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Alcoholism in the Elderly

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ALCOHOLISM IN THE ELDERLY

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Abstract

The purposes of this study were to examine the problem of alcohol abuse in the elderly, to look at the physician's understanding, detection, and treatment of this subject, and to gain knowledge regarding the older adult's view of this problem, and the willingness of these adults to discuss it openly with health professionals.

The methodology employed in this research project was qualitative. Information was obtained from both physicians and older adults through brief questionnaires. The sample consisted of 61 physicians and 47 older adults.

Findings suggest that physicians may be deficient in the knowledge needed to detect and treat alcohol abuse in the elderly. Findings also indicate that older adults may not be willing or interested in discussing this topic with physicians or anyone else.

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Dedication

To my husband, children, and grandchildren - for their unfailing belief in me.

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Chapter I

Introduction

The older adult population in the United States is increasing at a rate never before equaled in society. With this increase in numbers comes growth in the awareness of the issues of aging. Alcohol abuse is one of these issues.

Although an abuse problem is acknowledged, it continues to be sparsely researched, and therefore is not a well defined and understood entity. Brody (1982) and Brown (1982) point out that the major clinical observations by Zimberg and by Rosin and Glatt to determine the extent of alcohol abuse in the elderly, were made in the early 1970's or before, and that none of their work has been repeated or expanded upon. In addition to being limited in scope, the existing data on alcohol abuse is difficult to compare because researchers have failed to reach consensus in defining their terminology (Brown, 1982; Douglass, 1984; Finney & Moos, 1984; Gomberg, 1980; Graham, 1986; Kelly & Remley, 1987; Mayer, 1979; Williams, 1984). The terms alcoholism, alcohol abuse, problem drinking, and alcohol problem appear interchangeable, and there is difficulty in definition of these words. Therefore, these terms are used on an interchangeable basis by this writer. Inconsistent definitions of the term "elderly" can also cause problems. Some researchers define "elderly" as those over 53 years

(Atkinson, Turner, Kofoed and Tolson, 1985; Kofoed, Tolson, Atkinson, Toth and Turner, 1987). Brown (1982) uses 55 years and above, while 60 years and older is used by Curtis, Geller, Stokes, Levine & Moore, 1989; Droller, 1964; Hinrichsen, 1984; Kelly & Remley, 1987. Those using 65 years and above include Blake, 1990; Brody, 1982; Marion & Stefanik-Campisi, 1989; Rosin & Glatt, 1971. Hinrichsen (1984) suggests that age 60 to 64 years of age are "young elderly" while "old elderly" are those over 65 years of age. Therefore, for the purpose of this study, 60 years is used as the cut-off age.

The estimated percentage of older adults with an alcohol problem varies. The research of Bailey, Haberman and Alksne (1965) and Siassi, Crocetti and Spiro (1973) have allowed Schuckit and Miller (1975) to derive the figure that between 2 to 10% of the general elderly population have a problem with alcohol. The percentage found in clinical research settings is higher. Zimberg (1978) estimates that 18 to 56% of elderly medical admissions in general hospitals are alcoholic. Zimberg (1974) and Schuckit and Pastor (1978) suggest that 10 to 15% of those older adults who seek medical attention for any reason have alcohol related problems. In some nursing homes it is estimated (Zimberg, 1974) that up to 20% of that population suffer from alcoholism.

Butler (1975) has estimated that while in 1975 10% of the American population was over 65 years of age, by the

year 2020 this figure could increase to 25%. The United States Bureau of the Census predicts that by the year 2000, 12.2% of the population will be 65 years or older, and that this figure will rise to 17.2% by 2025 (Zimering & Domeischel, 1982).

In a paper prepared by the National Institute on Aging for the White House Conference on Aging, Brody (1982) states "Demographic information suggests that the problems of alcohol abuse among the elderly will increase at least in proportion to the population growth of that sector" (p. 123). In view of the projected increase in numbers of older persons, it is of concern that physicians and other health professionals may be deficient in the knowledge needed to detect and treat alcohol abuse in the general population, and among the elderly more specifically (Blake, 1990; Curtis, Geller, Stokes, Levine & Moore, 1989; Schuckit, 1982; Zimberg, 1974a, 1974b).

Purpose of The Study

The purposes of this study are to examine the problem of alcoholism in the elderly, to look at the physician's understanding, detection, and treatment of this subject, and to gain knowledge regarding the older adult's view of this problem, and his willingness to discuss it openly with health professionals. As the number of elderly increases, the health service needed by them will rise proportionately.

This study was developed to help facilitate better communication, diagnostic information, and working alliance between the older patient and the health professional.

Chapter II

Literature Review

According to the U.S. Department of Commerce 1990 Census of population and housing (1992) there are 58 million adults in this nation over the age of 60 years old. The majority are leading lives that are both productive and fulfilling. There is however, a significant minority who are experiencing problems related either to intentional abuse or unintentional misuse of alcohol (Abrams & Alexopoulous, 1987). The extent of the problem is not agreed upon. Schuckit and Miller (1975) indicate that the prevalence of those abusing alcohol is between 2 and 10%. This is low compared with the rate for some other age groups. Graham (1986) has found that existing data indicates a very low rate of alcohol abuse compared with other age groups. Williams (1984) and Hindrichsen (1984) agree that the rate of alcohol problems in the elderly is about the same as in the general population, while Bloom (1983) suggested that the extent of the problem among older adults may be "grossly underestimated" (p. 111). The rate of alcohol abuse cited varies considerably, according to Barnes (1979) "depending upon the criteria employed to define "alcoholism" or alcohol abuse, and upon the population chosen for study" (p. 244). Curtis, Geller, Stokes, Levine and Moore (1989) and Schuckit and Miller (1975) are in agreement with Barnes.

The definition of alcoholism also lacks consistency. There is no clear and simple definition being used throughout the research (Brown, 1982; Douglas, 1984; Finney & Moos, 1984; Gomberg, 1980; Graham, 1986; Kelly & Remley, 1987; Mayer, 1979; Williams, 1984). Zimberg (1974b) suggests a definition based on "whether the consumption of alcohol causes or is related to problems with one's family, physical or mental health, employment, finances, or with the law" (p. 135). Zimberg (1974b) indicates that if there are problems in any of these areas, and the person is either unwilling or unable to modify his drinking habits in order to eliminate the problems, "he is an alcoholic" (p. 136).

According to Beresford, Blow and Brower (1990) the diagnosis of alcoholism rests on four factors: tolerance to alcohol, withdrawal symptoms when alcohol is not used, loss of control of drinking behavior, and social decline. Schuckit (1982) diagnoses alcoholism when the individual shows any one major life problem related to alcohol: marital separation or divorce, or physical evidence that alcohol has harmed the health (including withdrawal), or multiple arrests related to alcohol, or job layoff, or loss related to drinking. Schuckit observes that, if drinking continues, the individual has demonstrated "that alcohol is more important to him than the problems it was causing" (p. 397). Blose (1978) finds that "alcoholism as a clinical entity requires loss of control over drinking and a state of dependence on the drug" (p. 20),

while Gomberg (1980) states that if a person has problems related to his alcohol intake, that person is a problem drinker. In a study by Kelly and Remley (1987) there was general agreement among professionals that "alcoholism is a physiological disorder with attendant psychological and behavioral implications" (p. 107).

In general, there are two sources of data for alcohol use research: household surveys and clinical studies (Finney & Moos, 1984) done in nursing homes, hospitals and other nonhousehold settings. The research is difficult to compare because it is based on dissimilar populations (Douglass, 1984; Mayer, 1979; Schuckit & Pastor, 1978; Williams, 1984). Douglass (1984) finds that most of the information that we have is not suitable for generalization to nonclinical populations, for it is descriptive and clinical, and is generally based on male alcoholism.

If the abuse rate is indeed lower among the elderly, as some researchers indicate, several possible explanations are suggested by Williams (1984). One suggestion is that few longtime alcohol abusers survive to old age. This would, in effect, lower the rate. A second probability is that long term drinkers who do survive may decrease their alcohol intake because of medical problems associated with their lifetime usage. Another possibility is the cohort effect, that today's older generation is reflecting the drinking mores of their generation.

It has been indicated (Blake, 1990; Bloom, 1983; Brody, 1982; Marion & Stefanik-Campisi, 1989; Schuckit, 1982; Schuckit & Pastor, 1978) that it is not necessary for an older adult to have a dependency on alcohol or even to be a heavy drinker in order to have problems from the use of alcohol. It is a well recognized, physiological fact that there is a decreased tolerance to alcohol in the elderly, and because of the slowing of metabolism, individuals will often experience increased effects of even small amounts of alcohol (Rosin & Glatt, 1971).

A second factor of importance (Schuckit, 1982) is that approximately 25% of older adults over the age of 65 (Brody, 1982) are on some medication, either prescribed or over-the-counter. Some individuals exchange medications with friends (Williams, 1984). This factor puts these individuals at high risk for potential drug and alcohol interaction.

Gomberg (1980) indicates that there are four possible patterns of medication/alcohol usage in the elderly:

1. Compliance with medication on regime along with occasional use of alcohol.
2. Non-compliance with medication regime and substitution of moderate amounts of alcohol.
3. Compliance with medication regime plus heavy or problematic use of alcohol.
4. Non-compliance with medication regime with heavy or problematic use of alcohol.

A third consideration (Schuckit, 1977; Schuckit & Pastor, 1978) is that alcohol can exacerbate physical problems such as those associated with the liver or pancreatic disease, diverticuli, heart diseases, anemia, and neurologic disorders. Those individuals with angina (cardiac pain on exertion) may risk having the pain masked. Anginal pain serves as a valuable warning symptom. Pattee (1982) emphasizes that alcohol affects the sleep pattern, and the discontinuance of alcohol may cause dreams, poor sleep, and waking during the night. Pattee continues that conditions of decreased coordination plus alcohol ingestion can contribute to falls and burns; decreased cognitive ability plus alcohol can result in confusion of the individual; borderline hypertension with alcohol intake can result in worsening hypertension; borderline diabetes with alcohol intake can lead to overt diabetes; mild depression plus alcohol can cause deeper depression. Kelly and Remley (1987) suggest that alcohol also lowers the inhibitions, at least initially, and may therefore cause people to seem happy, when in fact they may be having problems that they believe could not be managed without the use of alcohol.

Identifying alcoholism in the elderly is a difficult undertaking (Bloom, 1983; Marion & Stefanik-Campisi, 1989; Olsen-Noll & Bosworth, 1989; Rosin & Glatt, 1971; Schuckit & Pastor, 1978; Thienhaus & Hartford, 1984; Williams, 1984; Zimberg, 1974b, 1984). A major impediment to diagnosis of alcohol abuse is suggested by Curtis, Geller, Stokes, Levine

and Moore (1989). The data of their study suggests that current medical education is inadequate in its provision of the knowledge and skills necessary to detect and treat the older adult who suffers from problem drinking. There is less recognition and understanding of the problems of alcoholism among the elderly (Marion and Stefanik-Campisi, 1989; Pattee, 1982; Schuckit, 1982; Zimberg, 1974a, 1974b) than among the general population. It is observed by Gurnack and Thomas (1989) that the effects of alcohol abuse in the elderly can be mistaken for senility or irreversible dementia by the physician. This error can result in custodial care for an individual rather than a treatment program.

Stereotypical thinking regarding alcoholics, on the part of health professionals, can be detrimental to the diagnosis of alcoholism. Schuckit (1982) and Schuckit and Pastor (1978) contend that the tendency of the physician to overlook alcohol problems in the elderly may result from the fact that he believes alcohol abuse is, in the main, limited to younger persons or "skid-row derelicts" (p. 36) or "skid-row bums" Olsen-Noll & Bosworth (1989, p. 176). Curtis, Geller, Stokes and Moore (1989) found the stereotypical view of an elderly person with alcoholism to be black, male, and less well educated. While most professionals have had some alcoholism related education based on the younger population (Marion & Stefanik-Campisi, 1989), Pattee (1982) finds this information not applicable when dealing with the

elderly because the variables are either different or non-existent.

Identification of alcohol abuse is further hampered (Graham, 1986) because existing instruments for identifying and measuring alcohol abuse in the older population are inappropriate since they have been standardized on a younger population. The validity of survey instruments that measure alcohol usage is also questioned (Brody, 1982; Mayer, 1979) since older adults tend to deny any drinking problems. Brody (1982) notes that there is no research in this age group directed toward how to question about alcohol use and to get reliable responses. Additionally, Zimberg (1974a, 1974b) finds that physician are often unwilling to recognize alcoholism in their patients. This unwillingness is generally related to the physician's overall feeling of helplessness about treating alcoholism. Along with this, in some instances, is a lack of understanding of the pharmacological effects of alcohol.

Another factor seen as a deterrent to diagnosis is that the elderly are often "outside the mainstream of American thought and activity" (Williams, 1984, p. 4). In the younger alcohol abuser, problems often surface in either their marital life, job, school, or with the criminal justice system. These indicators are of little value with the older drinker (Abrams & Alexopoulous, 1987; Bloom, 1983; Hinrichsen, 1984; Pattee, 1982; Schuckit & Pastor, 1978; Thienhaus & Hartford, 1984). Olsen-Noll and Bosworth (1989) point out

that many of the elderly receive health care from several sources. Because of this all information concerning an individual is not pulled together in one place.

Many older individuals live alone, and their drinking goes undetected. It is suggested (Blake, 1990) that inadequate diagnosis is one of the major reason elderly problem drinkers do not get into treatment programs. This failure to diagnose results in misdirection of referrals for help and in inadequate treatment planning.

The identifying symptoms of alcoholism in the elderly fall into two categories: physical symptoms and social problems. There appears to be general consensus among many researchers that such physical manifestations as falls, burns, bruises, broken bones, malnutrition, deterioration of personal hygiene, general physical deterioration, and change in mental processes (confusion, memory lapses, disorientation) may signal alcohol abuse problems (Brody, 1982; Dupree & Zimberg, 1984; Olsen-Noll & Bosworth, 1989; Rosin & Glatt, 1971; Zimberg, 1984). Dupree and Zimberg (1984) would question individuals in areas such as accident or lack of interest in normal activities. Depression, unusual forgetfulness, or a decrease in the effectiveness of the patient's medication are also revelant to these clinicians. According to Pattee (1982) loss of ability to function in the environment may be the only clue to an alcohol problem.

Zimberg (1984) finds that there are rarely acute manifestations of alcohol abuse in the elderly, for while

older individuals may drink oftener than their counterparts, they consume less alcohol at each sitting. It is felt (Marion & Stefanik-Campisi, 1989; Rosin & Glatt, 1971; Schuckit, Atkinson, Miller & Berman, 1980; Williams, 1984) that some of the presenting symptoms are often mistaken for either the natural effects of the aging process or of a physical illness. Prolonged seclusion, refusal to answer the door (Bloom, 1983), and "meticulous self-grooming" (p. 112) and an ultra-clean home are behaviors that may be of consequence. Identification of an alcohol problem in the aging may need to include (Blake, 1990): the pattern of alcohol use (quantity, frequency, place, occasions); concerns about or adverse consequences related to alcohol use; symptoms of dependence; attitudes and beliefs about alcohol; other health related factors that could contraindicate the use of alcohol.

Social problems seen in older persons abusing alcohol may include (Olsen-Noll & Bosworth, 1989) family quarrels and paranoia, violence to family members (Bailey, Haberman & Alksne, 1965), trouble in the neighborhood and with police, and social isolation (Graham, 1986; Rosin & Glatt, 1971). Olsen-Noll & Bosworth (1989), and Zimberg (1978) find that social problems are more frequently encountered by the elderly than are medical problems; that alcoholism manifests itself more subtly in the elderly than in younger persons, and that it is more difficult to determine these problems. It is suggested (Graham, 1986; Hinrichsen, 1984;

Olsen-Noll & Bosworth, 1989) that information elicited from friends and relatives can be of help in discovering problems.

Both fear and denial on the part of the older adult can prevent the individual from seeking help. While Berger (1983) proposes that "when alcoholism is evident, the elderly patient is more likely to consult a doctor and even volunteer a history of excessive alcohol use" (p. 330), other researchers (Schuckit & Pastor, 1978) find that "the fear of being diagnosed as terminally ill, denial of symptoms, and fear of alcoholism-associated stigma" (p. 36) will cause individuals to withhold information. Denial is also a defense that has been specifically linked with alcoholism (Bailey, Haberman, & Alksne, 1965). Graham (1986) contends that many of the current elderly grew up in an era of bias against drinking and may be reluctant to admit to any consumption of alcohol. In addition families will often tend to hide the fact of a drinking problem in an older relative, for fear of gossip (Droller, 1964).

Problem drinkers (Zimberg, 1974a, 1974b) fall primarily into two categories: those with early onset (EO) of alcohol abuse, and those with late onset (LO) of their drinking problem. The early onset group, approximately two-thirds of all elderly alcoholics, have had a significant problem over an extended part of their lives. Late onset drinkers, one-third of alcoholics, seem to begin drinking in response to the stresses of aging. Schuckit and Pastor (1978) have found that frequently older adults begin their problem drinking after the age of 40, and the course of their alcohol abuse is

more benign than that of younger alcoholics. Gomberg (as cited by Williams, 1984) suggests "a small but noticeable third group of alcoholics-intermittents" (p. 7). These individuals have a history of having periods of heavy drinking. Olsen-Noll & Bosworth (1989) indicate that the occasional binge drinker may become a frequent drinker, as a result of age related stressors.

The etiology of alcoholism is unclear. Schuckit and Pastor (1978) indicate that "alcoholism is probably genetically influenced with a level of heritability approximately equal to that of diabetes" (p. 37). Given this factor, plus the degree of vulnerability, the amount of stress experienced, and the individual's defenses against alcohol abuse, drinking can become problematic. In a study by Kelly and Remley (1987) it was found that five of six practitioners knowledgeable about alcohol abuse in the elderly agree that a genetic component exists. Atkinson, Turner, Kofoed and Tolson (1985) observe "there is indirect evidence of a heavier loading of some genetic determinant of alcoholism in the EO group", with family alcoholism "far more common" in EO alcoholics (p. 514).

Excessive drinking in the elderly, according to Brody (1982), Dupree-Zimberg (1984), Olsen-Noll and Bosworth (1989) and Rosin and Glatt (1971) appears directly related to external or situational factors associated with aging. These stressors can include retirement, decreased financial resources, poor health, social isolation, and deaths among

family and friends with the awareness that more are to come. Marian and Stefanik-Campisi (1989) indicate that older adults are living longer and facing stresses that generations before have not had to face.

On the other hand, however, Schuckit (1977) suggests that "the concomitance of life problems and substance abuse in the same individual is no proof that one caused the other" (p. 173), and that the vast majority of people who undergo these stresses do not develop substance abuse. Barnes (1979) finds that stresses of aging, such as retirement and widowhood, are not associated with increased drinking. More than two thirds of the professionals interviewed by Brown (1982) identified either some aspect of the self over which an individual could reasonably be expected to have some control, or some aspect of the person's interpersonal relationships as being the primary cause of substance abuse.

Another theory on the cause of alcohol abuse (Hochhauser, 1981) is that problem drinking may arise from reactions to "unpredictable/uncontrollable experience" (p. 128). By being exposed to these life situations, the person learns that he is "helpless". This feeling of helplessness is characterized by "emotional changes (depression), cognitive deficits (a belief that things can not be changed), and a motivational deficit (a tendency to give up)" (p. 128). In this theory of learned helplessness there are both internal and external sources of unpredictable or uncontrollable events. Internal events are those that occur within the

individual, such as health status, sleep patterns, and changes in metabolism. External events are those that come from the environment and involve such situations as deaths, retirement, relocation, and significant change in financial status. Hochhauser contends that a crucial factor is the way in which the individual interprets these experiences (i.e., his belief system). He further suggests that in the initial stages of usage, alcohol is not used so much to relieve tension and anxiety as it is used because, at that point, the individual feels that he has control over this usage. Those in nursing homes seem to drink (Butler, 1975) because it is seen as one of the last remaining pleasures available to them, and it makes institutional living more bearable.

The rate of alcoholism in the elderly varies within age groups. Bailey, Haberman and Alksne (1965) find the rate of probable alcoholics at:

Ages	45-54 years	23/1000 population
	55-64 years	17/1000 population
	65-75 years	22/1000 population
	after 75 yrs	12/1000 population

Barnes (1979) suggests that the drinking rates were considerably lower among those ages 50-59 years. Gomberg (1980) has observed that from age 50 on, the percentage of persons who drink decreases. Gomberg finds that there is a dramatic drop in the proportion of women who drink heavily after the age of 50, and after the age of 65 in the male population.

Causes seen for this decrease in drinking rates vary. Gomberg (1980) attributes the decrease to an increased cost of alcohol at a time of decreasing financial security, changes in life style and forms of social activity. Rosin and Glatt (1971) cite lack of money, different social patterns following retirement, and a decline in the desire for alcohol. A combination of diminished tolerance, increased toxic effects, less pleasant effects on mood and behavior, and unpleasant side effects are cited by Zimberg (1982). It is hypothesized (Zimberg, 1983) that there is a spontaneous remission rate as persons age, that their alcoholism tends to "burn out" (p. 171), that they tend to drink less or stop altogether. In Dupree and Zimberg (1984) Dupree states his belief that "the concept of spontaneous remission is just that - a theoretical concept". He continues that "...if it does exist...it exists in all age groups for various reasons, like distaste, increased negative input on health and family relationships, or change in the metabolic system" (p. 51).

While treatment for the elderly alcoholic is available, it has been estimated (Bloom, 1983) that only 15% of elderly alcoholics over age 60 receive adequate treatment. Hinrichsen (1984) finds that identification of the problem may be a factor; that social agency staff who work with the elderly may mistake symptoms of alcoholism for symptoms related to ill health or aging rather than excessive intake of alcohol. Curtis, Geller, Stokes, Levine and Moore (1989) state that older alcoholics are less likely to be diagnosed and

treated than their younger counterparts, while Olsen-Noll and Bosworth (1989) find that they do not seek treatment until medical problems arise because of their alcohol consumption. It is not until physical problems have increased that the older adult may consider (Dupree & Zimberg, 1984) the situation treatable. Embarrassment, difficulty that is encountered when help is sought, and resistance by both the client and the helper are factors that can cause delay in seeking help (Gomberg, cited by Williams, 1984).

Dupree and Zimberg (1984) state that older persons are often not comfortable talking openly about an alcohol problem. They are reluctant to talk to "outsiders" (p. 49), and tend not to use mental health centers. Olsen-Noll and Bosworth (1989) find ignorance and fear are deterrents to seeking help.

Notwithstanding this reluctance, it has been found that more older individuals are likely to complete treatment successfully (Schuckit, 1977, 1982; Williams, 1984; Zimberg, 1974b, 1978) than are their younger counterparts. Atkinson, Turner, Kofoed and Tolson (1985) find older adults "remarkably more treatment compliant than younger alcoholics" (p. 54). They respond well to a soft, gentle and non-confrontive approach (Kofoed, Tolson, Atkinson, Toth & Turner, 1987; Olsen-Noll & Bosworth, 1989; and Zimberg, 1974b, 1978) and to a peer-group setting and support group (Kofoed et al.; Williams, 1984; Zimberg, 1983, 1984).

In a peer setting such as (Williams, 1984; Zimberg, 1984) senior centers, nutritional sites, geriatric or medical outpatient settings, these individuals are able to receive the support needed. Droller (1964) finds "the most important therapy is social" (p. 139), Atkinson, Turner, Kofoed and Tolson (1985) agree that a treatment using a "common social approach" (p. 515) is successful. The emphasis of an age-oriented program should be concentrated toward (Olson-Noll & Bosworth, 1989) the needs and concerns of aging.

Often (Bloom, 1983; Hinrichsen, 1984; Olsen-Noll & Bosworth, 1989) it must be clarified that alcoholism is not a moral issue but a medical problem. It is important that the attitude of the caregivers (Beresford, Blow & Brower, 1990; Blake, 1990; Zimberg, 1984) reflect both hope and optimism. Blose (1978), Gomberg (1980), and Zimberg (1974b) agree that the older individual faces two sets of problems. He is stigmatized both by being old and by having a drinking problem. It is suggested (Dupree & Zimberg, 1984) that it would be of great benefit to clients to have a staff person "who can be effective in dealing with elderly clients, optimally an elderly recovering alcoholic or substance abuser -- someone to whom they can relate" (p. 50).

Prevention efforts and education are stressed by many researchers. As mentioned earlier, there is need for further education of health professionals. Because of the growing number of older individuals (Hinrichsen, 1984) persons who work with the elderly need to learn about alcoholism while

those who work in the alcoholism field must become knowledgeable about the aging process. Dupree & Zimberg (1984) and Zimberg (1974a) emphasize the need to educate professionals in order to identify and treat the elderly problem drinker. Preretirement seminars are indicated as a means (Gomberg, 1980; Rosin & Glatt, 1971; Williams, 1984) of preparing individuals for some of the stresses that often accompany the aging process. Included in these seminars (Williams, 1984) are suggested such topics as volunteerism, consumerism, and part time work in order to maintain self esteem.

While Williams would also target the late onset group for prevention education, Bloom (1983) and Brody (1982) suggest a younger cohort group. It has been indicated (Brown, 1982; Finney & Moos, 1984; Graham, 1986; Gurnack & Thomas, 1989; Marion & Stefanik-Campisi, 1989) that while the elderly of today were raised with temperance and prohibition, the current younger generations have been widely exposed to "different drinking values, mores, and increased public acceptance of moderate and social drinking" (Williams, 1984, p. 52). Higher rates of abuse of alcohol can be expected with the aging of the younger cohorts. "This 'new elderly' population (Marion & Stefanik-Campisi, 1989) has learned to use alcohol and drugs as a coping mechanism on a greater scale than the elderly who lived through the Prohibition Era" (p. 33).

As the literature indicates, focus on research in detection and treatment is important. The number of older adults requiring professional help will increase in the coming years, and the population at risk for alcohol abuse will grow.

Chapter III

Methodology

The purpose of this study was to examine the question of whether physicians address alcohol abuse with their elderly patients in a manner which elicits accurate diagnostic information. In addition, older adults were surveyed to gain information regarding their attitudes and perceptions of alcoholism, and to determine if the issue of alcohol usage has been addressed by their physician. The methodology employed was the use of the questionnaire.

Subjects

The names of the 159 physicians to whom surveys were mailed were obtained from the 1990 Membership Directory of the St. Louis Metropolitan Medical Society. They are all specialists in Internal Medicine, and were selected because of the focus of their chosen field. Sixty-one physicians (35%) responded to the survey. The 47 older adults were members of 2 separate groups. One group was affiliated with a church, the other group meets in a church but has no affiliation with the organization. All participants were volunteers, and were selected because of their availability for the survey.

Materials

Two separate survey forms were used. The survey for physicians consisted of a cover letter of introduction to this researcher (Appendix A) from a fellow physician, along with an 8 question survey (Appendix B). The questionnaire was multiple choice. The purpose of the survey was to ascertain what questions were asked of older adults, what knowledge and attitudes physicians have toward alcohol abuse, and what courses of action they follow in dealing with this issue.

The older adult survey consisted of a survey explanation (Appendix C), a consent form (Appendix D), and the survey (Appendix E), which had 4 multiple choice and 3 subjective questions. There was additional space for comments.

Procedure

One hundred fifty nine questionnaires were mailed to physicians along with a return addressed, stamped envelope. Sixty one were returned completed, two were returned unanswered, fourteen were returned undelivered by the postal service. The returned surveys were delivered by the usual postal service.

The survey of older adults was gathered at three separate meetings. In each situation the questionnaires were distributed and collected within the same session. No directions were given to the older adult group before the survey was distributed. There was negligible response or

questions by this group after the questionaires were collected.

All results were tabulated according to the number of responses to each question. These responses are presented both by number of respondents and by percentage of the total respondents.

Chapter IV

Results

Physician Survey Response

Surveys containing 7 multiple choice questions were mailed to 159 physicians specializing in Internal Medicine. Sixty-one (38%) responded. In order to determine physician knowledge, results were tabulated both by actual number of respondents, and by percentage of total responses. The results are as follows:

1. When you see a new patient over the age of 60 do you ask about his/her use of alcohol?

		#/respondents	%
a.	Always	47	77%
b.	Frequently	10	16%
c.	Occasionally	2	03%
d.	Seldom	2	03%
e.	Never	none	none

2. What questions do you ask pertaining to the use of alcohol? (Answer as many as are appropriate)

		#/respondents	%
a.	Quantity consumed	58	95%
b.	Frequency of consumption	58	95%
c.	Choice of alcohol (beer, wine, etc.)	43	70%
d.	Hangovers	12	20%
e.	Bruises, falls, broken bones	11	18%
f.	Other questions (Please specify)	13	21%

Driving while intoxicated, car accidents 8% (15 respondents); withdrawal symptoms 5% (3 respondents); any problem with

usage 3% (2 respondents). 2% (1 respondent) of respondents questioned about each of the following: use of other drugs, patient perception of the problem, missed work, morning drinking, alcohol induced illness, attempts to quit, treatment for alcoholism, social consequences, memory lapses, fear of losing control of amount consumed, confusion, weight loss, job loss, marital problems, blackouts.

3. Do you use any psychological tests to determine possible alcohol abuse?

		#/respondents	%
a.	Yes	5	08%
b.	No	53	87%
	Sometimes (write-in)	1	02%

If yes, please specify which ones.

	#/respondents	%
CAGE	5	08%
MAST	1	02%

4. What impact do you believe alcohol abuse has on an elderly person?

		#/respondents	%
a.	Physical	none	none
b.	Psychological	none	none
c.	Both	59	97%
d.	Neither	none	none

5. When you suspect alcohol abuse in an elderly patient what course of action do you follow? (Circle as many as applicable)

		#/respondents	%
a.	I talk with the patient	56	92%
b.	Refer to treatment program	34	56%
	1) In-patient	6	10%
	2) Out-patient	10	16%
c.	Recommend attendance at A.A. (Alcoholic Anonymous) meetings	27	44%
d.	Wait and watch	4	07%
e.	Talk with the family	37	61%
f.	Other (Please specify)	5	08%

"Refer for diagnosis and treatment recommendations".
"Try to persuade patient to discontinue alcohol abuse".
"Patient education".
"Depends if family member is mother/father or husband/wife".
"Suggest they discuss with primary care physician".

6. Do you believe an elderly person is capable of overcoming an alcohol abuse problem?

		#/respondents	%
a.	Yes	45	74%
b.	No	none	none
c.	Seldom	7	11%
d.	Often	4	07%
e.	Uncertain	2	03%
	Sometimes (write-in)	1	02%

Additional yes comments:

"Depending on family support and patient willingness to go to treatment program", "usually, if diagnosed and treated properly."

7. Is it possible to detect alcohol abuse in an elderly patient upon initial contact?

		#/respondents	%
a.	Yes	39	64%
b.	No	11	18%

If yes, please specify

Physical examination 26% (16 respondents); history 15% (9 respondents); with information from spouse/family 10% (6 respondents; CAGE 5% (3 respondents); odor 3% (2 respondents); "If patient is honest in their responses" 3% (2 respondents) . Response was 2% (1 respondent) for the following: falls, accidents etc; quantity consumed; "Sometimes, if evidence is strong"; "If the possibility is considered"; "In moderate/severe cases possibly 50%; "If having psychological problems with ETOH".

Write-in to the NO response included: Sometimes 5%, and 2% to each of the following: usually not, maybe, infrequently, generally not, don't know.

8. Please state the date of your graduation from medical school.

Cohorts:	#/respondents	%
1940-1949	2	03%
1950-1959	1	02%
1960-1969	7	11%
1970-1979	35	57%
1980-1989	15	25%

Older Adult Survey Response

Forty-seven surveys were completed. The purpose of this survey was to gain knowledge of the older adult's view of alcohol abuse, and the willingness of these adults to address this issue. The 7 question survey was handed out and collected in the same session. Three separate older adult groups participated in this voluntary survey. The results were tabulated both by actual numbers of respondents, and by percentage of total responses. The results are as follows:

You are free to write any additional comments at the end of the questionnaire.

1. Has your primary physician asked about your use of alcohol?

	#/respondents	%
a. Yes	10	21%
b. No (If NO, please skip to question 4)	31	66%
c. If yes, when did he last ask? (write-in) do not recall	2	04%

2. How often does he ask about your alcohol consumption?

	#/respondents	%
a. Regularly (yearly)	3	06%
b. Occasionally	2	04%
c. Seldom	2	04%
d. Never	15	32%
Only once (write-in)	1	02%

3. Did he ask you..... (Circle all that apply)

		#/respondents	%
a.	How often you drink?	7	15%
b.	How much (quantity) you drink?	6	13%
c.	What you drink? (beer, wine, etc)	5	11%
d.	If you have any problems related to your drinking habits?	2	4%

4. If an older adult has a problem with alcohol, how might a physician find out about this problem? What questions might he ask?

Direct questioning regarding usage 28% (13 respondents); physical examination findings 17% (8 respondents); solicit family input 6% (3 respondents); judge by appearance 4% (2 respondents); no idea - no thought given to question 4% (2 respondents); questions regarding depression 2% (1 respondent).

5. Alcoholism is a ..... (circle all that apply)

		#/respondents	%
a.	Moral problem	10	16%
b.	Disease	32	68%
	perhaps (write-in)	1	02%
c.	Mental illness	6	13%
	perhaps (write-in)	1	02%
	may lead to (write-in)	1	02%
d.	Inherited	14	30%;
	partly	1	02%
	unsure	1	02%
	maybe	1	02%
e.	Treatable	32	68%
f.	Non-treatable	none	none

6. What do you think an alcoholic looks like?

Basically like anyone else 55% (26 respondents) --- except in late stages 09% (4 respondents); "tell-tale" physical appearance 13% (6 respondents); "crazy-stupid" 06% (3 respondents); don't know 4% (2 respondents).

7. What does an alcoholic act like?

Basically like anyone else 13% (6 respondents) --- except when drinking 11% (5 respondents). Drinking behavior: "confused, crazy, nervous, obnoxious, stupid" 19% (9 respondents); erratic, emotional extremes 15% (7 respondents); mean, violent, grabby 13% (6 respondents); secretive, lie 09% (4 respondents); denies problem, defensive regarding drinking, does not realize actions 06% (3 respondents); depressed, "zombie" 04% (2 respondents); unable to work, requires alcohol early in day, does not know "when to stop", don't know 02% (1 respondent).

Chapter V

Discussion

This study has examined data gathered from physicians and older adults. The purpose of the study was to gain information which might facilitate increasing detection of alcohol abuse in the elderly and increase communication between health professionals and the older patient in relation to this issue.

An important finding is the discrepancy in physician versus older adult response to the question of whether the issue of alcohol consumption is addressed by the physician. Forty-seven physicians responded (77%) that a new patient is always asked about his alcohol usage, 31 older adults responded (66%) that the primary physician has not asked about alcohol consumption. It is unclear whether this discrepancy is due to physician over estimate, older adult error, or failure of this researcher to better construct the question.

The use of the word "new" in physician question #1 might suggest to the physician that this particular question and/or questionnaire may not be asking about all of his patients over the age of 60, but merely the new patients in his practice. The wording of Older Adult Survey question #1 may be ambiguous. It is not known what the term "primary physician" means to the individual older adult.

While the literature shows general consensus among researchers (Brody, 1982; Dupree and Zimberg, 1984) that bruises, broken bones and falls may signal alcohol abuse, only 18% (11 respondents) of physicians questioned in this area. Ninety-five percent, however, did ask about quantity and frequency of consumption, although research indicates (Rosin and Glatt, 1971) that older adults will often experience increased effects of even small amounts of alcohol. Physicians would appear to relate quantity with abuse. There is no evidence in the literature that choice of alcohol is an important factor, yet 70% of physicians (42 respondents) asked about this. While it is a widely recognized fact that Alcoholics Anonymous offers a good success rate of recovery, only 44% of physicians (27 respondents) recommended this course of action. Sixty-one percent of physicians (37 respondents) talk with the family; literature supports the importance of this resource (Graham, 1986; Hinrichsen, 1984). Physician response to the belief (74%) that an elderly person is capable of overcoming an alcohol problem is also supported by the literature (Williams, 1984; Zimberg, 1974b, 1978). In general however, it would appear that the concern expressed in the literature (Blake, 1990; Schuckit, 1982) that health professions may be somewhat deficient in the knowledge needed to detect and treat alcohol abuse is relevant.

This survey would seem to indicate that the physician does indeed ask questions of the older adult, but is

somewhat uninformed as to what the focus of those questions should be. Since there has been no research done on how to question about alcohol consumption and get reliable responses, it is difficult to know whether asking "the right questions" would make a significant difference. There is no evidence in this survey that physicians are unwilling to recognize the problem of alcohol abuse, as has been suggested by Zimberg (1974a, 1974b).

It has been pointed out (Brody, 1982) that there is no research in this age group directed toward how to question about alcohol use and get reliable responses. Twenty-eight percent of older adults responded that direct questioning might be appropriate, while 6% suggested soliciting family input. Denial however, is a defense specifically linked with alcoholism. This defense would need to be taken into account in setting up further research.

While many older individuals live alone, and therefore their drinking goes undetected, it was suggested by one older adult that the physician ask "What do you do in the evenings all winter?" A second question suggested was "Do you ever get depressed? What do you do for it?" These questions seem, to this researcher, to be revealing of issues not addressed by the older adult's written or verbal responses.

While the research (Graham, 1986) shows that today's cohort well may believe alcoholism to be a moral issue, because of temperance and prohibition, this researcher

found only 16% of older adults surveyed believe alcoholism to be a moral problem. Thirteen percent felt it to be a mental illness, 68% a disease. Fifty-five percent of those surveyed believe an alcoholic looks basically like everyone else, except in the late stages (9%). Thirteen percent believe an alcoholic behaves like anyone else except when drinking (11%). These figures would not seem to be high enough to keep older adults from giving reliable and open responses to questioning, yet responses to this survey were short written comments, with little interest expressed verbally. Four of the five written comments are as follows:

"Do not know any --- the above questions were guesses."

"I have not been around an alcoholic enough to comment."

"I do not know any alcoholics nor were there any in my family or friends."

"I can't comment about anything." I never drank in my life. To be an alcoholic -- I think, is to suffer inferiority complex."

It is not known if this sparse communication is due to lack of interest or unwillingness to self disclose, or perhaps to the response style of the individuals.

It seems apparent from the survey results that there is some lack of information on the part of the health professional, and therefore a lack of diagnostic information available to him. This result is supported by Schuckit (1982) and by Zimberg (1974a, 1974b).It is not clear whether increased knowledge of alcohol abuse on the part of

the professional would affect the amount or type of information given by the elderly person.

Evaluation of Research Procedure

This study used questionnaires to collect the data. The surveys were mailed to physicians. The return rate of completed forms was 38%, a much greater response than was anticipated. This researcher speculates whether the response was influenced by the cover letter of introduction that accompanied the survey or the method used.

The questionnaire presented to the elderly participants did not appear to be of interest to them. It is of concern that if this is true, in what way it might have affected the responses given. They did not ask questions, did not make written comments, nor engage the researcher in conversation about this subject. The question arises, for this writer, as to whether this is a subtle form of evasion and/or denial because of a perceived societal stigma associated with the subject of alcohol and it's abuse.

Of concern to this researcher are two possible errors in the research design. The first area concerns the choice of an older adult group that is affiliated with a church whose views on drinking are not liberal. This was not taken into account by the researcher. The second concern is question #1 of the Physician Survey. The question refers to 'new' patients, while the Older Adult Survey assumes the patient

not to be new to his/her physician. This difference in question approach may skew the responses.

A final area of consideration would be Older Adult Survey questions #6 and #7. The phrase "perception of" might be more apt to capture the essence of the information desired. It might be important to get the participant's definition of alcoholic and/or alcoholism.

Suggestions for Further Research

Because it appears that more knowledge of alcohol abuse in the elderly would benefit the health professional, further research might be directed toward finding the optimal way to deliver this information, (i.e., mini-workshops, videotape, printed information, etc.). A second area of research might be further exploration of a means of incorporating an older "recovering" professional into the health care network as a way to bridge whatever communication gap exists between the health care community and the elderly. Further research into the attitudes and beliefs of the elderly toward the issue of alcohol abuse, alcoholism, and the alcoholic might also well be a fruitful pursuit.

WEST COUNTY
SPORTS FITNESS & REHABILITATION CENTER

Appendix A

August 3, 1992

Dear Doctor:

This letter is to introduce Jo Koehler. Jo is a friend for many years, who has recently returned to school to pursue a Masters degree in Professional Counseling.

The enclosed survey is a crucial part of her masters thesis, entitled "Alcoholism in the Elderly." The survey should take no longer than 5-10 minutes to complete and a self addressed stamped envelope is enclosed to make it easier to return it to her.

I hope that you will choose to participate in this survey.

Sincerely,

Miles C. Whitener, M.D.

Miles C. Whitener

Enclosure

West County Sports Fitness
and Rehabilitation Center
11628 Old Ballas Road
Creve Coeur, MO 63141

Appendix B

Physician Survey

1. When you see a new patient over the age of 60 do you ask about his/her use of alcohol?

    a. Always
    b. Frequently
    c. Occasionally
    d. Seldom
    e. Never

2. What questions do you ask pertaining to the use of alcohol? (Answer as many as are appropriate)

    a. Quantity consumed
    b. Frequency of consumption
    c. Choice of alcohol (beer, wine, etc.)
    d. Hangovers
    e. Bruises, falls, broken bones
    f. Other questions (Please specify)

3. Do you use any psychological tests to determine possible alcohol abuse?

    a. Yes
    b. No

    If yes, please specify which ones.

4. What impact so you believe alcohol abuse has on an elderly person?

   a. Physical
   b. Psychological
   c. Both
   d. Neither

5. When you suspect alcohol abuse in an elderly patient what course of action do you follow? (Circle as many as applicable)

   a. I talk with the patient
   b. Refer to treatment program
      1) In-patient
      2) Out-patient
   c. Recommend attendance at A.A. (Alcoholic Anonymous) meetings.
   d. Wait and watch
   e. Talk with the family
   f. Other (Please specify)

6. Do you believe an elderly person is capable of overcoming an alcohol abuse problem?

   a. Yes
   b. No
   c. Seldom
   d. Often
   e. Uncertain

7. Is it possible to detect alcohol abuse in an elderly patient upon initial contact?

   a. Yes
   b. No

   If yes, please specify

8. Please state the date of your graduation from medical school.

Appendix C

Older Adult Survey Explanation

Dear Participant,

As part of the completion of my masters degree in professional counseling at Lindenwood College I am conducting a research study concerning one of the issues of aging. I would like to ask your help in this survey.

The title of this study is Alcoholism in the Elderly. The purpose of the study is to examine the question of whether physicians inquire about alcohol abuse with their older age patients in a way that will best enable them to get accurate information from their patients.

This questionnaire will take no longer than 10-15 minutes to complete. You will not be asked to identify yourself, and as a participant you have the right to full protection of your privacy. Any questions that you may have concerning this study, or your participation in it, will be answered to the best of my ability.

I appreciate your willingness to participate in this research study. Your contribution will add to a better understanding of the issue of alcohol abuse in the older population.

Sincerely,

Jo Koehler

Appendix D

Consent Form

I give permission to Jo Koehler to use the information I have given on the Older Adult Survey form for her research.

I understand that my privacy will be protected and my name will not be used.

I understand that she will answer any questions I may have concerning her research study or my participation in it.

_____

Signature of Participant

Date: _____

Appendix E

Older Adult Survey

You are free to write any additional comments at the end of the questionnaire.

1. Has your primary physician asked about your use of alcohol?
    a. Yes
    b. No (If NO, please skip to question 4)
    c. If yes, when did he last ask?

2. How often does he ask about your alcohol consumption?
    a. Regularly (yearly)
    b. Occasionally
    c. Seldom
    d. Never

3. Did he ask you..... (Circle all that apply)
    a. How often you drink?
    b. How much (quantity) you drink?
    c. What you drink? (beer, wine, etc.)
    d. If you have any problems related to your drinking habits?

4. If an older adult has a problem with alcohol, how might a physician find out about this problem? What questions might he ask?

5. Alcoholism is a ..... (circle all that apply)

   a. Moral problem
   b. Disease
   c. Mental illness
   d. Inherited
   e. Treatable
   f. Non-treatable

6. What do you think an alcoholic looks like?

7. What does an alcoholic act like?

Comments

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