ELDERLY ALCOHOLISM

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ELDERLY ALCOHOLISM

Intervention Strategies

By

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Pensacola, Florida

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This book is dedicated primarily to my wife, Ruth, whose support for my alcoholism recovery is continuous. Too, it is she who word processed the manuscript and offered numerous suggestions to enhance its quality. Included in the dedication are my children, Eric and Amy, whose personal sacrifices made recovery possible. My Mother, Mabel, must also be included in the dedication for encouraging me to keep a journal of my feelings and experiences in treatment, which I hope will someday appear in book form

FOREWORD

Elderly Alcoholism: Intervention Strategies represents an important contribution to those interested in improving the lives of older adults. The field of alcohol and aging is a challenging one for researchers, policy makers, practitioners, older adults and their family members. With the aging of the population, one would think that this problem would be of greater interest as the baby boomers reach their later years. Yet, risky or excessive use of alcohol by the elderly has remained a "hidden problem," with relatively few older adults being screened for alcohol problems and far fewer finding their way to treatment. Perhaps this is due to the fact that many older adults no longer consume alcoholic beverages, let alone abuse them, or due to an ageistic view that alcohol is but one of a few pleasures left for an elder. More likely, the older adult lacks the visibility of the younger alcohol abuser and is less likely to be admitted to treatment.

The history of the field of alcohol treatment for older adults is not very old itself. In the late 1960s and early 1970s studies focused on the epidemiology of the problem. In the 1980s the focus seemed to be on treatment issues such as the need for elder-specific treatment programming. In the 1990's policy and best practices in the field were being discussed. These include the Treatment Improvement Protocol Manual (number 26) produced by a national panel of experts for the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA). Recent research has focused on less costly alternatives to formal treatment, i.e., brief physician advice and brief interventions.

In the past few years, several books have been published on various aspects of treatment of the older problem drinker, but Dr. Beechem's contribution offers a wider array of topics of interest to a wide audience. He has written this book based on his experience as a professional counselor and an academic, as well as from his personal perspective.

This book will be resource for students, and for professionals in the gerontological, addictions, social work, mental health, nursing, and medical fields. Rather than presenting a limited focus on treatment, Dr. Beechem offers the reader a wide array of issues and information. The book summarizes the various models of alcoholism and how they relate to the older adult. It

describes various precipitants for drinking problems in old-age, including "loss-grief theory." It addresses the issues faced by many professionals such as identification and assessment of the problem and how to work with special populations, perhaps the least known area in this relatively new field. The book also addresses the critical issue of relapses and the relationship of alcohol to suicide. Rather than just summarize the literature, Dr. Beechem traveled to locations in the U.S. and Canada known for the innovative programs for elders. He took the time to interview the program directors, researchers, and others to learn what made their treatment programs different from others.

We need to advocate for improved substance abuse treatment and its availability for our older citizens. *Elderly Alcoholism: Intervention Strategies* is an important contribution and can only help us to become more aware of the scope of the problem and what to do about it.

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PREFACE

As a beginning professional counselor in the early 1970s, I fervently avoided accepting clients with presenting problems suggesting substance abuse. On November 29, 1989, after innumerable, but futile, efforts to convince a university administrator that I was not an alcoholic, I decided to enter a thirty-day residential treatment program not with sobriety as a goal but, instead, to prove once and for all that I was not an alcoholic so that the administrator's incessant nagging would finally stop.

After a full hour of disclosing my seemingly endless beverages of choice to the facility's intake worker, the nurse took my rapidly escalating pulse and blood pressure. As she charged to the medicine cabinet for anticonvulsant medication, my tenacious grip on alcoholism denial started to crumble. Although nowhere near the acceptance stage, this very incident, day, and year indelibly inaugurated the beginning of my successful alcoholism recovery. With a certain sense of pride, I can now proclaim that "My name is Mike, I am a grateful recovering alcoholic."

Enthusiastic with prospects to start anew, I accepted a faculty position at The University of West Florida to coordinate the Aging Studies Program and to teach substance abuse courses. New to the community, I was invited to join a community mental health subcommittee to assess the seriousness of elderly alcoholism, the "hidden disease." After some six to eight months of study, all fourteen committee members concurred that alcoholism was rampant among the elderly in the Pensacola community. Like many fact-finding committees, the group disbanded with their mission completed, despite a rapidly growing elderly alcoholic population largely untreated. In all likelihood, the very same situation could be documented in countless communities throughout our country.

Primarily because of my teaching and research focus on gerontology, substance abuse, and the grieving process, I decided that this book should appropriately integrate those areas. It was further determined that as an interdisciplinary supplementary text, both undergraduate and graduate students in the physical and behavioral sciences would be served. Despite the

book's structure, which conveniently includes study questions for students' learning needs, it was purposively written with professional counselors in mind. As a reference book for professionals, including nurses, physicians, and others who provide services to an elderly clientele, it has practical value in focusing on the interplay between alcoholism and the aging process.

I would be remiss not to include my rationale for interspersing Beetle Bailey cartoons throughout. As a mere private with a career duration of two years, nine months, four days, and sixteen hours, I can readily identify with the lowly, yet lovable Private Beetle Bailey; but, it is General Amos Halftrack, whose alcoholic behaviors are highlighted. I selected twenty-three cartoons depicting the "mischievous" General Halftrack who superbly exhibits many alcoholism behaviors. I tried to match appropriate cartoons with situations. For example, in the cartoon with the General rationalizing that his alcoholism allows him to tolerate increased amounts of alcohol, he asserts, "the brain's ability, eh? About time I got some credit!" I, therefore, inserted this cartoon in Chapter V, Difficulty in Identification ("Hidden Alcoholism"). Then, again, there were cartoons that did not necessarily fit that well, but because they represented typical behaviors of elderly alcoholism, they were included.

With a strong sense of indebtedness and gratefulness, this book was passionately written for the purpose of perhaps making some contribution to the professional counseling community that supported me to recover successfully.

Michael Beechem

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I am very appreciative to those persons who contributed immeasurably toward the overall quality of my book. First, I must give substantial credit to the reviewers whose constructive criticism led to needed revisions. Those reviewers include:

General Reviewers:

Dr. James Boren, Northeastern State University

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My thanks to several students who were especially helpful. Gregory Kimbriel, Cynthia Jones, and Linda Torres ordered reading materials considered essential from various universities. Students Angela Bernard, Laura Leonard, Erin Robinson, and Karen Smith provided important student perspectives about the book. Another student, Sarah Nasca, proved enormously helpful in selecting and developing appropriate case studies and study questions.

A special thanks goes to Connie Works, who generously provided support in completing the manuscript when my wife contracted acute leukemia and was no longer able to continue her important role. Without Connie's invaluable support, the finished product would have been substantially delayed.

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ELDERLY ALCOHOLISM

Chapter I

INTRODUCTION

> It would be repetitious with other researchers if we were to say the problems of elderly alcohol abuse needs further verification of its extent and treatment implications. The problem may continue to be overlooked due to the older problem drinker's lack of visibility. However, as the number and proportion of older people increase, alcohol abuse in the elderly is likely to become less hidden.
>
> Schonfeld & Dupree, 1990, pp. 5–9

SERIOUSNESS OF THE PROBLEM: DIVERGENT VIEWPOINTS

Not a Problem

Elderly alcoholism has slowly been recognized as a serious health problem. Based on a population of 100 patients sixty years and older in a psychiatric hospital, Gaitz and Baer (1971) determined that 44% of the sample population was alcoholic. Although a large number of alcoholics was identified within the psychiatric population, the study concluded that elderly alcoholism for the general population is not at high levels and that the "percentage of people who drink excessively declines with increasing age," which they attributed to increased maturity, responsibility, reduced drive, less social involvement, fewer social pressures, and less affluence (Gaitz & Baer, April 1971). Conversely, other researchers insist that if there is a decline in elderly alcoholism, it is attributable to a high mortality rate among alcoholics; that is, many die from alcoholism-related ailments before they reach old age (Abrams & Alexopoulos, 1987). Leading researchers in elderly alcoholism are divided over whether elderly alcoholism declines, increases, or remains the same.

Problem is Serious

Generally, recognition that elderly alcoholism is a serious health problem has gained support from researchers in recent years. Butler, Lewis, and Sunderland (1991) insist that many elderly alcoholics are unreported, because many drink in the privacy of their homes. They estimate that 10 to 15 percent of elderly older than sixty are alcoholics (Butler, Lewis, & Sunderland, 1991). According to Bienenfeld (1987), most research studies identify at least 10 percent of Americans older than age sixty-five as having a "drinking problem," whereas at least 8 percent of elderly drinkers are "alcohol-dependent" (Bienenfeld, 1987). According to Levinthal (1996), "there is a widely held belief that alcohol abuse is not much of a problem with the elderly. Unfortunately, that is a myth" (Levinthal, 1996, p. 587).

Elderly alcoholism researchers commonly regard the elderly population to be the most vulnerable age group for alcoholism. Generally, the elderly are exposed to life events that frequently cause high stress levels, including chronic illness, spousal care giving (especially for Alzheimer's disease), poor health, ageism (or rather, the low status arbitrarily proscribed by society), and the depression associated with difficulty in grieving losses that occur in rapid succession. These and other factors will be subsequently addressed throughout this discussion on elderly alcoholism. Estimates of the number of elderly alcoholics vary considerably, from a low of 2 percent to a high of 20 percent, and this wide variance will likely continue as long as a precise data collection instrument remains undeveloped. Schuckit (1977) insists that precise data are lacking on the number of alcoholics, but he estimates that elderly alcoholism ranges from 2 to 10 percent of the elderly population (Schuckit, 1977). Researchers face difficulty in arriving at a definitive number of alcoholics for various reasons. As previously stated, many alcoholics drink at home; too, the institutionalized elderly are typically excluded from the statistics.

ALCOHOLISM DEFINED

Alcoholism is a broad term with varied meanings. In 1956, the American Medical Association (AMA) acknowledged alcoholism to be a disease. The Diagnostic and Statistical Manual IV (RTDSM-IVRT) (2000) identifies the conditions that constitute chemical dependency, of which alcohol is included. Geraldine Miller (1999) delineates these conditions for alcohol dependency:

To meet the criteria for dependence, the client must have a maladaptive use pattern causing some type of impairment with at least three of the fol-

lowing occurring within one year: tolerance; withdrawal; more or longer use than planned; desire without ability to cut down or control usage; time spent on obtaining, using, or recovering from the substance; impact on activities that are social, occupational, or recreational (do less or not at all); and continued use in spite of physical or psychological problems related to use.

Neither the World Health Organization (WHO), which publishes the International Classification of Diseases, nor the American Psychiatric Association (APA), publishers of DSM-IVRT, uses the term alcoholism. Both organizations, instead, establish the syndromes: alcohol dependence and alcohol abuse. The DSM-IV (4th edition) includes both alcohol dependence and alcohol abuse. The omission of the term alcoholism was an effort by the AMA and WHO to avoid confusion from the numerous varied understandings of alcoholism.

Character Defect Theory of Alcoholism

Once the leading explanation for alcoholism, the theory continues that alcoholism is attributable to a personal character defect that can only be removed through a moralistic, religious treatment orientation. Katherine van Wormer (1997) writes that:

> In the United States, there are religiously oriented shelters and halfway houses (missions) for recovering alcoholics or reformed drunks. Funded by private donations, churches, and community resources, treatment is in the form of preaching, praying, and work therapy. Drunkenness has long been viewed by major North American religions as sinful behavior. The criminal justice system takes a punitive stance toward those who commit offenses while intoxicated. Despite the official disease-model rhetoric, there is in the United States an undercurrent of moralism that coexists with the belief that the alcoholic is suffering from a disease.

ETIOLOGY: ALCOHOLISM AS A DISEASE

Both the WHO and the AMA classify alcoholism as a disease, which serves to dispel the myth that alcoholics exhibit character defects and must be dealt with harshly and punitively. Instead, the benefit of viewing alcoholism as a disease gives impetus to the need for treatment, and, in addition, the disease classification serves to lessen the deep sense of shame so deeply instilled in alcoholics. There is near unanimity of agreement among alcoholism counselors that alcoholics are generally more receptive and motivated toward a supportive treatment regimen; hence, an increased probability of successful treatment outcomes occurs if the alcoholic is not preoccupied with the deep feelings of shame and guilt associated with the disease. Alcoholism counselors also argue that for the alcoholic to successfully recover feelings of shame and guilt associated with years of alcoholism must be overcome. They also need to be motivated to affect lifestyle changes.

NATURE VS. NURTURE

Nature:

In the latter 1950s, WHO and the AMA established that alcoholism was a disease and that it runs in families; that is, there is a genetic predisposition to the onset of alcoholism. One study, the well-known twin studies, compared twins who had been separated through adoption. A significantly high incidence of alcoholism was reported in twins who had been separated from their biologically alcoholic parents and adopted into homes where alcoholism of the adopted parents was absent.

Nurture:

The opposing argument postulates that environmental "stressors," if not managed effectively, will likely lead to alcoholism. Related to stress theory is another theory that maintains that unresolved loss-grief issues, if not adequately addressed and grieved, will likely precipitate alcoholism.

Each position no doubt has merit in explaining alcoholism. The alcoholism counselor's task should be to individualize each case and apply the most relevant and applicable theories. The debate concerning nurture vs. nature continues as an endless and unabated intellectual exercise with purists