Motivational Strategies with Alcohol-Involved Older Adults: Implications for Social Work Practice

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Social workers and other health care professionals address problem drinking by older adults inconsistently. Reasons include client-related variables (for example, denial and poor information), practitioner-related factors (for example, inadequate knowledge about addictive behaviors, underdeveloped assessment tools, and limited empirically validated treatment options), and societal factors associated with "ageism." This article explores the nature and extent of problem drinking among older adults and barriers to assistance. The article outlines practice strategies that draw on motivational interviewing principles and a client's motivational readiness to change for reaching out to older adults, assessing their needs, and encouraging them to seek assistance.

Key words: *alcohol treatment; motivational interviewing; older adults; outreach*

Alcohol abuse by older adults is a hidden problem, frequently overlooked by professionals, family members, and others (Joseph & Harvath, 1998). Alcohol-related problems among older adults are addressed infrequently in gerontological and addictions literature. Few studies have examined predictors and correlates of alcohol abuse among elderly people. Fewer have investigated the efficacy of early identification, outreach, and assistance strategies. The dearth of information is particularly apparent in the social work literature.

Interest in identifying and assisting older problem drinkers has increased. Yet, given the current state of knowledge, social workers and other health care professionals have few empirically validated assistance strategies to guide their work. Thus, they must creatively infuse clinical experience with knowledge derived from available research to respond to this group of vulnerable clients. This article presents an integrative approach for reaching out to and engaging aging problem drinkers and encouraging them to recognize that they have alcohol-related difficulties and to seek assistance. It builds on two conceptual approaches from the addictions field—motivational readiness to change and motivational interviewing (Miller & Rollnick, 2002; Prochaska, DiClemente, & Norcross, 1992)—and ecologically based social work practice principles.

Problem Drinking among Older Adults

Most older adults consume less alcohol and drink less often than younger adults. Many, however, suffer from alcohol-related difficulties. For some individuals, identified as earlier-onset problem drinkers, the difficulties experienced in old age represent a continuation of life-long patterns of alcohol abuse and dependence. For them, drinking has become an overlearned, albeit maladaptive, coping response. Earlier-onset problem drinkers, who develop alcohol problems before

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age 60, account for two-thirds of all older people experiencing alcohol-related difficulties (Liberto & Oslin, 1997).

Other older adults, referred to as later-onset (and sometimes "reactive") problem drinkers, develop alcohol-related problems after age 50 (Atkinson, 1994). It is not surprising that later-onset problem drinkers are less likely than earlier-onset drinkers to have alcohol-related physical complications like cirrhosis (Morse, 1988) or comorbid psychiatric sequelae like mood and thought disorders (Schonfeld & Dupree, 1991). In addition, their drinking usually has created fewer cumulative negative strains on family and friends, important sources of support for older people (Brennan & Moos, 1995). Research suggests that later-onset problem drinking often is linked to stress associated with the life transitional crises of aging: increased free time; social pressures to drink; loss of a spouse; physical and cognitive changes; retirement; and social isolation (Brennan & Moos; Liberto, Oslin, & Ruskin, 1992).

Community prevalence rates for problem drinking by older adults vary considerably across studies. Estimates range from 5 percent to more than 15 percent of the elderly population depending on a study's location, the population studied, how alcohol-related problems are defined, and the age limits used. Despite methodological disagreements, most investigators believe that about 10 percent of all adults 65 and older have at least one alcohol-related problem, and about 8 percent meet diagnostic criteria for alcohol dependence (Adams & Cox, 1997). Government reports suggest that 2.5 million older adults have drinking-related difficulties and that more than one-fifth of hospitalized adults over age 60 have a diagnosis of alcoholism (Schonfeld & Dupree, 1995).

Surveys of clinical populations find that rates of problem drinking are higher among this group, with estimates ranging from 15 percent to 44 percent (Bristow & Clare, 1992; Holroyd & Duryee, 1997; Moos, Brennan, & Moos, 1991). Several investigators assert that not only does alcohol abuse occur more frequently among older people who use health care facilities, but it also is a major reason for hospitalization. One report indicated that alcohol-related complications account for more hospital emergency room visits by adults over 60 than do heart attacks (Bowman, 1998). Problem-drinking older adults also are at increased risk of suicide attempts, especially when they suffer from concomitant mood disorders (Blixen, Suen, & McDougall, 1997).

As surprising as these figures may seem, two facts appear certain. First, the figures probably are gross underestimates. Older adults are less likely than younger people to self-identify or to be identified by others as having drinking-related problems (Blow, 1998). In addition, diagnoses frequently are inaccurate. Consequently, alcohol-related difficulties are often confused with other health and psychosocial problems associated with the aging process, and they go untreated (Geller et al., 1989).

Second, the figures are likely to climb (Patterson & Jeste, 1999). Not only is life expectancy in the United States increasing, but younger cohorts, who came of age during eras that were more tolerant of alcohol use, drink at higher rates than their parents. Thus, they increase the risk of developing alcohol-related problems that will extend into old age. Furthermore, they establish heavier drinking practices that may continue in old age and increase the likelihood that they will develop drinking problems in later life. Taken together, these factors suggest that in the future alcohol-related problems among the elderly population will pose major challenges for health and social services professionals.

Gender, Racial, and Socioeconomic Factors

Much of the literature on problem drinking treats older adults monolithically. Research, however, suggests gender, racial, and socioeconomic differences. Regardless of age, women seem less likely than men to drink. Older men are twice as likely to experience alcohol-related difficulties. Yet, later-onset alcoholism is more common among women (DeHart & Hoffmann, 1997). In addition, women often suffer from concomitant prescription drug abuse (Gomberg, 1995). Older women problem drinkers show high rates of widowhood, whereas older men problem drinkers are more frequently married, divorced, or separated. The association between social network loss and heavier drinking is clearer among men than women (Gomberg).

Alcohol abuse by elderly people seems to be associated with lower educational achievement (Holzer et al., 1984) and low income (Gomberg, 1995). Among men, employed individuals are more apt to abuse alcohol. Among women, the rate is higher for individuals who are not in the

workforce and drink at home alone or with spouses or partners.

Limited research has examined racial and ethnic variations in drinking practices by elderly people. In general, white adults tend to consume more alcohol than do members of other racial groups. Several studies suggest, however, that African Americans experience more severe drinking-related health consequences than white Americans. In addition, heavy drinking by African American men appears to peak between the ages 50 and 59 and surpasses the rate for white men of that age (Jackson, Williams, & Gomberg, 1998). African American women have high abstinence rates, a trend that continues in old age (Herd, 1988). On the other hand, Chinese Americans, a group with a high rate of lifetime abstinence, are more tolerant of alcohol use by the elderly population, ostensibly for health reasons (Gomberg, 1995). Patterns by older members of other racial and ethnic groups are less clear.

Barriers to Assistance

Significant numbers of problem-drinking older adults come into contact with health and social services professionals. Yet, only 15 percent enter treatment (Parette, Hourcade, & Parette, 1990). Because of impaired memory, poor information about the adverse consequences of excessive drinking, stigma, and defensive patterns like denial, older adults may minimize the magnitude of a drinking problem (Liberto et al., 1992).

Older adults may "conspire" with family members and professional caregivers who either are unfamiliar with the signs and symptoms of alcohol abuse in elderly people or are hesitant to identify the condition when it is present. Several studies show that professional attitudes and practices impede case finding, screening, and treatment. Dupree (1989), for example, found that without ongoing contact and on-site visits to encourage them, formal caregivers and staff members of a community-based health clinic were reluctant to label older adults as alcohol abusers and to refer them for additional help. In another study, outreach workers were unlikely to refer older adults with milder drinking problems for treatment because they believed that to do so would intrude on the individual's right to privacy (Graham & Romaniec, 1986).

Professional caregivers' misinformed attitudes may take the form of ageist myths that older people do not become alcoholic, and that, if they do, they cannot be helped (Burlingame, 1997). As a result, some caregivers dismiss complaints presented by older adults and attribute them to the complications of aging. Others enable excessive drinking by rationalizing that older adults are entitled to the "pleasures" they derive from drinking (Blow, 1998; Morse, 1988).

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Other reasons why problem-drinking older adults are not linked with treatment arise from the difficulties practitioners encounter when they try to identify alcohol use disorders. Health and social services professionals lack adequate knowledge about the signs, symptoms, and consequences of problem drinking, in general, and problem drinking by older adults in particular. Even knowledgeable practitioners may miss indicators of alcohol abuse when faced with large caseloads and limited resources. Identification of alcohol-related problems is complicated further because alcohol abuse mimics many acute and chronic conditions of aging, like depression, cognitive impairment, dementia, and muscle wasting (Blow, 1998).

The quality of assessment and screening tools is a final factor impeding the timely and accurate identification of problem drinking. No standard definition exists for alcoholism or problem drinking among older adults. The most widely used diagnostic criteria—delineated in the *Diagnostic and Statistical Manual of Mental Disorders–Fourth Edition (revised)* (American Psychiatric Association, 1994)—were standardized primarily on younger adults and may not be appropriate or relevant for older populations (DeHart & Hoffmann, 1997). Consumption and frequency levels that apply for younger drinkers are invalid for older adults, because considerably less alcohol may cause impairment in older drinkers (Chermack, Blow, Hill, & Mudd, 1996). Likewise, signs of tolerance and indicators of

adverse interpersonal, recreational, and work-related consequences may be less apparent and less useful for identifying alcohol-related difficulties among the elderly population (DeHart & Hoffmann). Screening tools that have been validated for older problem drinkers have had limited effect (for example, the CAGE Questionnaire [Buchsbaum, Buchanan, Welsh, Centor, & Schnoll, 1992], the Michigan Alcoholism Screening Test-Geriatric Version [MAST-G, Blow et al., 1992]). The screening tools have not been tested or normed with a wide range of clinical populations, and many professionals are unfamiliar with them and feel ill-equipped to use them (Blow, 1998).

Motivational Readiness to Change

Studies of psychotherapy (McConnaughy, Prochaska, & Velicer, 1983) and addictions treatment (Prochaska et al., 1992) suggest that people move through predictable stages in the process of intentional change. As people recognize health-related difficulties, take steps to correct them, relapse, and repeat the process, they pass through five motivational stages in a cyclical fashion: precontemplation, contemplation, preparation, action, and maintenance.

In the precontemplation stage people do not link their actions to adverse consequences, nor do they intend to change targeted behaviors (for example, alcohol consumption) in the foreseeable future. Some are uninformed about the consequences of their actions; others deny the seriousness of the problem; still others lack confidence in their ability to effect lifestyle changes. Thus, they tend to resist external pressures to change. If they are pressured to change by significant others or by institutions like hospitals, they may try to change the others' actions or viewpoints instead of changing their own behaviors. If they make token changes as a result of coercion, they are likely to resume the problematic behavior when the pressure is removed.

The contemplation stage, in which people begin to think about change, is characterized by ambivalence. People in this stage struggle to understand a problem, and although they may be weighing change they have made no commitment to change. Although they are more receptive to feedback and suggestions for change, they remain stuck because of doubts about their abilities to change, as well as the costs and benefits of change.

People in the preparation stage have made a decision to change, but they have taken no sustained action. This stage combines intent with behavioral criteria (that is, "What I will do. What I will not do.") (Prochaska et al., 1992). Individuals who are preparing to change may have already taken some initial steps, like drinking less or experimenting with healthier habits. They also may make plans to take more definitive steps in the immediate future. Although they have begun to change, people in this motivational stage still question the need for change, and they remain unclear about the steps to take to eliminate negative consequences of their behaviors.

During the action stage, which can last up to six months, people take more decisive steps to modify problem behaviors, experiences, or environments (Prochaska et al., 1992). Generally, individuals in the action stage make lifestyle changes that are more obvious and acceptable to others. For example, problem drinkers may try to abstain from all alcoholic beverages for at least one week and keep all medical and social services appointments during that time.

During the maintenance stage, which begins after they have sustained behavioral change for around six months, people's change efforts focus on strengthening and consolidating gains, preventing relapse, and living healthier lifestyles. Maintenance is a life-long process with no clear end point. In the case of problem drinking, a great deal of movement occurs back and forth across stages. Relapse frequently happens, and, when it does, individuals may return to any of the earlier stages before eventually eliminating the problem behavior permanently.

Research on the change process by Prochaska and his colleagues (1992) indicates that before people alter unsafe health behaviors certain conditions must be met. They must be aware that a problem exists, that it is serious, that they are vulnerable, and that risk is imminent. Then they must learn that the risk can be reduced (that is, there is something to be gained by accepting assistance), "treatments" work, and they can carry out the steps needed to effect change. Finally, they must learn how to change unsafe practices, and they must receive social support for their efforts. At each stage in the process, health care and social services professionals must tailor their interventions to be responsive to clients' motivational state to help them choose courses of action.

Motivational Interviewing

Motivational interviewing is a brief, focused, client-centered, collaborative practice approach designed to elicit behavioral changes by helping alcohol- and drug-involved clients (and their partners) identify, explore, and resolve ambivalence (Miller & Rollnick, 2002). "Motivational interviewing is a narrative process of evoking from the client reasons for and commitment to change." (Miller, 1998, p. 169). It consists of two phases—phase 1 in which motivation for change is built, and phase 2 in which commitment to change is strengthened. Motivational interviewing facilitates change by evoking cognitive dissonance, usually between the current problem behavior (for example, excessive drinking) and the client's self-image, aspirations, or perceptions (Glasner, 2004). By selectively applying motivational interviewing tactics, professionals help clients recognize the adverse consequences of addictive behaviors and move from the precontemplation and contemplation stages toward preparation and action.

Proponents of motivational interviewing assert that people change when the costs of current behaviors begin to outweigh the benefits and when they perceive that the benefits of alternative actions outweigh the costs of those actions. Motivation is conceptualized as a dynamic state, fluctuating across time and situations. It is receptive to professional influence. During the initial phases of motivational interviewing, when clients are doubtful about the need to change, interview strategies use the clients' own statements to highlight the costs of current behaviors and the benefits of alternative behaviors. As motivational interviewing progresses and clients lean more toward change, interviewing strategies shift to helping clients explore the relative advantages of different change options, developing an action plan, identifying supports for and barriers to change, and enhancing their confidence to change.

Warmth, empathy, and genuineness characterize the collaborative motivational interviewing style. Practitioners avoid asserting authority. Instead, they share responsibility, build on client strengths, and assume that clients have the capacity to make informed, responsible decisions about their lives. This approach is particularly important for work with older people, who often are disenfranchised and given messages that they are not competent.

Five interview strategies and tactics are prominent in motivational interviewing (Miller & Rollnick, 2002). The first four consist of nondirective intervention skills—reflective listening, open-ended questions, affirmation (or validation), and summarization. Each of these tactics encourages clients to discuss their experiences in their own words. They show that the practitioner is interested in the client and willing to address concerns as the client sees them. The attention in the gerontological literature to reminiscence and life review attests to the importance of older people being able to tell their own stories.

A fifth interview strategy—eliciting self-motivational statements—is used to give direction and purpose to the intervention, to help clients examine ambivalence, and to encourage them to voice their concerns. Self-motivating statements are remarks made by clients that generally fall into four categories: (1) recognition that a current behavior or its consequences are problematic, (2) expressions of concern about the current situation, (3) indications of an intention or desire to change, and (4) words of hope and optimism about change (Miller & Rollnick, 2002).

Practitioners can elicit self-motivational statements in several ways: They can direct evocative questions toward the areas in which motivational statements are likely to emerge. (for example, "What do you think will happen with your health if you continue to drink as you have been?"). Practitioners also can help clients explore what they like and do not like about their current behaviors, as well as alternatives to those behaviors. Once clients make self-motivational statements, practitioners can use client-centered interview strategies, like reflective listening, to encourage them to expand on their concerns by taking a "what else" or "tell me more" approach to help them examine and clarify areas of ambivalent conflict. By reflecting the clients' self-motivational statements back to them, practitioners help clients "hear" themselves more clearly and increase motivation for change.

Labels are minimized in motivational interviewing (for example, "You are an alcoholic."). Personalized feedback that describes a person's actions and their consequences is presented instead. Clients are then invited to consider the implications of the new information. When clients express doubts about the accuracy of information, practitioners review the information at the clients'

own pace, using the client's words as much as possible. Practitioners avoid aggressive, confrontational techniques and encourage clients to examine their lives, face the discrepancies they discover, and decide what they will do about their discoveries.

Applications with Older Adults

Most older adults with drinking problems are encountered in nonaddictions settings, seeking assistance (or referred for assistance) for something other than an alcohol-related problem. Although they may acknowledge use of alcohol, they may not see it as a problem or have any intention of making long-term drinking-related changes. Thus, they are in either the precontemplation or the contemplation stage of change. Despite neither problem awareness nor intent to change, the contact with a health care or social services professional provides a chance for an opportunistic intervention. Such contacts offer chances to educate older people about how alcohol effects change as people age. Brief, hospital-based early intervention programs have been shown to be effective in encouraging clients, many of whom are in the precontemplation stage of change, to reduce alcohol use and accept referrals for treatment (Welte, Perry, Longabaugh, & Clifford, 1998).

Given that many older adults experience alcohol-related problems, professionals must remain alert to the possibility with all clients they encounter. In addition, they should guard against misinformation and biases about alcohol abuse and aging that hamper efforts to explore the possibility of problem drinking with clients. Interviewers should routinely include questions about drinking practices and alcohol consumption in all initial screening and assessment interviews. Screening questions should be asked in private locations that ensure confidentiality and communicate respect. They should be linked to the concerns for which the client is seeking assistance. Edwards and colleagues (1997) suggested that practitioners should anticipate clients' reactions to questions about alcohol use and use "disarming" statements to normalize the focus on drinking (for example, "I always ask people about their drinking practices, because it is important to be able to talk about all aspects of one's life."). These statements can be followed by a combination of open-ended and focused questions, delivered in a respectful, nonjudgmental, concerned manner, to help the practitioner understand the client's drinking and its fit in his or her life context.

Professionals can blend questions from the CAGE screening instrument (Buchsbaum et al., 1992) into an interview unobtrusively. CAGE consists of four questions (Have you ever thought about **cutting down** on your drinking? Do you get **annoyed** when people question or express concern about your drinking? Have you ever felt bad or **guilty** about your drinking? Have you ever drunk first thing in the morning when you get up, to steady your nerves or to treat a hangover [**eye opener**]?). Answers are scored 1 for "yes" and 0 for "no." A score of two or more is presumptive of a drinking problem, but an affirmative answer to any question should trigger fuller exploration and assessment.

Several other signs should alert a practitioner to a potential alcohol-related problem and should trigger more in-depth assessment:

- consuming more than one drink per day
- regular episodes of heavy alcohol use (five or more drinks)
- symptoms of clinical depression or unexplained mood and behavioral changes
- significant others' concerns
- the presence of life transitional crises, like approaching retirement, spousal death, or separation from children and family members
- a frail condition or persistent physical complaints (Blow, 1998).

When practitioners conclude that an older adult is at-risk of developing a drinking problem or may already have a drinking problem, they must present their findings to the client. Research on the active components of brief treatment, as well as interventions that take place when a client is not actively seeking assistance, suggest some guiding principles for this exchange (Miller & Rollnick, 2002). All feedback should be personalized and offered as an opportunity for discussion. Because most people see presenting complaints as their "main problem," it is advisable to use those concerns as focal points to facilitate discussion. Findings about alcohol consumption should be shared using the client's own words when possible. They should be supported by information from other sources (for example, laboratory results) to increase their validity. They then should be linked to the client's focal concern. For example, when

working with an older woman who reported drinking several glasses of wine each day and arguing with her daughter about her self-care habits, the social worker summarized their discussion, drawing attention to the total amount of alcohol consumed and physical complaints she reported to a physician. She then invited the client to comment on the drinking and the arguments, as well as the drinking and her physical complaints, asking her what connections, if any, she (the client) saw. In another instance, a social worker used a review of a client's drinking practices as an opportunity to explore and correct the client's knowledge about the consequences of drinking.

Information about drinking and its impact in a person's life paired with a recommendation to cut down can lead to reductions in alcohol consumption (Babor, 1994). However, to build motivation for sustained change, feedback must raise clients' awareness of the nature and extent of alcohol-related difficulties, affirm and validate their experiences, help them identify alternative courses of action, and give clear advice about the importance of doing something about their situations (Fleming, 2002).

Screening interviews should help clients take the "next" steps toward a fuller assessment and treatment, if indicated. Commitment to this process is strengthened by using client-centered interviewing strategies, directly addressing doubts the client might have, and actively involving the client in developing a viable action plan (Miller & Rollnick, 2002). The plan should include specification of the changes a client wants to make (for example, changes in alcohol consumption, becoming more socially active in a community center [a goal for an older adult who drinks heavily when he or she feels isolated and alone]); statements concerning the main personal reasons (motivations) for making the changes (for example, clients say they want to feel happier with their lives or they want to reconcile with their children); particular steps a client plans to take to effect change (for example, removing alcoholic beverages from his or her apartment); the names of people who can help and how they can help (for example, family members, friends, and professionals who can provide encouragement, transportation, or feedback); specification of people and situations that may interfere with change and what can be done about them (for example, staying away from friends with whom the client drinks or relatives who are overly critical of the client); and personalized criteria clients can use to judge the plan's effectiveness.

Spousal influence is an important factor in older adults' drinking (Graham & Braun, 1999). Thus, involving clients' families can increase the success of motivational counseling. Assuming a client is willing to involve a significant other, the role the other takes depends on the degree of interpersonal commitment between the client and the other, as well as the other's willingness to get involved. In cases where a client does not identify the other's role as important and the significant other has little investment in the client's sobriety, Burke and colleagues (2002) suggested that the person assume a "witness" role. That is, he or she provides information about the effects of the client's drinking, but takes no part in developing an action plan to change the behavior. In cases where there is high interpersonal commitment and interest on the other's part, he or she can become more active in promoting commitment to change and helping the client in mutually agreeable ways. Minimal or no involvement of the other should occur when there is a high level of interpersonal stress and hardship. In these latter cases, practitioners may need to help the other person disengage from the client and address his or her own concerns before trying to help the client.

Conclusion

Although it is a hidden epidemic, problem drinking among older adults is a serious matter with far-reaching consequences for individual clients, their associates, and society. Practice knowledge and research about this issue are poorly developed. Thus, health care and social services professionals must creatively blend the extant knowledge and clinical exigency to develop responsive and effective interventions.

Social workers are positioned well in most human services agencies to be gatekeepers who can identify people in need, locate available and accessible services, rally familial and organizational support, and link older problem drinkers with care. The assumptions underlying motivational interviewing are congruent with an empowering, ecological approach to social work practice. By specifying the process of creating discrepancy and establishing viable goals, motivational interviewing takes major steps toward operationalizing social work's strengths-based values.

Future practice and research efforts must try to develop and evaluate promising outreach and assistance strategies that are age, gender, and culturally relevant. The motivational readiness to change and motivational interviewing paradigms, which have proven useful for practice with other alcohol-involved individuals, must be tested with older adults. The viability of the practice approach in nonmedical and nonaddictions settings, like nursing homes and senior centers, must be explored. In addition, the particular "pushes" and "pulls" that are likely to motivate older adults before they "hit bottom" must be identified. Finally, efforts must be made to complete cost–benefit analyses to determine the advantages and limitations of motivational efforts to assist older adults. ■

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