Erin L. Woodhead

Unhealthy Alcohol Use in Older Adults

DOWNLOAD

hogrefe

Unhealthy Alcohol Use in Older Adults

About the Author

Erin L. Woodhead, PhD, is associate professor of psychology at San José State University, California. She is a licensed psychologist who has published over 30 journal articles in the areas of substance use, mental health, and aging, as well as an edited textbook entitled *Psychology of Aging*. She teaches courses in clinical psychology, adult psychopathology, psychology of aging, addictions, and lifespan development.

Erin L. Woodhead

Unhealthy Alcohol Use in Older Adults

hogrefe

Library of Congress Cataloging in Publication information for the print version of this book is available via the Library of Congress Marc Database under the LC Control Number 2023939163

Library and Archives Canada Cataloguing in Publication
Title: Unhealthy alcohol use in older adults / Erin L. Woodhead.
Names: Woodhead, Erin L., author.
Description: Includes bibliographical references.
Identifiers: Canadiana (print) 20230467679 | Canadiana (ebook) 20230467741 | ISBN 9780889375109 (softcover) | ISBN 9781616765101 (PDF) | ISBN 9781613345108 (EPUB)
Subjects: LCSH: Older people—Alcohol use. | LCSH: Alcoholism—Treatment.
Classification: LCC HV5138 .W66 2023 | DDC 362.292/80846—dc23

http://www.hogrefe.com

Cover image: © miodrag ignjatovic – iStock.com

PUBLISHING OFFICES

USA:	Hogrefe Publishing Corporation, 44 Merrimac St., Suite 207, Newburyport, MA 01950 Phone (978) 255 3700; E-mail customersupport@hogrefe.com
EUROPE:	Hogrefe Publishing GmbH, Merkelstr. 3, 37085 Göttingen, Germany Phone +49 551 99950-0, Fax +49 551 99950-111; E-mail publishing@hogrefe.com

SALES & DISTRIBUTION

USA:	Hogrefe Publishing, Customer Services Department, 30 Amberwood Parkway, Ashland, OH 44805 Phone (800) 228-3749, Fax (419) 281-6883; E-mail customersupport@hogrefe.com
UK:	Hogrefe Publishing, c/o Marston Book Services Ltd., 160 Eastern Ave., Milton Park, Abingdon, OX14 4SB Phone +44 1235 465577, Fax +44 1235 465556; E-mail direct.orders@marston.co.uk
EUROPE:	Hogrefe Publishing, Merkelstr. 3, 37085 Göttingen, Germany Phone +49 551 99950-0, Fax +49 551 99950-111; E-mail publishing@hogrefe.com

OTHER OFFICES

CANADA:	Hogrefe Publishing, 82 Laird Drive, East York, Ontario, M4G 3V1
SWITZERLAND:	Hogrefe Publishing, Länggass-Strasse 76, 3012 Bern

Format: PDF

ISBN 978-0-88937-510-9 (print) • ISBN 978-1-61676-510-1 (PDF) • ISBN 978-1-61334-510-8 (EPUB)
https://doi.org/10.1027/00510-000

Acknowledgments

I would like to thank Jennifer K. Manuel, PhD, and Derek D. Satre, PhD, who spent a significant amount of time on earlier versions of this book, providing edits and content for the clinical cases and clinical pearls throughout the book. I would also like to thank my mentors throughout my career, including Steven Zarit, PhD, Barry Edelstein, PhD, and Christine Timko, PhD. Dr. Timko encouraged my interest in substance use research and continues to be an invaluable mentor. I am also appreciative of my colleagues at San José State University and the students who were part of my research lab while I was working on this book.

Erin L. Woodhead, PhD

Table of Contents

1
Introduction

The proportion of older adults in the US population is increasing. Demographic trends indicate that by 2030, about 21% of the US population will be 65 or older, compared with 16% in 2019 (Administration of Community Living, 2021). This trend is also reflected internationally. In 2030, one in six individuals globally will be 60 years or older. Between 2020 and 2050, the world's population of older adults is expected to double from 1 billion to 2.1 billion (World Health Organization, 2022). As the population of older adults grows, so does concern about the impact of unhealthy alcohol use in this population.

This book highlights the unique concerns related to unhealthy alcohol use among older adults, and the clinical implications of the presented research. This book is intended for practitioners who are looking to expand their practice in this area, either toward expanding their work with older adults to include unhealthy alcohol use, or expanding work in the area of substance use to include older adults. Recommendations are offered throughout the book for ways to adapt diagnosis, assessment, and treatment to older adults; however, all of the recommendations need to be considered in the context of the individual client. Although older adults tend to be considered as one homogenous group, there are many differences between older adults, particularly those born in different generations. Some older clients may need treatment modifications to account for age-related cognitive changes, though caution is needed in assuming that all older adults need similar modifications.

This book offers a lifespan approach to understanding unhealthy alcohol use among older adults – that is, there are predictable shifts in alcohol use across the lifespan (Lee & Sher, 2018), particularly around common transitions points such as parenting and employment. Younger adults (ages 18–29) have the highest prevalence of drinking and alcohol-related problems (Barry & Blow, 2016). As individuals get older and gain more career and family-related responsibilities, they often reduce their alcohol consumption. Others, however, continue to drink at levels that put them at risk for health and psychosocial problems. For some groups, particularly women, new patterns of unhealthy alcohol use may emerge in middle age or later in life. These trends contribute to the increasing importance of better understanding unhealthy alcohol use among older adults, as well as appropriate psychological interventions.

4

Diagnosing Unhealthy Alcohol Use Among Older Adults

This chapter reviews the *Diagnostic and Statistical Manual of Mental Disorders,* 5th edition (DSM-5) criteria for alcohol use disorder (AUD) as well as ways in which the criteria may miss many older adults with unhealthy alcohol use. Common signs of unhealthy alcohol use are discussed, as well as differential diagnosis and common conditions that are comorbid with AUD and unhealthy alcohol use.

4.1 DSM-5 Criteria for Alcohol Use Disorder

The DSM-5 defines substance use disorders (including AUDs) according to 11 diagnostic criteria (American Psychiatric Association, 2013). To meet criteria for a *mild* specifier, two to three symptoms need to be present; for a *moderate* specifier, four to five symptoms, and for *severe*, six or more symptoms need to be present. Below is a subset of diagnostic criteria for AUD along with a discussion of how these criteria may be problematic for older adults. Specifically, there is a concern that the DSM-5 criteria may miss older adults with unhealthy alcohol use, resulting in underdiagnosis (Kuerbis, 2020).

- **Larger amounts of alcohol are taken, or alcohol is consumed over a longer period of time, than planned:** Because of age-related cognitive changes or mild cognitive impairment, some older adults may have difficulty monitoring how much they consume and determining whether that represents increases in the intended amount or duration. Therefore, self-reported alcohol quantity may have limited diagnostic value.

Clinical Pearl

For older adults, an AUD diagnosis based on the criterion of increasing amounts of alcohol consumed over time may lead to underdiagnosis. Remember that the sensitization process means that the same amount of alcohol consumed in older adulthood may now cause problems that were not present in younger adulthood. Rather, look for unsuccessful efforts to cut back, withdrawal, and social and/or interpersonal problems, which Kuerbis (2020) found were the criteria most successful in diagnosing AUD among older adults.

Table 5. Symptoms shared with unhealthy alcohol use

Symptoms	Clinical implications for alcohol use
Short-term memory loss or other cognitive changes	Age-related declines in working memory and short-term memory are common among older adults. These could indicate age-related declines, depression, anxiety, or an underlying medical condition, in addition to unhealthy alcohol use.
Fluctuations in weight and/or changes in appetite	Changes in appetite and weight may occur because of side effects of some prescription medications. Excessive weight gain could also be a result of unhealthy alcohol use, while weight loss or poor nutrition may be associated with skipping meals or poor diet.
Isolation from family and friends or a change in social groups	Some older adults live alone and this is associated with increased risk of loneliness. Loneliness can be an indication of depression or might be dismissed by health care professionals as a typical part of aging. On the other hand, social isolation may be a consequence of unhealthy alcohol use, because of time spent drinking alone and resulting loss of social connections.
Lethargy or low energy	Older adults may experience fatigue owing to medical conditions, pain, or medication side effects. Practitioners might assume that a client is experiencing low energy as a typical part of aging. Lethargy can also be an indicator of unhealthy alcohol use as individuals may feel sluggish after drinking heavily or have alcohol-related sleep disruptions.
Difficulties in work, school, or other roles	The roles that older adults occupy are often different from those of adults in other life stages. Older adults who are retired often have other responsibilities, such as helping members of their family or volunteering. Problems in fulfilling these interpersonal roles can be because of a mental health condition or unhealthy alcohol use.
Falls and/or bruises	Falls can result from side effects of new medication or medication interactions, and can also be a sign of unhealthy alcohol use.
Change in personal hygiene	A change in personal hygiene can be related to change in mood, such as an increase in depression or anxiety symptoms, as well as an indicator of unhealthy alcohol use.

6.6 Cognitive Behavioral Therapy

A *cognitive behavioral therapy* (CBT) model of psychotherapy for unhealthy alcohol use largely focuses on helping clients understand antecedents and consequences that are maintaining their current level of drinking (McCrady & Epstein, 2021). An overarching assumption is that drinking occurs in direct response to antecedents (factors that reliably precede alcohol use) and is maintained by its consequences. Antecedents and consequences can occur in multiple domains (see Table 3). Consequences can serve to reinforce alcohol use because of either the addition of positive experiences or the removal of negative experiences. The CBT model assumes that one way in which unhealthy alcohol use develops is through the repeated use of alcohol in certain situations, places, times of day, or emotional states. Over time, by using alcohol repeatedly in these situations, the client develops cravings to use alcohol in these trigger situations. Once an antecedent occurs, cognitions and affective status may determine the extent to which the antecedent leads to drinking behavior. For example, individuals may develop unhelpful beliefs about their ability to reduce drinking ("cutting down is not possible for me" or "I really would miss drinking if I stopped") which may lead to heavier drinking behavior compared with situations in which those beliefs are not activated.

CBT is readily adaptable to clients' individual contexts and beliefs around alcohol use. Practitioners may prefer the CBT approach for unhealthy alcohol use because it can be customized to focus on issues that are relevant to older adults (loneliness, health problems, etc.). There is also flexibility to customize treatment based on the appropriateness of cognitive versus behavioral techniques. There are many specific techniques that can be used within CBT treatment, and practitioners can tailor CBT by selecting primarily behavioral components, primarily cognitive components, or both.

For clients with low-severity problems where a single session may be appropriate, such as in health care settings, practitioners can use simple behavioral techniques such as asking the client to self-monitor alcohol intake. It may also be appropriate to give normative feedback to low-severity clients, such as the data by Chan and colleagues (2007) which found that the majority of older adults had zero or one drink per week and a minority of older adults were drinking above the NIAAA guidelines of no more than three drinks per day and seven drinks per week for women and no more than four drinks per day and 14 per week for men. If an older adult is drinking more than this, discussing the normative data may help the older client realize that they are drinking above the amount typically consumed by other older adults.

For clients who could use a few additional treatment sessions in the context of a brief intervention (three to four sessions), practitioners can intro-

8
Cultural Adaptations

Few studies have examined how race, culture, gender, and sexual and gender minority status influence treatment outcomes among older adults with unhealthy alcohol use. Although some studies focus on how prevalence rates of unhealthy alcohol use differ among older adults from minority groups in the US (see Section 2.2 Prevalence of Unhealthy Alcohol Use Among Older Adults), this line of research does not extend to treatment outcomes. Given the lack of research on substance use treatment outcomes by race and culture among older adults, this chapter reviews cultural adaptations for treatments that can be used across all adult age groups. Also included is a discussion of unhealthy alcohol use among older women compared with older men, including implications for treatment.

8.1 Cultural Adaptations to Treatment

There is a growing amount of research on cultural adaptations of *screening, brief intervention, and referral to treatment* (SBIRT) and motivational interviewing (MI) for unhealthy alcohol use (Green, 2018; Ornelas et al., 2015). Generally, *cultural adaptation* refers to modifying an existing evidence-based treatment to consider language, culture, and context (Bernal et al., 2009). There are many theoretical frameworks available to guide cultural adaptations. For example, the *ecological validity model* examines eight dimensions of how interventions can be adapted, including language, persons, metaphors, content, concepts, goals, methods, and context (Bernal et al., 2009). Other frameworks for cultural adaptation focus on surface versus deep adaptations. *Surface adaptations* refer to modification of intervention materials or messages to fit within a specific culture. *Deep adaptations* refer to incorporation of how the culture explains the cause, course, and treatment of the target behavior. Although this research has not included older adults, some themes can be applied to working with older adults from racial and ethnic minority populations.

Starting with screening and assessment, several measures have been validated on diverse populations and are translated for use with non-English speakers. For instance, the full 10-item Alcohol Use Disorders Identification Test (AUDIT) was validated on individuals identifying as Black, Latinx/Hispanic, and Northern Plains American Indians (Burrow-Sánchez &