

# Risk Factors Identified for Early Heavy Drinking

BY KERRI WACHTER  
Senior Writer

WASHINGTON — Tobacco use and the expectation of social and physical pleasure from alcohol consumption significantly predict the transition to heavy drinking among adolescents and young adults, a 5-year study of more than 200 people shows.

Tobacco use (100 or more cigarettes lifetime) and alcohol expectancies for social/physical pleasure significantly predicted increased rates of transition from first drink to heavy drinking with hazard ratios of 1.64 and 1.06 ( $P$  is less than .05), reported Karen G. Chartier, Ph.D., of the University of Connecticut Health Center in Farmington.

Interestingly, an early age of first drink (younger than 15 years) significantly predicted decreased rates of pro-

gression to heavy drinking, with a hazard ratio of 0.51 ( $P$  is less than .05).

The data were presented as a poster at a joint meeting sponsored by the Research Society on Alcoholism and the International Society for Biomedical Research on Alcoholism.

Participants in the study came from a community sample drawn from the greater Hartford, Conn., area. Initially, participants interviewed were between the ages of 13 and 21 years. Five years later, they were interviewed again. A total of 281 completed the second interview.

The researchers looked at a number of potential risk factors for progression to heavy drinking, including gender, parental history of alcoholism, disinhibition and thrill/adventure seeking, conduct disorder, negative affectivity, age of first drink, positive alcohol expectancies, marijuana use, and tobacco use.

At the 5-year follow-up, almost all (96%) reported ever having had a drink. Of these, slightly more were female (60%). More were white (62%) followed by black (23%), Hispanic (13%), and other (2%). The average age at follow-up was 16.5 years. The average age of the first drink was 15.5 years. The average number of drinks per day was 1.5, and the average number of drinks per occasion was 3.

Of those who reported ever drinking, one-third (35%) were heavy drinkers, defined as consuming alcohol at least 4 days per week and consuming three or more drinks per day. The average age of onset for heavy drinking was 20 years. The median time from the first drink to the start of heavy drinking was 9 years.

The study results suggest that interventions for heavy drinking in adolescence might need to target positive beliefs about alcohol, co-occurring tobacco use, and sensation-seeking behaviors, the researchers noted. ■

## Survey Addresses Pediatricians' Role in Identifying, Treating Mental Illness

BY DOUG BRUNK  
San Diego Bureau

Survey results suggesting that pediatricians are more comfortable identifying—but not treating—most children's mental health problems are consistent with previous findings, a leading child and adolescent psychiatrist says.

"With the exception of attention-deficit/hyperactivity disorder, most pediatricians have limited training and experience in the diagnosis and treatment of child psychiatric disorders," Dr. David Fassler, also a clinical professor of psychiatry at the University of Vermont, Burlington, said in an interview. "For this reason, we're seeing an increased emphasis on programs designed to enhance access to timely and appropriate consultation services."

The results, based on a survey of Cleveland-area primary care pediatricians and child and adolescent psychiatrists, showed that ADHD was the only psychiatric condition for which most of the respondents thought pediatricians should be responsible.

"The willingness of pediatricians to accept the responsibility for identifying children's mental health problems is encouraging," researchers led by Dr. Amy Heneghan of the department of pediatrics at Case Western Reserve University, Cleveland, reported (*J. Dev. Behav. Pediatr.* 2008;29:262-9). "It is an important first step toward reducing the morbidity, mortality, and costs associated with an inadequate and dysfunctional child mental health system."

In 2005, Dr. Heneghan and her associates mailed a survey to 338 primary care pediatricians and 75 child and adolescent psychiatrists who practice in the Cleveland area.

Each respondent was asked the same three questions about ADHD, depression, behavioral problems, learning disabilities, anxiety disorders, substance abuse, and eating disorders:

- ▶ How strongly do you agree or disagree that pediatricians should be responsible for identifying this problem?
- ▶ How strongly do you agree or disagree that pediatricians should be responsible for treating or managing this problem?
- ▶ How strongly do you agree or disagree that pediatricians should be responsible for referring this problem?

Researchers scored each response on a 3-point Likert scale, with the choices being disagree, neutral, or agree.

Each respondent also was asked 13 questions about barriers for pedia-

**Child and adolescent psychiatrists were far more likely to agree that pediatricians' lack of training in identifying childhood mental health problems was a barrier.**

tricians in their identification, referral, and treatment of childhood mental health problems, such as lack of time for treating them and lack of training for identifying them. Researchers scored these responses on a 5-point Likert scale, with the choices being strongly disagree, disagree, neutral, agree, or strongly agree.

Another part of Dr. Heneghan's survey asked respondents to share their opinions about the availability of children's mental health services. The final analysis included responses from 132 primary care pediatricians and 31 child and adolescent psychiatrists.

Dr. Heneghan and her associates reported that with the exception of ADHD, most of the respondents in both groups agreed that pediatricians should be responsible for identifying and referring but not treating child mental health problems.

For example, while less than 20% of respondents in both groups agreed that pediatricians should be responsible for treating depression, behavioral problems, learning disabilities, anxiety disorders, substance abuse, and eating disorders, 86% of primary care pediatricians and 57% of child and adolescent psychiatrists agreed that pediatricians should be responsible for treating ADHD.

More than 70% of respondents in both groups agreed that a lack of mental health services was a barrier for primary care pediatricians, but child and adolescent psychiatrists were significantly more likely than pediatricians to agree that pediatricians' lack of training in identifying childhood mental health problems was a barrier (70% vs. 47%, respectively).

Both groups strongly agreed that long waiting periods to see referred mental health providers, lack of time to treat mental health problems, and lack of qualified providers to refer to were barriers for pediatricians.

Dr. Fassler said that in his practice, child and adolescent psychiatrists are now providing on-site consultation to seven pediatric groups. He also pointed out that Massachusetts has a "well-regarded statewide initiative that includes telephone consultation with face-to-face backup, as needed."

In addition, he said, other states have developed innovative telemedicine programs to provide such services. "I don't think pediatricians will ever be treating the full range of child psychiatric disorders," Dr. Fassler said. "But they clearly are and should be critical members of the treatment team."

The study was funded by the Woodruff Foundation and the Annie E. Casey Foundation. ■

## Children's Hostility Tied to High BP

BY ROBERT FINN  
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HONOLULU — Children who perceive the world in hostile ways are significantly more likely to have hypertension, according to a study of almost 900 children.

A style of interaction marked by hostility has long been known to be a risk factor for hypertension in adults, but with this study Dr. Désirée Seeyave of the University of Michigan, Ann Arbor, and her colleagues extended that observation to children as young as 9 years old.

Among 873 children, those who scored in the highest tertile of hostility were 13.5 times more likely to have a diastolic blood pressure at or above the 90th percentile than were children in the lowest tertile after the investigators controlled for race, gender, maternal education, and body mass index z score, Dr. Seeyave reported in a poster presentation at the annual meeting of the Pediatric Academic Societies.

The children were enrolled in the National Institute of Child Health and Human Development Study of Early Child Care and Youth Development. When they were in the third, fourth, and fifth grades, investigators administered the Intent Attributions and Feelings of Distress Scale, Hostile Intent Instrumental Provocation Score.

This instrument assesses to what extent a child ascribes hostile intent to ambiguous situations. For example, the child is asked to imagine a scenario in which he or she lets another child play with a radio that then gets broken.

The interviewer will ask why the other child broke the toy and whether he or she was trying to be mean. The child will score high on hostile attribution if he or she assumes that the other child broke the toy intentionally in an effort to be mean.

A year later, when the children were in the fourth, fifth, and sixth grades, investigators measured blood pressure by standard protocols.

In the multivariate analysis, the investigators found no significant associations between high blood pressure and gender, race, or mother's education. Children whose BMIs were above average for their age were 3.8 times more likely to have diastolic blood pressure in the 90th percentile or above than were children whose BMIs were normal for their age.

These findings have implications for prevention of cardiovascular disease risk factors such as hostility and obesity beginning in childhood, the investigators wrote.

Dr. Seeyave stated that she had no conflicts of interest related to her presentation. ■