CHAPTER-I

INTRODUCTION

Anthropology is the scientific and holistic study of human beings across the Globe. The main focus of anthropology and anthropologist is to apply the knowledge of anthropology to human problems and miseries to overcome them over a period of time. The knowledge of anthropology is very much essential in the total understanding of humanity both in time and space. Anthropology is the study of humans, past and present. To understand the full sweep and complexity of cultures across all of human history, anthropology draws and builds upon knowledge from the social and biological sciences as well as the humanities and physical sciences. A central concern of anthropologists is the application of knowledge to the solution of human problems. Anthropology has several branches through which it tries to cover the holistic understanding of man both in time and space because of this anthropologists are very proudly claim that their study is the totality of the understanding of humans across the border without any discrimination of caste, creed, race, sex and language. The present study falls under the category of medical anthropology, which is one of the very important branches dedicated for the study of health and health related aspects of humans.
The concept of folk medicine was taken up by professional anthropologists in the first half of the twentieth century to demarcate between magical practices, medicine and religion and to explore the role and the significance of popular healers and their self-medicating practices. For them, popular medicine was specific cultural features of some group of humans which was distinct from the universal practices of biomedicine. If every culture had its own specific popular medicine based on its general cultural features, it would be possible to purpose the existence of as many medical systems as there were cultures and, therefore, develop the comparative study of these systems. Those medical systems which showed none of the syncretic features of European popular medicine were called primitive or pre-technical medicine according to whether they referred to contemporary aboriginal cultures or to cultures predating Classical Greece. Those cultures with a documentary corpus, such as the Tibetan, traditional Chinese or Ayurvedic cultures, were sometimes called systemic medicines. The comparative study of medical systems is known as ethnomedicine or, if psychopathology is the object of study, ethno psychiatry or transcultural psychiatry.

We all know that health and disease always go hand in hand. Since time immemorial man has developed several mechanisms to overcome his/her health disorders. It is also proved that the primitive ancestors of
the present day humans were wanderers and moving in Jungles in order to search a lively hood as well a favourable settlement. It is also true that since then our primitive people were badly affected by several health disorders and their disorders can be given new names in medical terminology now. It is also true that the primitive people started overcoming their health disorders by trial and error methods, which includes random chewing of some leaves and roots, which must have had medicinal values but now the same practice has been carry forwarded by the present day population under a new terminology called “Ayurveda”.

In the absence of medical pluralism (20th Century concept) people having no other alternative depended on nature and indigenously available medicine for curing, healing their health disorders. Over a period of time due to the tremendous development in the field of medicine and other related disciplines people started shifting their allegiance from Ayurveda to other medical systems because of their unquestioned faith in them.

Concept of health and health related aspects. WHO opines that Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. This has not been understood by the common people in the same fashion of what the medical scientists understand. The motto of WHO is to provide good health to all. This is the reason why majority of the nations in the world
have launched several programmes for providing good health to the people as a result of this now for every 10,000 population one could get a PHC through which several villages has been connected to cater to the needs of the needy people.

The concept of health:- For many Health is NOT mainly an issue of Doctors, social services and hospitals. It is an issue of social justice. Health is a common theme in most cultures. In fact, all communities have their concepts of health, as a part of their culture. Among definitions still used, probably the oldest is that health is the ‘absence of disease’. In some cultures, health and harmony are considered equivalent, harmony being defined as” being at peace with the self, the community, the god and cosmos”. The ancient Indians and Greeks shared this concept and attributed disease to disturbance in bodily equilibrium of what they called “humors”.

Modern medicine is often accused for its preoccupation with the study of disease, and neglect of the study of health. Consequently, our ignorance about our health continues to be profound, as for example, the determinants of health are not yet clear; the current definitions of health are elusive; and there is no single yardstick for measuring health. There is thus a great scope for the study of the “epidemiology” of health.
Health continues to be a neglected entity despite of lip services. At the individual level, it cannot be said the health occupies an important place; it is usually subjected to other needs defined as more important, e.g., wealth, power, prestige, knowledge, security. Health is often taken for granted, and its value is not fully understood until it is lost. At the international level, health was ‘forgotten’ when the convent of League of Nations was drafted after the First World War. Only at the last moment, was world health brought in. Health was again “forgotten” when the character of the United Nations was drafted at the end of Second World War. The matter of health had to be introduced ad hoc at the United Nations Conference at San Francisco in 1945.

Anthropology occupied a notable position in the basic medical sciences which correspond to those subjects commonly known as preclinical. However, medical education started to be restricted to the confines of the hospital as a consequence of the development of the clinical gaze and confinement of the patients in observational infirmaries. The relationship between medical practice and anthropology is well documented. Some of the characters share clinical and anthropological roles. Whereas a large number of contributions to 20th century medical anthropology had their primary training in medicine, nursing, psychology or psychiatry, including W.H. R Rivers, Abram Kardiner, Robert I. Levy,
Jean Benoist, Gonzalo Aguirre Beltran and Arthur Kleinman. Others came from anthropology or social sciences, like George Foster, William Caudill, Byron Good, Tullio Seppilli, Gilles Bibeau, Luis Mallart, Andras Zempleni, Gilbert Lewis, Ronald Frankenberg, and Eduardo Menendez. A recent book by Saillant and Genest describes a large international panorama of the development of medical anthropology, and some of the main theoretical and intellectual actual debates. The hegemony of hospital clinical education and of experimental methodologies suggested by Claude Bernard relegate the value of the practitioners’ everyday experience who was previously seen as source of knowledge represented by the reports called medical geographic and medical topographies both based on ethnographic, demographic, statistical and sometimes epidemiological data. After the development of hospital clinical training the basic source of knowledge in medicine was experimental medicine in the hospital and laboratory, and these factors together meant that over time mostly doctors abandoned ethnography as a tool of knowledge. Most, but not all because ethnography remained during a large part of the 20th century as a tool of knowledge in primary health care, rural medicine and in international public health. The abandonment of ethnography as one of the markers of its professional identity and started of depart from the initial project of general anthropology. The divergence of professional anthropology from medicine was never a complete split.
Different Branches of Anthropology

1. Biological anthropology

2. Cultural anthropology

**Biological anthropology**, also known as **physical anthropology**, is a scientific discipline in which research is concerned with the biological and behavioral variation of human beings, other non-human primates, and extinct hominin ancestors of the human species. It is a subfield of the broader discipline of anthropology, and it provides a biological perspective to the systematic study of human variation.

**Cultural anthropology** is a branch of anthropology focused on the study of cultural variation among humans and in contrast to the social anthropology perceives the cultural variation more as an independent (explanatory) “variable” than the dependent one.

Since the mid-1960s, medical anthropology has developed three major orientations. Medical ecology views populations as biological as well as cultural units and studies interactions among ecological systems, health, and human evolution. Ethnomedical analysis focuses on cultural systems of healing and the cognitive parameters of illness. Applied medical anthropology deals with intervention, prevention, and policy issues and analyses the socioeconomic forces and power differentials that influence access to care. In this triad, cultural anthropology is most
closely allied with ethnomedicine. In the formative years, some anthropologists favoured identifying the field as “Ethnomedicine,” while others preferred “anthropology of health.” The term “medical anthropology prevailed, however, coming to represent a diversified range of orientations.

It also studies “human health and disease, health care systems, and biocultural adaptation”. It views humans from multidimensional and ecological perspectives. It is one of the most highly developed areas of anthropology and applied anthropology, and is a subfield of social and cultural anthropology that examines the ways in which culture and society are organized around or influenced by issues of health, health care and related issues.

The term “medical anthropology” has been used since 1963 as a label for empirical research and theoretical production by anthropologists into the social processes and cultural representation of health, illness and the nursing / care practices associated with these. Furthermore, in Europe the terms “anthropology of medicine”, “anthropology of health” and “anthropology of illness” have also been used, and “medical anthropology”, was also a translation of the 19th century Dutch term “medische anthropologie”. The term was chosen by some authors during the 1940s to refer to philosophical studies on the health and illness.
Medial anthropology is an interdisciplinary field which studies “human health and disease, health care systems and biocultural adaption”. It views humans from multidimensional and ecological perspectives. It is one of the most highly developed areas of anthropology and applied anthropology, and is a subfield of social and cultural anthropology that examines the ways in which culture and society are organised around or influenced by issues of health, health care and related issues. Medical anthropology is the study of human health and disease, health care systems, and biocultural adaption. The discipline draws upon the four fields of anthropology to analyse and compare the health of regional populations and of ethnic and cultural enclaves, both prehistoric and contemporary. Collaboration among paleopathologists, human biologists, ethnologists, and linguists has created a field that is autonomous from any single sub discipline, with strong potential for integration of physical and cultural anthropology. The field is also highly interdisciplinary, linking anthropology to sociology, economics, and geography, as well as to medicine, nursing, public health and other health professions.

Doctors, anthropologists and medical anthropologists used these terms to describe the resources, other than the help of health professionals. The term was also used to describe the health practices of aborigines in different parts of the world, with particular emphasis on their ethnobotanical knowledge. This knowledge is fundamental for isolating alkaloids and active pharmacological principles. Furthermore, studying the rituals surrounding popular therapies served to challenge
Western psychopathological categories, as well as the relationship in the West between science and religion. Doctors were not trying to turn popular medicine into an anthropological concept, rather they wanted to construct a scientifically based medical concept which they could use to establish the cultural limits of biomedicine.

Though the present study is confined to Alcoholic dependents (Alcoholic Addicts) until unless we know what is health, good health, the idea and the motto of WHO on health one will not be able to understand.

However, during the past few decades, there has been a reawakening that health is a fundamental human right and a world-wide social goal; that it is the essential to the satisfaction of basic human needs and to an important quality of life; and, that it is to be attained by all people. In 1977, the 30th World Health Assembly decided that main social target of Governments and WHO in the coming decades should be “the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life” for brevity called “Health for All”. With the adoption of health as an integral part of socio-economic development by the United Nations in 1979, health, while being an end in itself, has also become a major instrument of overall socio-economic development and creation of a new social order.
**Health** is the level of functional or metabolic efficiency of a living being. In humans, it is the general condition of a person's mind and body, usually meaning to be free from illness, injury or pain (as in “*good health*” or “*healthy*”). The World Health Organization (WHO) defined health in its broader sense in 1946 as “a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.

**Medical anthropology** is the study of human health and disease, health care systems, and biocultural adaptation. The discipline draws upon the four fields of anthropology to analyse and compare the health of regional populations and of ethnic and cultural enclaves, both prehistoric and contemporary. Collaboration among paleopathologists, human biologists, ethnologists, and linguists has created a field that is autonomous from any single subdiscipline, with strong potential for integration of physical and Cultural anthropology. The field is also highly interdisciplinary, linking anthropology to sociology, economics, and geography, as well as to medicine, nursing, public health, and other health professions.

Alcoholic beverages in the Indus valley civilization appeared in the Chalcolithic Era. These beverages were in use between 3000 BC - 2000 BC. *Sura*, a beverage brewed from rice meal, wheat, sugar cane, grapes, and other fruits, was popular among the Kshatriya warriors and the peasant population *Sura* is considered to be a favorite drink of Indra.
The Hindu Ayurvedic texts describe both the beneficent uses of alcoholic beverages and the consequences of intoxication and alcoholic diseases. Ayurvedic texts concluded that alcohol was a medicine if consumed in moderation, but a poison if consumed in excess. Most of the people in India and China, have continued, throughout, to ferment a portion of their crops and nourish themselves with the alcoholic product.

In ancient India, alcohol was used by the orthodox also. Early Vedic literature suggests the use of alcohol by priestly classes. The two great Hindu epics, Ramayana and Mahabharata, mention the use of alcohol. In Ramayana, alcohol consumption is depicted in a good/bad dichotomy. The bad faction members consumed meat and alcohol while the good faction members were abstinent vegetarians. However in Mahabharata, the characters are not portrayed in such a black-white contrast. Alcohol abstinence was promoted as a moral value in India by Hindu sages like Mahavira, the founder of Jainism, Shankracharya, and by the Buddha.

**Mythology of Alcohol :**

**The Kegger of the Gods :**

Norse mythology tells of Aegir, the ale brewer of the gods, who held a big party for honored guests every winter. The party was held inside a great hall whose floor was littered with glittering gold, providing
enough light that no fires were necessary for illumination. The special beer for the event was brewed in a giant cauldron given to him by Thor and served in magical cups that refilled as soon as they were empty. He even had a couple of loyal servants who distributed food and otherwise cared for the guests’ needs. The shindig was the highlight of the social season and all the gods attended. However, like so many off-campus college parties, alcohol and animosity could sometimes spoil a perfectly good evening.

According to the *Poetic Edda*, a collection of mythological poems, the party started off great, with everyone drinking and eating and telling stories. As they sat down for the big feast, the inebriated guests offered praise to the two lowly servants, Fimafeng and Eldir. The snobby rich kid of the gods, Loki, in his drunken arrogance, took offense to the gesture, feeling the servants were not worth such accolades, and killed Fimafeng. The others kicked him out of the party for being a jerk, but he returned shortly after, demanding to be shown some respect and allowed back at the table.

At first everyone ignored him, but he guilt-tripped Odin, king of the gods, into letting him return. But Loki couldn't leave well enough alone. He insulted the other guests, challenged them to fights, called into question the fidelity of everyone at the table, and pulled old rumors and
skeletons out of the closet to “defend himself” against “attacks” from the other gods, who were simply asking him to shut up. This went on until Thor, the starting defensive lineman of the gods, arrived fashionably late and threatened to break every bone in Loki's annoying body. Knowing that Thor would actually do it, Loki decided to leave while he still walking.

Loki didn't get away unharmed, though. Skaoi, one of the goddesses he insulted that night, caught up with the god and tied him to a rock. Above his naked body, she hung a poisonous snake, whose fangs dripped acidic venom into a small dish, held up by Loki's wife, Sigyn. Whenever the dish filled, she had to pull it away and pour the venom on the ground. This meant the venom would occasionally drip onto her husband, causing him immense pain. According to legend, Loki's violent writhing is what causes earthquakes. Of course this could have all been avoided if Loki had simply known when to say when.

**Rum Warms more than the Soul:**

Rum has been known to do some very strange things to a person, many of which sound a lot like when a person is possessed by Ogoun, a warrior spirit in the voodoo religion. When Ogoun takes over a man, the original personality is replaced by one that is often completely different. For example, he will become brash and antagonistic, which is fine
because Ogoun is supposedly bulletproof. These possessed men will wildly wave a machete, smoke cigars, chase women, and demand rum by saying, “Gren mwe fret,” which translates to “My testicles are cold” (presumably the rum will warm them). Some have even been known to wash their hands in flaming rum without showing any signs of pain - at least, we can assume, until all that rum they drank wears off. Thankfully they don't use the flaming rum on other, chilly body parts.

**WHO definition of Health:**

The doctor–patient relationship is central to the practice of healthcare and is essential for the delivery of high-quality health care in the diagnosis and treatment of disease. The doctor–patient relationship forms one of the foundations of contemporary medical ethics. Most universities teach students from the beginning, even before they set foot in hospitals, to maintain a professional rapport with patients, uphold patients’ dignity, and respect their privacy.

Alcohol is being used and abused throughout the history of mankind. The old Testament prescribed the use of wine in religious rituals (Joel, Kum 1982). Alcoholic beverages have been used since the dawn of civilization. The common use of alcohol is well documented in the earliest writings of Mesopotamia & Egypt. In those writings descriptions of drunkenness were frequent, as were prescribed remedies. (Joel, Kum 1982) (Goodman & Gilman, 1996) Ancient Cuneiform and
Hieroglyphic inscriptions describe both the normal and abnormal use of alcohol. (Joel, Kum 1982) The wide spread use of alcoholic beverages was characteristic of all early civilizations, the oriental, the Greek and the Roman although the attitudes towards the drunkenness varied widely from place to place (Joel, Kum 1982).

The commonly consumed alcohol is ethanol (ethyl alcohol). The beverages containing ethanol is called alcoholic beverages, although the term is a generic one for a group of organic chemical compounds that contain one or more hydroxyl (-OH) groups. Non-beverage alcohols are products that contain alcohol that are not intended for consumption, such as mouthwashes and rubbing alcohol (Campbell. 2004). The simplest non-beverage alcohol is methanol (methyl alcohol, wood alcohol). It is used primarily as an industrial solvent. It is highly toxic and if ingested may produce blurred vision, blindness, coma, and death. It is one of the main ingredients of illicit liquor.

The ethanol obtained through fermentation of sugar by yeast. Under natural conditions, the conversion of sugar to alcohol stops when the alcohol concentration reaches 12% to 14% (as in unfortified wines and beers). Arabs (Arabian alchemist Geber) in the 9th century introduced the process of distillation through which alcohol is boiled out of its mixture with sugar and is recollected in almost pure form. The distilled alcohol is then diluted with water to bring it to the desired strength, or
“proof,” which is twice the alcohol concentration (i.e., a beverage containing 50% alcohol by volume is 100 proof). Other chemicals (congeners) are added to give a distinctive color and taste (Campbell, 2004).

Alcoholic beverages differ according to their source; sugar; grapes are used to produce wine, (24 to 28 proof), grain is used to produce beer and ale, (8 proof), grain and potatoes to produce vodka, rye or corn to produce whiskey, and sugar cane to produce rum. “Hard” liquors, such as whiskey, vodka, and gin, are 86 proof. Brandy is made by distillation of the fermented juice of grapes or other fruit; sherry is fermented grape juice fortified with brandy to bring it to approximately 40 proof (Campbell, 2004).

The advent of the process of distillation led to the major change in pattern of alcohol ingestion. The Arab alchemist believed that alcohol was the long sought elixir of life. Alcohol was therefore held to be a remedy for practically all diseases, as indicated by term whisky, (Gaelic; Usquebaugh, Water of Life) (Joel, Kum, 1982) (Goodman & Gilmann, 1996).

Towards the end of 13th century Arnauld de Villenueva, a Professor of Medicine at the university of Montpellier found that through repeated distillation of red or white wine, he could derive a clear, colorless liquid
of great purity and power, which he wrote; “Prolongs life, clears away ill-humors, revives heart and maintains youth”. On this noble fluid he bestowed the name AQUAVITAE (Joel, Kum, 1982).

In the Seventeenth century, Franciscus Sylvius discovered that aqua vitae could be obtained through the distillation of fermented grain (beer) as well as from wine, a discovery that permitted its production of alcohol in vast quantities. The spread of distilled liquor as Junever in Holland, then as Genie’ ure in France, Gin in England and Vodka in Russia was accompanied by the epidemics of drunkenness (Joel, Kum, 1982).

In the eighteenth century, when cheap Gin was introduced into England, the alcohol consumption increased substantially as also related problems which were more serious than those associated with beer and wine. (Rang, Dale, and Ritter, 2000) From social point of view alcohol consumption is considered as normal in some social situations and abnormal in other situations.

In modern times Alcohol is the most widely used psychoactive substance in Western countries. According to National Institute of Drug Abuse, NDA 1988, approximately eight out of ten persons living in Europe and USA would report drinking in their lifetime. The norm for drinking is to start in adolescence. Close to 50% of American students
have had their drinking experiences by the age of 13yrs and rate increases to 81.7% at 17yrs (Juan, 2000). Over the past 30yrs, increasing percentages of young people have started to drink alcoholic beverages, their alcohol consumption has increased in quantity and frequency, and the age at which drinking starts has declined. This situation is disturbing because the young people concerned may run a greater risk of alcoholic problems in later life and also, in the short term, because of increased rate of drunkenness and involvement in road traffic accidents (Park, 1997). In India, surveys in general population of drinking habit was around 2.9 to 82.5% and was about 5.2 to 58% in student survey. (Nimesh, Dhanesh, 1999) In U.K. for instance, hazardous drinking is thought to start at 21 units / week for men and 16 units / weeks for women. In Canada it is put at 14 units and 12 units for men and women respectively. In U.S. the equivalent guidelines are 4 and 7 units per week. (Juan, 2000).

The role of personality and personality pathology in the pathogenesis of addictive problems has been strongly and simultaneously influenced by a diversity of theoretical schools and public domains. The interest in the co-occurrence of personality disorders among alcohol abusers is fuelled by the idea that studying co-morbidity will lead to a better understanding of the etiology of both alcohol use and personality disorders and their interaction.
Understanding co morbidity is also thought to be of paramount interest for treatment planning and the development of more effective strategies for treatment of both alcohol abuse and personality disorders.

Alcohol use is associated with other substance abuse such as tobacco, marijuana, cocaine, and narcotics and is prevalent in patient with psychiatric disorders.

**Social Composition:**

<table>
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<th>Religion</th>
<th>Less than 20 Years</th>
<th>21 to 40 Years</th>
<th>More than 40 Years</th>
<th>Total</th>
</tr>
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<tr>
<td>Hindu</td>
<td>280</td>
<td>560</td>
<td>80</td>
<td>920</td>
</tr>
<tr>
<td>Muslim</td>
<td>20</td>
<td>48</td>
<td>12</td>
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<td>Total</td>
<td>300</td>
<td>608</td>
<td>92</td>
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The research in alcohol is quite extensive & varied comprising of topics of definition of alcohol, types of alcoholism, etiology, epidemiology, psycho pathology, comorbid psychiatric conditions and personality disorders. Screening for alcoholism, immediate and long term treatment and short and long term prognosis.

Review of Literature:

One of the burning issues in third world countries in the last phase of 20th century was the concern about individual health and also the facilities available to get good health. World Health Organization’s motto was to provide good health to all humans across the world. As a result, all the third world countries have launched several programmers to provide good health facilities to its citizens without any discrimination of caste, creed, race and gender.

Health plays an important role in the life of an individual. This is because of the fact that since inception man had faced several health hazards and to overcome this, tried through several mechanisms including Ayurveda, Homeopathy, siddha, unani, Tibet and Chinese. Before the recognition of medical systems our primitive ancestors had used and tried several means and ends to combat their health hazards by trial and error methods, with the indigenously available medical plants. Due to this mortality rates were considerably decreased. At present mortality rates were slowly and steadily reduced to the minimum.
India, in the initial stages dominated by poverty, illiteracy, superstition, and blind beliefs. As a result of this people did not pay much attention to their health in general and health in particular. Added to this India was known for Agrarian economy. Agriculture was not only an occupation but a way of life. They too contributed their might in the overall development of the economy and agricultural sector.

Health is a common theme in every society and has its own beliefs and practices regarding healing diseases and its treatment. Since time immemorial, man has been trying hard to control diseases. The medicine man, the priest, the herbalist and the magician all undertook various ways and means to cure man’s diseases and there by to bring relief to the sick. In the past health and illness were interpreted in a Cosmological as well as Anthropological perspective. Medicine in the past was dominated by magico-religious beliefs, which were an integral part of society itself. Dubos opines that, “ancient medicine” was the mother of every Culture. All of these practices are keenly interrelated with environment. During the past few decades the concept of health has emerged as a fundamental human right and a world wide social goal. In 1977, the 30th World Health Assembly decided that the main social target of the government and World Health organization in the coming decades should be “the attainment by all citizens of his world by the year 2000 of a level of health that will permit them to lead a social and economically productive life.” For brevity, called “Health for All”, with the adoption of health as an integral part of Socio-economic development by the United Nations in
1979, health while being an end in itself has also become a major instrument of overall Socio-economic development and the creation of a new social order.

Keeping in view the concept of alcoholism and health the present study entitled health been undertaken.

**Place and People :**

The present study has been carried out in Davangere and its surrounding villages. A multicastr village and also numerically big in size has been selected at random and studied in detail. The village so selected has been dominated by agriculture. In the beginning a pilot study was conducted to study to understand their overall socio-economic and cultural background. For a clear understanding of the health disorders, I restricted the sample size of one thousand subjects.

India, the second most populous country on the globe having more than one hundred crores of population. Basically India is known as an agrarian economy.

The research in alcohol is quite extensive & varied comprising of topics of definition of alcohol, types of alcoholism, etiology, epidemiology, psycho pathology, comorbid psychiatric conditions and personality disorders. Screening for alcoholism, immediate and long term treatment and short and long term prognosis.
Definitions of Alcoholism:

Jellinek's First Disease Conception:

Jellinek (1952) begins by restricting the concept of alcoholism to those excessive drinkers characterized by physical or psychological pathology and whose rehabilitation primarily requires medical-psychiatric treatment. Among those who may legitimately be called alcoholics, there are two distinct types, namely alcohol addicts’ to whom the disease concept of alcoholism attaches, and habitual symptomatic excessive drinkers to whom it does not. The differentiating criterion between these types is loss of control which occurs only among alcohol addicts.

Jellinek's delta and gamma species resemble Morey and Skinner's affiliate drinkers and schizoid drinkers respectively.

The official definition of alcoholism as reported by “World Health Organization’s expert committee (1954) is a technical one and reads as; Any form of drinking which in its extent goes beyond the traditional and customary “dietary' use or the ordinary compliance with the social drinking customs of the whole community concerned, irrespective of the etiological factors leading to such behavior and irrespective also of the extent to which such etiological factors are dependent upon heredity, constitution or acquired physiopathological and metabolic influences.

There were many definitions of alcoholism.
**Jellinek's First Disease Conception:**

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Jellinek's Second Disease Conception:

The background to Jellinek’s (1960) second disease conception was heavily influenced by the extensive international experience he had acquired after the publication of the earlier work. Jellinek’s (1960) book is best known for its Greek letter classification and the five species of alcoholism included in this are as follows:

“Alpha alcoholism” is said to represent a purely psychological and continual dependence or reliance upon the effect of alcohol to relieve bodily or emotional pain. There is no pharmacological addiction. Drinking may be undisciplined and may contravene the rules of society but does not lead to loss of control. There are no signs of a progressive process.

“Beta alcoholism” refers to the presence of physical complications from excessive drinking, such as, polyneuropathy, gastritis and liver cirrhosis, but without any physical or psychological dependence. In this case, heavy drinking may reflect customs of a particular social group combined with poor nutritional habits. Beta alcoholism may also develop into alcohol addiction but the transition is less likely than with the alpha variety.
“Gamma alcoholism’ is characterized by (i) acquired increased tissue tolerance to alcohol; (ii) adaptive cell metabolism; (iii) withdrawal symptoms and carving (i.e. physical dependence) and (iv) loss of control. In this species alone there is a definite progression from psychological to physical dependence, accompanied by the behavioural deterioration.

“Delta alcoholism’ shows the first three characteristics of gamma alcoholism just listed but instead of ‘inability to stop’, there is inability to obtain. That is, the ability to control intake on any given occasion remains unaffected but there is no capacity for abstention from alcohol even for a few days without the occurrence of withdrawal symptoms.

“Epsilon alcoholism’ describes the relatively rare and little known form of periodic alcoholism, previously called dipsomania. (Campbell) Morey and Skinner (Morey, Skinner,1986) applying cluster analysis to data obtained from an extensive alcohol use questionnaire identified three types of drinkers.

1) The first type, early-stage problem drinkers, represented a heterogeneous group who showed evidence of drinking problems, but had not accrued major symptoms of alcohol dependence.

2) The second type, affliative drinkers, was more socially oriented, tended to drink daily and demonstrated moderate alcohol dependence.
3) The third type, schizoid drinkers, were more socially isolated, tended to drink in binges, and reported the most severe symptoms of alcoholism.

**Cloninger et al** *(1981)* have proposed a neurobiological learning model of alcoholism that distinguishes two genetic subtypes termed

1) “milieu - limited” (type I) Type I alcoholics have a later onset of alcohol problems, show psychological rather than physical dependence and experience guilt feelings about their alcohol use. Type I alcoholics are thought to have high avoidance (behavior inhibitions, anticipatory worrying) and low novelty seeking (rigidity, reflectiveness).

2) “male -limited” (type -II). Type II alcoholics manifest alcohol problems at an early age, exhibit spontaneous alcohol seeking behavior and are socially disruptive when drinking. Type II alcoholics are hypothesized to lack harm avoidance (take risk) and to prefer novelty seeking (eg; impulsiveness and quick temper).

**Zucker's ( 1987)** developmental model postulates four kinds of alcoholism.

1) Developmentally cumulative alcoholism: The alcohol dependence is considered primary and over the life course, culturally induced drinking processes become sufficiently cumulative to produce alcohol dependence.
2) Developmentally limited alcoholism: It is characterized primarily by frequent heavy drinking and tends to remit to social drinking with the successful assumption of adult careers and family roles.

3) Negative-affect alcoholism: It is considered to occur primarily in women, is characterized by the use of alcohol for mood regulation or to enhance social relationships.

4) Anti social alcoholism: It is characterized by early onset of alcohol related problems and antisocial behavior.

**Babor et al (1992)** proposed two types of alcoholics, using cluster analysis.

1) The first, type B alcoholics, is characterized by early onset of problem drinking, rapid progression, indicators of childhood and familial vulnerability, more psychiatric disturbances, greater symptoms severity and poor prognosis.

2) The second group, called type A alcoholics, is characterized by later onset, fewer indicators of vulnerability, less psychiatric disturbances, a more benign alcohol-related problem profile and better prognosis. While type B alcoholics are more experimenting and uncontrolled, type A alcoholics tend to be more conservative and controlled.
Etiology:

Twins studies have shown concordance rates for alcohol-related psychosis to be 17.3% in monozygotic twins and 4.8% in dizygotic twins.

Thiamine deficiency also is a contributing factor and is known to be associated with more severe episodes of withdrawal psychosis, which may present as a delirious state, known as Wernicke-Korsakoff syndrome (Kaplan, Sadock, 2005).

Psychopathology:

The relationship between alcoholism and psychotic symptoms is often difficult to clarify. Alcohol abuse may cause, antedate, the exacerbate or mimic psychosis or complicate therapy and treatment.

Hays & Aidroos (1986) put forward the hypothesis that alcohol abuse is a important etiological factor in some schizophrenia-like psychoses.

Marcei (1989) in 1847 first described the phenomenon of hallucinatory psychosis in chronic alcoholism.

Glass (1989) reviewed six follow up studies on alcoholic hallucinosis from 1952 to 1978 and attributed the syndrome of alcoholic hallucinosis to chronic abuse of alcohol. The initial episode was acute onset and this may merge into a chronic illness. The findings on the relationship of the development of alcoholic hallucinosis to severity of
dependence, physical impairment, cognitive defect and their inter
relationships are particularly skimpy. From the analysis of genetic
studies from 1952 to 1986 it was concluded that physical symptoms in
alcoholics are unlikely to be related genetically to a schizophrenic
predisposition. Moreover, certain alcoholics are vulnerable to the
psycho to genie effects of alcohol in a manner, which appears to be genetically
determined.

Tsuang et al (1994) evaluated the characteristics of primary
alcoholics with alcoholic hallucinosis. Six hundred and forty-three
primary alcoholic men were recruited from a 28-day Alcohol and Drug
Treatment Program at the San Diego VA Medical Center. Subjects only
experiencing perceptual abnormalities during alcohol withdrawal, drug-
related hallucinosis, as well as those having abnormal sensations that did
not meet criteria for hallucinations were excluded from the study. The
remaining 532 subjects were divided into Group 1 (n=48), which
consisted of subjects with a DSM IIIR and ICD-10 diagnosis of alcoholic
hallucinosis and Group 2 (n=484), which consisted of those without any
history of hallucinations. A comparison of the two groups revealed that
Group 1 men where younger at the onset of alcohol problems, consumed
more alcohol per occasion] developed more alcohol- related life
problems, and had higher rates of drug experimentation as well as more
different types of drugs used. This study suggests that primary alcoholics who consume more drugs and/or alcohol might be at an increase risk for developing alcoholic hallucinosis.

Although distinguishing alcohol-related psychosis from schizophrenic through clinical presentation is often difficult, it is generally accepted that alcohol-related psychosis remits with abstinence, unlike schizophrenia persistent psychosis develops, diagnostic confusion can result.

At the end of the 19th century, Lawson and Korsakoff both described a syndrome, commonly but not always associated with alcohol abuse, in which memory was profoundly impaired while other cognitive functions remained intact. The fascination of the Korsakoff syndrome is that relatively small, and sometimes abrupt, neuropathological lesions give rise to a severe amnesic syndrome, disproportionate to any other impairment in cognitive functioning. The modern definition of the syndrome, provided by Victor et al (1971), is in terms of an impairment of “memory and learning... out of all proportion to other cognitive functions”, resulting from nutritional (thiamine) depletion. At an early stage, the association with the clinical features of Wernicke's encephalopathy was recognized, but it now appears that a history of Wernicke's syndrome is not invariably present, and that coma or an insidious onset are alternative initial manifestations of the disorder. The characteristic pathological features of the disorder are found in the paraventricular and periaqueductal grey matter. A variety of causes of
malnutrition or malabsorption have been reported to produce either the Wernicke or the Wernicke-Korsakoff syndrome. The common factor underlying the development of the Wernicke-Korsakoff syndrome is almost certainly thiamine depletion; but why some subjects should be especially vulnerable to thiamine depletion, and the precise manner by which it produces the characteristic Wernicke-Korsakoff lesions, are not understood. There is now general agreement concerning the pattern of the memory deficit in the Korsakoff syndrome, involving a severe impairment of new learning and extensive retrograde loss, with intact or well preserved working memory, priming, procedural memory and the rate of long term forgetting (Kopelman, 1995).

Acute and sub acute psychotic states in alcoholics have probably attracted more attention than those associated with other addictions or physical illnesses. Their classification into delirium tremens, alcoholic hallucinosis and alcoholic paranoia was officially recognised in 1965 in the ICD-8.

In ICD-10, alcoholic hallucinosis is also known as a psychotic disorder (predominantly hallucinatory). In DSM IV it is described as alcohol induced psychosis.

DSM IV diagnostic criteria (1994) for substance induced psychotic disorder.

A. Prominent hallucinations or delusions.

Note: do not include hallucinations if the person has insight that they are substance induced.
B. There is evidence from the history, physical examination, or laboratory findings of either (1) or (2).

(1) The symptoms in criterion A developed during, or within a month of substance intoxication or withdrawal.

(2) The medication use is etiologically related to the disturbance.

C. The disturbance is not better accounted for by a psychotic disorder that is not substance induced.

D. The disturbance does not occur exclusively during the course of a delirium.

**Axis I and Axis II Comorbid:**

In a study by Nurnberg et al (1993), fifty sober alcoholic outpatients enrolled in a treatment program were assessed by Structured Clinical Interview for DSM-III (SCID) instruments for the presence of axis I and axis II disorders. In this study 80% had either a coexistent axis I or II disorder, with 66% having an axis I disorder, 64% an axis II disorder, and 50% both axis I and II disorders. The most prevalent PD diagnoses were paranoid (44%), antisocial (20%), avoidant (20%), passive-aggressive (18%), and borderline (16%). Poorer outcome was associated with the presence of PD. Personality variables may offer a means of further characterizing the heterogeneity observed in axis I disorders.
The data derived from the 2001-2002 National Epidemiologic Survey on Alcohol and Related Conditions (N = 43,093) were used to present nationally representative data on the prevalence, sociodemographic correlates, and disability of 7 of the 10 DSM-IV personality disorders by Grant et al (2004). Diagnoses were made using the Alcohol Use Disorder and Associated Disabilities Interview Schedule-DSM-IV Version, and associations between personality disorders and sociodemographic correlates were determined. Overall, 14.79% of adult Americans or 30.8 million had at least 1 personality disorder. The most prevalent personality disorder in the general population was obsessive-compulsive personality disorder, 7.88%, followed by paranoid personality disorder 4.41%, antisocial personality disorder 3.63%, schizoid personality disorder 3.13%, avoidant personality disorder 2.36%, histrionic personality disorder 1.84%), and dependent personality disorder 0.49%. They concluded that personality disorders are prevalent in the general population and are generally highly associated with disability and this highlights the need to develop more effective and targeted prevention and intervention initiatives for personality disorders.

Cook et al (1994) did a study to determine whether antisocial personality disorder and other primary psychiatric syndromes identified
subgroups of alcoholics with differing characteristics. Alcoholic probands (n = 224) with alcoholism were divided into those with primary alcoholism (n = 128), antisocial alcoholism (n = 50), and secondary alcoholism (n = 46). These groups were evaluated with regard to alcohol-related symptoms and upon a variety of psychiatric signs and symptoms. The three groups demonstrated many similarities, but overall, the antisocial alcoholic group appeared most severe. The antisocial alcoholic group additionally exhibited dissociation between the subjectively reported and the observed behavior.

Schuckit (1971) examined the demographic parameters and family history of alcoholics with history of hallucinosis. They compared all probands having a history of alcoholic hallucinosis with those lacking such a history. They conclude that alcoholics presenting with a history of alcoholic hallucinosis were not distinguished by a prior history of schizophrenia or by a high incidence of schizophrenia within their families. Demographic factors indicated that they differed from other alcoholics by their long course of alcoholism along with many previous alcoholic admissions. The investigation lends no support to a theory linking alcoholism with hallucinosis to schizophrenia.
Personality and Alcohol:

In the study by von Knorring et al (1987), type I and type II alcoholics are compared on stable personality traits determined by the Karolinska Scales of Personality. Both groups were found to have high scores on scales that measured somatic anxiety, psychic anxiety, muscular tension, impulsiveness, detachment, psychastenia, suspicion, guilt and inhibition of aggression. Both groups had low scores on the scale that measured socialization. Type II alcoholics had significantly higher scores than type I alcoholics on Somatic Anxiety and Verbal Aggression scales and significantly lower scores on Socialization and Inhibition of Aggression scales. On the Impulsive Sensation-Seeking Psychopathy factor (Impulsiveness + Monotony Avoidance - Socialization), type II alcoholics were significantly differentiated from both type I alcoholics and healthy volunteers. Results of this study were consistent with those of other studies indicating that alcoholism accompanied by antisocial behavior should be kept separate from alcoholism that is unrelated to antisocial behavior.

The interplay of personality, an exogenous agent and inherited predisposition on the development of a particular psychotic pattern is a central preoccupation of psychiatrist. Hoch (1940) and Amark (1951) sought personality traits that could explain the development of one form of psychosis rather than the other.
Mc Gue et al (1997) explored the relationships between alcoholism and self-rated personality in a community-ascertained sample of 303 male and 103 female alcoholics, and 304 male and 770 female non-alcoholics. Personality was assessed using the multidimensional personality questionnaire. Personality risk appeared to be associated with a continuum of alcoholic risk such that individuals extreme in both negative emotionality and behavioral disinhibition have especially high rates of alcoholism.

Mulder (2002) reviewed the issues, research designs and current theories relating alcoholism and personality and concluded that antisocial behavior and hyperactivity are the most consistent behaviors with alcoholism. These behaviors are not specific for alcoholism and are associated with many other psychiatric conditions. Personality variables by themselves explain only a small proportion of the risk for alcohol dependence. He further concluded that there is no alcoholic personality nor are there personality measures which are specific to vulnerability to later alcohol dependence.

Sher and Trull (1994) reviewed empirical findings and theoretical models relating three broad-band personality trait dimensions neuroticism / emotionality, impulsivity / disinhibition / sociability to alcohol abuse and concluded that although no single personality
description is likely to be both a sensitive and specific indicator of alcoholism, personality variable are important components of etiological models.

Basiaux et al used Cloninger's (2001) Temperament and Character Inventory (TCI) personality profile to compare alcohol-dependent patients with non-psychiatric control subjects and a search was made for sub-types of alcoholics with different TCI profiles. Alcohol-dependent patients were characterized by higher novelty seeking and lower self-directedness than non-psychiatric control subjects. Lower self-directedness indicates a higher probability of personality disorder in the alcohol dependent population. They concluded that there is higher probability of personality disorder in alcohol-dependent patients, particularly those with early-onset.

Koppes et al (2001) investigated the relation between personality characteristics and alcohol consumption in a population of 483 subjects who were aged 13 to 32 years over the 20 year course of the study and concluded that alcohol consumption was associated with lower scores on Social Inadequacy, Rigidity and Self-sufficiency.

Conley (1981) categorized the MMPI profiles of male alcoholics into four groups: (a) “neurotic” with scales 1 (Hs: Hypochondriasis), 2 (D: Depression), 3 (Hy: Hysteria) and 7 (Pt: Psychasthenia) all with T-
scores greater than 60 and a secondary elevation on scale 2; (b) “classic” with scales 2, 4 (Pd: Psychopathic deviate) and 7 all above a T-score of 60 and secondary elevations on scale 8 (SC: Schizophrenia) and 2; (C) “psychotic” with the highest elevations on scale 8 the highest elevation on scale 6 (Pa: paranoid) 7 or 9 (Ma: Hypomania) and lower elevations on scales 2 and 4; and (d) “psychopathic” with scales 4 and 9 above a T score of 60.

Nerviano and Gross (1983) described seven adult alcohol personality prototypes from their research using MMPI. (a) a 2-7-8 code type characterized by chronic severe distress and most substantial elevations on scales 2, 7, 8 and 4; (b) a passive - aggressive and sociopathic personality with a primary scale 4 elevation and a secondary scale 2 elevation; (c) an antisocial - sociopathic personality with primary elevations on scales 4 and 9; (d) a personality with reactive - acute depression and a primary elevation on scale 2 with a secondary elevation on scale 4; (e) a severely neurotic - psychophysiological personality with elevations on scales 1, 2, 3 and 4; (f) a mixed character- dysphoric personality with elevations on scales 2, 4 and 7; (g) a paranoid - alienated personality with elevations on scales 8, 4, 7, 2, 6 and 9.

Fischer (1998) studied personality traits using a five factor model of personality as measured by Neo personality Inventory (NPI). 108
subjects were involved who were residing on an inpatient treatment programme for alcohol dependence. The subjects were followed for one year after discharge from the treatment programme. The substance abusers scored higher than the NPI normative sample on the personality domains of neuroticism and conscientiousness. The authors report in their study that neuroticism and conscientiousness from NPI as significant predictor of relapse.

Hart (1995) studied MAPI (Million Adolescent personality Inventory) personality correlates of comorbid substance abuse among adolescent psychiatric patients. The significant personality aspects that were discussed were marked aggressiveness, labile negativism, low conscientiousness, and behavioral trait of impulsivity and poor sense of academic confidence. The authors concluded that subjects who abused the culturally deviant non-alcoholic substances were markedly different from non-substance abusing or alcohol only abusing subjects in several aspect. However this study had not only included alcoholics but also alcohol and polysubstance abusers also.

The relation of comorbid psychopathology and Cloninger's and Babor's types of alcoholism was examined by Driessen et al (1998) in 250 hospitalized alcohol-dependent patients without additional substance-related disorders. Psychiatric comorbidity was assessed by the
Composite International Diagnostic Interview and the International Personality Disorder Examination. Additional Axis I disorders only were found in 24.0%, Axis II disorders only in 16.4%, and concurrent Axis I and Axis II disorders in 17.2%. Two clusters of alcohol dependence were found that substantially overlap with Cloninger's and Babor's types of alcoholism. The majority of type A subjects were found to be either not comorbid at all, or to be Axis I comorbid only. Type B, on the other hand, was preferably associated with personality disorders (mainly Clusters A and B) and dimensional scores of personality pathology (schizoid, schizotypal, all Cluster B, and passive-aggressive). They concluded that the entire spectrum of personality pathology should be assessed in the comorbidity research of alcoholism. The two types of alcoholism differ on a variety of alcohol-related and comorbid personality characteristics.

Matano (1994) studied MCMI (Millon Clinical Multiaxial Inventory) subtypes. Alcohol dependent outpatients were clustered on the basis of their responses to MCMI scales. The clusters were compared with respect to self-reported psychiatric, interpersonal and drinking problems. One type (more common in inpatients) scored high on negativistic and avoidant/schizoid or dependant scales and reported numerous problems and intense distress. A second type (more after in
outpatients) reported few problems and scores highest on compulsive or histrionic or narcissistic scales. A third group scored high on neuroticism and antisocial scales readily admitted substance problems.

Quirk (1998) studied personality subtypes in a sample of 3256 substance abusers. The Five-factor personality domains were measured using Neo - PI (Neo Personality Inventory). Three groups were reliably identified across clustering methods and the group differed in reported coping style, psychopathological symptoms and patterns of substance choice. The largest differences between group member's personality dimensions were found for measures of neuroticism, agreeableness and conscientiousness. Members of groups characterized by elevated levels of neuroticism demonstrated low levels of conscientiousness and agreeableness. The more extreme the group member's levels of aggressive / hostile cognitions, impulsiveness, maladaptive coping styles were, the more was the likelihood of abusing more than one substance.

Rounsaville (1998) has done a study in a clinical sample of 370 patients. The total prevalence rate of personality disorder was 57% and cluster B was being particularly prominent (45.7%) in which antisocial personality disorder constituted 27% and borderline personality disorder 18.4%.
Morgenstern et al (1997) assessed prevalence rates and overlap among Diagnostic and Statistical Manual of Mental Disorders (3rd ed., revised; DSM-III-R; American Psychiatric Association, 1987) personality disorders in a multisite sample of 366 substance abusers in treatment. Results indicated high prevalence rates for antisocial and non-antisocial personality disorders. There was extensive overlap between Axis I disorders and personality disorders, and among personality disorders themselves. Antisocial personality disorder, borderline personality disorder, and paranoid personality disorder were linked to more severe symptomatology of alcoholism and other clinical problems. However, only antisocial personality disorder and borderline personality disorder satisfied subtyping criteria, after controlling for other comorbidity.

Schuckit (1994) et al evaluated whether individuals' personality test scores at approximately age 20 predict their risk of subsequent development of alcohol abuse or dependence by about age 30. As part of a larger prospective study of sons of alcoholic and control subjects, subsets of up to 78 subjects (39 matched pairs) out of a sample of 223 men took various personality tests that included the Eysenck Personality Inventory, subtests of the MMPI, and evaluations of locus of control and anxiety. An average of more than 9 years later, the incidence of alcohol abuse or dependence in these 223 subjects was determined by structured interviews. The 55 men who subsequently went on to develop alcohol
abuse or dependence did not differ on any of the personality tests from the 168 men who did not develop alcoholism. These data are consistent with prospective studies indicating that except for antisocial personality disorder, it is difficult to identify a reliable personality profile associated with an individual's risk of alcoholism.

Martin et al (1994) examined NEO-FFI correlates of risk for alcoholism, alcohol use disorders and alcoholism subtyping dimensions in a mixed-gender sample of 468 young adults (mean age = 21.3) presumed to be at high risk (n = 239) or low risk (n = 229) for alcoholism on the basis of a family history of paternal alcoholism. The NEO-FFI is a brief personality inventory measuring each of the key dimensions of the five-factor model of personality (FFMP), comprehensive, empirically-derived model of personality structure. Familial risk for alcoholism was positively associated with openness and negatively associated with agreeableness and conscientiousness. Alcohol use disorders were positively associated with neuroticism and negatively associated with agreeableness conscientiousness. With the exceptions of alcoholism subtyped by comorbid antisocial personality disorder and by familial alcoholism, all of the alcohol subtypes examined were related to at least one of the five dimensions.
Nace et al (1991) determined the prevalence of personality disorders in a group of consecutively admitted middle-class substance abusers and compared the subjects who had personality disorders with those who did not. Of the 100 substance abusers, 51 had personality disorders. These patients differed significantly from the 43 patients without personality disorders in several ways: they had greater involvement with illegal drugs, had different patterns of alcohol use, had greater psychopathology, were less satisfied with their lives, and were more impulsive, isolated, and depressed. They concluded that because of the marked differences between the substance abusers with and without personality disorders, a uniform approach to substance abuse treatment may be inadequate.

De Jong et al (1993) examined the prevalence of personality disorders among hospitalized alcoholics and polydrug addicts and the extent and nature of the overlap between different axis II disorders. Subjects were 178 alcoholics admitted to a diagnostic unit of an addiction treatment institute and 86 polydrug addicts admitted to the therapeutic community of the same institute. Substance abuse was diagnosed according to DSM-III-R, and patients were assessed with the Structured Interview for DSM-III Personality Disorders (SIDP). In the alcohol group, 78% of the patients had at least one personality disorder and the average number of personality disorders was 1.8 per patient. In the
polydrug group, 91% of the patients met criteria for at least one personality disorder and the average number of personality disorders was 4.0 per patient. No single “addictive personality” emerged.

Verheul et al (1998) in their prospective study examined the association of DSM-III-R Axis II comorbidity with (time to) relapse since the end of treatment in a sample of 105 outpatient and 82 inpatient alcoholics. The study also addressed the role of motivation for change, time in program, and working alliance in the mechanism underlying the association between Axis II and relapse. Personality disorders (according to the DSM-III-R diagnostic criteria) were measured using the Personality Diagnostic Questionnaire-Revised (PDQR). The following findings emerged from the study: (a) Patients with Axis II comorbidity were more likely to be relapsed at 3-month follow-up than those without Axis II comorbidity. This effect occurred among outpatients but not among inpatients and was rather nonspecific across the different clusters of personality pathology, (b) Motivation for change and time in program appeared to modify (and not to mediate) the effect of Axis II on relapse; among those who were less motivated and/or had time in program shorter than 4 months, Axis II comorbidity strongly predicted relapse at 3-month follow-up, whereas the effect was far less pronounced and did not reach statistical significance among those who were more motivated and/or had longer time in program, (c) Inpatients with personality pathology showed poorer working alliance than those without personality pathology.
**Obsessive-Compulsive Personality Traits:**

The Epidemiologic Catchment Area study in the United States reported a high co prevalence of OCD and alcoholism. Karno et al (1988) found that 24% of persons with OCD also had an alcohol use disorder.

Hesselbrock et al (1985), in a study in a hospitalised male and female alcoholics reported that 10-12% had a lifetime diagnosis of OCD. Eisen and Rasmussen (1989) reported that 6% of alcoholics had DSM-III-R OCD.

De Jong et al (1993) showed that 19% of alcoholics had co-morbid compulsive personality disorders. Modell et al (1992) showed that alcoholic symptoms such as 'craving' have characteristics similar to OCD.

Susuki et al (2002) reported that young and middle aged male Japanese alcoholics have more obsessive-compulsive personality traits than non-alcoholic males of similar ages. They concluded that their alcohol-related psychological and behavioral characteristics might derive, in part, from their obsessive-compulsive symptoms.

**Borderline Personality Disorder:**

Tousignant et al (1989) analyzed the borderline traits of a sample of community alcoholics drawn from a rural and a metropolitan area of
the province of Quebec. The Diagnostic Interview Schedule and other questions from the Diagnostic Interview for Borderlines were administered. About one-third of the sample of alcoholics showed a high number of borderline traits, a proportion similar to that found in institutionalized samples elsewhere. The borderline alcoholics tended to be younger and they all came from the urban area.

Nace et al (1991) systemically documented the presence of borderline personality disorder in alcoholic patients were made in 94 alcoholic patients consecutively admitted to an inpatient alcoholism program. Operational diagnoses of borderline or not borderline used Gunderson's semistructured Diagnostic Interview for Borderlines (DIB). With the use of conservative criteria, 12.8% of alcoholic patients could be designated as having borderline disorders. Borderline alcoholics were significantly younger and were more likely to have a history of drug abuse, suicide attempts, and accidents. They also had diminished satisfaction with self and family life and a greater tendency to experience craving across a variety of situations.

**Impulsivity and Alcohol Use:**

Using data from the Epidemiological Catchment Area survey of over 20,000 individuals Reiger et al (1990), examined the lifetime prevalence of substance use disorders among persons with concomitant
non-substance-use psychiatric disorders. The results of that survey found that the two diagnoses with the highest rate of substance abuse or dependence were antisocial personality (83.6%) and bipolar I disorder (60.7%) which are associated with impulsivity.

Patton et al (1995) administered the Barrat Impulsiveness scale (BIS) to 164 patients with a discharge diagnosis of substance abuse disorders and to a control group of 412 college undergraduates. The average score on the BIS was significantly higher in the substance abusers than in controls.

Whiteside et al (2003) explored the relation among 4 personality traits associated with impulsive behavior and alcohol abuse. Personality traits were measured using the 4 subscales of the UPPS Impulsive Behavior Scale Urgency, (lack of) Premeditation, (lack of) Perseverance, and Sensation seeking. The UPPS and measures of psychopathology were administered to clinical samples of alcohol abusers high in antisocial personality traits, alcohol abusers low in antisocial personality traits, and a control group (total N = 60). Separate analyses of variance indicated that alcohol abusers high in antisocial personality traits had significant elevations on all 4 UPPS scales, whereas the alcohol abusers low in antisocial personality traits and controls differed only on the Urgency subscale. The results suggested that personality traits related to impulsive behavior are not directly related to alcohol abuse but rather are associated with the elevated levels of psychopathology found in a subtype of alcohol abusers.
In a study by Ketzenberger et al (2000), impulsiveness and compulsiveness questionnaires were completed by recovering alcoholics (N=54) and by a community sample (N=351). Alcoholics scored significantly higher on impulsiveness than nonalcoholics, and impulsiveness was negatively associated with age for both groups. Alcoholic and nonalcoholic compulsiveness scores showed no difference; however, compulsiveness was negatively related to age in nonalcoholics, but not alcoholics.

Lejoyeux. et al (1998), compared the levels of impulsivity and sensation seeking in age- and sex-matched groups of alcohol-dependent patients with concomitant impulse-control disorders (N=30), alcohol-dependent patients without impulse-control disorders (N=30) and control subjects (N=30). All the alcohol-dependent patients were hospitalized for alcohol detoxification. Diagnoses of impulse-control disorders were based on DSM-IV criteria and the Minnesota Impulsive Disorders Interview. All patients completed the Zuckerman Sensation-Seeking Scale (SSS) and the Barratt Impulsiveness Rating Scale (BIS). Mean scores on the SSS general factor, the SSS disinhibition subscale, and the SSS experience-seeking scale were significantly higher in patients with impulse-control disorder than in either patients without impulse-control disorder or control subjects. By contrast, total scores and subscale scores on the BIS showed no significant differences among the three groups.
Thus, it appears that measures of sensation seeking, rather than impulsivity, are relevant in distinguishing between alcohol-dependent patients with and without concomitant impulse control disorders.

Stefos et al (1997) compared 41 impulsive patients (21 with alcoholism and 20 without alcoholism) to 22 healthy control subjects. Patients were included in the study if they presented at least one of the modified Silverman et al criteria for impulsivity. Compared to controls, patients with or without alcoholism were younger (p < 0.05), scored higher on Barratt Impulsiveness Scale (B.I.S.) (p < 0.001), Buss-Durkee Hostility Inventory (B.D.H.I.) (p < 0.001) and Social Dysfunction and Aggression Scale (S.D.A.S.) (p < 0.001). On the Temperament! and Character Inventory (T.C.I.), patients scored higher on harm avoidance (p < 0.01) and novelty seeking (p < 0.05), but lower on self-directedness (p < 0.001) and cooperativeness (p < 0.05). The sole differences between alcoholic and non-alcoholic impulsive patients were gender with significantly more male subjects in the alcoholic group (p < 0.05) and scores on cooperativeness on the T.C.I. (nonalcoholic patients scored higher (p < 0.05)). Although impulsive patients as group scored higher on novelty seeking, only alcoholic patients, in contrast with non-alcoholics, were significantly differentiated from controls (p < 0.05) on this particular variable. These results were confirmed even after controlling
for the effect of age on these variables. The results suggested that, in their sample, alcoholism in impulsive patients is more prevalent among male subjects with an antisocial personality disorder and low scores on the T.C.I, dimension of cooperativeness.

**Antisocial Personality Disorder:**

Antisocial personality disorder is a well known major risk factor for development of alcohol dependence. (Cadoret, Yates, Troughton, Woodworth, Stewart, 1995). Alcohol dependence co-occurring with antisocial personality disorder reportedly is likely to have an earlier onset and result in more violence during intoxication than alcohol dependence without antisocial personality. (Schuckit, Klein, Twitchell, Smith, 1994)

Based on the Stockholm study, Cloninger (1987) classified alcoholics into two subtypes. Type 2 alcoholics were characterized by a positive family history of alcoholism, an early onset, and frequent violent associated with intoxication. Type 2 alcoholics can be difficult to distinguish from individuals with both ASP and alcohol dependence. (Anthenelli, Smith, Irwin, Schuckit, 1994)

Bahlmann et al (2002) studied 55 alcohol-dependent patients to assess the prevalence and age at manifestation of antisocial personality disorder, conduct disorder characteristics as well as alcohol dependence by employing the Semi-Structured Assessment for the Genetics of
Alcoholism and the Structured Clinical Interview for DSM-III-R. Results indicate that the onset of antisocial personality disorder characteristics precede that of alcohol dependence by some 4 years. This finding suggests that in patients with antisocial personality disorder, alcohol dependence might be a secondary syndrome as suggested by previous research.

Yoshino et al (2000) studied whether severe childhood conduct disorder and a family history of alcohol dependence are possible risk factors for the development of alcohol dependence in antisocial personality disorder. The subjects were 81 male Japanese criminals diagnosed with DSM-III-R antisocial personality disorder. Relative risks of alcohol dependence for severe conduct disorder and for a positive family history were estimated by using a multiple logistic model. Forty-three subjects (53.0%) met criteria for DSM-III-R alcohol dependence. The relative risk of alcohol dependence for severe conduct disorder (N=44), compared with mild conduct disorder, was 4.1; whereas the relative risk for a positive family history (N=31), relative to a negative family history, was 1.9. Severe childhood conduct disorder was also associated with severe adulthood antisocial behavior and an earlier onset of alcohol dependence. The results suggest that severe childhood conduct disorder and a positive family history of alcohol dependence are independent premorbid risk factors for developing alcohol dependence among persons with antisocial personality disorder.
Penick et al (1993) examined the lifetime co-morbidity of major psychiatric disorders among male alcoholics with the structured Psychiatric Diagnostic Interview (PDI), which was administered to 928 patients undergoing alcoholism treatment at six Veterans Administration Medical Centers. 38% were positive for alcoholism only; 62% fulfilled inclusive lifetime diagnostic criteria for at least one other additional psychiatric syndrome. Depression and antisocial personality were the most frequently identified co-occurring syndromes (36% and 24%, respectively) followed by drug abuse and mania (17% each).

Male and female alcoholics (N=321) with antisocial personality disorder or DSM III subtypes [conduct disorder; adult Onset Antisocial personality disorder] were compared to non-antisocial personality disorder alcoholics on several etiological features of alcoholism and its clinical presentation immediately prior to treatment by Hesselbrock et al(1994). The results show that alcoholics with a subtype of antisocial personality disorder, even if it occurred predominately during childhood, have a form of alcoholism similar to antisocial personality disorder alcoholics. Further, the severity of alcoholism among persons with antisocial personality disorder may vary according to the severity of the antisocial personality disorder.
In a sample of 127 male and 87 female adult adoptees, antisocial personality and alcohol abuse were related to biologic backgrounds and the environmental factors by Cadoret et al. (1995). In the men, alcohol abuse was increased by a background of problem drinking in first-degree biologic relative and by drinking problems in the adoptive home. Antisocial personality occurred more frequently in men whose first-degree biologic relatives had antisocial behavior problems. In the women, alcohol abuse was increased in adoptees whose first-degree relatives had problem drinking. Increased alcohol abuse in men and women was not predicted by biologic first-degree relatives with antisocial problems, nor did increased frequency of antisocial personality occur in adoptee with biologic relatives with problem drinking. The results suggest specificity of inheritance of antisocial and alcoholic conditions and the importance of environmental factors.

**Prognosis:**

Hunter et al. (2000) in a longitudinal study investigated which psychiatric comorbidities among alcoholics would predict very long-term drinking outcome. The predictors were the Symptom Checklist 90 (SCL), Minnesota Multiphasic Personality Inventory (MMPI), and Psychiatric Diagnostic Interview (PDI). The outcome measure was the Clinician Rating of Drinking Scale (CRDS). The study showed that antisocial personality characteristics alone were consistently associated with a
worse long-term drinking outcome. However, despite the consistent presence of a statistical association between antisocial personality characteristics and a poorer long-term drinking outcome, the small size of the relationship is a very important issue.

Alcohol-related psychosis is indicative of severe alcohol abuse and suggests a poor prognosis. The prognosis is similar to that of severe alcoholism. Of all psychosis cases, 10-20% tends to become permanent.

**Research Methodology:**

Doing research in Anthropology has a unique feature of its own. This is because of the fact that a researcher in anthropology does his research work keeping in view the holism of the discipline, learning the native language and staying with people for months together to explore the necessary and relevant data needed for his research work. By staying with people he establishes his first-hand rapport and at the same time he uses key informants to cross check the data which he gets in the field. By staying with them the researcher, creates an conducive atmosphere to make the group to feel this researcher as one of the members of the group which he studies. By doing so both the researcher and the community feel happy about each other’s temperament and at the same time both of them will be able to understand the nature of the work and also about the information of the research work. This is what Malinowski advocated the concept of participant observation in Anthropological research.
Observation is one of the important tools of anthropological research. Any amount of information can be gathered or collected by the virtue of this participant observation. Researcher observes all the spontaneous activity and situations which take place around him. Young (1961) opines that “observation means what all the spontaneous things that occur before him”. Participant observation is the foundation of anthropology. It involves getting close to people to make them to feel and educate about his research work. The technique also helped the researcher to know the depth and dimensions.

Apart from participant observation, the researcher also relied upon interview which is also treated as one of the very important tools of acquiring information. In this the researcher interviews the informants about his topic of research by maintaining a cent percent confidentiality and so on. Depending upon the quality of the people researcher has framed questions to ask. In majority of the amount of information which he collects will be cross checked whenever occasion demands from both the key informant and others. In doing so the researcher maintains his confidentiality so that nothing untoward incident happens. Being close to the people the researcher without spoiling the time and without distorting the informant he collects information.
This study has following objectives:

(i) To find out prevalence of psychological problems making an individual to be an alcohol dependent individuals.

(ii) To find out the variation in socio-economic status with respect to alcohol dependence.

(iii) To study the personality profile of alcohol dependent individual.

(iv) To study the psychological problems caused by alcohol dependency.

Materials and Methods:

Subjects: The sample subjects who fulfilled the criteria for “Alcohol Dependence Syndrome” were selected from different Villages, near Davangere.

Sample Size: 1000 patients from the community.

Sample Selection: consecutive Subjects / Participant / Patients who fulfilled inclusion criteria.

Type of Study: Cross sectional.

Inclusion Criteria:

1. Patients who meet ICD-10 Criteria for “Alcohol Dependence Syndrome”
2. Gender: Both genders.
3. Consent- Agreed to participate in study.
Exclusion Criteria:

1. Chronic physical illnesses: Hypertension, Diabetes Mellitus, Cerebro-Vascular Accidents, Endocrine & Neurological disorders except peripheral neuropathy.
2. History of psychotic illness prior to Alcohol use.
3. Co-existing other drug abuse/dependence.

Tools Used:

1. ICD-10 Diagnostic criteria for Alcohol Dependence Syndrome.
2. Consent form.
5. MINI International Neuropsychiatric Interview-Plus.
7. Eysenck Personality Inventory (EPI).
8. International Personality Disorder Examination (IPDE).

1. **ICD 10 Diagnostic Criteria for Alcohol Dependence Syndrome.**
   (World Health Organization. The ICD-10 Classification of Mental and Behavioral Disorders; Geneva: WHO; Geneva; 1992.)

   Diagnosis of dependence should be made if three or more of the following have been experienced or exhibited at some time during the last year.
1. A strong desire or sense of compulsion to take the substance.
2. Difficulties in controlling substance taking behavior terms of onset, termination, or levels of use.
3. Physiological withdrawal state when substance use has ceased or been reduced, as evidenced by either of the following: The characteristic withdrawal syndrome for the substance, or use of the same (closely related) substance with the intention of relieving or avoiding withdrawal symptoms.
4. Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses.
5. Progressive neglect of alternative pleasure or interests because of psychoactive substance use and increased amount of time necessary to obtain or take the substance or to recover from its effects.
6. Persisting with substance use despite clear evidence of overtly harmful consequences (physical or mental)

1. **Informed Consent Form: (Annexure-I)**

   The informed consent form, explained the nature of the study, the contents of which were explained in vernacular language, was read out to the subjects of study and their signature or left thumb prints in case of illiterates was obtained. They were also explained that they could leave the study if they desired without their treatment being affected in any manner.
2. General Information Sheet: (Annexure-II)

A self designed general information sheet was used to collect personal and socio-demographic details of the subjects. The details contained information about identification data like name, age, sex, residential address, place, religion, education, occupation, income, marital status, details about substance use and family history of substance use, mental illness, attempted suicide and completed suicide.

3. Classification Of Social Class: (Annexure-III)

Of the various social and socio-economic classifications proposed for Indian families, the one given by Prasad (Prasad scale Prasad BG.1961) is most widely used in Indian medical literature. Prasad proposed it for the first time in 1961 based on the per capita income per month. It was revised by Prasad in 1968 and then again in 1969 based on the cost of living. In 1984-85, Kumar modified it linking it to GNP and All India Consumer Price Index (AICPI) so that it could be indexed to any year based on that variable. As per the proforma, Income from all sources of the family and all the subjects of the family was collected and converted into per capita income per month (Total income/Total members in the family).
Classification of Social Class:

<table>
<thead>
<tr>
<th>Social class</th>
<th>1961 Per capita monthly income in rupees</th>
<th>2008 Per capita monthly income in rupees</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>100 and above</td>
<td>2785 and above</td>
</tr>
<tr>
<td>II</td>
<td>50 – 99</td>
<td>1392-2784</td>
</tr>
<tr>
<td>III</td>
<td>30 – 49</td>
<td>835-1391</td>
</tr>
<tr>
<td>IV</td>
<td>15 – 29</td>
<td>417-834</td>
</tr>
<tr>
<td>V</td>
<td>Below 15</td>
<td>Below 417</td>
</tr>
</tbody>
</table>


This is a structured diagnostic interview schedule developed by Sheehan et al (Sheehan, Lecrubier, Harnett-Sheehan, Amorim P, Janavs, Weiller, et al. 1998) for diagnosing psychiatric disorders as per DSM-IV and ICD-10 diagnostic criteria. It includes 26 modules. It features questions to diagnose and to rule out a disorder, disorder sub-typing and chronology (e.g. age at onset). It also features a number of algorithms to handle psychotic disorders and hierarchical rule outs in the event the patient had more than one disorder at a time. MINI plus has a good reliability and validity in eliciting symptom criteria used in making DSM-
IV and ICD-10 diagnoses and is comparable with that of Structured Clinical Interview for DSM-III-R, Patient Version (SCID-P) and Composite International Diagnostic Interview (CIDI). The assessment of Personality disorder was omitted as it was assessed through IPDE. Patients were assessed with the MINI-Screen, MINI-Plus and its positive modules. The MINI-Plus take around 5-10 minutes and 20-30 minutes to complete respectively.

5. Brief Psychiatric Rating Scale (Annexure-IV):

The BPRS was developed in the late 1960s by overall and Gorham (Overall, Gorham1962) as a short scale for measuring the severity of psychiatric symptomatology. It was developed primarily to assess change in psychotic inpatients. It covers a broad range of areas including thought disturbance, emotional withdrawal and retardation, anxiety and depression, and hostility and suspiciousness. It is an 18 item scale. The Items are rated on seven-point scale from 0 to 7, with the total score ranging from 0 to 180. Because the ratings include observations in addition to patient’s report of symptoms, the BPRS can be used to rate patients with very severe impairment. It can be administered in about 30 minutes, including patient interview and observation. The observations based items include (made by the rater during a 15 to 30 minute
interview) tension, emotional withdrawal, mannerism and posturing, motor retardation, uncooperativeness, excitement and disorientation. The verbal report items include conceptual disorganization, unusual thought content, anxiety, guilt feelings, grandiosity, depressive mood, hostility, somatic concern, hallucinatory behavior, suspiciousness and blunt affect. Reliability of the BPRS is good to excellent when raters are experienced. Anchored versions and semi structured interview have been developed to increase reliability. Validity is also good as measured by correlations with other measures of symptom severity, especially those concerning schizophrenia symptomatology. The BPRS is appropriate for evaluating baseline psychopathology. The clinical outcome and treatment response can also be known through repeated administration at the frequencies as planned by the clinical investigator.

6. **Eysenck Personality Inventory (EPI): (Annexure-V)**

Eysenck Personality Inventory (EPI) was designed by Eysenck. (Natraj,1970) It assesses the personality dimensions in domains of extroversion, introversion, neuroticism and emotional adjustment. It contains 57 items with YES – NO answers divided into 3 sets. It includes 24 questions for extroversion, 24 questions for neuroticism and 9 questions to detect the lie score.
Score norm:

**Extroversion Score:** Persons obtaining a score of 17 & above are considered as extrovert and those obtaining a score of 7 & below are considered as introvert.

**Neuroticism Score:** Persons obtaining a score of 14 & above are considered as neurotic and those obtaining a score of 4 & below are considered emotionally balanced.

If the total lie score is 5 & above, the data is considered unreliable and is rejected. Such cases are excluded from the analysis of only this variable.

7. **International Personality Disorder Examination (IPDE – ICD-10 Module): (Annexure-VI)**

International Personality Disorder Examination (IPDE) is a semi-structured interview schedule designed by Loranger et al (Loranger, Sartorius, Andreoli, Berger, Buchheim, Channabasavanna, et al. 1994) in 1994 to categorically and/or dimensionally assess DSM-IV and/or ICD-10 personality disorders. It is available in two versions: a DSM-IV module that contains 99 sets of questions and an ICD-10 module that contains 67 sets of questions. In this study, the latter version was utilized.
to assess for ICD-10 personality disorders. The YES-NO and open-ended questions are organized into the following six areas: Work, Self, Interpersonal relationships, Affects, Reality testing, and Impulse control.

Each criterion is scored 0 = absent or normal, 1 = exaggerated or accentuated, 2 = criterion level or pathological, NA = not applicable, or / = subject refuses or is unable to answer. A positive score (i.e. 1 or 2) requires a 5-year minimum duration. An average administration time is 60 minutes.

Procedure:

Patients in the community who fulfilled the ICD-10 diagnostic criteria for Alcohol Dependence Syndrome were screened for inclusion and exclusion criteria. Those who qualified for inclusion and gave consent for the study were interviewed. The general information was collected using a pre-designed general information sheet. Socioeconomic status was determined using Classification of Social Class by Prasad (Prasad scale Prasad, 1961). The subjects were assessed for ICD-10 criteria for alcohol-induced psychosis and other Axis I disorder using MINI International Neuropsychiatric Interview-Plus schedule. International Personality Disorder Examination was administered to patients and their attendants were reliable and who had at least stayed with
patient to diagnose personality disorders as per ICD – 10. The severity of psychotic symptoms was rated using Brief Psychiatric Rating Scale. Once the patient became co-operative & fit for psychological examination, they were administered Eysenck Personality Inventory to know the personality profile.

The results were tabulated along with appropriate statistical calculations and appropriate conclusion were drawn by comparing with available literature.