WHAT SHALL WE TELL OLDER PEOPLE ABOUT ALCOHOL?

Alcohol Problems in Older Adults: Prevention and Management, by Kristen Lawton Barry, David W. Oslin, and Frederic C. Blow. Springer Publishing Company, New York, 2001, 137 pp., $34.95 (paper).

Elderly Alcoholism: Intervention Strategies, by Michael Beechem. Charles C Thomas, Springfield, IL, 2002, 228 pp., $52.95 (cloth), $34.95 (paper).

There are varying attitudes about the use of alcohol between and within different societies. But from coffee-fueled Alcoholics Anonymous meetings in church basements to lavish banquet halls of the Commanderie de Bordeaux, it is recognized that some people's interactions with alcohol are benign, or even beneficial, whereas for others alcohol use only means degradation and even death. Many people are comfortable with this ambivalence, recognizing in alcohol another of the myriad opportunities for humans to succumb to excess, and, thus being wary of the danger, they achieve balance in their own lives. Others are much less certain of any useful role for alcohol.

Alcohol use is promoted as part of a multi-billion dollar, worldwide industry. Alcohol is widely available, and in the absence of evident excess, or unless consumed before driving, not much stigmatized in Western societies. Indeed, in some settings, abstinence is stigmatized more, unless, perhaps, when seen as part of a hard-won world-weariness.

It should be no surprise then if the literature on the use of alcohol reflects some of the ambivalence of the societies from which it springs. While there is no equivalent to the phrase "Tobacco Institute scientist" for opprobrium in studying the effects of alcohol, many readers will approach the topic with a certain skepticism.

Viewing Alcohol Use as an Incipient Threat

Neither of the two books reviewed in this essay could be seen as giving grounds for suspending that skepticism. Each, in considering alcohol problems, is on the side of viewing alcohol use as an incipient threat. Michael Beechem, MSW, PhD, author of *Elderly Alcoholism: Intervention Strategies,* is director of the Center on Aging at the University of West Florida. He writes as a professional counselor, an academic gerontologist and as a "grateful recovering alcoholic" (p. ix). Despite an introductory flurry of on-the-one-hand-this and on-the-other-hand-that summarizing of the literature, most readers will soon conclude that the book is partisan. Further reading will not prove them wrong. Even in the introduction, Beechem makes some sweeping undocumented generalizations about the West Florida experience, including that "alcoholism was rampant among the elderly," that there is "a rapidly growing elderly alcoholic population," and that "they are largely untreated"(p. ix). Getting off to such a start is disappointing in a book aimed at (a)

undergraduate and graduate students in the physical and behavioral sciences, (b) professional counselors, and (c) health care professionals serving an elderly clientele. An area so important to this readership should not be exempt from scientific rigor.

The logical structure of the book covers: definition of alcoholism; an examination of losses as precursors to alcoholism; interaction of alcohol abuse and aging; theories of aging; problems in detecting dependence; possible interventions; the counselors' problems; the spiritual components to interventions; and consideration of relapse and suicide. It concludes with an account of several intervention sites visited by the author.

Despite the promising structure, the book fails in much the same way that the introduction did. For example, there is no systematic analysis of the available epidemiology, meager though this might be. Simply stating that "most research studies identify at least 10% [of Americans] older than 65 as having a drinking problem" (p. 4) is inadequate, especially when in the author's later assertions this figure varies between 2% and 20%. Moreover, the text often strays into both wordiness and imprecision. Why advocate a "methodological systems approach for information gathering in the life review process" (p. 120) rather than simply "a way of finding out"? There are also frequent errors in editing and proofreading. The bibliography is slapdash in places; for example, there are omitted page references to journal articles, authors' names and page references at odds, and references to local newspapers rather than primary sources. A quotation from Satir (referenced year 1976) comes from a text by someone else published in 2000. The index is titled "Bibliography," as is the actual bibliography. The CAGE Questionnaire, a screening method, does not appear in the index and receives scant discussion, without information about its psychometric properties or reference to the many papers about it.

There is no scientific apparatus. The statement "alcohol tends to cause stronger reactions in the elderly largely because they metabolize alcohol slower [sic]" (p. 8) gives one the sense that the author has not aligned his text to his intended audience—professionals, scientists, and students. There is a superficial reference, rather than analysis, of the role of the immune system and its relationship with psychological states, such as anxiety or depression, that must operate in the setting of alcohol dependence. In discussion of "double suicide," a review text is quoted—"Heavy alcohol use by one or both partners is also common" (p. 171)—but there is no reference to the primary data sources and no indication of what "common" means.

In addition to these stylistic and documentation issues, we find ourselves at odds with important aspects of the content. In Beechem's introduction to "late onset alcoholism" much is made of "loss-grief issues" precipitating this, but there is no clear recognition of for whom new onset alcohol dependence in old age might be part of late life depression. This is an important omission, because management of this underlying cause will be the principal intervention to remedy the drinking behavior.

In chapter 9, "Practice Strategies: An Eclectic Approach," Beechem properly asserts that initial assessment not only involves identification of the drinking behavior—its antecedents, enablers, rewards, and so forth—but also the subject's personal strengths and attributes which might be used in the "treatment" phase. While one recognizes the tension between medicalization of alcohol and its imbibers, inadequate attention here is paid to its medical consequences, including occasional catastrophes. The near exclusive focus on social consequences (albeit positive and negative) is an inadequate account of the interaction between alcohol and humans.

Still, there are intriguing hypotheses here, and most readers will know to take them as such. Beechem claims that his Life Review Guide for interviewing older people will "promote high self-esteem" (p. 120). Apparently, the method has provided "countless mental health professionals world-wide" (p. 121) with an effective assessment and therapeutic guide for dealing with older adults. Also, we are told, it has helped the "intergenerational communication" between interviewers and interviewees. It seems that this is achieved because of the better feelings of the interviewee on completing this Life Review Guide than with those following use of the traditional drinking inquiry. The argument is that because the focus is on the subject's achievements as well as deficits, the overall conclusion is of satisfaction, if not pride, rather then denigration and guilt.

There are curious omissions and inclusions. For a book broadly aimed, there is no consistent distinction made between screening and testing. The book largely does not distinguish between the general social worker–client interaction, where alcohol dependence may be a possibility and has to be searched for, versus the situation where the person is referred specifically for counseling because of an alcohol problem. In the latter case, the degree to which that person appreciates his alcohol dependence and its consequences has to be ascertained and, at times, confronted. "Confrontation" does not appear in the index (although "Cubans" do, together with an intriguing political commentary on the situation in Cuba). The notions of "rational suicide" and indeed physician-assisted suicide are inadequately reviewed and no reference is made to the relevant literature, including the vital—and encouraging—point that an expressed desire for death is often transient (Chochinov et al., 1995). Much is made of the Raines Life Transition Model, but the only reference is to an unpublished university paper from 1983.

No textbook author should be expected not to make much of his own work; indeed this is often a valuable part of any book, as we get the opportunity to see what the author really is driving at, freed from the constraints of writing for an academic journal. Beechem spends six pages discussing a loss-grief inventory that he developed "as part of the journal-writing activity that I undertook as a former inpatient in an alcoholism treatment facility" (p. 131). He con-

cedes that the Beechem At Risk Inventory lacks testing of its reliability and validity (p. 59). Nevertheless, it does bear some relation to a helpful form of assessment that a person dependent on alcohol might undertake with his or her counselor, exploring the positive and negative outcomes of either stopping or continuing the alcohol dependence. Because such an analysis recognizes the negative outcomes of stopping (e.g., losing drinking buddies), it does enable the patient and counselor collaboratively to identify where problems might occur in the proposed alcohol cessation.

Beechem's volume concludes with nine brief case histories, seven of which describe people younger than age 70. The book's appendix gives further details of the treatment facilities he visited.

In sum, this is a valiant attempt by a professional, with personal insight into the problem of alcohol dependence, to apply his personal and professional knowledge to the challenges of being an older adult with alcohol dependence. Unfortunately, these good intentions are not entirely realized in this first edition.

Kristen Lawton Barry, David W. Oslin, and Frederic C. Blow are each associated with the United States Department of Veterans' Affairs and well published in the effects of alcohol use in older people. Dr. Blow, in particular, is known for his contribution to screening older adults for problem drinking, in the form of the Short Michigan Alcohol Screening Test-Geriatric version. Their book, *Alcohol Problems in Older Adults: Prevention and Management*, has a theme somewhat narrower than the title might suggest. They are concerned chiefly with the "brief alcohol intervention approach" (p. vii), which we are reassured at the outset "is based on well-designed research, conceptual strides, and practical breakthroughs" (p. vii). Their manual "is designed as a hands-on document and presents both the science and the art of the preventing and managing [sic] alcohol problems in older adults"(p. vii). (Like the Beechem volume, this book is riddled with errors in spelling and syntax.)

The book consists of five brief chapters, amounting to 49 pages, with 10 appendices, including two Spanish-language versions of health promotion handouts. It begins with a stage-setting chapter in which case definitions are proposed. Based on a consensus of the National Institute on Alcohol Abuse and Alcoholism, a reasonable limit of drinking is defined as no more than seven drinks per week, and, in different parts of the book, either no more than one drink per day or no more than four drinks at any one time.

Some acknowledgment is made of observational studies in which moderate alcohol use is associated, on a population basis, with favorable health. Here the authors have chosen not to burden the reader with conflicting details. For example, the "moderate drinking" of one-to-seven drinks per week, although in keeping with a recent American report (Mukamal et al., 2003) is somewhat lower than the levels of "moderate drinking" found to be beneficial in Australian and French studies (Orgogozo et al., 1997). (In the latter, "moderate-drinking" was 3–4 glasses of wine per day. In another more recent report, the optimal protective effect was "light-moderate" drinking, defined as 1–3 drinks per day [Ruitenberg et al., 2002].) But perhaps actual amounts are less important than the context in which alcohol is consumed, or the behavior to which it leads. As the authors note, such considerations can make fairly meaningless guidelines based on "alcohol inputs."

This appears to be the position that the authors have taken, at least to the extent that context might limit drinking. We are told that people with low-risk drinking (no family or past history of alcohol or drug problems, no medications that will interact with alcohol, of normal weight with a good exercise program) can consume "a glass of wine two or three times per week" without threat of causing "any additional problems at this time" (p. 3), although there is no evidence that they should take up alcohol consumption for putative health benefits. Such people "can benefit from preventive messages but may not need interventions" (p. 3). After low-risk drinking comes "at-risk" drinking. Again, behavioral consequences (i.e., the outputs) of alcohol are emphasized more than the amount consumed (the inputs). From at-risk drinking comes problem drinking, in which adverse consequences (medical, psychological, or social) have emanated. After this comes the "medical disorder" of alcohol dependence.

The book is strongest is in its three chapters devoted to a practical guide to providing brief alcohol interventions. The approach is spelled out in detail, even to the level of step-by-step instructions, with examples of potential dialogues around each of the main points. Chapter 4, "Frequently Asked Questions," provides especially pragmatic advice, set in the context of some general principles about interviewing around topics that are likely to cause patients some discomfort. Its many examples of likely points throughout an interview at which given objections will be raised reassure the reader that here are authors who care deeply about what they are doing, and who have much experience in their field.

Recognizing Alcohol Problems

We began this essay by considering the prejudices that the authors of these two volumes bring to bear. Although each book can be read with profit when those prejudices are understood (and to be fair to the authors, they are not undeclared), this is not a trivial issue in the context of bringing science to bear on clinical and policy questions. If the threshold for problem drinking must be individualized, and if "moderate drinking" can be as little or as much as one drink per week, then the specter of "heavy drinking" can be invoked for most use short of abstinence. Add to this the view that denial helps define "problem alcohol use," and then to accuse is to diagnose. The books sometimes stray into that country.

Here, then, is an important problem raised by each book that neither addresses satisfactorily. From the information that they cite, the variable and low thresholds for what constitutes a problem make it

difficult for health care professionals to agree with the assertion that they mostly miss alcohol problems. This would be unfortunate. Knowing how to recognize and deal with alcohol dependence is an important clinical skill, with many challenges. For example, those who seek to recognize and remedy alcohol-related issues in older adults will frequently meet resistance and resentment expressed as "it's his only pleasure left; it's cruel and unfair to try and stop him drinking now." It is an unexplained anomaly that alcohol dependence does not inevitably lead to cognitive impairment or liver cell failure or any other well-known adverse effects of alcohol. Hence the above response is partly or wholly based on the lack of evidence of any adverse outcome attributable to alcohol in that particular family member, so that the clash between clinician and kin cannot be distinguished from a clash in values. Similarly, whereas a younger person with alcohol dependence might be coerced into abstinence because of social constraints (e.g., loss of job, loss of driving license), this cannot be as easily employed when dealing with the older person with alcohol problems, so that a willingness to discuss values can be critical to modifying behavior.

Although most people who regularly drink within some acceptable limit will not have detectable problems, some will and intervention can prevent the development of complications such as brain failure or liver cell failure. Delay or reversal of these complications may occur with cessation of drinking and this is always a worthwhile objective. Thus, when dependence or other alcohol-related problems are discovered it is worth intervening.

Some resistance to detection may reflect that the "resister" is also an enabler. The son who protests that we are seeking to stigmatize his father and destroy his quality of life, may be the enabler, that is, the provider of the alcohol, and indeed be a fellow drinking buddy. Thus, detection and intervention would encroach upon the enabler's lifestyle. Conversely, other family members may have suffered being "children of alcoholics" for many years and have seen the older drinking person increasingly become alienated from their family and contract their social world to a milieu consisting solely of drinking and drinkers.

Considered in this context, it must also be recognized that neither book deals with the possibility that proposed remedies for overcoming under-recognition of alcoholism can lead to over-recognition. Indeed, it is a striking feature of these volumes that even though they discuss screening instruments, they provide little empirical detail on their sensitivity or specificity, no discussion of likelihood ratios, and no discussion of the harm of false positive screening.

Another piece of tough country for professional gerontologists and advocates for older people is the recognition of the elder person as abuser. Typically, one thinks of alcohol harming the imbiber—the abuser self-abuses. Equally, however, alcohol misuse by the abuser may precipitate or aggravate abusive behavior (physical, emotional, financial, and associated neglect) directed toward a fellow elder person. Alcohol misuse can also precipitate abusive behavior by others (Shugarman, Fries, Wolf, & Morris, 2003; Vida, Monks, & Des Rosiers, 2002).

Neither book grapples with abstinence versus controlled reduction as a treatment strategy. Interestingly, harm reduction approaches are recommended when abstinence based treatments fail in a comprehensive "best practices" review from the Office of Canada's Drug Strategy (Health Canada, 2002).

The greatest merit of these two books is that they provide guides to dealing with people in whom, on whatever basis, an alcohol problem seems clearly to exist. As a guide to prevention, they fall short because of the omission of a disinterested assessment of how to advise people on what represents a safe level of alcohol consumptions.

Aging and Alcohol Abuse

What, then, should we tell older people about alcohol? Several points seem to be worthy of attention. In the absence of controlled trials, inferences have to be made from observational studies. That alone suggests that clinical judgment will be key in individualizing any recommendations. In general, as people age, their thresholds for tolerance will decline. Consequently, lifelong rates of alcohol consumption can be expected to decline with age. There appears to be little rationale in taking up alcohol consumption for its alleged health benefits. It also seems to be the case that some of the benefits imputed to alcohol use are not readily disentangled from other considerations, such as healthy eating and social companionship, so that alcohol is likely best consumed as part of a healthy, engaged lifestyle. Daily alcohol consumption, in itself, is not harmful, but the amount should self-consciously be less than with increasing age and with co-morbidity. The latter is especially true when drugs taken to combat illnesses interact with alcohol (either pharmacokinetically, as in propranolol or doxycycline, or pharmacodynamically, as in sedatives or antihistamines). Within these broad guidelines, health care professionals can work with older individuals to help them decide about their alcohol use.

A proposal for individualized decision making is not without it limits, however, and these, together with its strengths, are well illustrated by a recent report about the Alcohol-Related Problems Survey (ARPS), a screening measure designed specifically to identify older adults with these risks (Fink et al., 2002). The ARPS classifies alcohol use as "harmful," "hazardous," or "non-hazardous," by considering whether consumption occurs alone or is combined with selected comorbidities and medication use. Harmful drinking (which includes but is not limited to alcohol abuse or dependence) is defined as the presence of problems (e.g., hypertension, adverse drug events, legal problems) that are "due to drinking." Hazardous drinking is defined as meaning that "risks for problems are likely," whereas non-hazardous drinking is that which poses no known risks for problems. The authors report "substantial" inter-rater reliability (kappa = 0.65) between expert panel members who reviewed cases.

In some lights, this could be seen as a first step, even if it might be a long way from what we need to know. For example, would such a screening test be generalizable to non-expert users to implement in primary care settings with predominantly older adults? If it did, would it lead to not just the alcohol problem being identified, but also more judicious alcohol use resulting? And if even this could be obtained, would the result be better health outcomes?

Importantly, however, we might also question whether this approach is even the first step. Might there be something about the lack of understanding of individual risk in relation to aggregate risk that confounds such interventions? For example, in the ARPS study, the decisions about individual cases were arrived at for individual patients by an expert panel review. This seems entirely appropriate—individualized decisions are properly the standard of clinical care, and there is no other way to make them than one at a time. But the boundary between judgment and judgmental can be a fuzzy one. If the impression one gains from these books is true (that conclusions are dictated largely by premises), then we have not overcome the problem of interpretation, even (or perhaps especially) in the individual case.

Both books recognize that "input" guidelines (labeling people by the amount that they consume) are likely to be arbitrary when applied to many people, with problems of both sensitivity and specificity. The default recommendation, to aim for consumption of as little alcohol as possible for persons in a given category, is only safest if it is not associated with adverse outcomes. For those people who fall in between abstinence and abuse, the risk/benefit ratio for this stance would appear to be unknown. Consider that some patients who would be labeled by some authors as heavy drinkers will not suffer the generally imagined consequences of such use. This is not unique to alcohol use. Indeed, in many circumstances, a "number-needed-to-treat" value of less than 10 (i.e., 10 patients are treated for every 1 who benefits) is felt to be quite favorable (Sinclair, Cook, Guyatt, Pauker, & Cook, 2001). Clearly, societal norms would counter such a ratio for alcohol interventions.

What would be helpful to know is not just whether interventions can change alcohol consumption, but whether, too, they can change outcomes. That one should necessarily follow from the other is not at all clear. Consider, for example, the case of treating hypertension, which at least has a clear method of measurement, a choice of proven treatments, and a clear relationship between exposures and outcomes (Lewington, Clarke, Qizilbash, & Collins, 2002). Still, it turns out that not every means of lowering blood pressure is equivalent (ALLHAT Officers et al., 2002) and that grades of increasing high blood pressure, while generally associated with increasing risk, show great variation and even discontinuities (Port, Demer, Jennrich, Walter, & Garfinkel, 2000; van den Hoogen et al., 2000).

It is not clear how soluble the problem of alcoholism among older people will be, even in the presence of guidelines. Individualized decisions will remain, and practice variability is likely to be the case, as intelligent people of good will disagree about the interpretation of the evidence in general, and its application in individual cases in particular. This too is an ancient problem. In *Prior Analytics*, Aristotle recognized that in nature, in contrast to physical systems, axioms often only hold "for the most part." Making determinations about policy and about the "middle cases" will thus need to be resolved by individuals. In such a circumstance, it is good that the authors of these books have made it clear where they stand. Their books, despite their limitations, can be read profitably in that light.

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