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BODY AND MIND

Alcohol Abuse: A Hidden Epidemic Among Elders

Among elders with physical or emotional disorders, even modest alcohol consumption can seriously impair their already fragile health.

Successful treatment requires identifying the problem, understanding the medical and social complexities involved, and providing the necessary support.

By M. Saleem Ismail

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As I was exploring her anxiety symptoms during my clinical evaluation, it did not even occur to me that Mrs. Williams might be abusing alcohol. My initial reflex was to think, "How could she?" She was a neatly groomed, seventy-three year-old widow who still worked fifteen to twenty hours a week as an attorney at her small private office. Her family lived several hundred miles away and saw her once or twice a year.

For our first meeting she came in with a briefcase and a folded newspaper in her hands. She asked me more questions than I asked her and denied that there was any reason for her primary care physician to be concerned. After repeated questions, she did admit that she used one to two drinks every night, and consented that I could call her assistant at their office.

This phone call revealed more to me than I would have gathered by several interviews with my

patient. The assistant told me that practice had come to a halt during the last year, but Mrs. Williams still provided informal consultations to her clients. Besides work, she had no other social engagements. She worked in the afternoons and had no regular sleep pattern. Her memory gaps looked mild but consistent; she also showed some tremulousness of hands and her nutrition was slipping away. She was drinking more than she initially admitted.

Myth or Bias?

The case of Mrs. Williams illustrates that spotting potential alcohol abuse among older adults may be difficult. In primary care and psychiatry practices it is not uncommon to come across affluent, retired professionals who do not conform to societal stereotypes of the down-and-out or antisocial alcoholics. A bias among health care professionals could preclude them from considering the possibility of alcohol abuse among geriatric patients.

Avoidance of this topic or sustaining belief that older adults could not possibly have access to or use alcohol may leave this disabling condition untreated. Such avoidance among health care workers seems to be even more pronounced for women drinkers. In addition, literature suggests that the paucity of research on treatment outcomes for older adults with alcohol problems is most prominent for women. As a larger proportion of the U.S. population reaches later life, it is predicted that there will be an enormous increase in the number of older adults with alcohol problems.

What's in a Name?

Alcohol use disorders are heterogeneous and occur over a broad continuum. Alcohol consumption can result in profound physical and social impairment (abuse and dependence) to less severe disorders (heavy, hazardous, harmful, or at-risk drinking). The terms used in the literature to define alcohol-related problems are based on certain thresholds, or patterns of consumption, that increase the risk for adverse health events. Simply put, the alcohol use that results in impairment of functioning, threatens health, and/or places the adult at risk for harm is considered problematic.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) set safe limits for alcohol consumption at no more than one drink per day for men and women older than sixty-five

years.¹ The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), published by the American Psychiatric Association, distinguishes alcohol dependence from alcohol abuse by the presence of a tolerance and withdrawal phenomenon not present in patients demonstrating abuse alone.² Tolerance is the need for markedly increased amounts of alcohol needed to achieve intoxication or the desired effects. Withdrawal involves clinical evidence of physical signs and symptoms such as insomnia, agitation, hallucinations, anxiety, seizure, nausea, vomiting, elevated blood pressure, sweating, or palpitations. Such signs and symptoms are seen in patients who have recently discontinued or reduced their consumption of alcohol.

Defining alcohol problems in later life is further complicated by the relationship of alcohol with common health problems and the interaction of age, disability, and alcohol use.

Special Considerations In Older Adults

It has been argued that the common criteria for recognizing alcoholism often may not be applicable to older patients. Consequences of alcohol abuse may not be readily recognizable, as many older adults are retired and have only a few social contacts.

Although some studies have suggested benefits of moderate alcohol consumption, the risks and/or benefits of moderate drinking are not completely

understood, especially in older adults. The effects of alcohol are increased in the elderly patients because of physiologic and pharmacological changes associated with aging. The interaction between alcohol and drugs, prescription and over-the-counter, may also be more serious in older adults because the combination of medications with alcohol may place them at higher risk for toxic effects. An increased sensitivity to alcohol results in higher blood levels, which in turn results in negative effects even with a relatively limited use.

A young adult will achieve a blood alcohol level of approximately 0.03% after 1.5 ounces of distilled liquor, 5 ounces of wine or 12 ounces of beer, while in a seventy-five year-old the level may be as high as 0.08% (the legal limit in many states). The presence of a chronic medical condition or use of medication can place the elderly at an even higher risk for undesirable effects.

Clinical evidence suggests that among elderly persons with chronic medical and psychiatric disorders, even modest alcohol consumption leads to excessive disability and poorer perceived health. As a higher proportion of older adults (compared with young adults) seek health care for acute and chronic conditions, the aging of the population poses new challenges to providing quality health care services for this group.

Among older adults with problematic drinking, two groups can be identified. In one,

alcoholism starts at a younger age and continues into late life, with periodic relief or worsening. This group of individuals represents “early onset alcoholics” and comprises two-thirds of the elderly with problem drinking. The early-onset alcoholics often have a family history of alcoholism, numerous chronic, alcohol-related medical problems, and serious psychiatric conditions.³

The problem drinking in the second group starts in later years. This group often begins hazardous or harmful drinking in response to certain stresses, including retirement, loss of spouse, and stress related to medical frailty. The “late onset alcoholics” have fewer physiologic consequences of the disease process due to the short duration of their use.

How Common Is the Problem?

Community surveys have failed to reveal the disability caused by alcohol in this age group. These surveys show that alcohol consumption is lowest among older adults compared to any other age group. The discrepancy between rates in community versus clinical samples is not surprising, given that alcohol abusers use a disproportionate amount of medical care and constitute a significant portion of medical patients.

In a large study of primary care patients, fifteen percent of men and twelve percent of women older than sixty years of age exceeded the recommended amounts of alcohol.⁴ On the other hand, data from the

Epidemiologic Catchment Area Study indicated a one-year prevalence (existing cases) of 3.1% for men and 0.46% for women older than sixty-five years of age who lived in the community.

As I discussed earlier, older women represent a particularly vulnerable group. They represent the largest single group of health care users in the country. Recognition of alcohol problems in older women is believed to be low despite the fact that women in late life have specific risks, including a swifter progression to alcohol-related illness. They are more susceptible to psychosocial risks because of the greater likelihood of widowhood and economic strain.

Furthermore, women with alcohol-related problems are likely to be married to men with the disease, be victims of domestic violence, and suffer from depression and/or anxiety. Women as a group also have significant barriers in accessing health care and respond differentially to standard treatment protocols. All these factors underscore the need for research to improve methods of screening, diagnosing, and treating alcohol-related problems with a special emphasis on certain vulnerable populations such as women.

Age-Related Risk Factors

Common risk factors associated with alcoholism in late life include a family history of alcoholism, a personal history of alcohol abuse, pain or medical illness, and psychiatric illness such as anxiety and depression. For the elderly, several

psychosocial challenges further add to their risk. Late-life years may be a time of decreased stress and increased personal and social freedom, but retirement years also bring many difficult transitions, heightened financial stresses, and even boredom. Loss of spouse, recent retirement, and social isolation add to the challenges of this vulnerable period in which alcohol may become a significant coping mechanism.

Age-related changes in physiology play a significant role in increasing the risks involved with alcohol use. There is a decrease in body water content resulting in a higher blood level in the same person when he/she is elderly than when a young adult. Thus, the older adult gets more intoxication per drink consumed. This intoxication potential is further enhanced by the fact that there is an age-related decrease in the level of enzyme that metabolizes alcohol. Certain medications commonly used by the elderly also interfere with levels of this enzyme, increasing the risk of alcohol-related illness. Physiologic changes associated with sleep pattern may also place older men and women at risk for alcohol abuse. All these factors alone or in combination may become reasons to initiate or continue alcohol consumption.

Alcohol: A Lousy Nutrient And Sleep Aid

I would like to dispel some myths about alcohol being a useful source of nutrition and a good sleep aid. Nearly fifty percent of people over the age of fifty complain of insomnia. Alcohol causes

a characteristic deviation of normal sleep pattern. The rapid-eye movement (REM) sleep is suppressed during drinking and is followed by "REM rebound"—a higher than normal amount of REM sleep that results in nightmares. Thus, alcohol may decrease the sleep latency (time to fall asleep), but sleep fragmentation and other changes contribute to less "restful sleep," ultimately leading to fatigue and irritability.

Another important concern is the effect of alcohol on nutrition and general health status in older adults. Individuals who consume a high percentage of their daily caloric intake as alcohol are at risk for severe malnutrition. A retired elderly person with no organized outings requires an average of 1,600 to 1,800 calories per day. The usual serving of wine or beer provides one hundred calories, which means a six-pack of beer may provide up to a third of the daily energy requirement in a form almost devoid of nutrients.⁵

Excessive alcohol consumption can interfere with nutritional needs in many ways. The alcohol budget competes with the food budget. Decreased income, decreased mobility, or living alone may contribute to the failure to purchase and prepare a balanced diet. If stomach irritation or inflammation has developed secondary to alcohol use, appetite is diminished and vomiting may reduce the amount of ingested food.

Damage to the intestine, liver, and pancreas may impair absorption and formation of minerals, vitamins, amino acids, and fats. The older adults with

problem drinking are likely to be in poor general health with an increased risk for morbidity and mortality.

Clinical Presentation and Consequences of Abuse

As seen in the case of my patient Mrs. Williams, individuals with alcohol abuse do not voluntarily seek help for their illness. Often, the clinician's suspicion about alcohol abuse is raised when patients present with increased medical, psychological, or environmental difficulties. Some common presentations that would suggest alcohol problems include anemia, peptic ulcer, poor control of diabetes, high blood pressure, high cholesterol, and heart diseases.

Similarly, liver diseases, gait or balance disturbances, nerve pain, falls, and bruising may point toward alcohol abuse. Alcohol abuse can also be a potential diagnosis when patients present with sleep disturbances, poor nutrition, memory problems, changes in mood, disturbed thought processes, and anxiety. A change in anxiety level in patients with alcohol abuse may suggest a withdrawal from alcohol.

The consequences of acute or chronic alcohol use include repeated falls with injury, functional disability, increased use of health care services, brain atrophy, and suicide. Problem drinkers and those with alcohol-related disorders are likely to be dissatisfied with their relationships with family members, spouses, and close friends. The depression, social isolation, and violent behavior that can accom-

pany alcohol intoxication and abuse may lead to suicide. Finally, higher rates of alcohol-related deaths have been demonstrated for alcoholics. These may result from cirrhosis of the liver, diseases of blood, cancers, accidents, and suicide.

Treatment Considerations

A comprehensive approach is required in treating older persons with alcohol problems. Clinicians need to have an adequate degree of suspicion to avoid overlooking potential alcohol abuse. Identification of this problem requires interviewing and examining the patient and obtaining information from family and close friends.

A diagnosis is generally made on the basis of established diagnostic criteria and by using standard screening tools. Two commonly used and convenient assessment tools are CAGE (Cut down, Annoyed, Guilt, Eye opener) and the MAST (Michigan Alcoholism Screening Test). An important component of the evaluation focuses on the potential for alcohol withdrawal and the need for inpatient detoxification. Hospitalization may be required if there is evidence of prescription medication abuse in addition to alcohol, the individual is suicidal, there is no social support, or if medical or psychiatric condition requires close monitoring. Treatment in outpatient settings is sufficient for individuals who are medically stable. Inpatient treatment should be followed by outpatient services for relapse prevention, such as a peer focused twelve-step program and adjunctive psychotherapy.

Use of pharmacological agents for relapse prevention should also be considered. More than one treatment option may be required, and involvement of families or other support systems may prove to be crucial. Despite beliefs to the contrary, older adults are more compliant, and treatment outcomes for this population in general are as good as, if not better than, for younger age groups.⁶

Summary

Older adults are particularly vulnerable to the adverse effects of alcohol. The paucity of literature regarding this subject, societal myths, and biases among health workers limit our understanding of alcohol-related problems in this group.

Risks associated with alcohol

consumption are many, and among elders with chronic medical and emotional disorders even modest alcohol consumption can lead to excessive disability and poorer health status. A successful treatment approach involves identification of the problem, recognition of recovery potential, and understanding of medical and social complexities, along with flexibility, education, and support.

Endnotes

1. Nat'l Inst. on Alcohol Abuse & Alcoholism, (Nat'l Inst. of Health, *The Physician's Guide to Helping Patients With Alcohol Problems*, 1995).
2. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL
- MANUAL OF MENTAL DISORDERS, 4th ed.
3. Center for Substance Abuse Treatment, (U.S. Dep't of Health and Human Serv., *Substance Abuse Among Older Adults*, 1998).
4. Wendy L. Adams et al., *Screening for Problem Drinking in Older Primary Care Patients*, 276 J.A.M.A. 1964 (1996).
5. Susan Klein & Frank L. Iber, *Alcoholism and Associated Malnutrition in the Elderly*, 7 NUTRITION 75, 79 (1991).
6. D. Olsin et al., Address at the Annual Meeting of the Gerontological Society of America (Nov. 1997).