World Journal of Pharmaceutical Science and Research
www.wjpsronline.com
Review Article
ISSN: 2583-6579
SJIF Impact Factor: 6.916
Year - 2026
Volume: 5; Issue: 4
Page: 236-252

A SYSTEMIC REVIEW OF ALCOHOL-INDUCED PSYCHOTIC DISORDER BASED ON PATIENT'S CLINICAL PROFILES

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Article Received: 14 February 2026 | | ***Article Revised: 6 March 2026*** | | ***Article Accepted: 27 March 2026***

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DOI: https://doi.org/10.5281/zenodo.19333308

How to cite this Article: P. Saranya, A. Manikandan, B. Madhumitha, G. Mathumitha, S. Marzook, A. Mohamed Thameem Ansari (2026) A SYSTEMIC REVIEW OF ALCOHOL-INDUCED PSYCHOTIC DISORDER BASED ON PATIENT'S CLINICAL PROFILES. World Journal of Pharmaceutical Science and Research, 5(4), 236-252.

ABSTRACT

Alcohol-induced psychotic disorder (AIPD) is a serious psychiatric complication associated with prolonged and excessive alcohol consumption, characterized by hallucinations, delusions, confusion, agitation, anxiety, and impaired cognitive functioning. This systematic review evaluates alcohol-induced psychosis based on patient clinical profiles, demographic characteristics, associated medical conditions, psychiatric comorbidities, and treatment outcomes using hospital-based clinical data. The study collected patient reports from multiple hospitals and analyzed variables including age, sex, marital status, educational level, employment, income, previous medical history, and psychiatric disorders. Results indicate that AIPD is more prevalent among young adults aged 15–30 years, predominantly males, individuals with low educational status, low socioeconomic background, and chronic alcohol dependence. Medical comorbidities such as hypertension, type-2 diabetes mellitus, epilepsy, head injury, alcohol-related liver disease, and pancreatitis were frequently observed among affected individuals. Psychiatric comorbidities including affective disorders, anxiety disorders, personality disorders, and substance use disorders significantly increased the complexity of clinical presentation. Mortality and suicidal tendencies were higher among patients with alcohol-induced psychosis, with males showing greater vulnerability than females. Neurochemical alterations involving dopamine, gamma-aminobutyric acid (GABA), glutamate, and serotonin play a major role in the pathophysiology of the disorder. Early diagnosis, integrated psychiatric management, alcohol withdrawal monitoring, and preventive public health strategies are essential to reduce morbidity and mortality associated with alcohol-induced psychotic disorder.

KEYWORDS: Alcohol-induced psychosis, Alcohol dependence, Hallucination, Psychiatric comorbidity, Psychotic disorder, Substance abuse, Clinical profile.

1. INTRODUCTION

Alcohol, scientifically known as ethanol (C2H5OH), is a psychoactive substance widely consumed across the world for recreational, cultural, and social purposes. It is produced through the fermentation of sugars by yeast and is present in beverages such as beer, wine, and spirits. Alcohol acts primarily as a central nervous system depressant, influencing brain function, mood, behaviour, and cognition. Although moderate alcohol consumption is socially accepted in many societies, excessive or prolonged use can lead to serious health consequences, including liver damage, cardiovascular disorders, mental health problems, and addiction.

Alcohol use has been documented since ancient civilizations and continues to be a major public health concern globally. According to the World Health Organization, millions of deaths, and disabilities each year are linked to harmful alcohol consumption. In addition to physical health risks, alcohol contributes to social problems such as violence, accidents, family issues, and workplace losses. Understanding the effects, risks, and patterns of alcohol consumption is therefore essential for promoting public health and developing effective prevention and intervention strategies.

1.1 PSYCHOSIS

Psychosis is a severe mental health condition characterized by a disconnection from reality. Individuals experiencing psychosis have difficulty distinguishing between what is real and what is not. This disturbance affects a person's thoughts, perceptions, emotions, and behaviours, often leading to significant impairment in daily functioning. Psychosis is not a disorder by itself but a symptom of several psychiatric and medical conditions, including schizophrenia, bipolar disorder, severe depression, substance base (such as alcohol or drugs), brain injury, and certain neurological or metabolic illnesses.

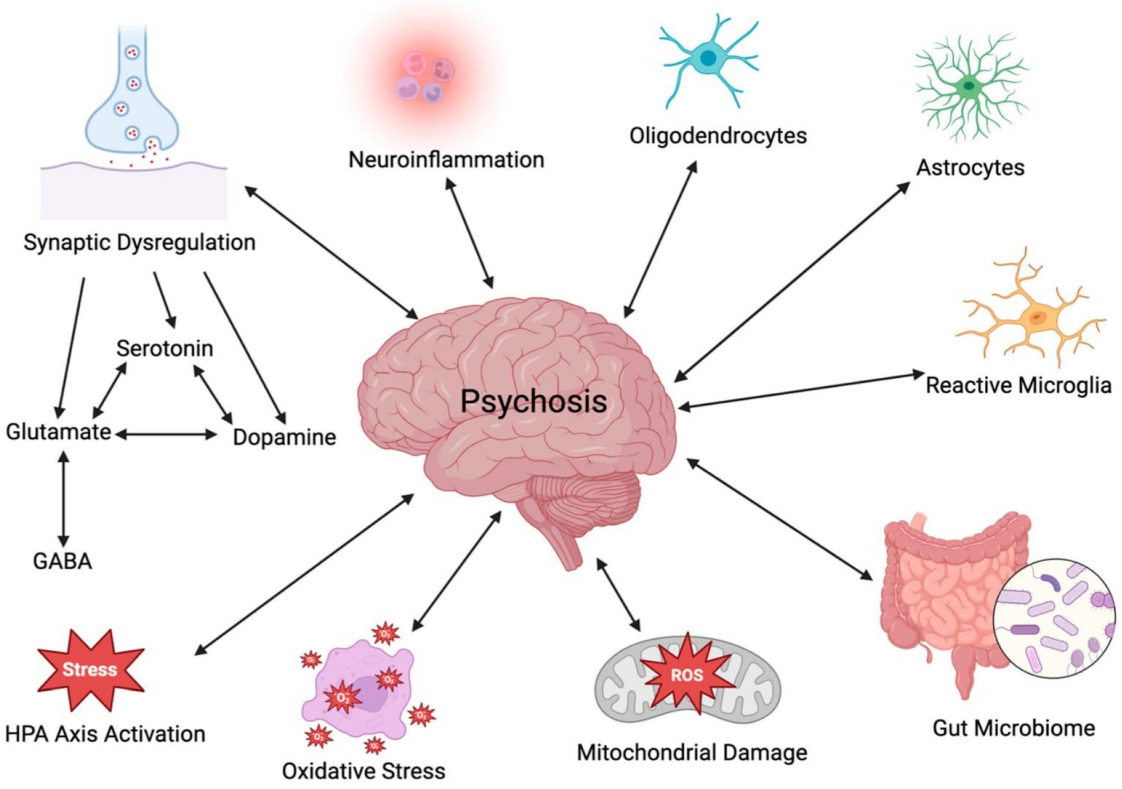


Fig. 1: Psychosis.

2. ALCOHOL INDUCED PSYCHOSIS

Alcohol induced psychosis is a well-established complication of heavy alcohol use, although poorly understood.[1] The association between alcohol use and psychosis was first recognized by Claude Marcel in 1847 when he described a case series of patients with folie diverge ("drunken madness").[2,3] In addition to this early term, this phenomenon has been called "alcohol insanity," "Kraepelin's hallucinatory insanity of drunkards, "Wernicke's acute hallucinosis of drunkards," and "alcohol hallucinosis."[4] The most current terminology used for this condition is alcohol-induced psychosis or Alcohol Related Psychosis Alcohol Induced Psychosis is a distinct entity from other withdrawal syndromes, example, delirium tremens, Wernicke's encephalopathy, Korsakoff's psychosis, and alcohol-induced dementia,[2] with the latter being caused by chronic alcohol use associated with nutritional deficiencies (example, thiamine).[5] Additionally, while delirium tremens is a severe withdrawal feature,[4] Alcohol Induced Psychosis and primary psychiatric conditions, example, schizophrenia, can be similar, and Alcohol Induced Psychosis may result from the unmasking of preexisting psychiatric disease or occur in conjunction with a psychiatric disorder.[6] All these entities share alterations in cognitive awareness and delusions and may involve auditory, tactile, or sometimes visual hallucinations. The classically taught diagnosis of Alcohol Induced Psychosis is known as alcohol hallucinosis, a rare consequence of alcohol use that occurs because of withdrawal.

Fig. 2: Types of Psychotic Disorders.

3. ETIOLOGY

A positive association between non-thought disorder psychiatric diagnoses (example, ADHD, PTSD, anxiety disorders, major depressive disorders) and alcohol use. Particularly with at-risk alcohol use or alcohol use disorder, has been strongly demonstrated in studies. The association between alcohol use and disorders of thought (example, schizophrenia, alcohol-induced psychiatric disorder).

Chronic and Excessive Alcohol Consumption: Long-term heavy drinking alters neurotransmitter systems (dopamine, GABA, glutamate), leading to dopamine hyperactivity — a major cause of psychotic symptoms. Alcohol withdrawal (especially abrupt cessation) can also trigger psychosis.

Neurochemical Imbalance: Dopamine dysregulation: Excess dopamine transmission in mesolimbic pathways leads to hallucinations and delusions. GABA and glutamate imbalance: Alcohol suppresses glutamate and enhances GABA; during withdrawal rebound glutamate activity can produce psychosis. Serotonin dysregulation: Affecting mood, behaviour, and perception.

Neuroinflammation and Oxidative Stress: Chronic alcohol intake increases inflammatory cytokines in the brain. Microglial activation causes neuronal damage and alters neurotransmission. Oxidative stress damages neural tissue and increases vulnerability to psychotic experiences.

Nutritional Deficiency: Alcoholics often lack essential nutrients, especially:

- Thiamine (Vitamin B1) → deficiency can cause Wernicke–Korsakoff syndrome and cognitive disturbances.
- Vitamin B12 & folate → affect nervous system functioning.
- These deficiencies increase the risk of brain damage and psychotic symptoms.

Structural Brain Changes: Long-term alcohol use may lead to:

- Cerebral atrophy (shrinkage of cortex and subcortical regions)
- Reduced volume of hippocampus and frontal lobe
- White matter degeneration
- These changes disrupt reality perception, memory, and impulse control.

Genetic and Individual Vulnerability: Family history of psychosis or alcohol use disorder increases risk. Individuals with pre-existing mental illness (schizophrenia, bipolar disorder) are more prone. Stress and trauma accelerate susceptibility.

Psychosocial and Environmental Factors: Social isolation, unemployment, family breakdown, and poverty may worsen alcohol consumption and psychological stress. Co-use of substances (cannabis, stimulants).

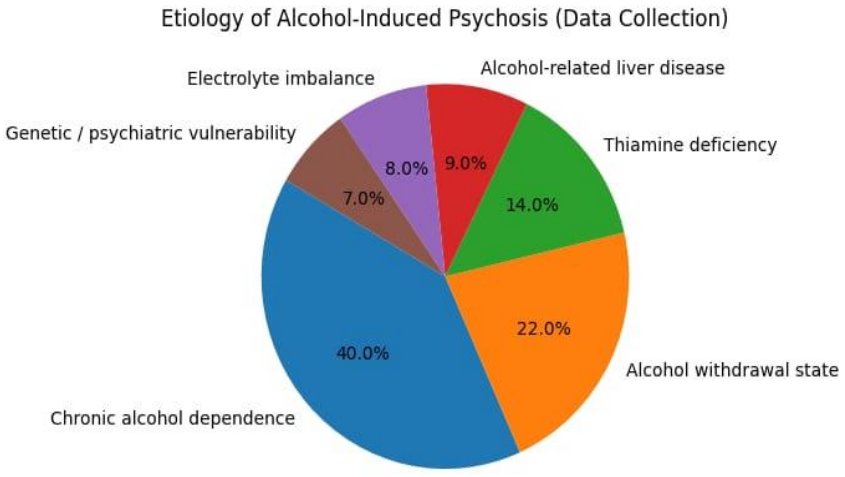


Fig. 3: Etiology of Alcohol Indued Psychosis.

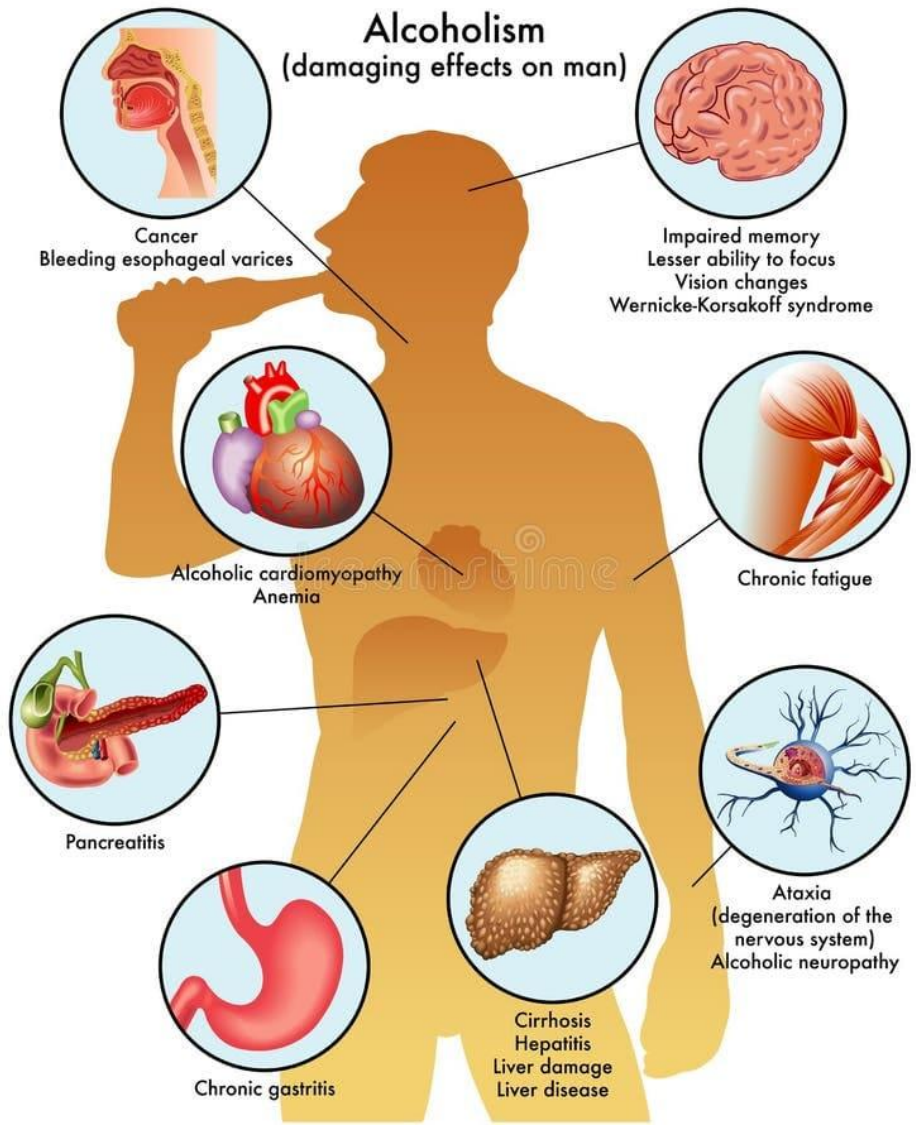


Fig. 4: Signs and Symptoms of AIPD.

1.4 PATHOPHYSIOLOGY

The pathophysiology of Alcohol Induced Psychosis is complex and not fully understood. However, it involves numerous neurotransmitters, including dopamine, serotonin, gamma-aminobutyric acid (GABA), and glutamate.

Dopamine Neurotransmitter Effects of Alcohol: Studies have demonstrated that alcohol administered to rats will increase the release of dopamine in the nigrostriatal and mesolimbic tracts. 18 Additionally an indirect marker of dopamine activity, homovanillic acid, is elevated in the cerebrospinal fluid of individuals with auditory and visual hallucinations occurring as part of alcohol withdrawal.[19]

Serotonin Neurotransmitters Effects of Alcohol: Serotonergic drugs, example, d-lysergic acid diethylamide, are known to cause hallucinations.[20] While alcohol is not directly serotonergic, it does have effects on the serotonin system. In primates, an increase in 5-HT1A serotonin receptor binding is observed during chronic alcohol self-administration but was independent of the amount of alcohol consumed.[21] Additionally, in humans, the concentration

of serotonin transporters was up to 35% less in the pregenual region of the cerebral cortex in patients with alcohol use disorder than it was in patients without alcohol use disorder, effectively causing a serotonin reuptake scenario.[22]

Gamma-Aminobutyric Acid and Glutamate Neurotransmitters Effects of Alcohol: Chronic alcohol use is also well known to cause decreased GABA-receptor concentration and inhibitory tone while at the same time increasing neuroexcitatory tone due to the direct effect of alcohol. Evidence demonstrates that patients with alcohol hallucinosis have increased concentrations of serum glutamate and aspartate, indicating that this imbalance and overexcitation may play a role in the development of hallucinations.[4] Experts have also theorized that aromatic beta-carboline compounds may be implicated in the pathogenesis of hallucinations. These compounds, when consumed as a plant extract, can cause hallucinations. One study determined that 2 compounds (norhormone and hormone) were significantly elevated in alcoholic patients compared with non-alcoholic patients. In a subgroup of individuals who were diagnosed with hallucinosis, the levels slightly rose over the 3-week detoxification period, while it dropped for those individuals without hallucinosis. However, this was not a statistically significant trend.[23] However, another study several years later demonstrated that tobacco use was a confounder.[24]

Fig. 5: Pathophysiology.

1.5 MECHANISM OF ACTION

- **Dopamine:** Alcohol increases dopamine release, leading to hyperdopaminergia, which contributes to psychotic symptoms.
- **GABA:** Alcohol enhances GABA activity, leading to inhibition of neuronal activity. Withdrawal can cause GABA hypoactivity, contributing to anxiety and psychosis.
- **Glutamate:** Alcohol affects NMDA receptors, leading to excitotoxicity and neuronal damage.
- **Serotonin:** Altered serotonin signalling contributes to mood disturbances and psychotic symptoms.

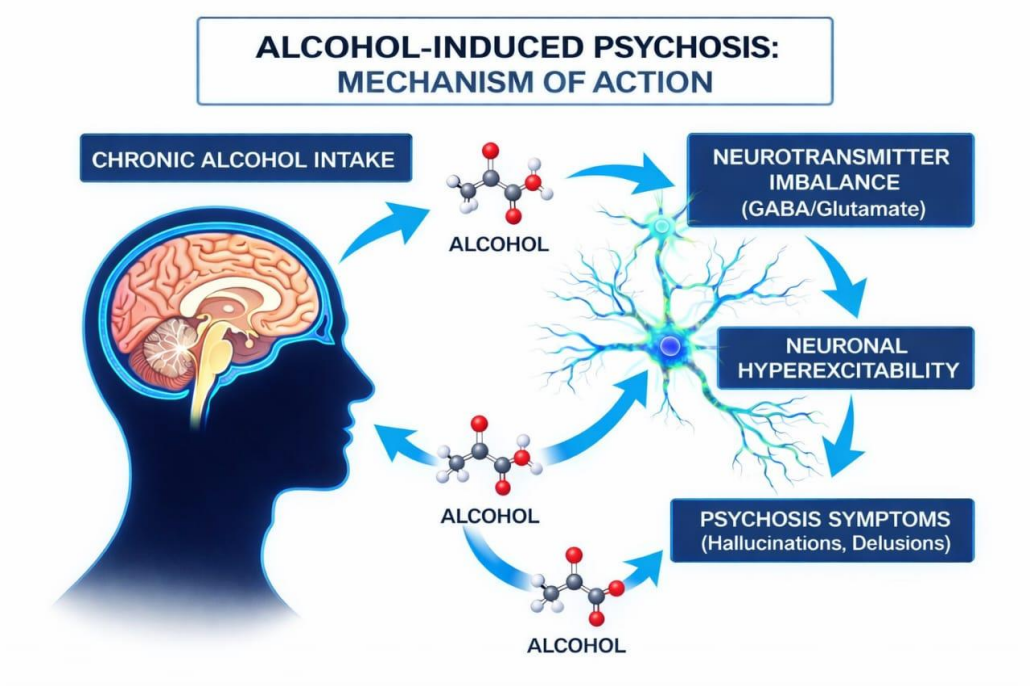


Fig. 7: Mechanism of Action.

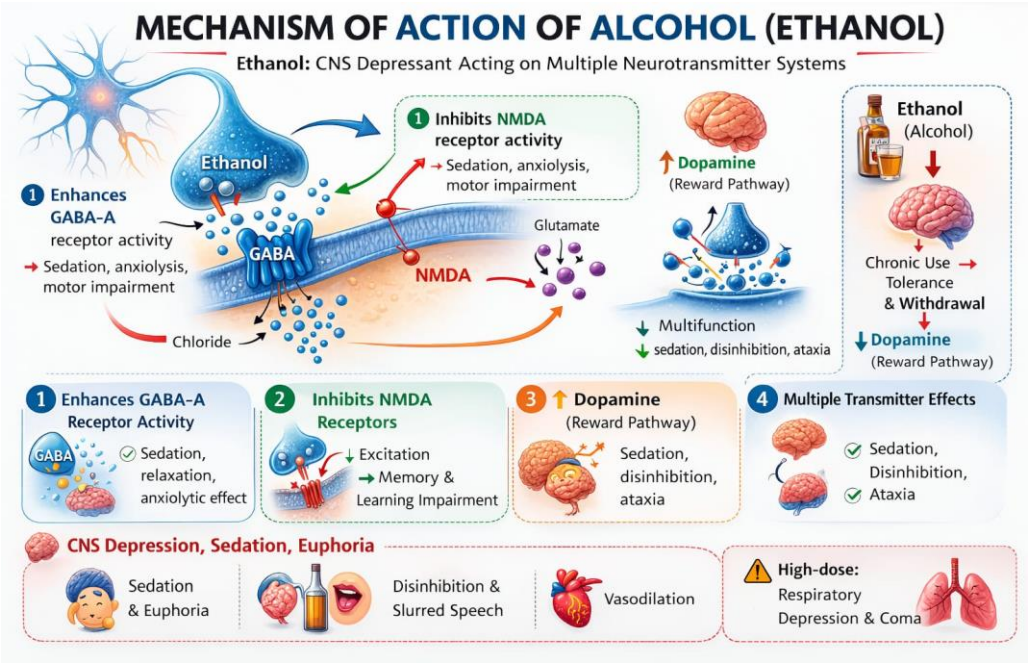


Fig. 8: Mechanism of Action of Ethanol.

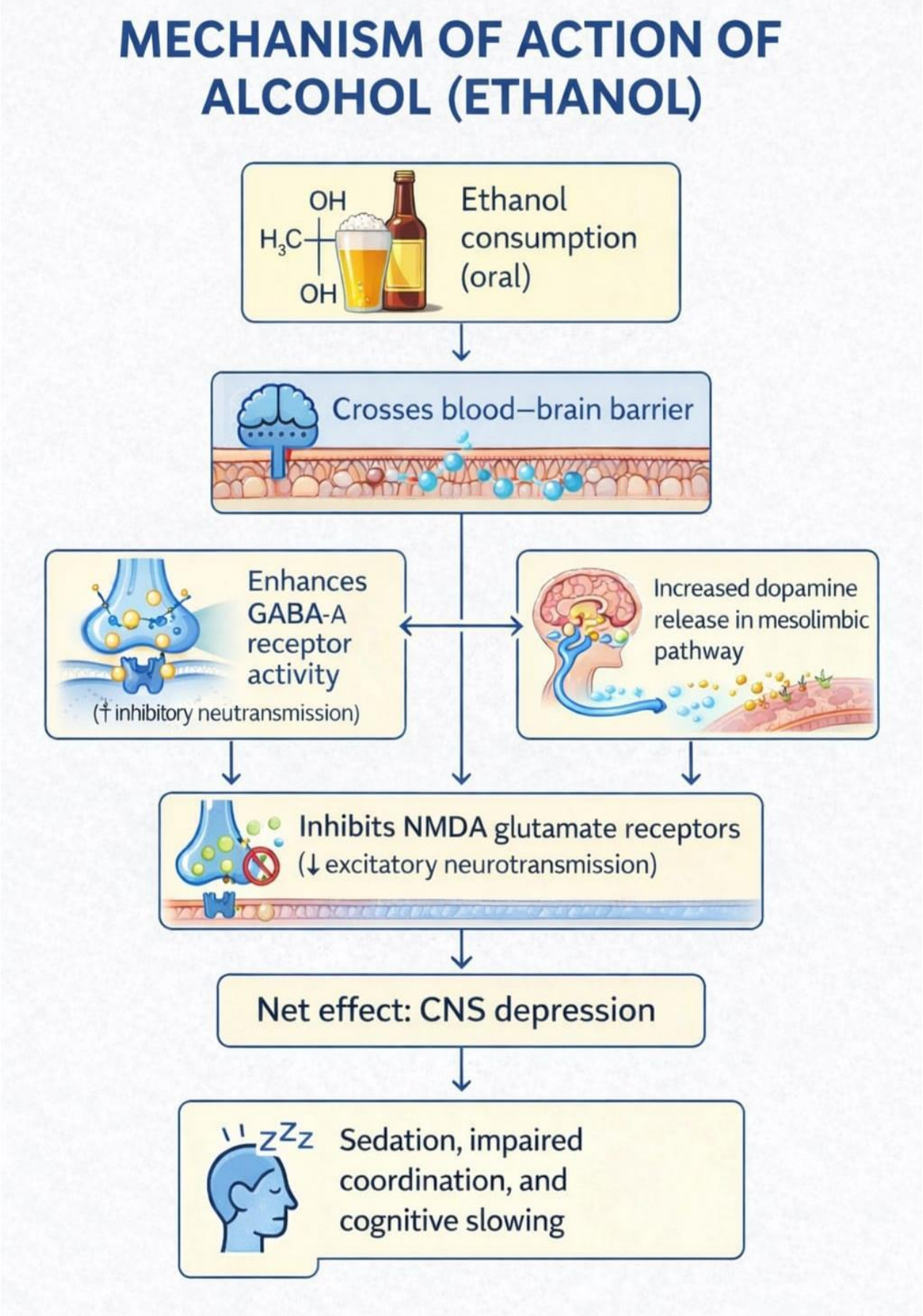
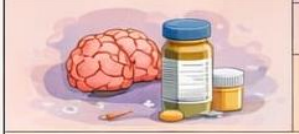


Fig. 9: Mechanism and Effects of Alcohol.

2 DRUG CLASSIFICATION

Table 1: Drug Classification.

	NAME	SIDE EFFECTS	USES
TYPICAL ANTIPSYCHOTICS (First Generation) 	Haloperidol	Dizziness, Sedation, Dry mouth, Constipation, Blurred vision	Schizophrenia, Acute psychosis, Bipolar disorder, Delirium
	Chlorpromazine	Drowsiness, Weight gain, Dry mouth, Constipation	Schizophrenia, Severe nausea, Hiccups
ATYPICAL ANTIPSYCHOTICS (Second Generation) 	Risperidone	Drowsiness, Weight gain, Increased appetite, Headhe	Schizophrenia, Bipolar disorder, Depression
	Olanzapine	Sedation, Weight gain, Dry mouth, Constipation	Schizophrenia, Bipolar disorder, Depression
	Quetiapine	Sedation, Weight gain, Increased appetite, Tremors	Schizophrenia, Bipolar disorder, Depression
	Aripiprazole	Tardive dykinesia, Seizures, Constipation, Insomnia	Schizophrenia, Bipolar disorder, Depression
BENZODIAZEPINES 	Diazepam	Respiratory depression, coma, Hypotension	Anxiety disorder, Muscle spasms, Seizures, Insomnia (short termiuse)
	Lorazepam	Depression Hypotension, Slured speech, Consipation,	Anxiety, Panic attack, Insomnia,
	Chlordiazepoxide		Anxiety, Pre-operative sedation
	Clonazepam	Depression, Insomnia	Seizure disorder, Panic disorder
MOOD STABILIZERS/ ANTICONVULSANTS 	Valproate	Hyperammonaemia, PCOD, Hypotension, Confusion	Epilepsy, Bipolar disorder, Seizures, Insomnia
	Carbamazepine	Depression	Anxiety, Panic attack, Insomnia
	Clonazepam	Depression, Stmilization, Insomnia	Anxiety, Pre-operative sedation
ANTIDEPRESSANTS 	Sertraline	Hyperammonaemia, Seizures	Epilepsy, Bipolar disorder, *Acute monia* Seizures, Insomnia
	Carbamazepine	Metabolic acdosis Indigestion, Insomnia drivmnis,	Epilepsy, Panic disorder
	Lithium	Mania/Dyprosias	Seizure disorder, Panic disorder
ANTIDEPRESSANTS 	Sertraline (SSRI)	Suicidal thought, Increased appelite	Depression, Panic disorder, *Acute mania*
	Venlafaxine (SNRI)	Dry mouth, Insomnia	Anxiety disorder
	Mirtazapine	Dry mouth, Insomnia, *heomnia*	Metalia acidosis, *Indigestion*
VITAMIN & NUTRITIONAL SUPPLEMENTS 	Naltrexone	Mid stomach upset, Irritability, sweating	Thiamine deficiency, *Anxiety diestia disorder, Anxiety, Leeima disorder, Mamia disorder*
	Thiamine (Vitamin B1)	Mild stomach upset, Irritation, sweating	Thiamine deficiency *Anxiety, Leoina disorder, Mania*
	Magnesium	Abdomiad camps, Metalic rashes, Dizziness	Anxiety, Panic disorder, Mama, *Leciame disorder, Mania*

2. REVIEW OF LITERATURE

Table 2: Plant Review.

S.No.	Plant Name (Botanical name)	Chemical Constituents	Type of Extraction Solvents	Uses
1	 **Brahmi** *(Bacopa monnieri)*	Terpenoid saponins, Alkaloids, Sterols, Flavonoids	Water, Ethanol / Hydro-alcoholic	Brain tonic, Memory enhancer, Antioxidant, Neuroprotective, Anti-convulsant
2	 **Shankhpushpa** *(Convoluulus pluricaulis)*	Alkaloids, Flavonoids, Glycosides, Coumarins, Fatty acids, volatile oil	Hydro-alcoholic solvent, Ethanolic extract, Aqueous extract, Methanolic extract	Memory loss, Anxiety, Stress, Hypertension, Migraine
3	 **Ashwagandha** *(Withania somnifera)*	Withanolides, Withaferin-A, Alkaloids, Steroidal lactones	Hydro-alcoholic extract, (root extract)	Mental fatigue, Hypertension, Migraine
4	 **Jatamansi** *(Nardostachys jatamansi)*	Sesquiterpenes, Essential oil, Alkaloids	Hydro-alcoholic extract, Steam distillation	Anxiety, Depression, Insomnia, Memory loss, Headache
5	 **Tagara** *(Valeriana wollichii)*	Sesquiterpenes, Hydro-alcoholic extract, Steam distillation	Alcohol extract, Hydro-alcoholic extract, Steam distillation	Drowsiness, Hypotension, Abdominal discomfort, Headache
6	 **Vacha** *(Acorus calamus)*	Sesquiterpenes, Volatile oils, Alkaloids	Ethanol or Hydro-alcoholic extract	Drowsiness, Hypotension, Headache, Dry mouth
7	 **Sarpagandha** *(Rauwolffa serpentina)*	Indole alkaloids, Resins, Fatty acids, Alkaloids	Ethanol or Methanol extract	Gastric irritation, Nausea, Drowsiness, Headache Excessive stimulation
8	 **Guduchi** *(Tinospora coraifolia)*	Glycosides, Alkaloids, Diterpenoid lactones, Steroids	Ethanol or Methanol extract, Water (decoction)	Diarrhea, Acidity, Hyper activity, Empty stomach effects
9	 **Amla** *(Emblica officinalis)*	Indole alkaloids, Steroids, Resins, Fatty acids	Ethanol or Methanol extract, Water (decoction)	Digestive system, Immunity, Empty stomach
10	 **Bibhitaki** *(Terminalia bellirica)*	Steroids, Resins, Tannins	Ethanol or Methanol extract, Water (decoction)	Constipation, Allergy, Excessive stimulation

2 DATA COLLECTION APPROACHES

Alcohol-induced psychosis is a severe psychiatric disorder that occurs due to prolonged and excessive consumption of alcohol. It affects an individual's mental stability, perception, emotional behaviour. and cognitive functioning. Patients suffering from this condition may experience hallucinations, delusions, confusion, anxiety, aggressive behaviour, and

impaired judgment. In recent years, alcohol abuse has become a significant public health concern, especially among young and middle-aged populations. The increasing number of alcohol-dependent individuals has resulted in a rise in psychological complications, making alcohol-induced psychosis a major area of medical and academic research. The present study is conducted as part of a final-year project with the objective of understanding the occurrence, causes, demographic distribution, and outcomes of alcohol-induced psychosis through hospital-based data collection and statistical evaluation.

The first stage of the project begins with the selection and detection of alcohol-induced psychosis as the primary disease condition for investigation. A detailed review of medical literature and psychiatric references is undertaken to understand the symptoms, diagnostic criteria, causes, and treatment procedures associated with the disorder. Alcohol-induced psychosis develops during heavy intoxication or withdrawal periods and may persist even after cessation of alcohol intake. Patients often present symptoms such as auditory hallucinations, paranoid thinking, restlessness, sleep disturbance, and emotional instability. Identifying these clinical features enables accurate selection of relevant patient cases during hospital data collection.

After defining the research topic, a structured plan for data collection is prepared. The study focuses on collecting patient data directly from hospitals located in Cheyyar, Kanchipuram, Vellore, and Adukkampaarai regions. Both government and private hospitals are selected to ensure diversity in patient population and healthcare accessibility. Inclusion of multiple institutions allows comparison between different treatment environments and improves the reliability of research findings. Hospital-based data collection provides authentic clinical information recorded by medical professionals, thereby enhancing the scientific validity of the study. Ethical approval and institutional permission form an essential component of the research process s. Before visiting hospitals, the college principal officially communicates with the Joint Director (JD) or Director of the respective hospitals through formal mail or authorization letters.

The letter clearly explains the purpose of the final-year academic project, objectives of data collection, confidentiality measures, and assurance that patient information will be used strictly for educational and research purposes. Obtaining permission demonstrates adherence to ethical standards and protects patient privacy throughout the study. Upon receiving the official request, hospital authorities verify the authenticity of the academic institution and research proposal. After careful review, the Joint Director or hospital administration issues an approval certificate permitting access to relevant departments for data collection. This approval acts as formal authorization for conducting academic research within hospital premises. It ensures cooperation from medical staff and allows the researcher to proceed without administrative obstacles while maintaining professional conduct.

Following approval, visits are made to the psychiatry or psychosis departments of the authorized hospitals. During these visits, meetings are arranged with chief doctors, psychiatrists, and departmental staff to discuss research requirements. The researcher explains the type of patient data required, duration of study, and methods of maintaining confidentiality. Interaction with healthcare professionals provides valuable clinical guidance and ensures accurate understanding of patient records. Establishing collaboration with medical experts improves the quality and credibility of collected information. The next phase involves collection of medical reports from patients diagnosed with alcohol-induced psychosis. A minimum of fifty patient case reports are collected from each participating institution wherever possible to ensure adequate sample size. These reports contain clinical observations, diagnosis details, treatment

procedures, and patient progress information. Personal identification details are excluded to maintain anonymity and ethical compliance. The collected reports serve as the primary source of data for further analysis and statistical interpretation.

Once the reports are collected, systematic verification of patient data is performed. Each record is carefully examined to confirm diagnosis accuracy and completeness of information. Data are categorized based on demographic variables such as age, gender, marital status, occupation, and residential background. Age-based analysis helps determine the most vulnerable population groups affected by alcohol-induced psychosis. Gender comparison provides insight into prevalence patterns, while marital status analysis reveals social and psychological influences associated with alcohol dependency. In addition to demographic details, previous medical history of patients is thoroughly reviewed. Information related to duration of alcohol consumption, frequency of intake, withdrawal symptoms, and history of psychiatric illness is analysed.

Chronic alcohol users are often more susceptible to neurological complications and mental disturbances. Evaluating past health conditions helps identify risk factors contributing to psychosis development and allows comparison between individuals with short-term and long-term alcohol dependence. The study also examines overall health conditions and associated complications among patients. Many individuals suffering from alcohol-induced psychosis may have co-existing disorders such as liver disease, malnutrition, depression, or anxiety disorders. These associated conditions influence treatment outcomes and recovery duration. Understanding comorbid health problems helps provide a comprehensive picture of patient health status and highlights the importance of integrated medical and psychological care.

Another significant component of the research involves analysing patient outcomes, including recovery status, relapse cases, mortality rates, and suicidal tendencies. Alcohol-induced psychosis is frequently associated with emotional distress and increased suicide risk. Therefore, reviewing survival and death statistics provides insight into disease severity and effectiveness of medical interventions. Comparative evaluation between recovered patients and those experiencing complications helps identify factors influencing successful treatment outcomes. After verification, all collected data are organized into structured formats suitable for statistical analysis. Tables and classification charts are prepared based on demographic variables, medical history, and clinical outcomes. Statistical tools such as percentage analysis, frequency distribution, mean calculation, and comparative evaluation are applied to interpret patterns within the dataset. Statistical representation converts raw patient information into meaningful research findings supported by numerical evidence.

Graphical representation plays a vital role in presenting statistical results clearly. Bar graphs, pie charts, and distribution tables are prepared to illustrate age-wise prevalence, gender distribution, marital status variation, and outcome comparison. Visual representation improves understanding of trends and enables easier interpretation of research conclusions. These graphical methods enhance the presentation quality of the final project report. The research further evaluates environmental and social factors contributing to alcohol abuse and psychosis development. Economic stress, unemployment, peer influence, family conflicts, and lack of awareness regarding alcohol-related health risks are considered important contributing factors. Understanding these social determinants provides insight into preventive strategies that can reduce alcohol dependency and associated psychiatric complications within communities.

Maintaining confidentiality remains a priority throughout the research process. Patient identities are protected, and collected information is used strictly for academic analysis. Ethical guidelines recommended by healthcare institutions are followed during data handling, documentation, and reporting stages. Responsible data management ensures respect for patient dignity and maintains trust between researchers and healthcare providers.After completing statistical evaluation, interpretation of findings is conducted. Observed trends are analysed to identify major risk factors associated with alcohol-induced psychosis. The study highlights vulnerable age groups, gender differences, health complications, and treatment outcomes. Conclusions are drawn based on statistical evidence rather than assumptions, ensuring scientific reliability of results.

The final phase of the project involves preparation and submission of a comprehensive statistical report. The report includes introduction, objectives, methodology, data collection procedures, ethical approval details, analysis results, discussion, conclusion, and recommendations. Suggestions for early diagnosis, awareness programs, rehabilitation services, and controlled alcohol consumption policies are included to support public health improvement.This research contributes to academic knowledge as well as healthcare awareness by emphasizing the psychological consequences of alcohol abuse. Hospital-based analysis provides real-world clinical evidence regarding the impact of alcohol dependence on mental health. The findings may assist healthcare professionals, policymakers, and community health workers in designing preventive measures and improving treatment strategies for affected individuals.

4. DISCUSSION AND REPORT

1.1 Alcohol Induced Psychosis Based on Age, Sex, Martial Status

Table 3: Alcohol Induced Psychosis Based On Age, Sex, Martial Status.

GROUP	ALL		MEN		WOMEN	
	(n)	%	(n)	%	(n)	%
Age						
Less than 15	10	15	10	16.9	-	-
15-30	35	53.8	29	49.1	6	75
More than 30	22	33.8	20	33.8	2	25
Marital status						
Married	37	56.9	31	70.4	6	46.1
Unmarried	12	18.4	09	20.4	3	23.07
Divorced	08	12.4	04	9.09	4	30.7
Educational status						
Educated	26	40	24	38.7	2	66.6
Uneducated	39	60	38	61.2	1	33.3
Employment						
Employed	12	18.4	08	13.7	4	44.4
Self-working	25	38.4	24	41.3	1	11.1
Retired	08	12.3	08	13.7	-	-
Unemployed	20	30.7	18	31.0	2	22.2
Income (%)						
Less than 500 RMB/ month	37	56.9	34	60.7	3	33.3
500-1000 RMB/month	14	21.5	12	21.4	2	22.2
More than 1000 RMB / month	14	21.5	10	17.8	4	44.9

5.1 ALCOHOL INDUED PSYCHOSIS BASED ON PREVIOUS HISTORY OR HEALTH CONDITION DEVELOP PSYCHOSIS

Table 4: Alcohol Induced Psychosis Based On Previous History Or Health Condition Develop Psychosis.

DISEASE	PREVIOUS HISTORY WITHOUT ALCOHOL DEPENDENCE (n=27)	PREVIOUS HISTORY WITH ALCOHOL DEPENDENCE (n=53)	ALCOHOL INDUCED PSYCHOTICN SYNDROM (n=38)
	%	%	%
1. HYPERTENSION			
No	3.2	0.97	3.76
Prehypertension	17.6	26.8	55
Hypertension	33	47	60
2.DIABETES [%]			
No			
Types	6.03	0.32	-
Type-1	13.8	23.3	38.2
Type-2	26.5	58.5	63.5
3. HEAD INJURIES	4.50	8.06	27.77
4. EPILESY	2.08	2.14	4.97
5. PSYCHOTIC SYNDROME	3.08	12.05	34.88
6. ALCOHOL RELATED LIVER DISEASE	2.03	6.83	18.44
7. ALCOHOLRELATED PANCREATITIS	0.49	9.37	21.03

4.3 LIFETIME COMORID DISORDERS IN PEOPLE WITH ALCOHOL INDUCED PSYCHOTIC DISORDER & DELIRIUM IN PSYCHOSIS

Table 5: Lifetime Comorid Disorders In People With Alcohol Induced Psychotic Disorder & Delirium In Psychosis.

S. NO.	COMORBID DISORDER	ALCOHOL INDUCED PSYCHOTIC SYNDROME (n=49)	ALCOHOL INDUCED PSYCHOTIC DISEASE (n=80)	ALCOHOL INDUCED DELIRIUM (n=18)
		%	%	%
1.	Affective disorder	40.8	50	24
2.	Anxiety disorder	33.1	34	31
3.	Other substance use disorder	35	30	45
4.	Other mental disorder	22	31	0
5.	Personality disorder	38	46	24

4.4 ALCOHOL INDUCED PSYCHOSIS DEATH RATES BASED ON DISEASED STATES VS SUCIDAL STATUS

Table 6: Alcohol Induced Psychosis Death Rates Based On Diseased States Vs Sucidal Status.

Condition	All	Men	Women	Ratio
Alcohol induced psychosis with suicide case	70	12	4	3:1
Without alcohol induced psychosis with suicidal case	63	6	2	

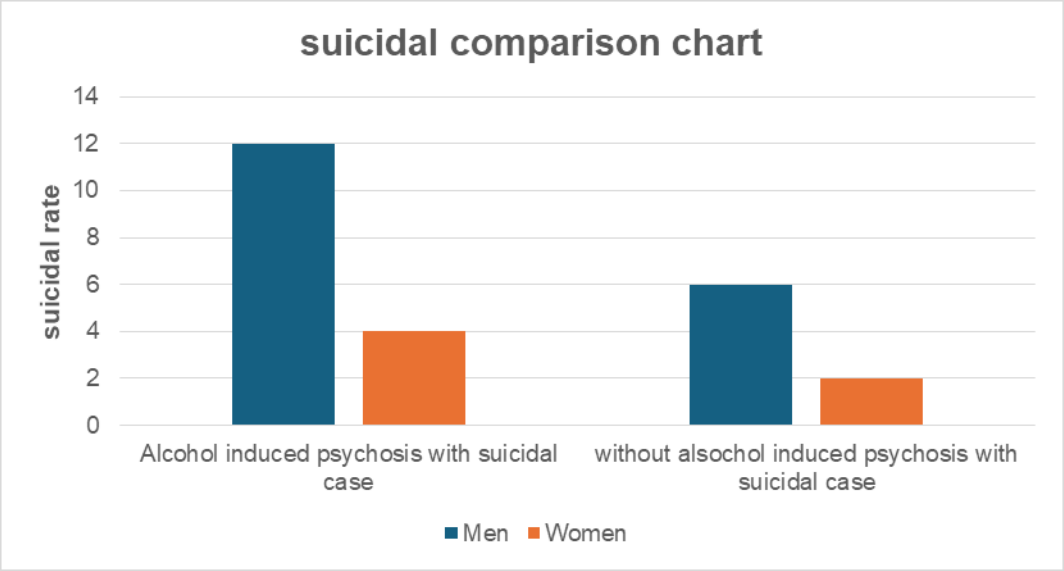


Fig. 10: Suicidal Comparison Chart.

4.5 DISCUSSION

- Past medical history
- Family history
- History of substance abuse
- Frequency of drinking (daily/weekly/occasionally)
- History of alcohol withdrawal
- Hallucination
- Delusion
- Agitation
- Confusion
- Anxiety/Depression
- Sleep disturbance
- Duration of psychotic symptoms
- Medication
- Condition at discharge (improved/not improved)
- Follow up advice
- Suicidal cases

Alcohol-induced psychosis is more commonly observed among young adults, particularly in the 15–30 years age group. It is frequently associated with individuals who have lower educational and socioeconomic status. Long-term alcohol consumption plays a major role in the development and severity of this condition. Several medical conditions such as hypertension, Type-2 diabetes, epilepsy, and head injury are commonly seen in affected patients. These comorbid health problems may increase the risk and complications of alcohol-induced psychosis. Psychiatric disorders, including affective and anxiety disorders, are also frequently present alongside alcohol-related psychotic conditions. Substance use disorders further contribute to the complexity of the illness. The presence of multiple comorbidities often worsens the clinical outcome. Mortality rates are higher among individuals with alcohol-induced psychosis, particularly

in those with suicidal tendencies. Studies indicate that men are more vulnerable, showing higher death rates compared to women. This highlights the serious mental and physical health impact of chronic alcohol use. Therefore, early identification, proper treatment, and preventive strategies are essential to reduce the burden of alcohol-induced psychosis.

Alcohol-induced psychosis was most common in the 15–30 years age group. Most patients were married, uneducated, and self-employed or unemployed. The majority had a low monthly income (less than 500 RMB). Overall, the condition was more frequent among young adults with lower socioeconomic and educational status.

The table shows that several medical conditions are associated with alcohol-induced psychosis. Hypertension and Type-2 diabetes were more common among individuals with alcohol dependence and alcohol-induced psychotic syndrome. Conditions like head injury, epilepsy, and previous psychotic history were also higher in patients with alcohol-induced psychosis. Overall, long-term alcohol use and related health complications may increase the risk and severity of alcohol-induced psychosis. Shows that several psychiatric disorders occur along with alcohol-induced psychotic conditions. Affective disorders and anxiety disorders were commonly found among patients with alcohol-induced psychotic syndrome and psychotic disease. Other substance use disorders were more frequent in patients with alcohol-induced delirium. Overall, these comorbid mental disorders may increase the severity and complexity of alcohol-related psychotic conditions. Shows that death rates were higher among individuals with alcohol-induced psychosis who had suicidal tendencies. Men showed a greater number of deaths compared to women in both psychosis and non-psychosis groups. The male-to-female death ratio was approximately 3:1, indicating higher vulnerability among males. Overall, alcohol-induced psychosis may increase suicide risk, highlighting the need for early treatment and prevention strategies.

5. CONCLUSION

In conclusion, the plan of work follows a systematic and ethical research approach beginning from disease identification and institutional approval to data collection, verification, statistical analysis, and final report submission. Each stage ensures accuracy, transparency, and scientific validity. The study not only full fills academic requirements but also promotes understanding of alcohol-induced psychosis as a serious mental health issue requiring timely intervention, medical support, and social awareness. Through careful examination of patient data and statistical interpretation, the project aims to contribute meaningful insights toward prevention and effective management of alcohol-induced psychiatric disorders.

Alcohol-induced psychosis is more commonly observed among young adults, particularly in the 15–30 years age group. It is frequently associated with individuals who have lower educational and socioeconomic status. Long-term alcohol consumption plays a major role in the development and severity of this condition. Several medical conditions such as hypertension, Type-2 diabetes, epilepsy, and head injury are commonly seen in affected patients. These comorbid health problems may increase the risk and complications of alcohol-induced psychosis. Psychiatric disorders, including affective and anxiety disorders, are also frequently present alongside alcohol-related psychotic conditions. Substance use disorders further contribute to the complexity of the illness. The presence of multiple comorbidities often worsens the clinical outcome. Mortality rates are higher among individuals with alcohol-induced psychosis, particularly in those with suicidal tendencies. Studies indicate that men are more vulnerable, showing higher death rates compared to women. This highlights the serious mental and physical health impact of chronic alcohol use. Therefore, early

identification, proper treatment, and preventive strategies are essential to reduce the burden of alcohol-induced psychosis.

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