Recognition of Alcoholism Among Patients With Psychiatric Problems in a Family Practice Clinic

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The prevalence of psychiatric disorders associated with alcoholism is reported to be as high as 65 percent. A retrospective chart study was performed to determine whether physicians in a primary care center were adequately evaluating for alcoholism their patients with psychiatric problems. Thirty-five percent of the patients with psychiatric problems seen over a six-month period were not questioned about alcohol use. Younger patients and those with a nonspecific psychiatric diagnosis were questioned even less frequently. In a review of the charts for signs of alcohol abuse, 23 percent of the psychiatric patients had signs of possible alcoholism, and 6 percent were definite alcoholics. Since the presence of alcoholism may significantly alter the approach to therapy, primary care physicians should fully evaluate all patients for this problem, especially if they present with a psychiatric disorder.

The prevalence of alcoholism in the general population is 5 to 12 percent and is probably much higher in those patients with psychiatric disorders.[1] Rimmer et al[2] reported that 32 percent of alcoholics had primary psychiatric problems independent of their alcoholism; conversely, the incidence of at least one psychiatric disorder in addition to alcoholism is reported to be 65 to 67 percent.[2,3] Because of the large number of psychiatric problems presenting to the primary care physician, this health care provider is in a unique position to recognize early alcoholism and to initiate appropriate therapy. The purpose of this study was to determine whether physicians in a rural family practice were adequately evaluating for alcoholism those patients who presented with psychiatric or emotional disorders.

Methods

The Family Practice Unit is located in a town of 6,300 residents, 12 miles from the University of Vermont Medical Center. It is staffed by four full-time family practice faculty and six family practice residents on a rotating basis. The Family Practice Unit provides primary medical care to a population of 8,000 people. The study period was from July 1, 1981, through December 31, 1981. The pa-

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were not screened for alcohol use. Since physicians do not record all their clinical impressions in the medical record, the accuracy of any retrospective chart audit is limited. These results may also be biased because many drinkers underreport their consumption.

Physicians are often reluctant to label a patient as alcoholic because of the well-known stigma of this syndrome. In this study if the medical record indicated signs of possible alcoholism, further evaluation was undertaken in only 17 percent of the patients, and follow-up in only 10 percent of the same group. In the definite alcoholic group, further evaluation occurred in 70 percent and follow-up for alcoholism in 60 percent of the patients. These patients were assigned to a category of alcohol use based on a group of indicators in their medical records.

To avoid falsely labeling a person as alcoholic, a comprehensive list of alcoholism indicators (National Council on Alcoholism Criteria) and a scoring system were used to categorize the patients. The low percentage of definite alcoholics in this study group was probably a reflection of this conservative rating system. Pattison[7] hypothesized that no single set of criteria for the diagnosis of alcoholism can be applied to the clinical situation because the syndrome of alcoholism is a continuum rather than a distinct entity. In this study the relatively subjective classification of either possible or definite alcoholism did not fully address the need for early identification.

Thirty-three percent of the psychiatric group in this report had the diagnosis of depression. Because of the high correlation of alcoholism and depression, this should be considered a special group. Several investigators[8,9] have reported as high as 41 percent of alcoholics have an episode of major depression. Pottenger and associates[9] determined that 59 percent of the alcoholics admitted to a mental health center for treatment were clinically depressed. Even more important, the combination of alcoholism and depression makes a person more prone to suicidal behavior.[10] Weissman et al[3] reported the suicide attempt rate to be higher in alcoholics with additional psychiatric disorders compared with psychiatric patients with no alcoholism.

The use of a standardized questionnaire for early assessment of alcoholism is gaining acceptance in the emergency room and primary care center.[11,12] Tennant and associates[13] used a short questionnaire and attention to abnormalities in the physical examination to screen a general medical population for drug or alcohol abuse. Seventy percent of the drug or alcohol abuse patients who were identified by this simple method subsequently entered a treatment program.[13] There are a variety of formal questionnaires available for screening purposes including the Michigan Alcohol Screening Test (MAST)[14] and the Self-Administered Alcoholism Screening Test.[15] The MAST appears to be most appropriate for use in the family practice setting.

In conclusion, primary care physicians should maintain a high index of suspicion for alcoholism when caring for a patient with psychiatric or emotional problems. A commitment to early recognition and appropriate therapy is vital to the management of this combination of disorders.

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