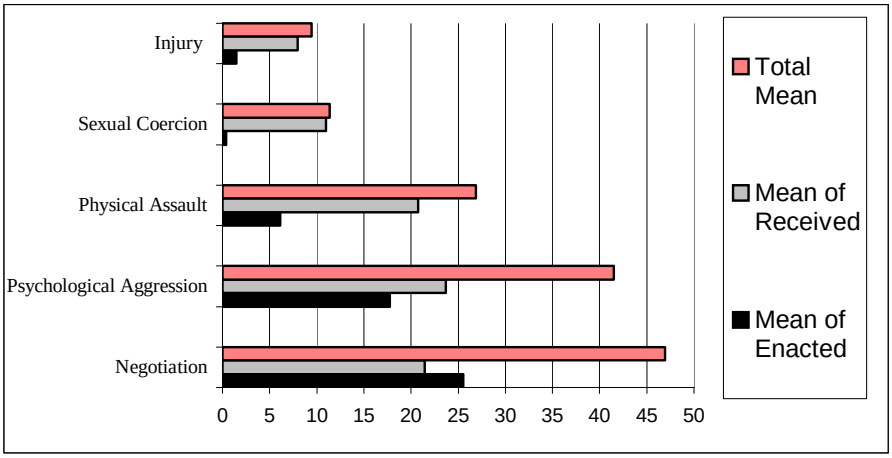
Table A.9.7: Sexual coercion frequencies of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I insisted on sex when my husband did not want to (but did not use physical force)	Minor	22	1	2	0	0	0	0	0	25
My husband did this to me	Minor	8	0	0	0	1	2	12	2	25
I insisted my husband have oral or anal sex (but did not use physical force)	Minor	25	0	0	0	0	0	0	0	25
My husband did this to me	Minor	14	2	0	0	3	0	5	1	25
I used force (like hitting, holding down, or using a weapon) to make my husband have oral or anal sex	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	16	2	0	0	0	1	5	1	25
I used force (like hitting, holding down, or using a weapon) to make my husband have sex	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	20	0	0	0	0	1	3	1	25
I used threats to make my husband have oral or anal sex	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	14	2	0	0	2	0	4	3	25
I used threats to make my husband have sex	Severe	24	0	0	0	0	1	0	0	25
My husband did this to me	Severe	14	0	0	1	3	1	5	1	25

Table A.9.8: Injury frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I had a sprain, bruise, or small cut because of a fight with my husband	Minor	12	2	2	3	0	0	4	2	25
My husband had a sprain, bruise, or small cut because of fight with me	Minor	24	0	0	0	0	0	0	1	25
I felt physical pain that still hurt the next day because of a fight with my husband	Minor	8	1	2	1	0	0	10	3	25
My husband still felt physical pain the next day because of a fight we had	Minor	22	0	0	0	0	0	2	1	25
I passed out form being hit on the head by my husband in a fight	Severe	12	3	5	0	0	0	2	3	25
My husband passed out from being hit on the head in a fight with me	Severe	19	4	0	1	0	0	0	1	25
I went to a doctor because of a fight with my husband	Severe	14	6	2	0	1	1	0	1	25
My husband went to a doctor because of a fight with me	Severe	22	0	0	2	0	0	0	1	25
I needed to see a doctor because of a fight with my husband, but I did not	Severe	15	1	0	0	2	1	5	1	25
My husband needed to see a doctor because of a fight with me, but did not	Severe	23	0	0	0	0	0	2	0	25
I had a broken bone from a fight with my husband	Severe	23	0	0	0	1	0	0	1	25
My husband had a broken bone from a fight with me	Severe	25	0	0	0	0	0	0	0	25

Figure A.9.2: Means of CTS



* In the table above means calculated in period of 12 months passed (7=0).

Appendix 10

Tables and Figures of the Sample of Women Married to Alcoholics

Table A.10.1: Respondents' thoughts on the relationship between alcohol and aggression

Alcohol and Aggression	Number	%
Yes	23	92
No	2	8
Total	25	100

Table A.10.2: Respondents' husbands' criminal problems related to drinking alcohol

Criminal Problems	Number	%
Yes	10	40
No	15	60
Total	25	100

Table A.10.3: Respondents' husbands' who had ever been imprisoned due to drinking

Imprisoned	Number	%
Yes	12	48
No	13	52
Total	25	100

Table A.10.4: Negotiation frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I showed my husband I cared even though we disagreed	Emotional	2	0	0	0	1	0	20	2	25
My husband showed care for me even though we disagreed	Emotional	6	1	1	3	4	0	10	0	25
I showed respect for my husband's feelings about an issue	Emotional	4	0	1	0	0	0	17	3	25
My husband showed respect for my feelings about an issue	Emotional	6	0	1	6	2	1	8	1	25
I said I was sure we could work out a problem	Emotional	7	3	0	0	0	1	11	3	25
My husband was sure we could work it out	Emotional	9	0	0	1	0	0	12	3	25
I explained my side of a disagreement to my husband	Cognitive	1	0	0	0	1	3	18	2	25
My husband explained his side of a disagreement to me	Cognitive	2	0	0	1	0	2	19	1	25
I suggested a compromise to a disagreement	Cognitive	2	2	0	1	3	2	12	3	25
My husband suggested a compromise to a disagreement	Cognitive	7	1	0	1	1	2	10	3	25
I agreed to try a solution to a disagreement my husband suggested	Cognitive	1	0	0	2	2	0	16	4	25
My husband agreed to try a solution I suggested	Cognitive	3	0	3	1	0	0	13	5	25

Table A.10.5: Psychological aggression frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I insulted or swore at my husband	Minor	8	0	3	1	0	2	9	2	25
My husband did this to me	Minor	2	0	0	0	2	0	17	4	25
I shouted or yelled at my husband	Minor	6	1	0	0	0	0	13	5	25
My husband did this to me	Minor	3	1	0	0	1	0	16	4	25
I stomped out of the room or house or yard during a disagreement	Minor	7	1	2	0	0	0	12	3	25
My husband stomped out of the room or house or yard during a disagreement	Minor	10	1	2	0	0	0	8	4	25
I did or said something to spite my husband	Minor	8	1	3	0	0	1	4	8	25
My husband did or said something to spite to me	Minor	5	1	0	0	0	3	11	5	25
I called my husband fat or ugly	Severe	19	1	0	1	0	0	2	2	25
My husband called me fat or ugly	Severe	13	0	0	0	0	1	8	3	25
I destroyed something belonging to my husband	Severe	10	0	3	2	0	0	7	3	25
My husband did this to me	Severe	6	1	2	0	2	0	11	3	25
I accused my husband of being a lousy lover	Severe	6	0	1	0	0	0	12	6	25
My husband accused me of being lousy lover	Severe	13	0	0	0	0	1	8	3	25
I threatened to hit or throw something at my husband	Severe	14	0	1	0	0	3	3	4	25
My husband did this to me	Severe	10	0	0	1	0	1	9	4	25

Table A.10.6: Physical assault frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I threw something at my husband that could hurt	Minor	15	5	2	0	0	0	3	0	25
My husband did this to me	Minor	12	1	2	1	2	1	6	0	25
I twisted my husband's arm or hair	Minor	24	1	0	0	0	0	0	0	25
My husband did this to me	Minor	12	2	3	2	0	3	3	0	25
I pushed or shoved my husband	Minor	13	7	2	1	0	0	2	0	25
My husband did this to me	Minor	16	2	1	0	0	0	6	0	25
I grabbed my husband	Minor	25	0	0	0	0	0	0	0	25
My husband did this to me	Minor	8	6	2	3	2	2	1	1	25
I slapped my husband	Minor	22	3	0	0	0	0	0	0	25
My husband did this to me	Minor	6	1	5	1	4	3	4	1	25
I used a knife or gun on my husband	Severe	20	5	0	0	0	0	0	0	25
My husband did this to me	Severe	25	0	0	0	0	0	0	0	25
I punched or hit my husband with something that could hurt	Severe	21	4	0	0	0	0	0	0	25
My husband did this to me	Severe	13	3	4	2	0	1	2	0	25
I choked my husband	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	15	10	0	0	0	0	0	0	25
I slammed my husband against a wall	Severe	9	10	2	4	0	0	0	0	25
My husband did this to me	Severe	17	2	0	1	0	1	3	1	25
I beat up my husband	Severe	24	1	0	0	0	0	0	0	25
My husband did this to me	Severe	17	6	2	0	0	0	0	0	25
I burned or scalded my husband on purpose	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	23	2	0	0	0	0	0	0	25
I kicked my husband	Severe	24	1	0	0	0	0	0	0	25
My husband did this to me	Severe	9	7	2	2	1	0	4	0	25

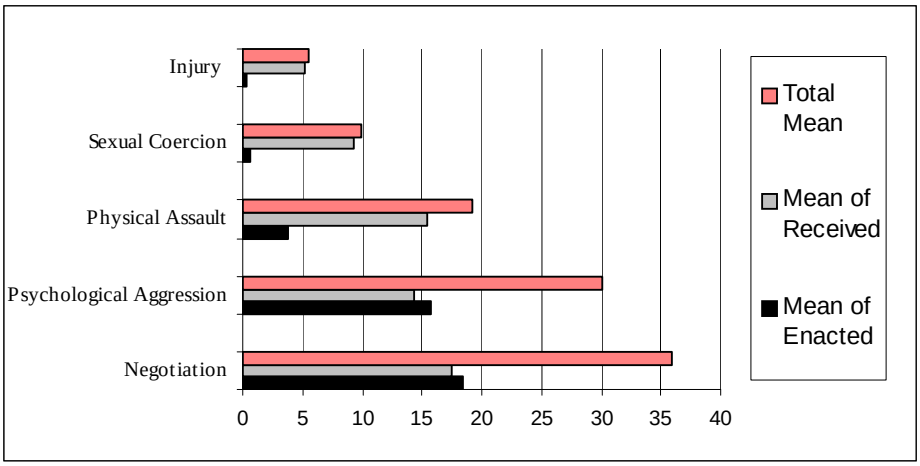
Table A.10.7: Sexual coercion frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I insisted on sex when my husband did not want to (but did not use physical force)	Minor	21	0	1	3	0	0	0	0	25
My husband did this to me	Minor	6	0	1	2	0	1	11	4	25
I insisted my husband have oral or anal sex (but did not use physical force)	Minor	24	1	0	0	0	0	0	0	25
My husband did this to me	Minor	13	1	1	0	0	1	6	3	25
I used force (like hitting, holding down, or using a weapon) to make my husband have oral or anal sex	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	20	3	0	2	0	0	0	0	25
I used force (like hitting, holding down, or using a weapon) to make my husband have sex	Severe	25	0	0	0	0	0	0	0	25
My husband did this to me	Severe	20	1	1	1	0	1	0	1	25
I used threats to make my husband have oral or anal sex	Severe	24	1	0	0	0	0	0	0	25
My husband did this to me	Severe	14	2	1	2	0	1	5	0	25
I used threats to make my husband have sex	Severe	24	1	0	0	0	0	0	0	25
My husband did this to me	Severe	13	1	1	2	2	1	4	1	25

Table A.10.8: Injury frequency of the CTS

Items	Subscale	0	1	2	3	4	5	6	7	Total
I had a sprain, bruise, or small cut because of a fight with my husband	Minor	17	4	2	1	0	0	1	0	25
My husband had a sprain, bruise, or small cut because of fight with me	Minor	25	0	0	0	0	0	0	0	25
I felt physical pain that still hurt the next day because of a fight with my husband	Minor	13	1	3	1	0	0	4	3	25
My husband still felt physical pain the next day because of a fight we had	Minor	24	0	0	1	0	0	0	0	25
I passed out from being hit on the head by my husband in a fight	Severe	11	8	4	0	1	0	1	0	25
My husband passed out from being hit on the head in a fight with me	Severe	23	1	0	1	0	0	0	0	25
I went to a doctor because of a fight with my husband	Severe	17	6	2	0	0	0	0	0	25
My husband went to a doctor because of a fight with me	Severe	25	0	0	0	0	0	0	0	25
I needed to see a doctor because of a fight with my husband	Severe	14	2	1	0	3	1	3	1	25
My husband needed to see a doctor because of a fight with me	Severe	25	0	0	0	0	0	0	0	25
I had a broken bone from a fight with my husband	Severe	22	3	0	0	0	0	0	0	25
My husband had a broken bone from a fight with me	Severe	25	0	0	0	0	0	0	0	25

Figure A.10.1: Means of CTS



* In the table above means calculated in period of 12 months passed (7=0).

References

Abracen, J., Looman, J. and Anderson, D. (2000) 'Alcohol and drug abuse in sexual and nonsexual violent offenders', *Sexual Abuse: A Journal of Research and Treatment*, **12**(4), 263-274.

Adams, D. (1988) 'Treatment models of men who batter: A profeminist analysis', in Yllo, K., and Bograd, M. (eds.) *Feminist Perspectives on Wife Abuse*. Newbury Park, CA: Sage Press.

Akers, R. L. and Sellers, C. S. (2004) '*Criminological Theories: Introduction, Evaluation, and Application*. (4th Edition). Los Angeles, CA: Roxbury Publishing Company.

Al-Amal Magazine. (1994, March) 'Policy and procedures manual', *Al-Amal Magazine*, **5**.

Al-Angari, S. A. M. (1988) 'The Minnesota Multiphasic Personality Inventory (MMPI) profile of patients with alcoholism in Al-Amal hospitals in Saudi Arabia', Ph.D Thesis. USA, Ohio: *Ohio University*.

Al-Aubaidi, A. M. (1990) 'Family impact on the prevention of drugs', *Security*, **3**, 83-109.

Al-Dakhil, A. A. (2002) 'Hospitalised Saudi problem drinkers: A psychosocial profile', Ph.D Thesis. UK, Glasgow: *University of Glasgow*.

Al-Farsy, F. (1982) *Saudi Arabia: A Case Study in Development*. London: Kegan Paul International.

Al-Khalidi, A. (ed.) (1983) 'Factors related to alcohol use and alcoholism', in *Alcohol Addiction: Prevention and Treatment*. Riyadh: Arab Security and Training Centre.

Al-Muateg, M. M. (1985) *Alcohol and its Laws in Islamic Sharea*. Riyadh: Arabic Centre for Security Studies and Training.

Al-Nahedh, N. (1999) 'Relapse among substance abuse patients in Riyadh, Saudi Arabia', *Eastern Mediterranean Health Journal*, **5**(2), 241-246.

Al-Najar, M. Y. (1998) 'Drug Taking among youth in the Arabian Gulf states', *Arab Journal for Human Science*, **16**(4), 194-223.

Al-Rasheed, M. and Vitalis, R. (2004) *Counter-Narratives: History, Contemporary Society, and Politics in Saudi Arabia and Yemen*. New York: Palgrave Macmillan.

Al-Rashid, I. (1976) *Documents on the History of Saudi Arabia*. (3 vols) Salisbury, North Carolina: Documents Publications.

Al-Ryias, A. N. (1995) *Social Factors Related to Return to Drug Taking After Treatment*. MA thesis, King Saud University, Riyadh.

Altorki, S. (1986) *Women in Saudi Arabia: Ideology and Behavior Among the Elite*. New York: Columbia University Press.

Al-Turki, S. A. (1989) 'Factors leading to drug taking and the Islamic perspective to tackle the problem', *Journal of Imam Muhammad Ibn Saud University*, **14**(1), 417-476.

American Psychiatric Association (1994; 1998) *DSM-IV: Diagnostic and statistical manual of mental disorders*. (4th ed.) American Psychiatric Association: Washington, DC.

Anton, R. F.; Moak, D. H. and Latham, P. (1995) 'The Obsessive Compulsive Drinking Scale: a self-rated instrument for the quantification of thoughts about alcohol and drinking behavior', *Alcoholism: Clinical and Experimental Research*, **19**(1), 92-99.

Arebi, S. (1994) *Women and Works in Saudi Arabia: The Politics of Literary Discourse*. New York: Columbia University Press.

Armor, D. I., Polich, J. M. and Stambul, H. B. (1978) *Alcoholism and Treatment*. New York: Wiley.

Babor, T. F., de la Fuente, J. R., Saunders, J., Grant, M. and Aasland, O. G. (2001) 'Alcohol Use Disorders Identification Test', in B. S. Plake and J. C. Impara (eds) *The Fourteenth Mental Measurements Yearbook*. Lincoln, NE: Buros Institute of Mental Measurements.

Bahry, L. (1982) 'The new Saudi woman: Modernizing in an Islamic framework', *Middle East Journal*, **36**(4), 502-515.

Bailey, D. S. (1991) 'Effects of alcohol and aggressive disposition on human physical aggression', *Journal of Research in Personality*, 25, 334-342.

Barker, R. L. (2003) *The Social Work Dictionary*. (5th edition). Washington, DC. NASW Press.

Bennett, L. W., Tolman, R. M., Rogalski, C. J. and Srinivasaraghavan, J. (1994) 'Domestic abuse by male alcohol and drug addicts', *Violence and Victims*, **9**(4), 359-368.

Bevan, E. and Higgins, D. J. (2002) 'Is domestic violence learned? The contribution of five forms of child maltreatment to men's violence and adjustment', *Journal of Family Violence*, **17**(3), 223-245.

Binney, V. Harkell, G. and Nixon, J. (1981) *Leaving Violence Men; Women's Aid Federation.* England.

Bloom, M.; Fischer, J. and Orme, J. (2003) *Evaluating Practice: Guidelines for the Accountable Professional*. Boston: Allyn and Bacon.

Bloor, M.; Frankland, J.; Thomas, N. and Robson, K. (2001) *Focus Groups in Social Research*. London: Sage Publication.

Bohn, M.J.; Krahn D.D. and Staehler B.A. (1995) 'Development and initial validation of a measure of drinking urges in abstinent alcoholics', *Alcoholism: Clinical and Experimental Research*, **19**(3), 600-606.

Borkowski, M., Murch, M., Walker, V. (1983) *Marital Violence: The Community Response*. London: Tavistock Press.

Boudy, A. (1999) The relationship of age, gender, and economic statues to adult students attitudes towards becoming literate in Al-Ahssa Saudi Arabia. PhD Thesis Dissertation. Ohio State University: United States.

Brecklin, L. R. (2002) 'The role of perpetrator alcohol use in the injury outcomes of intimate assaults', *Journal of Family Violence*, **17**(3), 185-197.

Brown, S. A.; Tate, S. R.; Vik, P. W.; Haas, A. L. and Aarons, G. A. (1999) 'Modeling of alcohol use mediates the effect of family history of alcoholism on adolescent alcohol expectancies', *Experimental and Clinical Psychopharmacology*, **7**, 20-27.

Burman, B., John, R. S. and Margolin, G. (1992) 'Observed patterns of conflict in violent, nonviolent, and nondistressed couples', *Journal of Psychopathology and Behavioral Assessment*, **14**, 15-37.

Burman, B., Margolin, G. and John, R. S. (1993) 'America's angriest home video: Behavioral contingentcies observed in home reenactments of marital conflict', *Journal of Consulting Clinical Psychology*, **61**, 28-39.

Bushman, B. J. (1997) 'Effects of alcohol on human aggression: Validity of proposed mechanisms', in M. Galanter (ed.), *Recent Development in Alcoholism*, 13, 227-244.

Bushman, B.J. (1993) 'Human aggression while under the influence of alcohol and other drugs: An integrative research review', *Current Direction in Psychological Science*, **2**(5), 148-152.

Bushman, B. and Cooper, H. (1990) 'Effects of alcohol on human aggression: An integrative research review', *Psychological Bulletin*, **107**(3), 341-354.

Buss, A. H. and Durkee, A. (1957) 'An inventory for assessing different kinds of hostility', *Journal of Consulting Psychology*, **21**, 343-349.

Buzawa, E. S. and Buzawa, C. G. (1996) *Domestic violence: The criminal justice response*. CA: Sage Publication, Thousand Oaks.

Byles, J. A. (1978) 'Violence, alcohol problems and other problems in the disintegrating family', *Journal of Studies on Alcohol*, **39**, 551-553.

Cahalan, D., Cisin, I. H., and Crossley, H. M. (1969) *American Drinking Practice: A National Survey of Drinking Behavior and Attitudes.* (Monograph No. 6). New Brunswick, NJ: Rutgers Centre for Alcohol Studies.

Chenet, L., Leon, D., Mckee, M. and Vassin, S. (1998) 'Deaths from alcohol and violence in Moscow: Socio-economic determinants', *European Journal of Population*, **14**(1), 19-37.

Chermack, S. and Giancola, P. (1997) 'The relationship between alcohol and aggression: An integrated biopsychosocial approach', *Clinical Psychology Review*, **6**, 621-649.

Chermack, S. T. and Taylor, S. P. (1995) 'Alcohol and human physical aggression: Pharmacological versus expectancy effects', *Journal of Studies on Alcohol*, **56**, 449-456.

Christensen, A. and Sullaway, M. (1984) *Communication Patterns Questionnaire*, Unpublished questionnaire. Los Angeles: University of California.

Clark, A. (1988) *Women's silence, men's violence: Sexual Assault in England 1770-1845*. London: Pandora.

Coleman, D. H. and Straus, M. A. (1983) 'Alcohol abuse and family violence', in E. Gotheil (eds) *Alcohol, Drug Abuse, and Aggression*. Springfield, IL: Charles C Thomas. pp. 104-124.

Collins, J. J., Kroutil, L. A., Roland, E. J., and Moore-Gurrera, M. (1997) 'Issues in the linkage of alcohol and domestic violence services', in M. Galanter (Ed.), *Recent Developments in Alcoholism: Alcohol and violence* (Vol. 13, pp. 387-405). New York, NY: Plenum.

Collins, J. J. and Messerschmidt, P. M. (1993) 'Epidemiology of alcohol-related violence', *Alcohol Health and Research World*, **17**, 93-100.

Collins, J. J. and Schlenger, W. E. (1988) 'Acute and chronic effects of alcohol use on violence', *Journal of Studies on Alcohol*, **46**(6), 516-521.

Colossians 3: 18,I (1991) *New American Bible*. Washington, DC: Confraternity of Christian Doctrine, Inc.

Conner, K. R. and Ackerly, G. D. (1994) 'Alcohol-related battering: Developing treatment strategies', *Journal of Family Violence*, **9**(2), 143-155.

Corcoran, K. and Fischer, J. (2000) *Measures for Clinical Practice: A Sourcebook*. (3rd edition, Vol. 1, Couples, Families, and Children). New York: The Free Press.

Cordova, J. V., Jacobson, N. S., Gottman, J. M., Rushe, R. and Cox, G. (1993) 'Negative reciprocity and communication in couples with a violent husband', *Journal of Abnormal Psychology*, **102**, 559-564.

Cowan, C. P., Cwan, P. A., Coie, L,. and Coie, J. D. (1978) 'Becoming a family: The impact of a first child's birth on the couple's relationship', in W. B. Miller and L. F. Newman (eds.) *The First Child and Family Formation*. Chapel Hill, NC: Carolina Population Center.

Crowne, D. and Marlowe, D. (1964) *The Approval Motive: Studies in Evaluative Dependence*. New York: John Weley.

Cunradi, C. B., Caetano, R. and Schafer, J. (2002) 'Alcohol-related problems, drug use, and male intimate partner violence severity among US couples', *Alcoholism: Clinical and Experimental Research*, **26**, 493-500.

Cunradi, C. B., Caetano, R., Clark, C. L., and Schafer, J. (1999) 'Alcohol-related problems and intimate partner violence among white, black, and Hispanic couples in the U. S.', *Alcoholism: Clinical and Experimental Research*, **23**(9), 1492-1501.

Davidson, T. (1978) *Conjugal Crime: Understanding and Changing the Wifebeating Pattern.* New York: Hawthorne Books.

Davis, L. V. (1995) 'Domestic violence', in Encyclopaedia of Social Work. (19th edition, Vol**. 1**, pp. 884-891). Washington D. C.: National Association of Social Workers.

Dearling, A. (1993) *The Social Welfare Word Book*. Loughborough, Leicester: Longman Group, UK.

Denzin, N. K. (1989*) The Research Act: A Theoretical Introduction to Sociological Methods*. London: Prentice Hall International.

Dermen, K. H. and George, W. H. (1989) 'Alcohol expectancy and the relationship between drinking and physical aggression', *Journal of Psychology*, **123**, 153-161.

Dobash, R. E. and Dobash, R. (1992) *Women, Violence and Social Change*. London: Routledge.

Dobash, R. E. and Dobash, R. P. (1980) *Violence Against Wives: A case against the patriarchy.* London: Open Books.

Dougherty, D. M., Cherek, D. R. and Bennett, R. H. (1996) 'The effects of alcohol on the aggressive responding of women', *Journal of Studies on Alcohol*, **57**, 178-186.

Doumato, E. (2002) 'Women and work in Saudi Arabia: How flexible are Islamic margins?', *Meddle East Journal*, **52**(2), 582.

Edwards, S. (1989) *Policing Domestic Violence: Women, the Law and the State*. London: Sage.

Edwards, G. and Gross, M. M. (1976) 'Alcohol dependence: Provisional description of a clinical syndrome', *British Medical Journal*, **1**, 1058-1061.

Eied, G. (1984) *The Application of Islamic Punishments and its Effects on Society: Conference on Islamic Jurisprudence*. Riyadh: Imam Muhammad Ibn Saud Islamic University Press.

Eilts, H. F. (1971a) 'Social revolution in Saudi Arabia-Pt, 1', *Parameters: The Journal of the Army War College*, **1**(1), 4-18.

Eilts, H. F. (1971b) 'Social revolution in Saudi Arabia-Pt, 2', *Parameters: The Journal of the Army War College*, **1**(2), 22-33.

El-Sheikh, Sel-G. and Bashir T. Z. (2004) 'High-risk relapse situations and self-efficacy: comparison between alcoholics and heroin addicts', *Addictive Behaviors*, **29**(4):753-758.

Ephesians 5: 22-24, in L. V. Davis (ed.) (1995) *Domestic violence*. Encyclopaedia of Social Work. (19th edition, Vol**. 1**, pp. 780-789). Washington D. C.: National Association of Social Workers.

Engelmann, J. (1992) *Domestic Violence, Substance Abuse are Separate Problems*. Hazelden News and Professional Update May: 6-8.

Fagan, R. W.; Barnett, O. W. and Patton, J. B. (1988) 'Reason for alcohol use in maritally violent men', *American Journal of Drug and Alcohol Abuse*, **14**, 371-392.

Fals-Stewart, W. (2003) 'The occurrence of partner physical aggression on days of alcohol consumption: A longitudinal diary study', *Journal of Consulting and Clinical Psychololgy*, **71**(1), 41-52.

Feuerlein, W., Ringer, C., Kufner, H., and Antons, K. (1979) 'Diagnosis of alcoholism: The Munich Alcoholism Test (MALT)', *Currents in Alcoholism*, **7**, 137-147.

Flanzer, J. P. (1993) Alcohol and other drugs are key causal agents of violence, in R. J. Gelles and D. R. Loseke (eds.) *Current Controversies on Family Violence*. Newbury Park, CA: Sage.

Flanzer, J. (1990) 'Alcohol and family violence: Then and now-who owns the problem', in Potter-Efron, R., and Potter-Efron, P. (eds.), *Aggression, Family Violence, and Chemical Dependency*. The Haworth Press: New York, pp. 61-80.

Freeman, M. (1979) *Violence in the Home*. Farnborough: Saxon House.

Gayford, J. J. (1975) 'Wife battering: A preliminary survey of 100 cases', *British Medical Journal*, **1**, 194-197.

General Presidency of Religious Enforcement Council's Statistical Report (1999; 2002) Riyadh: General Presidency of Religious Enforcement Council.

Giancola, P. R. and Chermack, S. T. (1998) 'Construct validity of laboratory aggression paradigms: A response to Tedeschi and Quigley (1996)', *Aggression and Violent Behavior*, **3**, 237–253.

Giancola, P. R. and Parrott, D. J. (2005) 'Differential effects of past-year stimulant and sedative drug use on alcohol-related aggression', *Addictive Behaviors*, **30**,1535-1554.

Gillespie, D. F. (1995) 'Ethical issues in research', in Encyclopaedia of Social Work. (19th edition, Vol**. 1**, pp. 884-891). Washington D. C.: National Association of Social Workers.

Goldman, M. S., Brown, S. A., and Christiansen, B. A. (1987) Expectancy theory: Thinking about drinking, in K. E. Leondard and H. Blane (eds) *Psychological Theories of Drinking and Alcoholism*. London: The Guilford Press.

Gondolf, E. W. (1995) 'Alcohol abuse, wife assault, and power needs', *Social Service Review*, **69**(2), 274-284.

Gondolf, E. W. and Foster, R. A. (1991) 'Wife assault among VA alcohol rehabilitation patients' *Hospital and Community Psychiatry*, **42**, 74-79.

Gorad, S. L. (1971) 'Communication styles and interaction of alcoholics and their wives', *Family Process*, **10**, 475-489.

Graham, K. (1980) 'Theories of intoxicated aggression', *Canadian Journal of Behavioural Science*, **12**(2), 141-158.

Graham, K. and Wells, S. (2002) 'The two worlds of aggression for men and women', *Sex Roles: A Journal of Research*, **45**(9/10), 595-622.

Greenfield, L. A. and Henneberg, M. A. (2000) 'Alcohol, crime and other criminal justice system', Paper presented at Alcohol Policy XII Conference, *Alcohol and Crime*, Research and Practice for Prevention, Washington, DC.

Grisso, J. A., Schwarz, D. F., Hirschinger, N., Sammel, M., Brensinger, C., Santanna, J., Lowe, R. A., Anderson, E., Shaw, L. M., Bethel, C. A. and Teeple, L. (1999) 'Violent injuries among women in an urban area', *The New England Journal of Medicine*, **341**, 1899-1905.

Hague, G. and Malos, E. (1993) *Domestic Violence: Action for Change*. Cheltenham: New Clarion Press.

Hamdan, A. (2005) 'Women and education in Saudi Arabia: Challenges and achievements', International Education Journal, **6**(1), 42-64.

Hamilton, C. J. and Collins, J. J. (1981) 'The role of alcohol in wife beating and child abuse: A review of the literature', in J. J. Collins (ed.) *Drinking and Crime: Perspectives on the Relationship Between Alcohol Consumption and Criminal Behavior*. New York: Guilford, pp. 253-287.

Harner, I. C. (1987) 'The alcoholism treatment client and domestic violence', *Alcohol Health and Research World*, **12**, 150-160.

Heady, S. B. and Vaus, D. (1999) 'Domestic violence in Australia: Are women and men equally?', Melbourne Institute of Applied Economic and Social Research: Melbourne.

Hecker, E. A. (1910) *A Short History of Women's Rights: From the Days of Augustus to the Present Time*. London: Putnam's Sons.

Hedlund, J. L. and Vieweg, B. W. (1984) 'The Michigan Alcoholism Screening Test (MAST): A comprehensive review', *Journal of Operational Psychiatry*, **15**, 55-64.

Heyman, R. E.; O'Leary, K. D. and Journal, E. N. (1995) 'Alcohol and aggressive personality styles: Potentiators of serious physical aggression against wives?', *Journal of Family Psychology*, **9**(1), 44-57.

Heyman, R. E., O'Leary, K. D., and Jouriles, E. N. (1995) 'Alcohol and aggressive personality styles: Potentiators of serious physical aggression against wives?', *Journal of Family Psychology*, **9**, 44-57.

Hoaken, P. N. and Pihl, R. O. (2000) 'The effects of alcohol intoxication on aggressive responses in men and women', *Alcohol and Alcoholism*, **35**(5), 471-477.

Holcomb, W. R. and Anderson, W. P. (1983) 'Alcohol and multiple drug abuse in accused murderers', *Psychological Report*, **52**(1), 159-164.

Hopwood, D. (1972). *The Arabian Peninsula: Society and Politics*. Totowa, New Jersey: Rowman and Littlefield.

Hotaling, G. T. and Sugarman, D. B. (1990) 'A risk marker analysis of assaulted wives', *Journal of Family Violence* **5**(1), 1-13.

Horn, J. L., Wanberg, K. W. and Foster, F. M. (1995)'Alcohol Use Inventory', in J. C. Conoley and J. C. Impara (eds) *The Twelfth Mental Measurements Yearbook*. Lincoln, NE: Buros Institute of Mental Measurements.

Hull, J. G. and Bond, C. F. (1986) 'Social and behavioral consequences of alcohol consumption and expectancy: A meta-analysis', *Psychological Bulletin*, **99**, 347-360.

Hutchison, I. W. (2003) 'Substance use and abused women's utilization of the police', *Journal of Family Violence*, **18**(2), 93-106.

Huyette, S. S. (1985) *Political Adaptation in Saudi Arabia: A Study of the Council of Ministers*. Boulder, Colorado: Westview Press.

Ibrahim, S. E. and Cole, D. P. (1978) *Saudi Arabian Bedouin: An Assessment of their Needs*. Cairo: Cairo Papers in Social Science. The American University in Cairo. Vol. 1.

Ito, T. A.; Miller, N. and Pollock, V. E. (1996) 'Alcohol and aggression: A meta-analysis on the moderating effects of inhibitory cues, triggering events, and self-focused attention', *Psychological Bulletin*, **120**, 60-82.

Jacob, T. and Leonard, K. E. (1988) 'Alcohol-spouse interaction as a function of alcoholism subtype and alcohol consumption interaction', *Journal of Abnormal Psychology*, **97**, 231-237.

Jensen, S. B. (1984) 'Sexual function and dysfunction in younger married alcoholics', *Acta Psychiatrica Sca*, **69**, 543-549.

Johnson, M. D. (2002) 'The observation of specific affect in marital interactions: Psychometric properties of a coding system and a rating system', *Psychological Assessment*, **14**, 423-438.

Jovchelovitch, S. and Bauer, M.W. (2000). Narrative interviewing, in M. W. Bauer and G. D. Gaskell (eds.), *Qualitative Researching with Text, Image and Sound: A Practical Handbook for Social Research*. London: Sage Publication.

Kahler, C. W. McCrady, B. S. and Epstein, E. E. (2003) 'Sources of distress among women in treatment with their alcoholic partners', *Journal of Substance Abuse Treatment*, **24**(3) 257-265.

Kantor, G. and Straus, M. A. (1989) 'Substance abuse as a precipitant of wife abuse victimizations', *American Journal of Drug and Alcohol Abuse*, **15**(2), 173-189.

Kantor, G. K. and Straus, M. A. (1987) 'The "drunken bum" theory of wife beating', *Social Problems*, **34**(3), 213-231.

Kinney, J., and Leaton, G. (1991) *Loosing the grip: A handbook of alcohol information* (Fourth ed.). St. Louis, Missouri: Mosby-Year Book, Inc.

Kogan, S.L. and Jacob, T. (1995) 'Psychosocial functioning in children of alcoholics fathers', *Psychology of Addictive Behaviors*, **9**, 101–113.

Kunitz, S. J., Jerrold, E. L., McCloskey, J. and Gabriel, K. R. (1998) 'Alcohol dependence and domestic violence as sequelae of abuse and conduct disorder in childhood', *Child Abuse and Neglect*, **22**(11), 1079-1091.

Kyriacou, D. N., Anglin, D., Taliaferro, E., Stone, S., Tubb, T., Linden, J. A., Muelleman, R., Barton, E. and Kraus, J. F. (1999) 'Risk factors for injury to women from domestic violence', *The New England Journal of Medicine*, **341**, 1892-1898.

Lackie, L. and Man, A. (1997) 'Correlates of sexual aggression among male university students', *Sex Roles: A Journal of Research*, **37**(5/6), 451-457.

Lang, A. R., Goeckner, D. J., Adesso, V. J. and Marlatt, G. A. (1975) 'Effects of alcohol on aggression in male social drinkers', *Journal of Abnormal Psychology*, **84**, 508-518.

Lee, W. V. and Weinstein, S. P. (1997) 'How far have we come? A critical review of the research on men who batter', in M. Galanter (ed.) *Recent Developments in Alcoholism* (Vol. **13**, pp. 337-357). New York, NY: Plenium Press.

Lemon, N. (1996) *Domestic Violence Law: A Comprehensive Overview of Cases and Sources*. San Francisco, CA: Austin and Winfield.

Leonard, K. E. (2005) 'Alcohol and intimate partner violence: When can we say that heavy drinking is a contributing cause of violence', *Addiction*, **100**, 422-425.

Leonard, K. E. (2001) 'Domestic violence and alcohol: What is known and what do we need to know to encourage environmental intervention?', *Journal of Substance Use*, **6**, 235-245.

Leonard, K. E. (1993) 'Drinking patterns and intoxication in marital violence: Review, critique, and future directions for research. Alcohol and Interpersonal Violence: Fostering Multidisciplinary Perspectives, *NIAAA Research Monograph* **24**, 253-280.

Leonard, K. E. and Blane, H. (1999) *Psychological Theories of Drinking and Alcoholism*. London: The Guilford Press.

Leonard, K. E. and Blane, H. T. (1992) 'Alcohol and marital aggression in a national sample of young men', *Journal of Interpersonal Violence*, **7**(1), 19-30.

Leonard, K. E., Bromet, E. J. Parkinson, D. K. Day, N. L. and Ryan, C. M. (1985) 'Patterns of alcohol use and physically aggressive behavior in men', *Journal of Studies on Alcohol*, **46**(4), 279-282.

Leonard, K. E. and Jacob, T. (1987) 'Alcohol, alcoholism, and family violence', in: V. D. Van Hasselt et al. (eds) *Handbook of Family Violence*. New York: Plenum.

Leonard, K. E. and Roberts, L. J. (1998) 'The effects of alcohol on the marital interactions of aggressive and nonaggressive husbands and their wives', *Journal of Abnormal Psychology*, **107**(4), 602-615.

Leonard, K. E. and Quigley, B. M. (1999) 'Drinking and marital aggression in newlyweds: An event-based analysis of drinking and the occurrence of husband marital aggression', *Journal of Studies on Alcohol*, **60**, 537-545.

Leonard, K. E. and Senchak, M. (1993) 'Alcohol and premarital aggression among newlywed couples', *Journal of Studies on Alcohol*, **l**(11), 96-108.

Leonard, K. E. and Senchak, M. (1996) 'Prospective prediction of husband marital aggression within newlywed couples', *Journal of Abnormal Psychology*, **105**(3), 369-380.

Levy, A. and Brekke, J. (1990) 'Spouse battering and chemical dependency: Dynamics, treatment, and service delivery', in R. Potter-Efron and P. Potter-Efron

(eds) *Aggression, family violence and chemical dependency.* New York: The Haworth Press, Inc.

Livingston, L. R. (1986) 'Measuring domestic violence in an alcoholic population', *Journal of Sociology and Social Welfare*, **13**, 934-951.

Locke, H. J., and Wallace, K. M. (1959) 'Short marital adjustment and prediction tests: Their reliability and validity', *Marriage and Family Living*, **21**, 251-255.

MacAndrew, C. and Edgerton, R. B. (1969) *Drunken Comportment*. Chicago: Aldine.

MacAndrew, C. (1981) 'What the MAC scale tells us about men alcoholics: An interpretive review', *Journal of Studies on Alcohol*, **42**, 604-625.

MacAskill, E. (2004, July) 'Beaten Saudi TV presenter drops case against husband', *The Guardian*, p. 3.

Maiden, R. P. (1996) 'The incidence of domestic violence among alcoholic EAP clients before and after treatment', *Employee Assistance Quarterly*, **11**(3), 21-46.

Manson, M. P., Melchior, L. A. and Huba, G. J. (1992) 'Alcadd Test', in J. J. Kramer and Conoley J. C. (eds) *The Eleventh Mental Measurements Yearbook*. Lincoln, NE: Buros Institute of Mental Measurements.

Margoline, G. (1980) *The Conflict Inventory*. Unpublished manuscript, Lost Angles: University of California.

Markowitz, S. (1999) 'The price of alcohol, wife abuse and husband abuse', *National Bureau of Economic Research*, 6916.

Marsden, D. (1978) 'Sociology perspectives on family violence', in Martin, J. P. (ed) *Violence and the family*. John Wiley and Sons. New York.

Marshal, M. P. (2003) 'For better or for worse? The effects of alcohol use on marital functioning', *Clinical Psychology Review*, **23**(7), 959-997.

Martin, A.; Chu, M.; Sage, R.; et al. (1997) *Alcohol and Drug Abuse Among Domestic Violence Survivors and Batterers*. Rockville, MD: National Clearinghouse for Alcohol and Drug Information.

Martin, S. (Ed.) (1993) 'Alcohol and interpersonal violence: Fostering multidisciplinary perspectives', (NIH Publication No. 93-3496). Rockville, MD: *US Department of Health and Human Services, Public Health Service*, National Institutes of Health, National Institute on Alcohol Abuse and Alcoholism.

Martin, D. (1977) *Battered Wives.* New York: Pocket Books.

May, M. (1978) 'Violence in the family: An historical perspective', in Martin, J. P. (ed) *Violence and the family*. New York: John Wiley and Sons.

Mayfield, D. (1976) 'Alcoholism, alcohol, intoxication, and assaultive behavior', *Disease of Nervous System*, **37**(5), 288-291.

Mayfield, D., Mcleod, G., and Hall, P., (1974) 'The CAGE questionnaire: Validation of a new alcoholism screening instrument', *The American Journal of Psychiatry*, **131**(10), 1121-1123.

Maynard, M. (1993) 'Violence towards women', in Richardson, D. and Robertson, V. (eds.). *Women's Studies*. The Macmillan Press.

Mehlum, H.; Miguel, E. and Torvik, R. (2006) 'Poverty and crime in 19th century Germany' *Journal of Urban Economics*, **59**, 370-388.

McCurdy, K. and Daro, D. (1994) Current Trends in Child Abuse Reporting and Fatalities: The Results of the 1993 Annual Fifty State Survey. Chicago: National Committee to Prevent Child Abuse.

McKenry, P. C., Julian, T. W. and Gavazzi, S. M. (1995) 'Toward a biophysical model of domestic violence', *The Journal of Marriage and Family*, **57**, 307-320.

McLellan, A. T., Luborsky, L., Woody, G. E., and O'Brein, C. P. (1980) 'An improved evaluation instrument for substance abuse patients: The Addiction Severity Index', *Journal of Nervous and Mental Disease*, **168**, 26-33.

Micheli, D. D. and Formigoni, M. L. (2004) 'Drug use by Brazilian students: Association with family, psychosocial, health, demographic and behavioral characteristics', *Addiction*, **99**(5), 570-578.

Miller, R. S. and Lefcourt, H. M. (1982) 'The assessment of social intimacy', *Journal of Personality Assessment*, **46**, 514-518.

Miller, M. and Potter-Efron, R. (1990) 'Aggression and violence associated with substance abuse', in R. Potter-Efron and P. Potter-Efron (eds) *Aggression, Family Violence and Chemical Dependency*. New York: The Haworth Press, Inc.

Ministry of Interior Statistical Books (1980; 1990; 1995; 1999; 2000; 2001; 2002) Riyadh: Ministry of Interior.

Moos, R.H., Finney, J.W. and Gamble, W. (1982) 'The process of recovery from alcoholism. II. Comparing spouses of alcoholic patients and matched community controls', *Journal of Studies on Alcohol*, **43**, 888–909.

Mordechai, A. (1988) *Saudi Arabia in the Oil era: Regime and elites: Conflict and Collaboration*. London: Croom Helm.

Morrison, R. L., and Van Hasselt, V. B. (1980) *The Physical Abuse Questionnaire (PAQ) for assessing marital violence*. Unpublished manuscript, University of Pittsburgh.

Murdoch, D., Pihl, R. O. and Ross, D. (1990) 'Alcohol and crimes of violence: Present issues', *International Journal of the Addictions*, **25**(9), 1065-1081.

Murphy, C. M. and O'Farrell, T. J. (1997) 'Couple communication patterns of marritally aggressive and nonaggressive male alcoholics', *Journal of Studies on Alcohol*, **58**, 83-90.

Murphy, C. M. and O'Farrell, T. J. (1996) 'Marital violence among alcoholics', *Current Directions in Psychological Science*, **5**, 183 186.

Murphy, C. M. and O'Farrell, T. J. (1994) 'Factors associated with marital aggression in male alcoholics', *Journal of Family Psychology*, **8**(3), 321-335.

Murphy, C. M.; Winters, J.; O'Farrell, T. J.; Fals-Stewart, W. and Murphy, M. (2005) 'Alcohol consumption and intimate partner violence by alcoholic men: Comparing violent and nonviolent conflicts', *Psychology of Addictive Behaviors*, **19**(1), 35-42.

Neidig, P. (1985) 'Domestic violence in the military: Research findings and gram implications', *Military Family*, **5**(3), 3-6.

Niblock, T. (1982) *State, Society and Economy in Saudi Arabia*. London: Croom Helm.

Norstrom, T. (1998) 'Effects on criminal violence of different beverage types and private and public drinking', *Addiction*, **93**(5), 689-699.

O'Donnell, W. E., DeSoto, C. B. and DeSoto, J. L. (2001) 'Maryland Addictions Questionnaire', in B. S. Plake, and J. C. Impara, (eds) *The Fourteenth Mental Measurements Yearbook*. Lincoln, NE: Buros Institute of Mental Measurements.

O'Farrell, T. J., Hutton, V. V. and Murphy, C. M. (1999) 'Domestic violence before and after alcoholism treatment: A two-year longitudinal study', *Journal of Studies on Alcohol*, **35**(4), 317-321.

O'Farrell, T. J. and Murphy, C. M. (1995) 'Marital violence before and after alcoholism treatment', Journal of Consulting and Clinical Psychology, **63**(2), 256-262.

O'Farrell, T. J., Murphy, C. T., Neavins, T. M. and Hutton, V. V. (2000) 'Verbal aggression among male alcoholic patients and their wives in the year before and two year after alcoholism treatment', Journal of Family Violence, **15**(4), 295-310.

O'Leary, K. D. and Schumacher, J. A. (2003) 'The association between alcohol use and intimate partner violence: Linear effect, threshold effect, or both?', *Addictive Behaviors*, **28**(9), 1575-1585.

O'Leary, K. D., Vivian, D., and Malone, J. (1992) 'Assessment of physical aggression against women in marriage: The need for multimodal assessment', *Behavioral Assessment*, **14**, 5-14.

Pahl, J. (ed) (1985) *Private Violence and Public Policy*. Routledge & Kegan Paul Plc: London.

Pan, H. S.; Neidig, P. H. and O'Leary, K. D. (1994) 'Predicting mild and severe husband-to-wife physical aggression', *Journal of Consultant Clinical Psychology*, **62**, 975-981.

Peace at Home (1995) *Domestic Violence: The Facts*. Boston: Peace at Home.

Pernanen, K. (1976) 'Alcohol and crimes of violence', in B. Kissin and H. Begleiter (eds) *Social Aspects of Alcoholism*, The Biology of Alcoholism, Vol. **4**. New York: Plenum.

Pearlin, L. and Schooler, C. (1978) 'The structure of coping', *Journal of Health and Social Behavior*, **19**, 2-21.

Peter 3: 1 (1991) *New American Bible*. Washington, DC: Confraternity of Christian Doctrine, Inc.

Pihl, R. O., Zeichner, A., Niaura, R., Nagy, K. and Zacchia, C. (1981) 'Attribution Attribution and alcohol-mediated aggression', *Journal of Abnormal Psychology*, **90**, 468- 475.

Pokorny, A. D., Miller, B. A. and Kaplan, H. B. (1972) 'The brief MAST: a shortened version of the Michigan Alcoholism Screening Test', *American Journal of Psychiatry* **129**, 342–345.

Prokop, M. (2003) 'Saudi Arabia: the politics of education', *International Affairs*, 79, **I**, 77-89.

Quigley, B. M. and Leonard, K. E. (2000) 'Alcohol and continuation of early marital aggression', *Alcoholism: Clinical and Experimental Research*, **24**(7), 1003-1010.

Qur'an (1979) '*The Holy Qur'an*'. Translation of verses is heavily based on A. Yusuf Ali's translation, The Glorious Qur'an, text translation, and Commentary. The American Trust Publication: Plainfield, IN 46168.

Radford, J. and Russell, D. (1992) *Femicide: The Politics of Woman Killing* .New York: Twayne Publishers.

Risk and Needs Assessment, Inc. (2001) 'Domestic Violence Inventory', in B. S. Plake, and J. C. Impara (eds) *The Fourteenth Mental Measurements Yearbook*. Lincoln, NE: Buros Institute of Mental Measurements.

Roberts, A. R. (1988) 'Substance abuse among men who batter their mates: The dangerous mix', *Journal of Substance Abuse Treatment*, **5**, 83-87.

Roizen, J. and Schneberk, K. (1978) 'Alcohol and crime', in M. Aarens, T. Cameron, J. Roizen, R. Roizen, R. Room, D. Schneberk, and D. Wingard (eds), *Alcohol*,

Casualties and Crime (Research Report No. C-18). Berkley, CA: University of California, Social Research Group.

Roscoe, B. and Callehan, J. (1985) 'Adolescent' self report of violence in families and dating relationt', *Adolescence*, **20**(79), 545-553.

Rosenbaum, A. and O'Leary, K. D. (1981) 'Marital violence: Characteristics of abusive couples', *Journal of Consulting and Clinical Psychology*, **49**, 63-71.

Rossow, I. (1996) 'Alcohol-related violence: The impact of drinking pattern and drinking context', *Addiction*, **91**(11), 1651-1661.

Roy, D. (1992) 'Saudi Arabian education: Development policy', *Middle Eastern Studies*, **28**, 477-508.

Rugh, W. A. (1973) 'Emergence of a new middle class in Saudi Arabia, '*Middle East Journal*', **27**(1), 9-20.

Rusakaniko, S. Mushunje, A. and Muchemenye, O. (1997) ' Domestic violence against married women in a peri-urban area of Chitungwiza, Zimbabwe', *Journal of Clinical Epidemiology*, **50**(1), 39S.

Saunders, D. (1980) *The Police Response to Battered Women: Predictors of Officers' Use of Arrest, Counselling and Minimal Action*. Dissertation Abstract International 40: 6446A. (University Microfilms No. 80-08840).

Schumacher, J. A., Fals-Stewart, W. and Leonard, K. E. (2003) 'Domestic violence treatment referrals for men seeking alcohol treatment', *Journal of Substance Abuse Treatment*, **24**(3), 279-283.

Selzer, M. L. (1971) 'The Michigan alcoholism screening test: The quest for a new diagnostic instrument', *The American Journal of Psychiatry*, **127**(12), 1653-1658.

Shelton, J.; Holister, J.; and Gocka, E. (1969) 'Quantifying alcohol impairment', *Modern Medicine*, November. 188-189.

Sherman, L. W., Douglas, A. S., Janell, D. S., and Dennis, P. R. (1992) 'Crime, punishment, and stake in conformity: Legal and informal control of domestic violence', *American Sociological Review*, **57**, 680-690.

Shepard, M. F. and Campbell, J. C. (1992) 'The Abusive Behavior Inventory: A measure of psychological and physical abuse', *Journal of Interpersonal Violence*, **7**, 291-305.

Skinner, H. A. and Allen, B. A. (1982) 'Alcohol dependence syndrome: Measurement and validation', *Journal of Abnormal Psychology*, **91**(3), 199-209.

Skinner, H. A. and Holt, S. (1998) 'Alcohol Clinical Index', in J. C. Impara, and B. S. Plake (eds) *The Thirteenth Mental Measurements Yearbook*. Lincoln, NE: Buros Institute of Mental Measurements

Skinner, H. A. and Horn, J. L. (1989) 'Alcohol Dependence Scale', in J. C. Conoley and J. J. Kramer (eds) *The Tenth Mental Measurements Yearbook*. Lincoln, NE: Buros Institute of Mental Measurements.

Skinner, H. A.; Steinhauer, P. D. and Santa-Barbara, J. (1984) *The Family Assessment Measure: Administration and Interpretation Guide*. Toronto: Addiction Research Foundation.

Smith, L. (1989) *Domestic violence: An overview of the literature*. London: HMSO Books.

Spanier, G. (1976) 'Measuring dyadic adjustment: New scales for assessing the quality of marriage and similar dyads', *Journal of Marriage and Family*, **38**, 15-30.

Spieker, G. (1983) 'What is the linkage between alcohol abuse and violence?', in E. Gottheil (ed.) *Alcohol, Drug Abuse and Aggression*. Springfield, IL: Charles C. Thomas.

Spielberger, C. R., Jacobs, G., Crane, R., Russell, S. Westberry, L., Baker, L., Johnson, E., Knight, J. and Marks, E. (1979) *Preliminary Manual for the State Trait Personality Inventory (STPI)*. Tampa: Florida, Human Resource Institute, University of South Florida.

Steele, C. M. and Josephs, R. A. (1990) 'Alcohol myopia: Its prized and dangerous effects', *American Psychologist*, **45**, 921-933.

Steele, C. M. and Southwick, L. (1985) 'Alcohol and social behaviour: I. The psychology of drunken excess', *Journal of Personality and Social Psychology*, **48**, 18-34.

Stith, S. M., Crossman, R. K. and Bischof, G. P. (1991) 'Alcoholism and marital violence: A comparative study of men in alcohol treatment programs and batterer treatment programs. *Alcoholism Treatment Quarterly*, **8**, 3-20.

Stockwell, T. R., Hodgson, R. J., Edwards, G., Taylor, C. and Rankin, H. (1979) 'The development of a questionnaire to measure severity of alcohol dependence', *British Journal of Addiction*, **74**, 79-87.

Stosny, S. (1995) *Treating Attachment Abuse.* New York: Springer.

Straus, M. A. (2004) 'Cross cultural reliability and validity of the revised Conflict Tactics Scales: A study of university student dating couples in 17 nations', *Cross-Cultural Research*, **38**(4), 407-432.

Straus, M. A. (1995) *Handbook for the Conflict Tactics Scales (CTS).* Family Research Laboratory, University of New Hampshire.

Straus, M. A. (1979) 'Measuring interfamily conflict and violence: The Conflict Tactics Scales', *Journal of Marriage and the Family,* **41**, 75-88.

Straus, M. A. and Gelles, R. J. (1990) Physical violence in American families: Risk factors and adaptations to violence in 8,145 families. New Brunswick, NJ: Transaction Publishing.

Straus, M. A.; Hamby, S. L.; McCoy, S. B. and Sugarman, D. B. (1996) 'The revised Conflict Tactics Scales (CTS2): Development preliminary psychometric data', *Journal of Family Issues*, **17**(3), 283-316.

Streifel, C. (1997) 'Gender, alcohol use, and crime', in R. W. Wilsnack and S. C. Wilsnack (eds) *Gender and Alcohol*. Individual and social perspectives. New Brunswick, NJ: Rutgers Centre of Alcohol Studies.

Taylor, S. P. and Chermack, S. T. (1993) 'Alcohol, drugs, and human physical aggression', *Journal of Studies on Alcohol*, **11**, 78-88.

Tedeschi, J. and Quigley, B. (1996) 'Limitations of laboratory paradigms for studying aggression', *Aggression and Violent Behavior*, **1**, 163–177.

Teijlingen, E. R. and Hundley, V. (2004) Pilot study. In Lewis-Beck, M. S.; Bryman, A. and Liao, T. F. (ed.). *Encyclopaedia of Social Science Research Methods*. London: Thousand Oaks.

Telch, C. and Lindquist, C. (1984) 'Violent versus nonviolent couples: A comparison of patterns', *Psychotherapy*, **21**, 242-248.

Testa, M.; Quigley, B. M. and Leonard, K. E. (2003) 'Does alcohol make a difference? Within-participants comparison of incidents of partner violence', *Journal of International Violence*, **18**(7), 735-743.

Tolman, R. M., and Bennett, L. W. (1990) 'A review of the quantitative research on men who batter', *Journal of Interpersonal Violence*, **5**(1), 87-118.

Thomas, M. and Pierson, J. (1995) *Dictionary of Social Work*. London: Collins Educational LTD.

Triandis, H. C. (1990) 'Cross-cultural studies of individualism and collectivism', in J. Berman (Ed.), *Nebraska Symposium on Motivation*, 1989, 37, Cross-cultural perspectives. Lincoln, NB: University of Nebraska Press.

Van Hasselt, V. B., Morrison, R. L. and Bellack, A. S. (1985) 'Alcohol use in wife abusers and their spouses', *Addictive Behaviors*, **10**(2), 127-135.

Van Hightower, N. R. and Gorton, J. (1998) 'Domestic Violence Among Patients at Two Rural Health Care Clinics: Prevalence and Social Correlates', *Public Health Nursing*, **15**(5), 355-362.

Virkunnen, M. (1974) 'Incest offenders and alcoholism', *Medicine Science and Law*, **14**, 124-128.

Vold, G. B.; Bernard, T. J. and Snipes, J. B. (2002) *Theoretical Criminology*. (5th Edition). Oxford: Oxford University Press.

Walker, L. E. (1999) *The Battered Woman Syndrome*. New York: Springer Publishing Company Incorporated.

Walker, L. E. (1989) 'Psychology and violence against women', *American Psychologist*, **44**, 695-702.

Weiss, R. L. (1993) *MICS-IV: Marital Interaction Coding System Training and Reference Manual for Coders.* Eugene, Oregon: Oregon Marital Studies Progam, University of Oregon.

Weiss, R. L., and Cerreto, M. C. (1980) 'The marital status inventory: Development of a measure of dissolution potential', *American Journal of Family Therapy*, **8**, 80-86.

Wells, S. Graham, K. and West, P. (2000) 'Alcohol-related aggression in the general population', *Journal of Studies on Alcohol*, **61**, 626-632.

Jovchelovitch, S. and M. Bauer, M. (2000) Narrative interviewing, in M. Bauer and G. Gaskell (eds) *Qualitative Research with Text, Image and Sound: A Practical Handbook.* London: Sage Publications.

Widom, C. S.; Ireland, T. and Glynn, P. J. (1995) 'Alcohol abuse in abused and neglected children followed-up: Are they at increased risk?', *Journal of Studies on Alcohol*, **56,** 207–217.

Williams, K. R. and Hawkins, R. (1989) 'The meaning of arrest for wife assault', *Criminology*, **27**, 163-181.

Wilson, E. (1983) *What is to be Done About Violence Against Women?*. Harmondswoth: Penguin.

Wolfgang, M. E. (1956) 'Husband-wife homicide', *Corrective Psychiatry and Journal of Social Therapy*, 2, 263-271. Reprinted in *Deviancy and the Family*, edited by C.D. Bryand. Philadelphia: F. A. Davis.

Yamani, M. (2005) 'The limits of political reform in Saudi Arabia' in Birgitte R. (ed.) *Democratisation and the Middle East*. Asrhus University Press. Denmark.

Young, K. (1994) *Alcohol Misuses and Violence: Alcohol and Violence Against Women and Children in the Home* (Vol. 4). Canberra: Australian Government Publishing Services.

Zufair, S. M. (1995) *Conviction Procedures in Crimes Punishments and the Consequences on Stability and Security in Saudi Arabia*. Riyadh: Samha Press.

Bibliography

Abd Al-Ati, Hammudah (1977) *Islam in Focus*. The American Trust Publications, Plainfield, IN 46168.

AbdelKharim, A. O. (1992) 'Social status, heath status and therapy response in heroin addicts', Eastern Mediterranean Health Journal, **12**, 289-293.

Al-Anazy, E. S. (1999) 'Some characteristics of the personality of drug addicts in Al-Amal hospital in Riyadh: Casework approach', Master Thesis. Saudi Arabia, Riyahd: *King Saud University*.

Al-Ansari, E. A. Negrete, J. C. (1990) 'Screening for alcoholism among alcohol users in a traditional Arab Muslim society', Acta Psychiatrica Scandinavica, **63**, 284-288.

Al-Harthi, A. (1999) *Drug Abuse in the Gulf Status/Oman: An Evaluation of the Death Penalty as a Deterrent*. Unpublished thesis, United Kingdom, Manchester: University of Manchester.

Al Helali N. S.; Abolfotouh, M. A. and Ghanem, H. M. (2001) 'Pattern of erectile dysfunction in Jeddah city' *Saudi Medical Journal*, **22**(1), 34-38.

Al-Subaie A.S. (1994) 'Traditional healing experiences in patients attending a university outpatient clinic', *Arab Journal of Psychiatry*, **5**(2), 83-91.

Badawi, J. A. (1997) *The Status of Woman in Islam.* Riyadh: World Assembly of Muslim Youth (WAMY).

Barron, (2002) *Five Years on: A Review of Legal Protection*, WAFE.

Beck, A. J. (1991) *Profile of Jail Inmates, 1989*. Washington, DC: Bureau of Justice Statistics.

Beck, A. J., Kline, S. A. and Greenfeld, L. A. (1988) *Survey of Youth in Custody, 1987*. Washington, DC: Bureau of Justice Statistics.

Bennett, L. and Lawson, M. (1994) 'Barriers to cooperation between domestic violence and substance abuse programs', *Families in Society: The Journal of Contemporary Human Services*, **75**(5), 277-286.

Bergman, B. K. and Brismar, B. G. (1992) 'Can family violence be prevented? A psychosocial study of male batterers and battered wives', *Public Health*, **106**(1),45-52.

Bland, R. and Orn, H. (1986) 'Family violence and psychiatric disorder', *Canadian Journal of Psychiatry*, **31**, 129-137.

Boland. F., Henderson, K. and Baker, J. (1998) 'Case need domain: Substance abuse assessment review', *Forum on Corrections Research*, **10**, 32-34.

Brady, K. T. and Randall, C. L. (1999) 'Gender differences in substance use disorders', *Psychiatric Clinics of North America*, **22**, 241-252.

Brain, P. F. (1992) *Alcohol and Aggression*. London: Croom Helm.

Brown, T. G., Caplan, T., Werk, A., and Seraganian, P. (1999) 'The comparability of male violent substance abusers in violence or substance abuse treatment', *Journal of Family Violence*', **14**(3), 297-314.

Brown, T. G., Caplan, T., Werk, A., and Seraganian, P. (1997) 'Violent substance abusers in treatment', *Poster presented at the American Psychological Association Annual Convention,* Chicago, August.

Brown, T. G., Werk, A., Caplan, T. and Seraganian, P. (1999) 'Violent substance in domestic violence treatment', *Journal of Violence and Victims*, **14**, 179-190.

Brown, T., Werk, A., Caplan, T., Shields, N. and Seraganian, P. (1998) 'The incidence and characteristics of violent men in substance abuse treatment', *Addictive Behaviors*, **23**(5), 573-586.

Browne, A. (1987) *When Battered Women Kill*. New York: The Free Press.

Bruun, K. (1959) 'Significant of rle and norms in the small group for individual behavior changes while drinking', *Journal of Study on Alcohol*, **20**, 53-64.

Bureau of Justice Statistics (1994) *Domestic Violence: Violence Between Intimates*, NCJ 149259. US: Department of Justice, Office of Justice Programs.

Cantos, A. L., Neidig, P. H. and O'Leary, K. D. (1994) 'Injuries of women and men in a treatment program for domestic violence', *Journal of Family Violence*, **9**(2), 113-124.

Chaiken, M. and Chaiken, J. (1990) *Redefining the career criminal: Priority prosecution of high-rates dangerous offenders*. NCJ 124136, National Institute of Justice: Washington, D.C.

Chaiken, M. and Chaiken, J. (1987) *Selecting "Career Criminals" for priority prosecution*. NCJ 106310, National Institute of Justice: Washington, D.C.

Chaiken, M. and Johnson, B. (1988) *Characteristics of different types of drug-involved offenders*. National Institute of Justice: Washington, D.C.

Challier, B., Chau, N., Predine, R., Choquet, M. and Legras, B. (2000) 'Associations of family environment and individual factors with tobacco, alcohol, and illicit drug use in adolescents', *European Journal of Epidemiology*, **16**, 33-42.

Cheon, J. S., Han, H. S. and Jung, H. J. (1996) 'Mechanism of sexual dysfunction in alcohol dependence: A pudendal sep study', *Biological Psychiatry*, **39**(7), 626.

Cherpitel, C. J. (1997) 'Alcohol and violence-related injuries in the emergency room', *Recent Development in Alcoholism*, **13**, 105-118.

Chilton, R. and Jarvis, J. (1999) 'Victims and offenders in two crime statistics program: A comparison of the National Incident-Based Reporting System (NIBRS) and the National Crime Victimization Survey (NCVS', *Journal of Quantitative Criminology*, **15**,193-205.

Chinnian, R.R.; Taylor, L. R.; al Subaie, A.; Sugumar, A. and al Jumaih, A. A. (1994) 'A controlled study of personality patterns in alcohol and heroin abusers in Saudi Arabia', *Journal of psychoactive drugs*, **26**(1), 85-88.

Cobbe, Frances Power (1878) *'Wife-Torture in England' The Contemporary Review* 32 (April-July 1878): 55-87.

Coggans, N. and McKellar, S. (1995) *The Facts About Alcohol, Aggression and Adolescence*. London: York House.

Collins, J. J. (1993) 'Drinking and violence: an individual offender focus', in Martin, S. E. (ed.), *Alcohol and Interpersonal Violence: Fostering Multidisciplinary Perspectives*, pp. 221-235.

Collins, J. J. (1981) 'Alcohol carers and criminal carers', in J. J. Collins (ed), *Drinking and Crime: Perspective on the Relationships Between Alcohol Consumption and Criminal Behavior*. New York: Guilford Press. pp. 152-206.

DeKeseredy, W. S. and Schwartz, M. D. (2003) 'Backlash and whiplash: A critique of statistics Canada's 1999 general social survey on victimization', *Online Journal of Justice Studies*, **1**(1), January: 2003.

Demerdash, A. M.; Mizaal, H.; El Farouki, S. El Mossalem, H. (1981) 'Some behavioural and psychological aspects of alcohol and drug dependence in Kuwait psychiatric hospital', Acta Psychiatrica Scandinavica, **63**, 173-185.

Diduck, A. and Kaganas, F. (1999) *Family Law, Gender and the State: Text, Cases and Materials*. Oxford: Hart Publishing.

Dobash, R. E., Dobash, R. P., Cavanagh, K. and Lewis, R. (2000) *Changing Violent Men*. California: Thousand Oaks.

Dobash, R. E. and Dobash, R. P. (1981) 'Community response to violence against wives: Charivari, abstract justice and patriarchy', *Social Problems*, **28**, 563-581.

Dobash, R. P. and Dobash, R. E. (1977) 'Wife beating: Still a common form of violence', *Social Work Today*, **9**(12), 14-17.

Dowden, C. and Brown, S. L. (1998) 'Case need domain: Substance abuse', *Forum on Corrections Research*, **10**, 28-31.

Dutton, D. G. (1988) *The Domestic Assault of Women: Psychological and Criminal Justice Perspectives*. Boston: Allyn and Bacon.

Easton, C. J., Swan, S. and Sinha, R. (2000) 'Prevalence of family violence in clients entering substance abuse treatment', *Journal of Substance Abuse Treatment*, **18**(1), 23-28.

El-Bassel, N., Gilbert, L., Schilling, R. and Wada, T. (2000) 'Drug abuse and partner violence among women in methadone treatment', *Journal of Family Violence*, **15**(3), 209-228.

Elfawal, M. A. (1999) 'Trends in fatal substance overdose in eastern Saudi Arabia', *Journal of Clinical Forensic Medicine*, **6**(1):30-34.

Elliot, F. R. (Winter 1989) 'The family: Private arena or adjunct of the state?', *Journal of Law and Society*, **16**(4), 443-463.

El-Sheikh, Sel-G. and Bashir T. Z. (2004) 'High-risk relapse situations and self-efficacy: comparison between alcoholics and heroin addicts', *Addictive Behaviors*, **29**(4), 753-758.

Eron, L. and Huesmann, L. (1989) 'The genesis of gender differences in aggression', in P. N. Hoaken and R. O. Pihl, *The effects of alcohol intoxication on aggressive responses in men and women, Alcohol and Alcoholism*, **35**(5), 471-477 (2000).

Fagan, R. W., Barnett, O. W. and Patton, J. B. (1988) 'Reasons for alcohol use in martially violent men', *The American Journal of Drug and Alcohol Abuse*, **14**, 371-392.

Finch, J. (1996), 'Women, 'the' family and families', in T. Cosslett, Easton, A. and Summerfield, P. (eds) *Women, Power and Resistance: An Introduction to Women's Studies*. Buckingham: Open University Press.

Flanzer, J. (1982) *The Many Faces of Family Violence*. Charls C Thomas, Springfield, IL.

Fostering Multidisciplinary perspectives (NIH Publication No. 93-3496), *National Institutes of Health*, Rockville, MD, pp. 253-280.

Freeman, M. D. (1996) *The Family Law Act 1996: With Annotations by Michael Freeman*. London: Sweet and Maxwell.

Gelles, R. J. (1993) Alcohol and other drugs are associated with violence-they are not its cause, in R. J. Gelles and D. R. Loseke (eds.) *Current Controversies on Family Violence*. Newbury Park, CA: Sage.

Gelles, R. J. (1974) *The Violent Home: A Study of Physical Aggression Between Husbands and Wives*. Newbury Park, CA: Sage.

Gelles, R. J. (1972) *The Violent Home*. CA: Sage, Beverly Hills.

Gerson, L. W. and Preston, D. (1979) 'Alcohol consumption and the incidence of violent crime', *Journal of Studies on Alcohol*, **40**(3), 307-312.

Gondolf, E.W. and Foster, R.A. (1991) 'Wife assault among VA alcohol rehabilitation patients', *Journal of Hospital Community Psychatric*, **42**, 74-79.

Gorney, B. (1989) 'Domestic violence and chemical dependency: Dual problems, dual interventions', *Journal of Psychoactive Drugs*, **21**(2), 229-238.

Gotlib, I. H. and McCabe, S. B. (1990) 'Marriage and psychopathology', in F. D. Fincham and T. N. Bradbury (eds), *The Psychology of Marriage: Basic Issues and Applications*. New York: Guilford Press, pp. 226-257.

Grace, S. (1995) *Policing Domestic Violence in the 1990's*. London: Home Office Research Study 139, HMSO.

Grady, A. (2002) 'Female-on-male domestic violence: Uncommon or ignored?', in Hoyle, C. and Young, R. (eds) *New Visions of Crime Victims*. Oxford: Hart Publishing.

Greene, B. T. (1981) 'An examination of the relationship between crime and substance abuse in drug/alcohol treatment population', *International Journal of the Addictions*, **16**(4), 627-645.

Gunby, P. (1991) 'Service in strict Islamic nation removes alcohol, other drugs from major problem list', *Journal of the American Medical Association*, **265**(5), 560-562.

Hafeiz, H. B. (1995) 'Socio-demographic correlates and pattern of drug abuse in Eastern Saudi Arabia', *Drug Alcohol Dependence*, **38**(3), 255-259.

Halford, W. K., Bouma, R., Kelly, A. and Young, R. McD. (1999) 'Individual psychopathology and marital distress: Analysis the association and implications for therapy', *Behavior Modification*, **23**, 179-216.

Hanmer, J. (1996) 'Women and violence: commonalities and diversities', in B. Fawcett, B. Featherstone, J. Hearn, and C. Toft (eds) *Violence and gender relations: Theories and interventions*. London: Sage Publications.

Hanmer, J. and Maynard, M. (eds) (1987) *Women, Violence and Social Control*. Basingstoke: Macmillan.

Hanmer, J., Radford, J. and Stanko, E. A. (eds) (1989) *Women, Policing and Male Violence: International Perspectives*. London: Routledge.

Hasselt, V. B.; Morrison, R. L. and Bellack, A. S. (1985) 'Alcohol use in wife abusers and their spouses', *Addictive Behaviors*, **10**, 127-135.

Hearn, J. (1998) *The Violences of Men: How Men Talk About and How Agencies Respond to Men's Violences to Women*. London: Sage Publications.

Hein, D. and Hein, N. (1998) 'Women, violence with intimates, substance abuse relevant theory, empirical findings and recommendations for future research', *American Journal of Drug and Alcohol Abuse*, **24**(3), 419-438.

Herek, Gregory M. and Berrill, Kevin T. (eds), (1992), *Hate Crimes: Confronting the Violence Against Lesbians and Gay Men*. London: Sage Publications.

Hester, M., Kelly, L. and Radford, J. (eds) (1996) *Women, Violence and Male Power: Feminist Activism, Research and Practice*. Buckingham: Open University Press.

Hester, M., Pearson, C. and Harwin, N. (eds) (1999) *Making an Impact: Children and Domestic Violence: A Reader*. London: Kingsley.

Hoff, L. A. (1990) *Battered Women as Survivors*. London: Routledge.

Hoffeller, K. H. (1982) *Social, Psychological and Situational Factors In Wife Abuse*. California: R & E Research Associates, Incorporated.

Holtzworth-Munroe, A., Bates, L., Smutzler, N. and Sandin, E. (1997) 'A brief review of the research on husband violence, Part I: Maritally violent versus nonviolent men', *Aggression and Violent Behavior*, **2**(1), 65-99.

Innes, C. A. (1988) *Drug Use and Crime. Washington*, DC: U.S. Department of Justice.

Jacobson, N. S., Gottman, J. M., Waltz, J., Rushe, R., Babcock, J. and Holtzwrth-Munroe, A. (1994) 'Affect, verbal content, and psycho-physiology in the arguments of couples with a violent husband', *Journal of Consulting and Clinical Psychology*, **62**, 982-988.

Jagger, G. and Wright, C. (1999) 'End of century, end of family? - Shifting discourses of family 'crisis', in G. Jagger, and C. Wright, (eds) *Changing Family Values: Feminist Perspectives*. London: Routledge.

Jensen, S. B. (1984) 'Sexual function and dysfunction in younger married alcoholics', *Acta Psychiatrica Scandinavica*, **69**, 543-549.

Johnson, B., Williams, T., Dei, K., and Sanabria, H. (1990) 'Drug abuse and the inner city: Impacts of hard drug use and sales of low income communities' in Wilson, J., and Tonry, M. (eds), *Crime and Justice: An Annual Review of Research*, 13. University of Chicago Press: Chicago, pp. 6-67.

Katz, L. (1982) *Counselors Learn to Help Violent Alcohol Abusers*. NIAAA Information and Feature Service, 96, 2.

Kelly, L. (1989) *Surviving sexual violence*. Cambridge: Polity Press.

Kelly, L. and Radford, J. (1998) 'Sexual violence against women and girls: An approach to an international overview', in Dobash, R. E. and Dobash, R. P. (eds) *Rethinking Violence Against Women*. London: Sage Publications.

Kilpatrick, D., Acierno, R., Resnick, H., Saunders, B. and Best, C. (1997) 'A 2-year longitudinal analysis of the relationship between violence assault and substance use in women, *Journal of Consultant Clinical Psychology*, **65**(5), 834-847.

Klien, A. (1996) 'Re-abuse in a population of court restrained male batterers: Why restraining orders don't work', in E. Buzawa and C. Buzawa (eds), *Do Arrests and Restraining Orders Work?* Sage, Thousand Oaks, pp. 192-213.

Kua, E. H. and Ko, S. M. (1991) 'Family violence an Asian drinkers', *Forensic Science International*, **50**(1), 43-46.

Kunitz, S. J., Levy, J. E., Gabriel, K. R., Henderson, E., Lampert, K., McCloskey, J., Quintero, G., Russell, S., and Vince, A. (in press) 'Alcohol dependence and conduct disorder among Navajo Indians', *Journal of Studies on Alcohol*.

Labell, L. S. (1979) 'Wife abuse: A sociological study of battered women and their mates', *Victimology: An International Journal*, **4**, 258-267.

Langevin, R. and Lang, R. A. (1990) 'Substance abuse among sex offenders', *Annals of Sex Research*, **3**, 397-424.

Langevin, R., Paitich, D., Orchard, B., Handy, L., and Russon, A. (1982) 'Diagnosis of killers seen for psychiatric assessment: A controlled study', *Acta Psychiatrica Scandinavica*, **66**, 216-228.

Lasngan, P. and Innes, C. (1986) *U.S. Bureau of Justice Statistics Special Report: Preventing Domestic Violence Against Women. Washington,* DC: U.S. Bureau of Justice Statistics.

Lenke, L. (1990) 'Alcohol and criminal violence-time series analysis in a comparative perspective' in I. Rossow (ed.) 'Alcohol-related violence: The impact of drinking pattern and drinking context', *Addiction*, **91**(11), 1651-1661.

Leonard, K. E. and Blane, H. T. (1992) 'Alcohol and marital aggression in a national sample of young men', *Journal of Interpersonal Violence*, **7**, 19-30.

Lipsey, M. W., Wilson, D. B., Cohen, M. A. and Derzon, J. H. (1997) 'Is there a causal relationship between alcohol use and violence? A synthesis of evidence', *Recent Development of Alcoholism*, **13**, 245-282.

Lobel, K. (ed) (1986) *Naming the Violence: Speaking Out About Lesbian Battering*. New Leaf Series, Seattle: The Seal Press.

Maudoodi, Syed Abul Ala (1980) *Human Right in Islam*. Leicester: Islamic Foundation.

McGee, C. (2000) *Childhood Experiences of Domestic Violence*. London: Kingsley.

Morgan, M. and Pratt, O. E. (1982) 'Sex, alcohol and the developing fetus', *British Medical Bulletin*, **38**, 43-52.

Mullender, A. and Morley, R. (eds) (1994) *Children Living With Domestic Violence: Putting Men's Abuse of Women on the Child Care Agenda*. London: Whiting and Birch.

Mullender, A., Humphreys, C. and Saunders, H. (eds) (1999) *Domestic Violence and Child Abuse: Policy and Practice Issues for Local Authorities and Other Agencies*. London: LGA Publications.

Nofal, F. H.; Saeed, A. A. Anokute, C. C. (1996) 'Aetiological factors contributing to road traffic accidents in Riyadh City, Saudi Arabia', *Journal of the Royal Society of Health*,**116**(5), 304-311.

Nurco, D., Hanlon, T., Kinlock, T. and Duszynski, K. (1988) 'Differential criminal patterns of narcotic addicts over an addiction career', *Criminology*, **26**(3), 407-423.

O'Brien, R. and Chafetz, M. (1982) *The Encyclopedia of Alcoholism*. London: Library Association.

O'Donovan, K. (1985), *Sexual Divisions in Law*, Weidenfeld and Nicolson, London.

O'Farrell, T. J., Kleinke, C. L. and Cutter, S. G. (1997) 'A Sexual Adjustment Questionnaire for use in therapy and research with alcoholic and their spouses', *Journal of Substance Abuse Treatment*, **14**(3), 259-268.

O'Farrell, T. J., and Rotunda, R. J. (1997) 'Couples interventions and alcohol abuse', in W. K. Halford and H. J. Markman (eds), *Clinical Handbook of Marriage and Couples Interventions*. New York: Wiley, pp. 556-588.

O'Leary, K. D., Barling, J., Arias, I., Rosenbaum, A., Malone, J., and Tyree, A., (1989) 'Prevalence and stability of physical aggression between spouse, *Journal of Consulting and Clinical Psychology*, **57**, 263-268.

Pagelow, M. D. (1984) *Family Violence*. New York: Praeger.

Pahl, J. (ed) (1985), *Private Violence and Public Policy – The Needs of Battered Women and The Response of the Public Services*. London: Routledge and Kegan Paul.

Pan, H. S., Neidig, P. H. and O'Leary, K. D. (1994) 'Predicting mild and severe husband-to-wife physical aggression, *Journal of Consulting and Clinical Psychology*, **62**, 975-981.

Pernanen, K. (1991) *Alcohol in Human Violence*. New York: Guilford Press.

Plummer, Ken. (1995) *Telling Sexual Stories: Power, Change and Social Worlds*. London: Routledge.

Quigley, B. M. and Leonard, K. E. (2000) 'Alcohol, drugs, and violence', in V. B. Van Hasselt and M. Hersen (eds.), Aggression and violence: An introductory text. Boston: Allyn & Bacon. pp. 259-283.

Quigley, B. M. and Leonard, K. E. (1999) 'Husband alcohol expectancies, drinking, and marital-conflict styles as predictors of severe marital violence among newlywed couples, *Psychology of Addictive Behaviors*, **13**, 49-59.

Qureshi, N. A. (1992) 'Sociodemographic correlates, pattern, and co-morbidity of drug abuse among psychiatric patients', *Arab journal of psychiatry*, **3**, 98-106.

Qureshi, N. A. and AI-Habeeb, T. A. (2000) 'Sociodemographic Parameters and Clinical Pattern of Drug Abuse in AI-Qassim Region-Saudi Arabia', *Arab journal of psychiatry*, **11**(1).

Qureshi, N. A.; Al-Ghamdy, Y. S. and Al-Habeeb, T. A. (2000) 'Drug addition: a general review of new concepts and future challenges', *Eastern Mediterranean Health Journal*, **6**(4), 723-733.

Roizen, J. (1997) 'Epidemiological issues in alcohol related violence, in Galanter, M. (ed.), *Recent Development in Alcoholism*, **13**. New York: Plenum Press, pp. 7-40.

Rose, N. (1987) 'Beyond the public / private division: Law, power and the family', in P. Fitzpatrick and A. Hunt (eds) *Critical Legal Studies*. London: Basil Blackwell.

Roy, M. K. (1977) 'A current survey of 150 cases', in Roy, M. (ed.), *Battered Women: A Psychological Study of Domestic Violence*. New York: Van Nostrand Reinhold. pp. 244-255.

Roy, M. K. (1977) 'A research project probing a cross-section of battered women', in Roy, M. (ed.), *Battered Women: A Psychological Study of Domestic Violence*. New York: Van Nostrand Reinhold.

Saunders, D. G. (1986) 'When battered women use violence: Husband-abuse or selef-defensed?', *Violence and Victims*, **1**, 47-60.

Savarese, V. W., Suvak, M. K., King, L. A. and King, D. W. (2001) 'Relationships among alcohol use, hyperarousal, and marital abuse and violence in Vietnam veterans', *Journal of Traumatic Stress*, **14**(4), 717-732.

Schuerger, J. M. and Reigle, N. (1988) 'Personality and biographic data that characterize men who abuse their wives', *Journal of Clinical Psychiatry*, **44**(1), 75-81.

Seuffert, N. (1994) Lawyering and domestic violence: A feminist integration of experience, theories and practices', in J. Stubbs (ed) *Women, Male Violence and The Law*. Sydney: The Institute of Criminology Monograph Series, No.6.

Smart, C. (1984) *The Ties that Bind: Law, Marriage and the Reproduction of Patriarchal Relations*. London: Routledge.

Smith, L. J. (1989) *Domestic Violence: An Overview of the Literature*, Home Office Research Study No.107. London: A Home Office Research and Planning Unit Report, HMSO.

Stalford, H., Baker, H., and Beveridge, F. (2003) *Children and Domestic Violence in Rural Areas: A Child Focused Assessment of Service Provision*. London: Save the Children Publications.

Stanko, E. A. (1985) *Intimate Intrusions: Women's Experiences of Male Violence*. London: Routledge and Kegan Paul.

Stanko, E. A. (1990) *Everyday Violence – How Women and Men Experience Sexual and Physical Danger*. London: Pandora.

Stanko, E. A. (ed) (1994) *Perspectives on Violence*. London: Quartet Books, Howard League Handbooks 1.

Steadman, H. J., Mulvey, E. P., Monahan, J., Robbins, P. C., Appelbaum, P. S., Grisso, T., Roth, L. H. and Silver, E. (1998) 'Violence by people discharged from acute psychiatric facilities and by others in the same neighborhoods', *Archives of General Psychiatry*, **55**(5), 393–401.

Straus, M. A., Gelles, R. J. and Steinmetz, S. K. (1980) *Behind Closed Doors: Violence in the American Families.* Anchor Press: New York.

Straus, M. A. and Gelles, R. J. (1986) 'Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys', *Journal of Marriage and the Family*, **48**, 465-479.

Straus, M. A., Hamby, S. L., Boney-McCoy, S. and Sugarman, D. B. (1996) 'The revised Conflict Tactics Scales (CTS2): Development and preliminary psychometric data', *Journal of Family Issues*, **17**(3), 283-316.

Tardiff, K., Marzuk, P. M., Leon, A. C., Portera, L. and Weiner, C. (1997) 'Violence by patients admitted to a private psychiatric hospital', *American Journal of Psychiatry*, **154**, 88–93.

Taylor, S. P. (1991) 'Effect of alcohol and aggressive disposition on human physical aggression', *Journal of Research in Personality*, **25**, 334-342.

Tardif, G. (1967) 'Les delits de violence a Montreal', in Quebec Society of Criminology (ed), *Fifth Research Conference on Delinquency and Criminality*. Montreal: Quebec Society of Criminology.

The Cabinet Office and The Home Office (June 1999) *Living Without Fear: An Integrated Approach to Tackling Violence Against Women*. London: HMSO.

The Home Office (January 1999) *Domestic Violence – Break the Chain – What You Can Do About Domestic Violence*. London: HMSO.

Tolman, R. and Bennett, L. (1990) ‘A review quantitative research on men who batter’, *Journal of Interpersonal Violence*, **5**(1), 87-118.

van Thiel, D. H. and Lester, R. (1974) ‘Sex and Alcohol’, *New England Journal of Medicine*, **291**, 251-253.

Wells, S., Graham, K., West, P. (2000) ‘Alcohol-related aggression in the general population’, *Journal of Studies on Alcohol*, **61**, 626-632.

Wilsnack, R. W., Vogeltanz, N. D., Wilsnack, S. C. and Harris, T. R. (2000) ‘Gender differences in alcohol consumption and adverse drinking consequences: Cross-cultural patterns’, *Addiction*, **95**, 251-265.

Wilson, E. (1983) *What Is to Be Done about Violence Against Women?*. London: Penguin Books in association with The Socialist Society.

Younis, Y. O. and Saad, A. G. (1995) ‘A profile of alcohol and drug misuse in an Arab community’, *Addiction*, **90**, 683-684.

Zeichner, A. and Pihl, R. O. (1980) ‘Effects of alcohol and instigator intent on human aggression’, *Journal of Studies on Alcohol*, **41**, 265-276.

Zeichner, A. and Pihl, R. O. (1979) ‘ Effects of alcohol and behavior contingencies on human physical aggression’, *Journal of Abnormal Psychology*, **88**, 153-160.

Zernig, G.; Saria, A.; Kurz, M. and O’Malley, S. S. (2000) *Handbook of Alcoholism*. London: CRC Press.