Assignment 3.3 – Research Paper: Alcoholism in the Elderly

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Introduction

Although alcoholism is recognized as a major health problem in our society, we are only just beginning to realize its importance in the field of geriatrics. Older Americans are the fastest growing segment of the United States population due to lower birth rates, longer life expectancies, and an increased birth rate during and after World War II. The number of geriatric alcohol-related disorders are expected to rise with this population change (Menninger, 2002).

For many, drinking alcohol accelerates in old age. Excessive drinking and alcohol dependence (with the inherent myriad of medical, psychological, and social consequences that come with them) are becoming increasingly recognized as common problems in older adults (Menninger, 2002). This is important knowledge for health care providers because the medical consequences of acute alcohol intoxication are accentuated in the elderly. Therefore, screening for alcoholism should be a part of every regular physical examination of the elderly.

Elderly patients present with some special problems to health care professionals interested in diagnosing alcoholism. Diagnostic limitations result in deceptively low reported numbers of geriatric alcoholism (Menninger, 2002). The elderly have higher sensitivity and higher blood levels at lower consumption amounts so they are apt to drink less in terms of both quantity and frequency. The older alcoholic's consumption of relatively low amounts of alcohol may not fulfill the criterion of spending a great deal of time in activities related to substance use (Menninger, 2002). Also, the criterion of giving up activities is often unhelpful in diagnosing alcoholism in retired elderly who have fewer regular activities and responsibilities to give up. Fewer social warning signs are seen in older adults with alcoholism because they have far fewer

alcohol related legal difficulties, suicide attempts, and occupational problems. Finally, alcohol related pathology is more likely to be obscured by concurrent medical conditions and medications (Menninger, 2002). For all of these reasons, dependence and withdrawal symptoms may easily escape detection by health care professionals.

It is important to note that there are two primary drinking patterns among older adults: early onset and late onset geriatric alcoholism (Menninger, 2002). Early onset geriatric alcoholism describes those who have a lifelong pattern of drinking, have probably been alcoholic all their life, and are now elderly. The late onset group encompasses those who become alcoholic in their drinking pattern for the first time late in life. Late onset alcoholics are more amendable to treatment, more likely to have spontaneous recovery, but also more likely to be overlooked by health care professionals (Menninger, 2002). This distinction between early and late onset is important to some of the research that I encountered.

The alcohol problems of older adults are frequently misidentified. Primary risk factors helpful in the identification of the elderly alcoholic include male gender, major life changes, and losses (Menninger, 2002). Substantial losses, such as a decline in economic status, the death of a spouse or close friends, and deterioration of health with worsening medical problems, are all risk factors for drinking in the elderly. Alcohol may be used to reduce the psychological, emotional, or physical stress of aging.

Taking all of this information into account, more research needs to be done on geriatric alcoholism. Also, screening for alcoholism should be a part of every regular physical examination of the elderly.

Literature Review

Although the research on alcoholism in younger individuals is rampant, there is not a lot of research on geriatric alcoholism. The following are the resources that I discovered regarding alcoholism in the elderly.

Data suggests that current medical education is deficient in providing physicians with the skills to detect and treat elderly patients with alcoholism (Curtis et al., 1989). The purpose of this study by Curtis et al. was to examine the ability of physicians to diagnose alcoholism in the elderly patient and to define characteristics specific to the elderly patient with alcoholism (1989). The specific goals in this analysis were to determine the prevalence of alcoholism in elderly medical inpatients using alcoholism screening instruments, to examine characteristics of elderly patients with alcoholism that might either help or hinder the clinician in making the diagnosis of alcoholism, and to determine the physicians' rates of diagnosis and intervention for these elderly patients on general medical wards. Age was dichotomized by those 60 years or older (elderly) and those less than 60 years (nonelderly). The elderly patients with alcoholism were significantly less likely to be diagnosed with alcoholism by their physician if they were white, female, or had completed high school (Curtis et al., 1989). This suggests that the stereotype of an elderly individual with alcoholism being black, male, and less well educated may interfere with the diagnosis of alcoholism. Even when diagnosed, elderly patients with alcoholism were less likely than younger patients with alcoholism to have treatment recommended by their physicians, and if treatment was recommended, it was less likely to be initiated (Curtis et al., 1989). These findings demonstrate that medical professionals need more education in detecting and treating alcoholism in the elderly population.

In addition, little is known about treatment seeking among older adults with alcohol dependence. The aim of a study by Jirwe et al. was to describe the elderly's views on alcohol

dependence, treatment seeking, and treatment preferences (2024). This study was a descriptive qualitative study. Two themes and five subthemes were identified by Jirwe et al. (2024). The first theme was (a) "regret and feelings of shame when losing control" consisting of two subthemes: (1) loss of control over your alcohol consumption and (2) regret and feelings of shame. The participants attributed their increase in the use of alcohol to specific life-changing phases, in which their responsibility, feeling of being needed, or belonging in the community had decreased. The participants further described that loss of control over alcohol use led to regret and feelings of shame (Jirwe et al., 2024).

The second theme discovered in the study by Jirwe et al. was (b) "taking back control over your life" which consisted of three subthemes: (1) becoming aware that you have problematic alcohol use, (2) seeking help for alcohol dependence, and (3) views on treatment options and treatment settings (2024). The participants agreed that acknowledging they had a problem with alcohol was an important precursor to seeking formal treatment. After becoming aware of problematic alcohol use, the next step was to seek help. All participants stated it was important that the place where they sought help 1) acknowledged their wishes, 2) treated them respectfully and 3) allowed controlled drinking as a treatment goal. The participants also agreed that there was no need to tailor treatment to general factors such as age or gender, but rather to individual factors irrespective of age and gender (treatment should be individualized to their specific needs and wishes) (Jirwe et al., 2024). It was important to the participants to meet the right therapist. The participants in this study stated concern for their current and future health, and also concern for their interpersonal relationships, as important motivational factors to change alcohol use (Jirwe et al., 2024). This study provides important insight into the elderlies' views, showing that they do not differ all that much from the views of younger people.

As mentioned in my introduction, when studying alcoholism in the elderly, it is important for professionals to distinguish between late onset and early onset alcoholism. Today, there is a growing emphasis on involving patients in their own treatment as a key to healthy behavior change and improved self-management of addiction. The patient's free choice of treatment goals for alcohol use disorder is predictive for treatment outcome. A study by Emiliussen et al. investigated whether there are differences in choice of treatment goal between patients with very late onset alcohol use disorder (>60 years) and those having early or mid-age onset of alcohol use disorder (<60 years) (2019). The findings indicated that individuals with late onset alcohol use disorder have characteristics different from individuals with early onset alcohol use disorder. The study found that individuals with late onset alcohol use disorder were more likely to aim for temporary abstinence ("I want to be totally abstinent from all alcohol for a period of time, after which I will make a new decision about whether or not I will use alcohol again in any way") while individuals with early onset alcohol use disorder were more likely to aim for permanent abstinence goals (Emiliussen et al., 2019). One reason for this may be that those with a longer lasting alcohol use disorder may have experienced more negative consequences and, hence, are more likely to choose total abstinence. Oppositely, people with late onset alcohol use disorder may find it easier to cut back on drinking instead of stopping completely. This study determined that counselors should take into account onset / timing when discussing a patient's treatment goal.

Finally, alcoholism in the elderly general hospital population is an important problem. The purpose of this study was to assess the prevalence of alcohol abuse in an unselected elderly hospital population (Speckens et al., 1991). In addition, the recognition of alcohol problems by the physician in charge of the patient was evaluated. Scores on the Dutch version of the Munich

Alcoholism Test and medical records were obtained from 132 patients aged 65 and over (Speckens et al., 1991). Most of the alcohol problems were not recognized by the physician caring for the patient. In this study alcohol problems were recognized in only one third of the cases (Speckens et al., 1991). Alcoholism still appears to be an underdiagnosed syndrome among elderly patients. This is probably because clinical presentation of alcohol abuse among elderly people is described as atypical and variable.

Limitations of Research

There are several limitations to the research I found on alcoholism in the elderly. One is how old much of the research on this topic is. It was difficult to find current information, but I did the best that I could. In addition, oftentimes, the participants in these studies were seeking treatment. This means that they were not a random group. Nontreatment seekers may have different perceptions than those seeking treatment, and it is important to note this difference. Also, the culture where each study took place is important. Can the results be generalized beyond the particular alcohol culture and treatment system of the study? Finally, most of the studies adopt questionnaires which may not be a reliable diagnostic instrument when used in an age group for which problems related to drinking are different from the ones encountered in the younger alcoholic. The elderly present with alcoholism differently than the younger population, and therefore need special screening tools. The lack of specialized geriatric screening tools may result in the underestimation of alcoholism in the elderly.

Implications

I want to work with the elderly population, and (as this population grows) geriatric alcoholism is rising. Therefore, this research paper is extremely pertinent to my counseling of future clients. Alcohol use in the elderly can worsen existing health problems as well as can lead

to a higher risk of falls, fractures, and car crashes. However, health care professionals often seem to miss alcoholism in their elderly patients because it presents differently than in younger patients. Therefore, it seems that it will be important for me to learn to assess each of my clients in terms of their use of alcohol. Also, training medical professionals (doctors, nurses, counselors, psychologists, etc.) in geriatric alcoholism is becoming more and more important. In general, more research is required on this topic, and health care professionals need to be more aware of and better trained on this topic.

There is a difference between alcoholism in the elderly and alcoholism in the younger population. It presents differently in the geriatric population. Currently, there is not really a good screening test for geriatric patients. Therefore, a valid and reliable screening test should be developed to be used in health care settings so that a diagnosis of alcoholism is not missed in elderly patients. Also, this new screening test should be used with every geriatric patient so that alcoholism is not overlooked.

Future research should also focus on interventions to reduce the stigma of alcoholism in the elderly. Geriatric patients are often embarrassed of their drinking and the consequences thereof. These feelings of shame must be dealt with because they often get in the way of the older population admitting they have an alcohol problem and getting the help they need. I believe that the first step is building a good, respectful relationship with elderly patients (this applies to doctors, nurses, psychologists, as well as counselors).

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