DOCUMENT RESUME

ED 265 479 CG 018 803

AUTHOR Dupree, Larry W.; Schonfeld, Lawrence
TITLE High Risk Situations for Elderly Alcohol Abusers.
PUB DATE 24 Aug 85
NOTE 19p.; Paper presented at the Annual Convention of the American Psychological Association (93rd, Los Angeles, CA, August 23-27, 1985).
PUB TYPE Reports - Research/Technical (143) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.
DESCRIPTORS *Age Differences; *Aging (Individuals); *Alcohol Education; *Alcoholism; *Drinking; *Older Adults
IDENTIFIERS *Risk Factors

ABSTRACT

The Gerontology Alcohol Project, a treatment/research program investigating the characteristics of the late-life onset elderly alcohol abuser, was used as a model for a new program which emphasized teaching the elderly abusers how to break down their personal drinking behavior chain and deal with the antecedents of drinking behavior, to use general problem solving skills, and to understand consequences of alcohol abuse. Physical health, mental health, social/family relationships, legal problems, and financial problems of the 67 program participants were also assessed for effects of alcohol abuse. The results from administration of the Drinking Profile revealed that most physical/medical problems were related to episodes of drinking, that the majority of abusers lived alone and had a small social network, and that few financial or legal problems relating to alcohol abuse were found. Antecedents of drinking behavior were markedly different for older abusers than younger abusers. Intrapersonal rather than interpersonal antecedents of alcohol abuse were common in the elderly. The elderly abuser's antecedent depressed mood was related to the drinking episode rather than to peer pressure or anger as in young abusers. Most younger abusers consumed alcohol in social settings but most elderly abusers drank liquor at home alone. Elderly alcohol abuse was found to be related to loneliness, lack of social contacts, age-related changes, and intermittent depression and did not cause major psychological/interpersonal impairment. Eight data tables are appended. (ABL)

HIGH RISK SITUATIONS FOR ELDERLY ALCOHOL ABUSERS

Larry W. Dupree, Ph.D.
Chairperson, Department of Aging and Mental Health
Florida Mental Health Institute
University of South Florida
Tampa, Florida 33612

and

Lawrence Schonfeld, Ph.D.
Director, Community Aging Program
Florida Mental Health Institute
University of South Florida
Tampa, Florida 33612

Presented at the Ninety-Third Annual Convention of the
American Psychological Association
Los Angeles, California
August 24, 1985

HIGH RISK SITUATIONS FOR ELDERLY ALCOHOL ABUSERS

ABSTRACT

This paper details a typical drinking profile of late-life onset (elderly) alcohol abusers, giving special attention to the antecedents for alcohol abuse in this older population in comparison to antecedents typically noted in younger alcohol abusers. For late-life onset alcohol abusers, fewer antecedents for abuse are directly related to interpersonal conflict (interpersonal conflict was typically the consequence of using alcohol as a palliative in response to age-related changes, insults, and stresses). Intrapersonal determinants (negative affect) prompt more the inappropriate use of alcohol in this older population. Also, the number of categories of antecedents reported by elderly alcohol abusers was markedly restricted as compared to younger populations, as was the location of alcohol use. The elderly most often drank at home, alone; whereas the younger groups drank in the presence of others, usually at bars and/or lounges.

HIGH RISK SITUATIONS FOR ELDERLY ALCOHOL ABUSERS

INTRODUCTION

Dupree, Broskowski, and Schonfeld (1984) developed the Gerontology Alcohol Project, a treatment/research program specifically for the late-life onset elderly alcohol abuser (the individual who began abusing alcohol late in life typically in response to age-related stressful events). Prior to this project, there had been only speculation as to the extent of the problem, method of treatment, and identifying characteristics (Dupree & Schonfeld, 1984). Initial indications were that the characteristics of these individuals were different from younger alcohol abusers. These differences then determined how treatment approaches would be altered to suit the needs of the elderly. The present paper describes the noted differences between the antecedents observed for 67 elderly alcohol abusers and those reported within the literature to be most frequent for younger alcohol populations.

THE GERONTOLOGY ALCOHOL PROJECT (GAP)

The Gerontology Alcohol Project was a day treatment program for later-life onset, elderly alcohol abusers (individuals age 55 and over whose onset of an abusive alcohol pattern occurred at age 50 or later). The GAP followed a behavioral (A-B-C) paradigm relative to assessment and intervention, with an emphasis on the functional analysis of drinking behavior (i.e. the drinking behavior chain), acquisition of self-management skills, and re-establishment of viable social support networks.

Our current program is based upon the GAP program and consists of four major approaches. First, it attempts to teach the elderly abusers how to analyze or break down their personal drinking behavior chain into its components (antecedents, behavior, and consequences) as well as instructing them in the methods of monitoring their own behavior. Second, when the elderly

alcohol abusers can successfully identify their personal drinking behavior chain, we then teach them (via behavior rehearsals, lectures, practice) the methods to deal with the identified antecedents of their drinking behavior. Using this behavioral/self-management approach within a group format, elderly individuals enter training to deal with depression, drink refusal, cues for drinking, urges to drink, relapse, tension/anxiety, and anger/frustration (assertiveness). Third, clients are taught general problem solving skills so that they will be able to deal with any problem situation (antecedent) which may arise in the future. Fourth, the consequences of their alcohol abuse are attended to via an alcohol education group. Finally, as Zimberg (1974) has proposed, we teach the elderly alcohol abusers the skills necessary for them to expand their social support network using similar techniques (rehearsal, practice, lectures).

According to Pattison, et al. (1977), the best method of identifying individuals with alcohol problems is to consider "multiple measures". That is, in addition to the quantity and frequency of alcohol consumed, it is necessary to consider what areas of one's life are affected by alcohol abuse. We currently assess five "quality of life" areas: physical health, mental health, social/family relationships, legal problems, and financial problems. Information regarding the influence of alcohol use in these areas, together with the quantity and frequency of alcohol consumption, not only demonstrates the presence of an alcohol problem, but also can be used as outcome measures (i.e., does the individual improve in the noted problem areas following treatment?). Assessment instruments such as structured interviews, behavior ratings and psychosocial inventories are also used; as well as the GAP Drinking Profile, a structured interview administered prior to any intervention. The

Drinking Profile (DP) yields the majority of the information regarding the individual's antecedents to drinking. This inventory allows the planning and implementation of individualized alcohol treatment by highlighting each individual's specific antecedents for abusive alcohol use. Using the results from the Drinking Profile, the elderly were taught self-control/ self-management skills specific to their drinking behavior chains.

From repeated administration of the DP, specific antecedents to alcohol abuse (as well as the likely bases for relapse) have been identified for elderly alcohol abusers. For this paper, the subjects were 67 late-life onset alcohol abusers admitted on an outpatient basis to the Department of Aging and Mental Health at the Florida Mental Health Institute (University of South Florida) in Tampa. Table 1 offers demographic data regarding the 67 subjects (35 males, 32 females). The sections which follow are primarily a summary of admission data from our treatment and research program.

RESULTS

Quality of Life Indicators

Physical/Medical Problems. Relatively few medical problems existed at any time in the client's lives (see Table 2). Most of the reported physical symptoms were those noted subsequent to a period of drinking. Thus, physical withdrawal symptoms may be incorrectly interpreted as aging-related physical problems. Also, medication use was less than expected for this age group.

Social/Family Relationships. The clients had a relatively small social network (see Table 3). The majority were divorced or widowed and were experiencing interpersonal conflict as a result of their current alcohol use. Also, most clients lived alone.

Legal Problems. Most of the clients did not drive; therefore, only 17 percent had Driving While Intoxicated (DWI) arrests. Other than this legal issue (DWI), no other legal problems as a result of alcohol were reported.

Financial/Occupational. The later-life onset alcohol abuser has typically led a successful life; being a contributor rather than a problem to his/her family and community. Ninety-seven percent of the sample were retired, with Social Security and personal savings being the major income sources (for 55 and 37 percent, respectively). Also, few financial problems as a result of alcohol use was noted, despite high liquor bills.

Mental Health. Global assessments (see Table 4) indicate adequate levels of functioning, reflecting sufficient skills and abilities to continue residing in the community. With the exception of the PARS alcohol and drug use scale, most assessments did not demonstrate severe behavioral/psychological problems. However, periodic episodes of negative affect (e.g. depression, grief, sadness) were noted to immediately precede the first drink on a typical drinking day.

Drinking History

The drinking pattern for our elderly subjects drastically changed after age 50. Before age 50, approximately 18 percent were steady drinkers. After age 50, 38 percent reported being steady drinkers; and at admission (mean age of 64) 71 percent reported being steady drinkers. Also, the preferred alcoholic beverage changed over time (see Table 5).

Current Drinking Behavior Chain

Table 6 gives a drinking profile summary and Table 7 reflects the typical drinking behavior chain at admission. Thirty days prior to the last drink consumed prior to admission to treatment served as a baseline period by which future assessment periods were compared. Within that 30 day baseline period

the clients drank a great majority of the time and more often drank until intoxicated. Seventy-one percent were steady drinkers, 19 percent binge drinkers, with 10 percent indicating a weekend drinking pattern.

Alcohol consumption was measured in "SECs" (one standard ethanol content unit or SEC is equivalent to one ounce of 100-proof alcohol). The amount of alcohol consumed on a typical drinking day (11.97 SECs) is the approximate equivalent of ten 12-ounce cans of beer, or 51 ounces of wine, or 15 ounces of 80-proof liquor.

Antecedent (High Risk) Situations Promoting Alcohol Abuse

For the 67 later-life onset alcohol abusers in this study, specific antecedents preceding alcohol abuse have been identified (see Table 8). These antecedents do not correspond to those antecedents typical among younger alcohol abusers. Fewer antecedents for alcohol abuse are directly related to interpersonal conflict for the elderly (interpersonal conflict typically was the consequence of using alcohol as a palliative in response to age-related changes, insults, and stresses), whereas for the older abuser intrapersonal determinants prompt more the use of alcohol. The number of categories of antecedents reported by the elderly was markedly restricted as compared to younger populations. Also, whereas both age groups report negative mood states as major antecedents or high risk conditions prior to the first drink on a typical drinking day, the older abusers' primary antecedent mood state seems to be a momentary form of negative affect (e.g. depression, sadness, grief, feelings of loneliness); with abusive drinking or relapse not being as related to peer pressure or anger/frustration (interpersonal conflict) as seen with younger populations. Another difference relates to where the alcohol misuse occurs. Whereas younger alcoholics report that they are more likely to misuse

alcohol in bars and/or lounges, the elderly alcohol abusers in this study reported that they were more likely to drink at home and alone. Use of alcohol for this elderly group was not for social purposes. Also, the typical result, or noted feelings, after the first drink was one of feeling better (70%), if only for a short period of time; and 30 percent reported feeling even more negative.

CONCLUSIONS

In our initial evaluation contacts with late-life onset (elderly) alcohol abusers there appeared to be a conflict in that well validated depression assessment instruments indicated only mild to moderate levels of depression, even though these individuals reported "feeling depressed" as the most frequent antecedent to the first drink on a typical drinking day. However, with increasing numbers, we found that the depression appears to be more of a state or transient nature (not easily detected by current depression instruments), rather than a prolonged or trait characteristic. This "depression" also does not appear to be global, having little of the traditional life disrupting consequences noted in the DSM-III. It seems to be a reaction to loneliness, a lack of social contacts, age-related changes, and certain negative cognitions intermittently occurring. Alcohol is subsequently used as a palliative; a form of self-medication. Also, the alcohol abuse problem seems to be fairly discrete rather than representative of major psychological/ interpersonal impairment. The alcohol is primarily being misused in response to age-related physical, social, financial, cognitive, personal control and self-image changes.

Specific to negative affect as a high risk variable or antecedent to alcohol abuse, the more effective treatment techniques centered on teaching clients skills for developing social support networks, how to self-manage negative cognitions and affect, problem solving, and skills necessary for increased personal control.

A summary drinking pattern for the 67 elderly late-life onset alcohol abusers is: a) they are most likely to drink at home and alone until intoxicated, b) in response to depression, grief, loneliness, and c) are more likely to consume liquor than wine or beer. Also, by the late 50's the drinking pattern shows a dramatic shift from binge and/or weekend drinking to steady, almost daily drinking.

REFERENCES

Dupree, L. W., and Schonfeld, L. (1984). Strategies for recognizing and treating elderly alcohol abusers. Paper presented at the Ninety-Second Annual Convention of the APA, Toronto, Ontario, Canada, August 24, 1984.

Dupree, L. W., Broskowski, H., and Schonfeld, L. (1984). The Gerontology Alcohol Project: A behavioral treatment program for elderly alcohol abusers. The Gerontologist, 24, 510-516.

Marlatt, G. A., and Gordon, J. R. (1980). Determinants of relapse: Implications for the maintenance of behavior change. In P. O. Davidson and S. M. Davidson (Eds.), Behavioral Medicine: Changing health lifestyles. N.Y.: Brenner/Mazel Publishers.

Pattison, M., Sobell, M., and Sobell, L. (1977). Emerging concepts of alcohol dependence. N.Y.: Springer.

Zimberg, S. (1974). The elderly alcoholic. The Gerontologist, 14, 221-224.

TABLE 1

PROFILE OF THE LATE-LIFE ONSET ALCOHOL ABUSER

DEMOGRAPHIC INFORMATION

(n=67)

Age (mean)	64
Males	35
Females	32
Education	73% H.S. Graduate or higher
Verbal I.Q.	115
Monthly Income	
Less than $300	23%
$301 - $600	40%
More than $600	45%
Employment	97% Retired, Unemployed
Marital Status	
Widowed	46%
Divorced/Separated	22%
Married	31%
Time at Present Residence	
2 years or more	46%

TABLE 2

QUALITY OF LIFE INDICATORS

PHYSICAL/MEDICAL PROBLEMS

I. History (At Any Time)

Illnesses (most frequent)

Hypertension	44%
Chest Pains	24%
Pneumonia	24%
Liver Problems	19%
Alcohol Treatment	52%

II. Recent Reports

Physical Health

Excellent/Good	68%
Fair	21%
Poor	10%

Medications

Minor Tranquilizers	24%
Major Tranquilizers	12%
Antihypertensives	10%
In Hospital or E.R.	52%

Withdrawal Symptoms Following a Period of Drinking:

Hands Shake	52%
Restlessness	50%
Blackouts	48%
Nausea	45%
Sleep Disturbances	43%
Severe Inner Shakes	42%

TABLE 3

QUALITY OF LIFE INDICATORS

FAMILY AND SOCIAL RELATIONSHIPS

Average Size of Social Network	8 people
Daily Friends	1.5 Friends
Daily Relatives	1.4 Relatives
Percentage who "lack" spouse (divorced, widowed)	68%
Has someone to discuss problems	70%
Conflicts with others related to drinking:	
with spouse	40%
with relative	21%
with neighbor	10%
Live alone	47%
Live with spouse	24%
Live with children	10%
Live with others	19%

TABLE 4

MENTAL HEALTH QUALITY OF LIFE INDICATORS

ASSESSMENT	SCORE	SO	IMPLICATION
Brief Psychiatric Rating Scale*			
Anxiety	3.3	1.9	Mild to Moderate Severity
Guilt	3.1	1.8	Mild to Moderate Severity
Depression	3.1	1.7	Mild to Moderate Severity
Beck Depression Inventory	11.4	8.2	None to Mild Oepression
State-Trait Anxiety Inventory	29.4	8.1	Moderate Anxiety Level
Life Satisfaction	12.5	4.6	Adequate Self-Esteem
Locus of Control (I-E)	7.7	3.4	"Internality"
PARS Alcohol & Orug Use Scale**	9.5	3.2	Poor Adjustment

* Only those subscales on which more than 50% of the clients were rated as having mild or higher ratings of severity.

** Collaterals' ratings using PARS indicate average adjustment except for alcohol and drug abuse.

TABLE 5

DRINKING HISTORY

Drinking Pattern Changes Drastically after age 50

% of Steady Drinkers:

Before Age 50	18%
After Age 50	38%
Currently	71%

First Age Intoxicated (mean)	31.4	(SD = 12.8)
Age First Told He/She Had a Problem	57.8	(SD = 9.7)
Age The Client Felt Problem Began	57.4	(SD = 9.0)
Sought Outside Help for Alcohol Abuse	59%	
Attended Alcoholics Anonymous at least once	39%	

Preferred Beverage:	AGE				
Beverage Type:	20's	30's	40's	50's	Current
Beer	40%	35%	29%	19%	21%
Liquor	37%	38%	41%	51%	48%
Wine	8%	5%	7%	5%	9%
Beer & Liquor	3%	5%	12%	12%	16%
Beer & Wine	3%	5%	5%	2%	5%
Liquor & Wine	0%	3%	0%	2%	0%
All 3 Beverages	0%	2%	0%	0%	0%
None	10%	7%	0%	5%	0%

TABLE 6

DRINKING PROFILE SUMMARY

CATEGORY	DATA SUMMARY	
Mean age of onset of drinking problem	58	SD = 9.7
Sought outside help for drinking problem	59%	
Hospitalized at any time for alcohol abuse	52%	
Attended AA at least once	39%	
In the 30 days before last drink prior to admission:		
Mean number of days drinking	23	SD = 9.7
Mean number of days intoxicated	16	SD = 9.7
Steady drinking pattern	71%	
Binge drinking pattern	19%	
Weekend drinking pattern	10%	
Mean alcohol consumption on typical drinking day	11.97 (SEC Units)	SD = 9.5
Median alcohol consumption	8.40 (SEC Units)	
Typical antecedents to drinking		
Being at home	75%	
Being alone	75%	
Experiencing negative mood states:		
Intrapersonal (depression, loneliness)	70%	---82%
Interpersonal	12%	
Feelings after first drink on a drinking day:		
Positive	70%	
Negative	30%	

TABLE 7

CURRENT DRINKING BEHAVIOR CHAINS

ANTECEDENTS:		
Situations/Thoughts		
At Home	75%	
Alone	75%	
Feelings Before Drinking		
Negative	82%	
Positive (Calm, Happy)	16%	
BEHAVIOR:		
Drinking Patterns:		
Steady Drinkers	71%	
Periodic/Binge	19%	
Weekend	10%	
Days Drinking out of 30 (mean)	23	SD = 9.1
Days Intoxicated out of 30	16	SD = 11.8
Average Alcohol Consumed	11.97 (SEC units)	SD = 9.5
Median Consumption	8.40 (SEC units)	
Most Preferred Beverage	8.40 (SEC units)	
Liquor	48%	
Beer	21%	
Both Liquor & Beer	16%	
Wine	9%	
Wine & Beer	5.4%	
CONSEQUENCES:		
Feelings <u>After</u> First Drink		
Positive	70%	
(Relaxed, Calm, Friendly)		
Negative	30%	
(Angry, Depressed, Lonely)		

TABLE 8

ANTECEDENT (HIGH RISK) SITUATIONS

	Younger Alcohol Abusers[1]	Older Alcohol Abusers
Intrapersonal Determinants	61%	86%
Negative Emotional States	38%	70%
Negative Physical States	3%	0%
Positive Emotional States	0%	16%
Testing Personal Control	9%	0%
Urges & Temptations	11%	0%
Interpersonal Determinants	39%	14%
Interpersonal Conflict	18%	12%
Social Pressure	18%	2%
Positive Emotional States	3%	0%
Physical Setting		
Bars/Lounges	63%	10%
Own Home	12%	76%
Other's Home	9%	0%
Miscellaneous	16%	14%

[1] Marlatt and Gordon, 1980