

The Association of Parental Alcoholism and Rigidity with Chronic Illness and Abuse Among Women

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Background. This study determined whether women in a primary care practice who described one or both of their parents as alcohol dependent (group A) or harsh, rigid, or difficult (group B) were more likely to have chronic illness than women who denied having parents with these characteristics (group C).

Methods. A consecutive sample of 120 women scheduled for comprehensive physical examinations were interviewed to determine parental characteristics, demographic data (age, education, employment, and marital status), and clinical information (chronic illness and lifetime surgeries). In addition, all women were asked standardized questions about sexual and physical abuse.

Results. The overall difference among the groups for women with a history of chronic illness was significant

($P < .001$). More women in groups A (55%) and B (48%) were identified with chronic illness than in group C (18%). Women in groups A and B also reported more sexual and physical abuse (32% and 44%, respectively) than women in group C (8% [$P < .001$]). Women identifying abuse were diagnosed with more chronic illness (67%, compared with 25% [$P < .001$]) and more lifetime surgeries (3.3 compared with 1.75 [$P < .05$]) than women denying abuse.

Conclusions. Parental alcoholism and parental rigidity were associated with increased prevalence of chronic illness and physical or sexual abuse among women patients.

Key words. Chronic illness; alcoholism; sexual and physical abuse. *J Fam Pract* 1992; 35:54-60.

Primary care physicians are frequently challenged and frustrated by patients who present with physical complaints but in whom no organic disease is found. A focus on somatic symptoms often leads to unproductive investigation and treatment. Even if physicians are familiar with literature linking somatization to psychiatric disorders, formulating accurate diagnoses and effective treatment may be difficult.¹⁻⁵

Various approaches have been suggested for minimizing this dilemma.⁶⁻¹⁰ These approaches encourage the physician and the patient to enter into a dialogue in a collaborative manner. How do family physicians adopt a new approach when 20th century medicine has emphasized technological advances that have resulted in high expectations on the part of patients and physicians for total resolution of problems? How can physicians give patients clear messages about the complexity of physical problems in order to avoid somatic fixation?

This research explored one attempt to minimize

somatic fixation. The approach required a consistent expansion of the typical family history interview.

Family history taking generally involves obtaining knowledge about the health problems of family members (eg, father's heart disease, mother's breast cancer). This can be expanded to include basic questions about family function. What was the family like (eg, happy, sad, everyone angry, no one talks). In addition, simple genograms can easily be constructed to clearly delineate family relationships.^{11,12} Asking for this additional information on family of origin (the family in which a person has his or her beginnings, physically and emotionally) often results in discussions about psychosocial concerns and gives patients a clear message that the physician is interested in all aspects of their health.

When using this style of family history taking, two patterns were observed in the author's practice. Women who described one or both parents as alcohol dependent appeared to be prone to somatization and often described stress-related health problems. Generally, they described chaotic and difficult childhoods. Another group of women seemed to have stress-related health problems similar to women from alcohol-dependent family systems; these women described a family system that

Submitted, revised, December 7, 1991.

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was rigid and usually emotionally overinvolved. In general these women seemed relieved to talk about their families of origin, even when it was obviously painful. In addition, these discussions allowed patients to relate similar problems or concerns in their present families. In time, this information became profoundly valuable in terms of understanding patients and their health.

The last decade has seen an increased focus on understanding how family systems influence health or produce illness in individuals.¹³ In addition, the need for common terminology and uniform design methodology for family medicine research has been advocated.¹⁴ Family-oriented interventions to physical health have been recently reviewed.¹⁵

Few studies, however, have directly addressed a possible association between parental alcoholism or other parental characteristics and chronic physical illness. Studies have addressed both the psychological effects of having an alcohol-dependent parent,^{16,17} and the relationship between alcohol and the family system.¹⁸ Daughters of alcoholics have been shown to have an increased risk of depression,¹⁹⁻²⁰ when raised by biological parents. Prior research demonstrated that daughters emerging from families with male-limited (type 2) alcoholism were at an increased risk of diversiform somatization.²¹ Most studies in the field of alcoholism have been directed toward the risk and genetics of alcoholism, with men constituting the majority of subject samples.²²

The aim of this study was to determine whether women in this primary care practice who identified alcohol-dependent parents or harsh, rigid, or difficult parents were more likely to have chronic illness than women who denied having parents with these characteristics.

Methods

Study Population and Procedure

The study population consisted of 120 consecutive women who had been scheduled to have a complete physical examination at the Parsons Clinic in Red Deer, Alberta. (This is a private clinic operated by 15 family physicians and one surgeon.) Three to four complete examinations were booked each day, and approximately 30 minutes was allotted for these appointments. Men were excluded from the study because of the low numbers of men scheduled for complete physical examinations. The author collected all data for this descriptive study at the time of the examinations. Patients were interviewed and examined in the usual manner in a clinical setting. Patients were advised that a research project was in progress, which included asking questions

about their families. Answering was optional. This approach allowed for patient care to proceed as usual if the patient refused to participate.

Data Collection

DEMOGRAPHIC DATA

Questions generally used in a clinical setting were asked to obtain demographic data. Information requested included: (1) age, (2) education (<grade 12, grade 12, >grade 12, or 4 years college), (3) financial support (employed, social assistance, or homemaker/other support) and (4) marital status (single, married or common-law, or divorced or separated).

ALCOHOL USE

All women were asked if they drank alcohol more than twice per week and responses were categorized as (1) never drink alcohol, or less than twice per week, or (2) drink alcohol twice per week or greater. In addition the women were asked: "Have you been in a married or common-law relationship with an alcohol- or drug-dependent partner?" The answers were coded as yes or no.

FAMILY HISTORY DATA

Family-history-taking techniques used in research generally are not easily used in the clinical setting. Structured interviews or self-administered questionnaires may provide reliable and valid data, but do not provide the opportunity for the physician and the patient to converse in a meaningful way. Clinical experience suggested that the way in which questions about family of origin were asked was just as important as determining the validity of the patient's response. The following two exploratory questions were formulated to elicit reliable information as well as initiate meaningful dialogue. The questions were asked during the family history portion of the interview.

1. While growing up, as well as since leaving home, was the use of alcohol or drugs by your parent(s) (step-parents or other parental figures) ever a concern to you or any other family member?
2. While growing up, would you describe that either parent (step-parent or other parental figures) was particularly harsh, rigid, or difficult?

Patients were categorized into group A, B, or C according to their responses.

- Group A: Question 1—Yes, question 2—Did not ask
 Group B: Question 1—No, question 2—Yes
 Group C: Question 1—No, question 2—No.

Women in group A identified alcohol-dependent parent(s), women in group B identified harsh, rigid, or difficult parent(s), and women in group C did not identify parents with either of these characteristics. Women identifying alcohol-dependent parents were not asked the second question as it was considered redundant; clinical experience suggested that essentially all women from alcohol-dependent family systems will describe one or both parents as harsh, rigid, or difficult to some extent.

ABUSE DATA

Survey questionnaires have been developed to measure sexual or physical abuse or both. Although useful research tools, these instruments are cumbersome in clinical settings. With this in mind, the author asked two standardized questions about abuse. The intent was to probe for information about the occurrence of abuse while simultaneously observing how patients in this study group reacted to questioning about abuse. In addition, this approach allowed for dialogue to progress in accordance with the patient's needs.

As part of the family history, the following two questions were asked after asking questions about family of origin. Again, each woman was informed that everyone was asked the same research questions, and that responding was optional.

1. While growing up, were you aware of any sexual or physical abuse to yourself or any other family member?
2. In your present family situation, are you aware of any sexual or physical abuse to yourself or any other family member?

Answers were categorized in the following manner: sexual abuse; physical abuse; sexual and physical abuse; sexual or physical abuse or both in the family excluding self; and no abuse.

CHRONIC ILLNESS DATA

Recognizing the confusion that can exist in diagnosing chronic health problems, it was thought appropriate to define chronic illness in terms of duration. For example, neck pain that lasted for 1 week was not relevant to this study, but neck pain that lasted for months or years was relevant. The specific diagnosis of the neck pain, whether fibromyalgia, depression, or one of the somatoform dis-

Table 1. Percentage of Parents Described by Female Patients as Alcohol Dependent or Harsh, Rigid, or Difficult

Parent	Parental Characteristics	
	Group A Alcohol Dependent (n=31)	Group B Harsh, Rigid, Difficult (n=27)
Father	77	33
Mother	6	19
Both	10	30
Stepfather	6	15
Stepmother	—	4

orders, was considered less important than the chronicity of the symptoms.

Chronic illness was defined as any complaint(s) raised during the complete examination, or health problem(s) diagnosed by the author, that had lasted either continuously or intermittently for 6 months or longer.

Depression was defined as a chronic problem if the patient was in therapy or taking medication, or both, irrespective of the length of time the depression had existed. Depression was diagnosed at the time of the examination if depressed mood and physical symptoms interfered sufficiently with work or home life to prompt the author to initiate medication or therapy. All chronic illness was described as either a diagnosis or a complaint.

The number of lifetime surgeries was based on self-report. Minor skin procedures were excluded.

DATA ANALYSIS

Statistical analysis was performed using an SPSS-PC statistical software package.²³ The Student's *t* test was used to determine the differences in mean age and number of surgeries between the groups. Chi-square tests were used to determine the associations between the three family-of-origin groups for the following variables: education, employment, marital status, abuse awareness, chronic illness, and alcohol use. A difference was considered statistically significant if $P < .05$.

Results

Complete data were obtained for all persons except for one woman in group A, who did not answer the abuse question. This left 31 in group A, 27 in group B, and 61 in group C. Table 1 categorizes the parents depicted as alcohol or drug dependent, and harsh, rigid, or difficult.

Demographic Data

All women were white except for one native American and one Oriental. There were no significant differences

Table 2. Demographic Data of Women, by Parental Characteristics

Patient Characteristics	Parental Characteristics		
	Group A Alcohol Dependent (n=31)	Group B Harsh, Rigid, Difficult (n=27)	Group C Neither A nor B (n=61)
Age (y)*	30 ± 10	35 ± 12	35 ± 15
Source of financial support (%)†			
Employed	65	67	62
Social assistance	3	22	0
Other	32	11	38
Marital status (%)‡			
Single	23	15	20
Married	52	56	72
Divorced	26	30	8

*Student's *t* test, NS.

†A vs C, NS; A vs B, $\chi^2 = 7.2$, $P < .05$; B vs C, $\chi^2 = 18$, $P < .001$.

‡A vs B, NS; A vs C, $\chi^2 = 5.92$, $P = .05$; B vs C, $\chi^2 = 6.83$, $P < .05$.

for age and education among the groups. The mean ages for groups A, B, and C were 30 years ± 10, 35 years ± 12, and 35 years ± 15, respectively. Education levels achieved by the complete sample were: 19%, <grade 12; 38%, grade 12; 29%, >grade 12; and 13%, 4 years college. The difference for source of financial support among the groups was significant ($\chi^2 = 20.70$, $P < .001$). There was a marginally significant difference among the groups for marital status ($\chi^2 = 8.59$, $P = .07$). Table 2 summarizes some of these demographic data.

Data Pertaining to Alcohol and Drug Use

Alcohol use by the patients was low, with no significant difference among the groups. Only five women were identified who drank alcohol more than twice per week. Alcohol or drug dependency in a partner was identified most often in group B (37%) and less frequently in group A (26%) and group C (12%). Overall this was significant ($\chi^2 = 7.95$, $P < .05$). In direct comparisons between the groups, the only significant difference found was between groups B and C ($\chi^2 = 7.8$, $P < .05$).

Abuse Reporting

Most women reported having thought about abuse at some prior point. Two women who reported having been sexually abused in childhood were not sure whether their experiences constituted abuse. Because both cases involved unwanted physical contact of a sexual nature, they were categorized as sexual abuse victims. All remaining women responded with minimal uncertainty.

Table 3. Chronic Illness and Sexual and/or Physical Abuse in Women, by Parental Characteristics

Patient Characteristics	Parental Characteristics		
	Group A Alcohol Dependent (n=31)	Group B Harsh, Rigid, Difficult (n=27)	Group C Neither A nor B (n=61)
Chronic illness identified (%)*	55	48	18
Sexual/physical abuse revealed (%)†	32	44	8

* $P < .001$.

† $P < .001$. Excludes abuse that occurred in a family member other than the patient.

The overall difference for abuse awareness was significant ($\chi^2 = 21.29$, $P < .001$) (see Table 3). Groups A and B did not differ significantly. The differences between groups A and C ($\chi^2 = 13.02$, $P < .01$) and between groups B and C ($\chi^2 = 18.83$, $P < .001$) were significant. In group A, 13 (42%) women identified abuse (5, sexual; 2, physical; 3, sexual/physical; and 3, abuse in family excluding self). In group B, 14 women (52%) identified abuse (2, sexual; 6, physical; 4, sexual/physical; and 2, abuse in family excluding self). In group C, 6 women (10%) identified abuse (3, sexual; 2, physical; and 1, abuse in the family excluding self).

All women reporting abuse named one or more individuals. Sexual abusers named were father (4), stepfather (4), uncle (2), grandfather (1), brother (2), mother (1), other male relative (1), and unrelated male (5). Physical abusers named were father (2), mother (1), both parents (2), stepfather (2), and spouse (9).

Chronic Illness

The overall difference in chronic illness between the three groups was significant ($\chi^2 = 15.23$, $P < .001$) (Table 3). Chronic illness was identified with more women in groups A and B than in C (A = 55%, B = 48%, C = 18%). Groups A and B did not differ significantly. The difference between groups A and C was significant ($\chi^2 = 13.12$, $P < .001$), as was the difference between groups B and C ($\chi^2 = 8.56$, $P < .05$).

Depression was the most commonly detected problem (13.3%). This represented 26%, 15%, and 7% of the chronic illness in groups A, B, and C, respectively. Overall this was significant ($\chi^2 = 6.6$, $P < .05$). The only significant difference in the incidence of depression between groups was between A and C ($\chi^2 = 6.7$, $P < .01$).

Other chronic problems identified in groups A, B, and C, respectively, included cervical problem (3, 1, 3), tension headache (3, 1, 0), irritable bowel syndrome (2, 2, 0), lumbar problem (1, 1, 2), hypothyroid in the past, currently taking medication (1, 4, 0), hypertension (0, 0,

Table 4. Comparison of Women Reporting Sexual and/or Physical Abuse with Those Reporting No Abuse

Patient Characteristics	Abuse (n=27)	No Abuse (n=92)	P Value
Age (y)	34 ± 13	34 ± 14	NS
Marital status (%)			
Single	15	21	
Married	41	70	<.001
Divorced	44	10	
Relationship with alcoholic and/or drug dependent partner (%)	59	10	<.001
Chronic health problem (%)	67	25	<.001
Lifetime surgeries (mean)	3.3	1.75	<.05

4), gastritis (1, 1, 0), cystitis (0, 0, 1), osteoarthritis (0, 0, 1), asthma (0, 0, 1), and allergic rhinitis (1, 0, 0). Two chronic problems were identified with 4, 3, and 2 patients in groups A, B, and C, respectively.

The mean number of surgeries reported by patients in group A were 1.77; group B, 3.18; and group C, 1.79. Significant differences were found between A and B ($P < .05$) and between B and C ($P < .05$).

Comparison of Women Reporting Abuse vs No Abuse

Because of recent reports suggesting an association between chronic pain or psychiatric problems and abuse issues,²⁴⁻³² women who identified abuse were compared with those who did not, irrespective of their family of origin. There were no significant differences between the groups (abuse vs no abuse) for age, education, or employment. However, the differences in marital status, chronic illness, alcohol use by partner, and number of surgeries were significant (Table 4).

Of the 10 women identifying sexual abuse, 5 had chronic illness and 1 had two chronic problems. Of the 10 women identifying physical abuse, 8 had chronic illness and 2 had two chronic problems. Of the 7 women identifying sexual or physical abuse or both, 5 had chronic illness and 3 had two chronic problems.

Discussion

This study found that parental characteristics were associated with health outcome. Women who identified parental alcoholism (group A) or parental rigidity (group B) were found to have more chronic illness than those

women who denied having parents with these characteristics (group C).

It was anticipated that group A women would have significant chronic illness. The surprise was the amount of chronic illness experienced by group B women and the similar pattern of abuse shared by group A and B women. This was in sharp contrast to the women in group C, who seemed exceptionally healthy. They had experienced significantly less abuse, experienced a much lower level of chronic illness, and were remarkably stable in their marriages.

In the last decade there has been an increased interest in the difficulties encountered by children of alcoholic parents with the emergence of self-help groups and a cottage industry devoted to counseling and treatment, which seems to be of particular interest to women.²² This study may offer some further insight into the possible effects on daughters of alcoholic parents. The group A women in the study reported minimal problems with their own use of alcohol (they appeared to follow the aversion pattern of alcohol consumption³³), but experienced major problems with their health. In addition, this study, similar to previous reports,^{19,20} found that adult daughters of alcohol-dependent parents were more likely to suffer depression.

With this increased awareness of problems in alcohol-dependent family systems, there has been a tendency to directly compare adult children of alcoholics with adult children of nonalcoholics. This has produced studies with conflicting results.³⁴ This study identified a group of women (group B) with a pattern of chronic illness similar to that of a group of adult daughters of alcoholics, and thus emphasizes the complexity of family-of-origin issues. Directly comparing adult children of alcoholics with adult children of nonalcoholics without controlling for the disturbed psychosocial milieu that can exist in families where alcoholism is not a factor will likely continue to produce conflicting results.

The conclusions drawn from this study concerning the women in groups A and B must be viewed with caution because the population from which the participants were recruited was limited, only women who had scheduled a complete examination were included, and the patients were relatively young. In addition, when chronic illness was identified, the author already knew into which group the patient's answers had placed her. This bias in data collection limits the reliability of the conclusions. Because the information on family of origin was important to the author in providing good patient care, it was ethically impossible for the author to design the study using a different method. More research in varied primary care environments is required to determine whether

a similar correlation between parental characteristics and chronic illness would be observed.

Before this study, the author inquired about abuse only when she thought it was relevant to the patient's presenting problems. The surprise in the study was the extent of abuse revealed and the dialogue that resulted from the study questions. Unfortunately, the study design did not include data regarding the disclosure of abuse.

The pattern of chronic pain, psychiatric problems, and lifetime surgeries found in this study is similar to findings in prior studies in which abuse was more specifically defined.²⁴⁻³⁰ Asking patients for their own assessment about abuse appeared as effective as a more structured attempt by the physician to determine if abuse had occurred.

Prior reports have suggested the importance of inquiring about abuse, particularly when chronic pain exists or overutilization of health services is an issue.^{26,27} Primary care physicians by the nature of their specialty are oriented to prevention. They may wish to consider screening for abuse. Perhaps early detection may prevent establishment of some chronic pain problems and unnecessary surgeries. Research in primary care practices is needed to investigate these possibilities.

In summary, women who identified alcohol-dependent or harsh, rigid, or difficult parents were at increased risk for chronic illness and experienced more abuse than women who denied having parents with these characteristics. Specific exploratory questions were valuable in eliciting their stories. These observations illustrate the clinical importance of understanding the association between family-of-origin issues and chronic illness.

Acknowledgments

This study was supported in part by a Research and Development Award from the College of Family Physicians of Canada. The author would like to thank staff in the Primary Care Research Unit, Department of Family Medicine, University of Calgary, for their assistance with statistical analysis and support of this study. This paper was presented during the scientific sessions at the 19th Annual North American Primary Care Research Group, May 1991, in Quebec City.

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