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When children of problem drinkers grow old: Does the increased risk of mental disorders persist?

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Abstract

It is well established that children of problem drinkers have an increased risk of developing mental health problems, not only during childhood but also when they grow up into adolescents and adults. However, it has not been examined whether this risk is also present during the old age of these children. In this study, we examine the question whether this increased risk is present in inhabitants of eleven residential homes (mean age 85 years). A total of 355 residents indicated whether one of their parents ever had problems with alcohol. We also used the MINI diagnostic interview to assess the presence of mental disorders. We found that parental problem drinking was significantly associated with having a major depression (current and lifetime), and with the number of drinks in the past week. No significant relationship was found with alcohol-related disorders and anxiety disorders. It was already known that parental problem drinking results in mental health problems in children. We found clear indications that these problems do not disappear when these children grow old.

Keywords: Children of problem drinkers; Children of alcoholics; Major depression; Older adults; Residential homes

1. Introduction

It is well established that children of problem drinkers have an increased risk of developing mental health problems. Many studies have shown that during their childhood, children of problem drinkers have an increased risk of depression, eating disorders, conduct disorders, and delinquency (Van

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Steinhausen, 1995; Von Knorring, 1991; West & Prinz, 1987). Furthermore, the risk of abuse and neglect is considerably higher; they have more physical problems, have lower intelligence, and do less well at school.

When children of problem drinkers grow up into adolescents and adults, they have an increased risk of addiction problems, depressive disorders, and anxiety disorders (Cuijpers, Langendoen, & Bijl, 1999; Johnson, Sher, & Rolf, 1991; Zeitlin, 1994). During their adult life, they also have more problems with intimacy and relationships, have less social skills, and often marry someone with alcohol problems (Greenfield, Swartz, Landerman, & George, 1993).

It is assumed that this increased risk is caused by a combination of genetic and social factors. Family, adoption, and twin studies have shown that genetics is one of the important causal factors, especially in sons of alcoholic men (Merinkangas, 1990; Searles, 1988). There is also considerable evidence that the social situation in which the parents and the child live is an important etiological factor. The environment can influence the child in three ways (Johnson et al., 1991): (1) the parental drinking can influence family life negatively, causing violence and abuse within the family, and prevent normal attachment between parent and child; (2) families with a drinking parent can be stigmatized by their social environment; and (3) the parents can have or develop other mental disorders, such as depression or antisocial personality disorder, which in itself cause a problematic situation for the child.

Although it is clear that children of problem drinkers have an increased risk of getting mental health problems during their childhood and adulthood, it has not been examined whether this risk is also present during their old age. There is no a priori reason to assume that the genetic risk and the harm caused during their childhood should decrease when these people grow older. But, as far as we know, no study has examined this empirically. In this study, we examine the question whether this increased risk is still present in older adults. We examined the mental health of the inhabitants of nine residential homes (mean age 85 years) and tested whether this is associated with parental problem drinking.

2. Method

2.1. Subjects and procedure

The Boards of Directors of nine residential homes for the elderly in Amsterdam and in the surrounding area were approached for participation in this study and all agreed to participate. All inhabitants of the homes received a letter in which they were notified of the study. Within 2 weeks they were approached by master-level clinical psychology students and asked whether they wanted to participate in the study. If they wanted to participate, they were asked for informed consent. Then they were interviewed. Each interview lasted about one and a half hours.

Cognitively impaired elderly people were excluded from the study. Those elderly residents who were clearly cognitively impaired were not asked for participation (selection was conducted by the staff of the residential home). The remaining 782 inhabitants were requested to participate in the study, of whom 371 (47.4%) agreed to participate. A total of 411 subjects did not participate for various reasons: illness ($N=109$; 11%); deafness ($N=23$; 2%); 232 refused without clear reason (24%); and 47 could not be contacted (5%). The remaining 371 respondents were interviewed using the Mini Mental State Examination (MMSE), an instrument to measure cognitive functioning (Folstein, Folstein, & McHugh,