Alcoholism in the Families of Family Practice Outpatients

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As part of a screening process for alcoholism, 147 patients at a university-based family practice center were each asked to complete two tests: the Michigan Alcohol Screening Test (MAST) concerning themselves and a modified MAST concerning their families. Charts of patients with positive results for family alcoholism were reviewed for presenting complaints, ongoing medical problems, and recognition or mention of family alcoholism by the physician. Over 34 percent (50) of patients had definite alcoholism problems in their families. Women were more likely than men to have a positive family MAST (37.7 percent women vs 24.4 percent men, $P < .001$), whereas men were more likely to be alcoholic (34.1 percent men vs 10.4 percent women, $P < .001$). Nearly 40 percent of patients with a positive family MAST had complaints that could be attributed to the family disruption of alcoholism, and another 20.8 percent had medical problems that might be exacerbated by stress, but use of alcohol by a family member was mentioned in only 12.5 percent (5/40) of charts reviewed.

Families of alcoholics are especially in need of primary care: they are battered, abused, physically ill, accident prone, and emotionally distressed.[1-8]

As the alcoholic's disease progresses, the family goes through predictable stages of reaction and adjustment.[9,10] Initially there are attempts on all sides to ignore or deny an alcohol problem. As the difficulties with alcohol become less deniable, the next stage in the family adjustment to alcoholism begins, with the spouse attempting to control the alcoholic's drinking and behavior. When efforts at control fail, the family becomes increasingly isolated socially. Multiple crises drive the family to leave the alcoholic, seek treatment, or accommodate somehow to the cyclic crisis pattern. It is during these crises that health care providers are most likely to see alcoholic families. It may be for the problem itself or for medical problems arising from the family disequilibrium.

Identification of patients with alcoholic family members can be the initial step to an intervention in the alcoholic process. There is increasing evidence from adoption studies, twin studies, and animal pharmacogenetic studies that an alcoholic diathesis can be inherited.[2,4,11] Certain patterns of family reaction to alcoholism may promote its transmission to the next generation.[12,13] Families experiencing disruption of traditions and rituals are much more likely to have alcoholism in the children than families that are able to preserve routines and rituals.

Intervention in the alcoholic process might prevent its passage to the succeeding generation.[13] Although no one has reported the effect of alcoholism treatment on medical morbidity in family

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members of alcoholics, it is clear that treatment of other disorders in one family member can decrease the medical morbidity of other family members.[14]

Increasingly, those experienced in alcoholism treatment are intervening in the alcoholic's disease process to confront the situation and to precipitate or utilize current or pending family crises to force initiation of treatment of the alcoholism. Employee Assistance Programs have provided a model in which the rationale has been to prevent further deterioration, and such efforts have been successful. Health crises, in either the alcoholic or the alcoholic's family, should provide ideal opportunities for physician intervention.

To address these issues in a family practice center, questions about alcoholism in the identified patient and in the family of the patient were included as part of an alcoholism screening process. The intention was to determine how many patients had family members with alcohol problems, whether those who did were different demographically from those who did not, and how the medical problems of the patient might relate to the presence of problems of alcohol use in the family.

The authors modified the Michigan Alcohol Screening Test (MAST) for this purpose. The MAST, which has 25 questions that assess alcoholism based on the consequences of drinking, has been most useful as a screening, rather than a diagnostic, tool to indicate probable alcoholism.[15-18] As MASTs adapted for family members of alcoholics have been shown to underestimate alcoholism in the affected family member, the results would be expected to be conservative.[19]

Methods

One hundred forty-seven consecutive patients seeking care at the University of New Mexico Family Practice Center on Tuesday and Wednesday mornings during the months of July and August 1982 were given one MAST to answer for themselves and a modified version to answer regarding their family members. Almost all of the patients seen on various half-day segments were screened. Family was defined as "anybody that you are living with or have significant frequent contact with (ie, not just relatives)." The patients filled out the two MASTs and a demographic questionnaire while waiting for their physician. The charts of patients with a score of ≥ 5 on either the self-MAST or the modified family MAST were identified, and these charts were later reviewed by a family physician and a psychiatrist for presenting complaint and pertinent medical history. Patients who scored 5 on the MAST because of attendance at an AA meeting as a student or with a spouse were excluded.

Table 1. Comparison of Scores on MAST and Family MAST

Score on Family MAST	Score on Self-MAST	
	0-4	≥ 5
0-4	84	13
≥ 5	38	12

Results

Thirty-four percent (50) of the patients had a family member or members with a definite alcoholism score (≥ 5) on the family MAST. Slightly fewer than 13 percent more had family members with potential problems (MAST score 1 to 4). Over 16 percent had definite alcoholism problems themselves (MAST ≥ 5). These numbers represent 34.1 percent of the male patients and 10.4 percent of the female patients.

Of those without definite alcoholism themselves (MAST < 5), 31.2 percent had one or more family members with alcoholism. Of those with alcoholism (MAST ≥ 5), 48 percent had a family member positive for alcoholism. Of the total study population, 42.9 percent were alcoholic or were involved with someone with alcoholism (Table 1).

Patients with family alcoholism were more likely to be women, to be unmarried, to be employed, and to have medical insurance, Medicaid, or Medicare (Table 2). Of these trends, only the difference in sex was statistically significant ($P < .001$). Nearly 40 percent of the patients (alcoholic or nonalcoholic) who had family alcoholism also had medical complaints that could be directly related to the disruption in the family related to alcoholism, eg, anxiety, depression, fatigue, decreased energy. Another 20.8 percent had conditions that might be exacerbated by the stress of alcoholism in the family: insomnia, gastritis, irregular menses, headaches, colitis. The remaining 38.6 percent presented with seemingly unrelated problems,

Table 2. Demographic Characteristics (Percentage) of Study Population

	Nonalcoholic Family Negative (n = 84)	Nonalcoholic Family Positive (n = 38)	Alcoholic Family Negative (n = 13)	Alcoholic Family Positive (n = 12)
Men*	25	15.8	76.9	33.3
Women	75	84.2	23.1	66.7
Average age	38.9 yr	33.1 yr	42.8 yr	34.5 yr
Education beyond high school	67.9	63.2	61.5	58.3
Employed	45.7	55.3	43.1	58.3
Married	54.8	47.3	46.1	25
White	86.9	76.3	84.3	83.3
Other	13.1	23.7	15.2	16.7
Third-party payment	66.7	57.9	76.9	66.7

*($P < .001$)
($\chi^2 = 18.83$, 3 *df*)

such as streptococcal pharyngitis, atrial fibrillation, pregnancy, and vaginitis.

In reviewing physician recognition of family alcohol problems, only five of 40 charts reviewed made any mention of a family member with alcoholism, present or past. Ten of the 50 family charts with MAST scores ≥ 5 were unavailable for review.

Comment

The study makes it clear that there are alcoholic members in many of those families from which individual members present to this family practice center and that the alcoholism is not being recognized. The study did not attempt to ascertain whether the alcoholism in these family members was acute or in remission. It did not evaluate a patient's own assessment of how stressful the alcohol problem was or is, it did not attempt to correlate the onset of symptoms with the progression of the alcoholism or with the stage of family adjustment to alcoholism, and it did not ask whether intervention for the alcoholism was appropriate. The finding that 42.9 percent of patients attending this outpatient clinic had a definite direct or indirect problem with alcoholism indicates both that an outpatient medical clinic is fertile ground for case finding and that answering the questions contained in the MAST and family MAST would provide a more complete data base for realistically assessing how to appropriately design a more active intervention program.

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