

Vulnerability to Alcoholism: The Role of Parental Absence and Psychiatric Distress

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Parental absence during critical developmental years and antecedent psychiatric disorder may be important vulnerability factors for the development of alcoholism. To explore these possibilities 52 male and one female alcohol dependent patients diagnosed according to the DSM-III-R criteria were compared with 20 male controls matched for age, marital status, and employment type. Parental absence through death, separation, divorce, working abroad, and gross neglect or abuse was studied for the first 15 years of the subject's life. Absence of the father was found to be significantly associated with the later development of alcoholism. It was detected in 50.9% of alcohol dependent subjects compared to 15% of controls. Psychiatric morbidity was evaluated through individual administration of the Revised Self-Report Symptom Inventory, SCL-90-R (Derogatis, 1975). Alcoholics were found to experience significantly higher levels of psychiatric symptoms than controls. Significant reductions in psychopathology, and improvement in adaptive functioning take place after participation in Alcoholics Anonymous (AA) group therapy. The favourable influence resulting from AA involvement may be direct on core symptoms or indirect through the promotion and maintenance of the abstinent state.

(Egypt. J. Psychiat., 1992, 15: 163-174).

Introduction

The links between psychiatric disorder and alcohol dependence are not well understood. Psychiatric disorders are frequently detected in alcohol dependent pa-

tients, and alcohol abuse is frequently associated with a number of psychiatric disorders (Bukstein et al., 1989). Several possible relationships were suggested by Meyer (1986) for the addictive disorders in general and are applicable to alcoholism: 1) Alcoholism may lead to psychiatric symptoms or disorders, 2) Psychiatric disorders may be risk factors for the development of alcoholism, 3) Both alcoholism and psychopathology may originate from a common vulnerability, 4) Alcoholism may influence the course of psychiatric disorder, and 5) Psychiatric disorder may influence the course of alcoholism. Resolving the controversy surrounding the relative contribution of each of these possible links would be beneficial in classifying alcohol dependent patients into homogeneous subgroups

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requiring more specific treatment approaches (Meyer et al.,1983).

Most studies of alcohol dependent patients report a high prevalence of affective and anxiety disorders compared to the general population (Dorus et al, 1987, Hesselbrock et al.,1985). In one study 40% of alcohol dependent patients suffered from an anxiety disorder (Weiss and Rosenberg,1985). Individuals who abuse alcohol and other CNS depressants appear to have relatively higher rates of anxiety disorders than opiate or cocaine abusers (Hesselbrock et al.,1985; Weiss and Rosenberg,1985). There is some additional evidence that the level of psychiatric distress is correlated with the severity of drinking (Dryman et al.,1989; Dryman and Anthony, 1989). The frequent association between psychopathology and alcohol dependence together with the observation that the majority of substance abusers prefer a certain class of drugs lend support to the self-medication hypothesis of substance use disorders (Khantzian,1985). This hypothesis assumes that in some individuals substance use disorders are initiated by attempts to control painful affects and distressing symptoms through the use of psychoactive chemicals. The effects of these substances is to ward off the unpleasant affects. Repeated use is associated with positive reinforcement establishing the chemical as a habit (Day and Leonard,1985).

The self-medication hypothesis is contradicted by evidence that alcohol comorbidity rates are not sufficiently high to explain the development of alcoholism in the majority of cases. Several authors (e.g. Edwards,1987) have made the point that alcohol related psychopathology is in the greater part secondary to alcohol dependence and not the cause of it.

In order to study psychiatric morbidity as a vulnerability factor in alcoholism it should therefore be studied in prospec-

tive alcoholics, or recovered alcoholics, i.e. those who have become abstinent for sufficiently long periods so that alcohol-related psychiatric disability can be ruled out. These methodological considerations have not been addressed in many studies dealing with the psychiatric comorbidity of alcohol dependence (Group for the Advancement of Psychiatry, 1991).

There is a considerable amount of literature suggesting that parental loss in the crucial developmental years up to adolescence may be a vulnerability factor for adult psychiatric disorders. This literature has focussed on the association between parental loss and adult anxiety and depressive disorders (e.g. Brown et al.,1977; Roy,1978;1981 , Okasha and Lotaief,1979). Scant attention has been dedicated to the study of this association in alcoholism. McCord and McCord (1960) suggested that the absence of a suitable adult male on which to model behaviour is an important element in the development of alcoholism in males. In alcoholism, parental unavailability may deprive the developing child of a figure of identification, as well as a reasonable authority for preventing and checking deviant conduct. Parental absence may directly predispose to deviance or alcoholism, or else it may be indirectly responsible through predisposing the individual to depression and anxiety later in life.

The present research is an attempt to identify some of the vulnerability factors, namely parental absence and psychiatric distress, that may be associated with alcohol dependence. Alcohol dependent patients who have been in remission for a sufficiently long period to rule out the influence of alcohol in producing psychiatric distress, are compared with hospitalized alcohol dependent patients who have recently given up alcohol , and both groups are compared to a group of

non alcohol using controls. The aim of the study is to establish whether psychiatric symptoms associated with alcohol dependence are primary or secondary, and whether parental absence is a significant vulnerability factor for the later development of alcohol dependence.

Subjects and Method

The first group of subjects (N=25) included in the study comes from an Alcoholics Anonymous (AA) group organized and attended by the first author in Rashid Hospital, Dubai between October, 1989, and February, 1992. A second sample comprising 27 alcohol dependent males and one female were recruited from the inpatient admissions to Rashid Hospital. Subjects from the hospital who exhibited withdrawal symptoms and /or cognitive impairment at the time of the interview were not included.

All 53 subjects met the DSM-III R criteria at one time for the diagnosis of alcohol dependence. 20 male control subjects were included in the study as a comparison group. Controls were included if they had no history of using alcohol or other substances of abuse, no psychiatric complaints, or previous psychiatric consultation. Alcohol patients and controls were matched in terms of age, marital status, and type of profession, but were not matched in terms of educational level, and nationality (Tables 1 and 2).

All 73 subjects of the study were interviewed by :

1) A structured interview designed by the author in order to elicit the following information:

- Demographic data (tables 1 and 2).
- Pattern of upbringing with special emphasis on availability of the biological parents in the first 15 years of life. Unavailability was scored as present if the parent was deceased, divorced , separ-

ated and living away from the subject, suffered an incapacitating illness, lived abroad or travelled for the most part of the year, or grossly mistreated and neglected the subject on account of a substance dependence problem.

- A complete substance dependence history including a checklist for withdrawal symptoms, evidence of tolerance, periods of spontaneous abstinence, prior treatment-related periods of abstinence, and date of the last drink.

- Assessment of social functioning : Subjects were required to answer specific questions in five domains of social functioning:

a- occupational : including temporary or full time employment, duration of periods of unemployment, financial self-sufficiency, warnings, suspensions or dismissals from work, frequent job changes, satisfaction with the job, and relationship with peers.

b- Legal problems : history of traffic accidents, arrests, convictions and lawsuits.

c- Family relationships including conflict with spouse and parents, separation and divorce history, jealousy, and sexual difficulties.

d- State of health including physical complications due to alcohol.

e- Religious involvement including religious faith, practice of rituals, and the subject's perception of his use of religious principles in daily life.

2) The Revised Self-Report Symptom Inventory, SCL-90-R.(Derogatis , 1975,1977):

This questionnaire comprises 90 psychiatric symptoms that may be scored as present or absent, and the degree of severity is noted on a 4 point scale. The questions cover most aspects of depression, anxiety, phobias, and obsessions, and in addition cover somatization, a

number of psychotic symptoms, paranoid ideation, and hostility. Manic symptoms, and personality disorders are not covered by the SCL-90R (Mackinnon and Yudofsky, 1986). The questionnaire was translated by the author for Arabic speaking subjects and administered individually.

The 25 subjects recruited from the AA group were required to respond to the SCL-90R and to enquiries about social adaptation once for the period before AA attendance and once for the period after AA attendance. These periods coincide with periods of abstinence. Their mean duration of abstinence was 47 months. Non AA alcohol dependent subjects were required to give a single answer to the questionnaire and social functioning aspects of the structured interview. The mean duration since the last drink in the latter group was 6.38 weeks.

This design allows the study of psychiatric symptoms and adaptive functioning associated with alcohol dependence at various stages of the illness and contrast them with the responses of controls. The scores of Non AA alcoholics and AA alcoholics before AA attendance evaluate symptoms that may be inherent aspects of personal psychopathology added to symptoms that could be the result of alcohol dependence (secondary). Scores of AA alcoholics after abstinence through AA involvement indicate the basal level of psychopathology in the patient who is vulnerable to alcohol dependence free from the direct influence of alcohol (primary). The same principle applies to enquiry about social adaptation.

Results

The criteria adopted for the identification of parental availability

during the first 15 years of life were relatively narrow. Physical abuse by the parent and neglect were scored only when repeated and associated with an abnormality in the parent which in all our cases consisted of alcohol and or drug dependence. The father was physically or functionally absent in 27 out of 53 cases of alcohol dependence (50.9%) compared to 3 out of 20 controls (15%). The difference is statistically significant at the 0.01 level. The mother was absent in 16/53 cases (30.2%), and both parents were absent in 24.5% of alcohol dependent patients, but the differences did not reach statistical significance (table 3, fig. 1). Unavailability of the father was the most common form of parental absence detected (fig. 2)

Table 1
Sample Characteristics

	AA Alcoholics (in remission) n=25		Non AA Alcoholics (Detoxified) n=28		Controls n=20	
Mean Age@±S.D.	40.56±8.12		36.32±7.6		36.93±8.54	
Marital Status*	n	%	n	%	n	%
Married	21/25	84%	19/28	68%	19/20	95%
Single	2/25	8%	8/28	28.5%	1/20	5%
Post marital	2/25	8%	1/28	3.5%	0/20	0%
Employment**						
Professional	6/25	24%	4/28	14.3%	4/20	20%
Employee	10/25	40%	12/28	43%	7/20	35%
Skilled	5/25	20%	5/28	18%	5/20	25%
Semiskilled	4/25	16%	3/28	10.7%	4/20	20%
Unemployed	0/25	0%	4/28	14.3%	0/20	0%

@ One way ANOVA, F= 1.97, df= 2,70, 72, N.S.

* X²= 6.87, df=4, N.S.

** X²= 8.25, df=8, N.S.

Table 2
Sample Characteristics (contd.)

	AA Alcoholics (in remission) n=25		Non AA Alcoholics (Detoxified) n=28		Controls n=20	
Education*	n	%	n	%	n	%
Illiterate	0/25	0	2/28	7.1%	—	—
Preparatory	3/25	12%	11/28	39.3%	2/20	10%
Secondary	10/25	40%	8/28	28.6%	8/20	40%
College & Postgr.	12/25	48%	7/28	25%	10/20	50%
Nationality**						
Indian subcont.	19/25	76%	10/28	35.7%	10/20	50%
European, USA	5/25	20%	0/28	0.0%	2/20	10%
U.A.E.	0/25	0.0%	15/28	53.6%	3/20	15%
Others	1/25	4%	3/28	10.7%	5/20	25%

* $\chi^2=11.87$, $df=4$, $P<0.025$

** $\chi^2=10.07$, $df=6$, $P<0.005$

Table 3
Biological Parent Availability in the First 15 Years of Life

	Alcoholics in remission		Detoxified Alcoholics		Controls	
	n	%	n	%	n	%
Absent Father*	12/25	48%	15/28	53.6%	3/20	15%
Absent Mother**	9/25	36%	7/28	25%	2/20	10%
Absence of both@	7/25	28%	6/28	21.4%	2/20	10%

* $\chi^2=7.75$, $df=1$, $P<0.01$

** $\chi^2=3.19$, $df=1$, N.S.

@ $\chi^2=1.88$, $df=1$, N.S.

Table 4
Total Psychopathology Scores (SCL-90 R)

	Alcohol Dependent Patients	Controls	U Test@	P
Before AA				
Mean	225.9	79	118.5	40.9
S.D.	± 120.8	± 38.79	± 61.9	± 36.2
Median	224.5	74.5	108.5	25
Max.	452	452	452	452
After AA*				
Mean	79	118.5	40.9	115
S.D.	± 38.79	± 61.9	± 36.2	63
Median	74.5	108.5	25	
Max.	452	452	452	

* Wilcoxon Matched Pairs Signed Ranks Test for comparisons before and after AA ($T<16$, $N=24$, $P<0.001$).

@ Mann Whitney U Test for all other comparisons:

U1= Alcoholics After AA x controls.

U2= Non AA Alcoholics x controls.

Figure 1

Biological Parent Availability

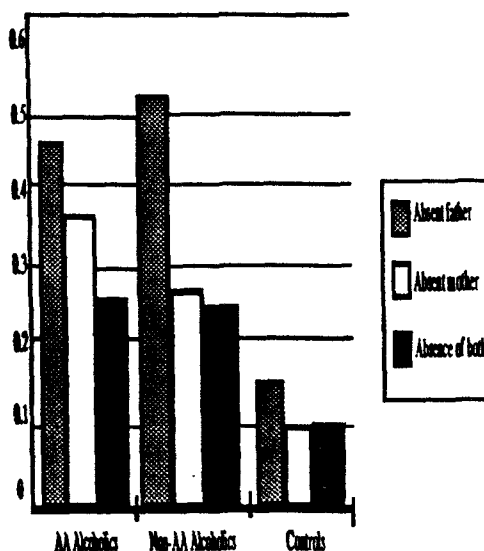


Table 5
Mean Scores on Symptom Groupings (SCL-90 R)

	Alcoholics before AA	Alcoholics after AA	Alcoholics Non AA	Controls	U Test	P
Depression	62.3±30.7	23±10.4	36±19.5	11.4±10.6	U1= 102.5 U2= 57.5	<0.005 <0.0005
Anxiety	58.5±33	19.2±11.5	31.4±15.3	9.7±9.5	U1= 121 U2= 55	<0.01 <0.0005
Phobias	16.6±12.8	5.1±5.3	8.0±6.8	2.6±2.6	U1= 161.5 U2= 149	N.S. <0.01
Obsessions	16.3±9.2	7.5±4.4	7.2±6	4.5±3.8	U1= 144 U2= 197.5	<0.05 N.S.
Somatic	18±10.9	5.3±3.7	8.5±5.7	3.5±3.9	U1=159 U2= 109.5	N.S. <0.005
Psychotic	19.7±12.5	6.3±3.3	10.1±6.6	2.6±2.7	U1= 90.5 U2= 52.5	<0.005 <0.0005
Paranoid Ideation	26.7±12	10.2±5.9	14.6±9.1	5.5±5.1	U1= 131 U2= 105	<0.01 <0.005
Hostility	7.8±5.1	2.5±2.2	2.5±3.2	1.3±1.8	U1= 151 U2= 208	<0.05 N.S.

* Comparisons before and after AA: T< 16, N= 24,

P<0.001 (Wilcoxon Matched Pairs Signed Ranks Test).

@ Man Whitney U Test for all other comparisons:

U1= Alcoholics After AA x controls.

U2= Non AA Alcoholics x controls.

Figure 2
Reasons for Father Unavailability

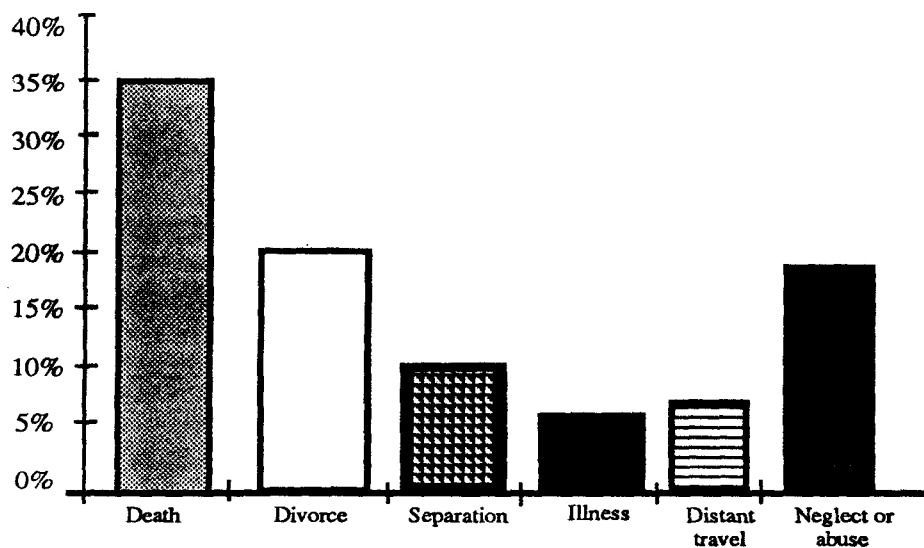


Table 6
Global Assessment of Functioning (GAF)

	Alcoholics before AA		Alcoholics after AA		Alcoholics Non AA		Controls	
Slight & no impairment (71-90)	1	4.6%	15	71.4%	3	10.7%	19	95%
mild impairment (61-70)	5	22.7%	4	19.1%	2	7.1%	1	5%
moderate impairment (51-60)	7	31.8%	2	9.5%	5	17.9%	-	-
Serious impairment (31-50)	9	40.9%	-	-	18	64.3%	-	-

5 Alcohol dependent patient forms had inadequate information

After AA x Non AA x Controls: $\chi^2=37.3$, $df=6$, $P<0.001$

Before AA x Non AA : $\chi^2=4.97$, $df=3$, N.S.

Before AA x After AA : $\chi^2=24.13$, $df=3$, $P<0.001$

After AA x controls : $\chi^2=4.25$, $df=2$, N.S.

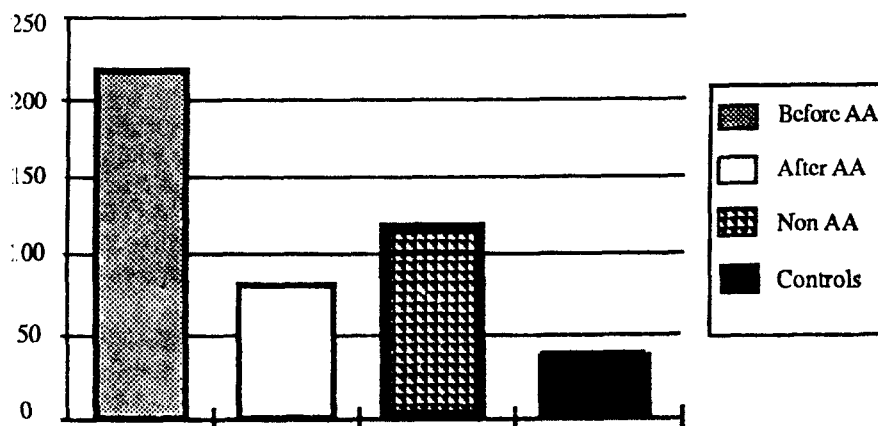
Non AA x controls : $\chi^2=34.6$, $df=3$, $P<0.001$

Table 4 presents the mean and median total psychopathology scores on the SCL-90-R for alcohol dependent patients and controls. There is a wide degree of variation in the scores of all samples indicated by the large standard deviation. The fluctuations in total scores occur on both sides of the mean since the median scores are not notably different from the means. Alcoholics before AA involvement have the highest mean scores, almost one half of the maximum possible total score. They are followed by alcoholics who did not participate in AA groups who have a mean total score that is 26% of the maximum score. Alcoholics after the AA experience score closest to controls. The latter have a mean total 9% of the maximum score (fig. 3).

Two group statistical comparisons were conducted throughout. For comparisons between the scores of Alcoholics before and after AA

Figure 3

Total Psychopathology Scores



attendance the Wilcoxon Matched Pairs Signed Ranks test was used (Roscoe, 1969; Siegel, 1956). The other comparisons were carried out between non AA alcoholics, and alcoholics before AA, on one hand, and controls. All comparisons are statistically significant. (table 4).

The higher psychopathology scores of alcoholics before attending AA, and alcoholics not attending AA compared to Alcoholics after AA, and controls are replicated when the symptom groupings are analyzed (table 5). All the differences are statistically significant with few exceptions. After AA alcoholics do not differ significantly from controls on symptoms related to phobias and somatization. Non AA alcoholics do not differ significantly from controls on obsessions and hostility scores. Alcoholics after AA have higher mean obsession scores and equal mean hostility scores compared to non AA alcoholics. The differences are not significant.

The relative prevalence of each type of psychopathology in alcohol dependent patients may be derived by obtaining the mean score per symptom in each category. This score is obtained by dividing the mean score for the category by the number of symptoms used in its calculation (figure 4).

The most common syndrome associated with alcohol dependence is paranoid ideation followed by depression and obsessive symptoms. The ranking is slightly different in controls but the top ranking three categories remain the same. The least commonly encountered categories are those of psychosis, somatization and phobia

The subject's responses on the assessment of adaptive functioning were listed and a total score was derived for the five aspects of functioning. Subjects were then categorized using the dimensional scoring of the global assessment of func-

tioning scale, GAF (American Psychiatric Association, 1987). Levels of disability due to psychiatric symptoms were excluded from the present evaluation in order to allow an independent judgement of change taking place in alcohol dependent subjects before and after the AA experience. AA members were questioned on the structured interview for two time frames, before abstinence and after abstinence, while non AA alcoholics were questioned about their behaviour during their drinking period. Controls were not restricted to a particular time frame.

Compared to controls both groups of alcohol dependent subjects show higher levels of impairment (Table 6). The most serious levels of impairment in functioning are detected in non AA alcoholics (64.3%). With abstinence through involvement in AA there is an appreciable improvement in adaptive functioning as indicated by a comparison of frequencies of subjects in the various impairment categories before and after the AA experience. Alcohol dependent subjects after recovery function more adequately and the differences between them and controls are insignificant. The degrees of impairment in alcoholics before AA and non AA alcoholics are also similar and the differences are not significant (table 6).

Discussion

The principle findings of this study consist of an association between unavailability of the father during the first 15 years of life and alcoholism, and the association between high degrees of psychiatric morbidity and alcoholism that are significantly reduced upon recovery. The main findings require separate consideration.

The criteria used for defining parental absence were restricted to definable facts. The only variable that may be subject to a value judgement on the part of the sub-

ject was the possibility of parental abuse or neglect. In relation to father absence, this item was scored positively in 5 alcohol dependent subjects, but was in all cases based upon reports by the patient of repeated physical abuse, and alcoholism of one and in 2 cases both parents. Even when these 5 subjects are excluded father absence is almost significantly associated with alcoholism from a statistical standpoint. Finally, in the present study physical and moral abuse are considered forms of faulty parenting interfering in attachment and identification. Therefore, it is a form of absence of normal parenting during development. The link between absence of the father and alcoholism in a sample of male alcoholics cannot be underestimated. Identification with the parent of the same sex is a crucial element in acquiring codes of behaviour and patterns of interpretation of the surrounding world. However, the developmental issues at hand seem to be more complex. First, a high proportion of subjects also reported evidence consistent with absence of the biological mother. Second, a "search after meaning" (Henderson, 1988, Tennant et al., 1980) leads some patients to try and explain their illness and find plausible causes from their immediate experience. This is hardly the case in the present study, since the subject was not required to give value judgements about the quality of parenting except within restricted terms. Lastly, a deeper look into this issue should take in consideration the quality of parenting after the loss since this factor has been implicated as even more important than the loss itself in predisposing an individual to the effects of adverse loss in childhood. The effects of these two variables are likely to be additive, rather than mutually exclusive.

The Revised Self-Report Symptom Inventory (SCL-90R) has been widely used in clinical and research settings

aiming at surveying the presence of a range of psychopathological phenomena (Mackinnon and Yudofsky, 1986). It is more specific in describing symptoms than the General Health Questionnaire (Goldberg, 1972), and less time consuming than the semistructured interview approach (e.g. Wing et al., 1974). However, its results should be considered in the light of the limitations of self-report questionnaires in general, e.g. the halo effect, and differences in the cultural expression and relative importance of symptoms. As a clinical instrument it is certainly not one that can provide a definite diagnosis. It offers however, a broad coverage of the areas which it addresses. With these precautions in mind, the SCL-90 offers a valuable opportunity to study the presence and severity of a variety of psychiatric syndromes.

In the present study, the SCL-90 has been used in two design formats, the paired design for alcoholic patients in AA, and an unpaired design comparing two experimental groups with controls. The unpaired design demonstrates that psychiatric morbidity is appreciably high in alcohol dependent patients compared to controls. The paired design, shows that psychiatric symptoms improve significantly with abstinence, and or participating in AA over a period of time. Still, alcoholics who have recovered have an appreciably higher psychiatric morbidity than non-alcohol using, and non psychiatric controls.

The highest morbidity levels were detected when alcoholics describe their condition before attending AA. At an initial look, this finding indicates that this group of patients suffers more psychiatric disability. However, it is equally likely that those patients who succeed in utilizing the AA experience for the sake of recovery are distinct in terms of reflective awareness, emotional and communication needs. Furthermore, the 12

steps of the AA programme invite more self-awareness, and interpersonal learning which may be a contributing factor towards better self-description. Peculiarities of experience and behaviour that may pass unnoticed and unformulated in someone who is not attending a therapy programme may be more pressing and conscious in someone who is attending such a programme. The second possibility related to the present cohort of subjects has to do with the implementation of the questionnaire. The need to contrast and emphasize change after abstinence may have led to unduly higher scores before AA. It is difficult to explain otherwise, the uniformly higher levels of psychopathology reported by alcoholic subjects before the AA experience compared to non-AA alcoholics.

The psychiatric comorbidity of alcohol dependence may be primary or secondary. Many studies fail to distinguish between these two forms when their design does not include subjects with a sufficient period of sobriety allowing the assessment of symptoms independent from the direct chemical and psychosocial effects of alcohol abuse. This methodological problem is largely avoided in the present study through the inclusion of an abstinent group with a mean duration of abstinence of 47 months. Psychopathology scores of this group are independent of the effects of alcoholism and represent basal premorbid levels in addition to the effects of treatment. One study dealing with mood states after a median period of 5 years abstinence indicated that mood disturbances were not different in alcoholics from controls (Bokstrom et al., 1989). The scores of this group on the SCL-90R are between the higher scores of non AA alcoholics and the least scores characteristic of controls. The differences are mostly significant and cannot be taken in favour or against the hypothesis of self medication. They do

indicate that the majority of symptoms of alcohol dependence are illness related and may be lowered significantly through abstinence and/ or AA attendance. This finding is confirmed by improved adaptive functioning after AA and has been reported in other studies dealing with the report of subjects on their experience with AA. (Edwards et al, 1983; and O'Connor and Daly, 1985).

Conclusions

1. Unavailability of the father during the crucial development years, is probably one of the vulnerability factors for alcohol dependence.

2. A good deal of psychiatric symptoms associated with alcohol dependence may be secondary to dependence and not the basis of it as suggested by the self-medication hypothesis.

3. The AA experience is associated with significant reductions in psychopathology and improved adaptive functioning in alcohol dependent patients.

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La Vulnérabilité à l'Alcoolisme: Role de l'Absence parentale et des Troubles Psychiatriques

L'absence parentales durant la periode critique de développement ainsi que des antécédents de troubles psychiatriques pourraient être considérés comme d'importants facteurs de vulnérabilité à l'alcoolisme. Afin de vérifier cette hypothèse, un groupe de patient souffrant de dépendance alcoolique, selon les critères du DSM-III-R, ont été comparé à un groupe control. Nous avons trouvé que l'absence du père, due à la mort, la séparation, le divorce, ou au travail à l'étranger, était significativement associée au développement ultérieur de la dépendance alcoolique chez 50,9% de nos patients contre 15% du groupe control. Nous avons trouvé aussi que nos patients alcooliques présentaient une symptomatologie psychiatrique beaucoup plus accentuée que le groupe control. La participation au groupe d'alcooliques anonymes a amené une amélioration significative sur le plan psychopathologique ainsi que sur celui des fonctions adaptatives.

القابلية لإدمان الكحولية: دور غياب الأبوين والاضطراب النفسي

تتناول هذه الدراسة مشكلة غياب أحد الأبوين أو كليهما خلال الخمسة عشر عاماً الأولى من الحياة بصفتها أحد العوامل المؤثرة في إحداث الإدمان الكحولي فيما بعد. كما تتناول العلاقة التبادلية بين الاضطراب النفسي والإدمان الكحولي من خلال دراسة مقارنة لثلاث عينات تتكون العينة الأولى من ٢٥ عاماً مدمناً كحولياً سابقاً ثم شفاؤهما بواسطة العلاج النفسي الجماعي من خلال جماعة "الكحولي المجهول"، وتتكون العينة الثالثة من ٢٨ كحولياً عولجوا داخل المستشفى من أعراض الانسحاب، بينما تتكون المجموعة الثالثة من ٢٠ رجلاً سويّاً يشكلون العينة الضابطة. تمت الدراسة من خلال مقابلة بينية تتضمن استقصاء التاريخ الطويل ومدى القدرة على التكيف وشدة الأعراض النفسية، وقد درست الأعراض النفسية من خلال تطبيق اختبار الأعراض النفسية المعدل (ديروجاتس، ١٩٧٥).

تمت مقارنة النتائج إحصائياً في الكحوليين قبل وبعد العلاج النفسي بنفس المتغيرات في العينة الضابطة، حيث تبين أن غياب الأب من خلال الموت، أو الانفصال عن الأم، أو الطلاق أو العمل بالخارج، أو الإهمال وإساءة المعاملة لفترات طويلة يتواتر بنسبة ٩٠,٥٪ من العينة الضابطة وهو ما يؤكد الفرض الأول للبحث، كما تبين ارتفاع نسبة وشدة الأعراض النفسية في الكحوليين عن الأسوياء بصورة كبيرة، وتبين أن هذه الأعراض تتحسن بصورة ملموسة ودالة إحصائياً بعد العلاج النفسي وزوال تأثير الكحول على الجسم وهو ما يرجع كفاءة العلاج النفسي في هذا المجال ولكنه لا يقطع بدور مسبب للاضطراب النفسي الصريح في إحداث الإدمان الكحولي.