Alcohol Misuse Among The Elderly

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Statistics have shown that in Finland 5-10% of the elderly have problematic or risky alcohol consumption tendencies at least occasionally. At least 1% of this group is estimated to have long-term alcohol dependency. The majority of alcohol misuse is thought to be hidden. The population of the elderly has grown over the decade and is expected to increase in years to come since the baby-boomers are growing old. An estimated 2/3 of the elderly started drinking alcohol in their youth. The other 1/3 started drinking later in life. The elderly people experience loneliness, losing social contact, illness, traumatic experiences and these may exacerbate alcohol misuse. The purpose of this paper is to create awareness on the existence of alcohol misuse to the healthcare givers and to enlighten them on how to dispense treatments and measures that can be used to curb this problem. The research questions were: What does alcohol misuse among the elderly mean? What are the signs and consequences of alcohol misuse among the elderly? How can alcohol misuse among the elderly be assessed? The theoretical framework was based on Erikkon's (2006)theory of the suffering human being. Literature review and content analysis was used to gather information to help answer these questions. Results show that men tend to drink more than the women. The quantity of alcohol taken is higher among the men than women. There is evidence of harmful drinking among the elderly which could result to falls, hospital visits emergency admissions and to some extremes loss of life. Loss of cognition, anxiety and depression are some of the psychological adversities that come with misuse of alcohol. It is not easy to identify the signs of alcohol misuse among the elderly especially because they tend to hide and avoid talking about it. Diseases like stroke, Parkinson's disease, dementia syndromes and mental problems. CAGE, MAST-G and AUDIT can be used to assess alcohol consumption. Family is important in the intervention and recovery stage.

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Statistik har visat att i Finland 5-10% av de äldre har problematiska eller riskabla tendenser för ökad alkoholkonsumtion åtminstone tillfälligt. Minst 1 % av denna grupp beräknas ha långsiktiga alkoholberoende. Majoriteten av alkoholmissbruk antas vara dold. Antalet äldre har ökat under senaste decenniet och förväntas öka under kommande år sedan efterkrigstidens stora barnkullar blir äldre. Uppskattningsvis 2/3 av de äldre började dricka alkohol i sin ungdom. Den andra 1/3 började dricka senare i livet. Äldre människor upplever ensamhet, förlust av social kontakter, sjukdom, traumatiska upplevelser och dessa kan förvärra alkoholmissbruk. Syftet med denna studie var att skapa medvetenhet hos vådare om förekomsten av alkoholmissbruk bland de äldre samt att belysa vårdare om hurdana behandlingar och åtgärder kan användas för att stävja detta problem. Frågeställningarna var: Vad betyder alkoholmissbruk bland de äldre? Vilka är de tecken och konsekvenserna av alkoholmissbruk bland de äldre? Hur kan alkoholmissbruk bland de äldre bedömas? Den teoretiska referensramen byggde på Erikssons (2006) teori om den lidande människan. Litteraturstudie och innehållsanalys användes som studiens metoder. Resultaten visar att män tenderar dricka mer än kvinnorna. Det finns tecken på skadlig alkoholkonsumtion bland de äldre vilket kan leda till fall, besök på skadlig alkoholkonsumtion bland de äldre vilket kan leda till fall, på sjukhusens jourmottagningar och även förlust av liv. Förlust av kognition, ångest och depression är några av de psykologiska hindren som kommer med missbruk av alkohol. Det är inte lätt att identifiera tecken på alkoholmissbruk bland äldre, särskilt eftersom de tenderar att dölja och undvika att tala om det. Sjukdom som stroke, Parkinsons sjukdom, demens syndrom och psykiska problem. CAGE, MAST-G och AUDIT kan användas förr att bedöma alkoholkonsumtion. Familjen är viktig i interventions och återhämtnings skede.

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1 INTRODUCTION

Alcohol misuse among the elderly in Finland has increased considerably over the last four decades. The volume of annual alcohol consumption according to statistics has risen to 8.5 liters of pure alcohol. (Paihdelinkki, 2011)

It has been estimated that 5- 10% of elderly Finns have problematic or risky alcohol consumption tendencies at least occasionally. Around 1% if these group is estimated to have long-term alcohol dependency. The majority of alcohol misuse use is thought to be hidden. According to statistics in 2007, 1796 people died due to alcohol use. Among these, 371 were pensioners (over 64 years). (Paihdelinkki, 2011)

An estimated 2/3 of the elderly people with alcohol misuse problems started using alcohol heavily in their youths. Later on as a result of retirement and ageing, these problems accumulate and become more apparent to those around the person. The other 1/3 started using alcohol heavily later in life. Reasons for these may include loneliness, traumatic experiences, illness, inactivity and existential fears. (Paihdelinkki, 2011)

Alcohol misuse among the elderly is a serious problem and can go unidentified and consequently not treated. The subject is neglected and its occurrence under-estimated. There are currently not enough instruments and specialized methods to diagnose alcohol misuse. As a result in the case and elderly person gets a condition as a result of alcohol dependence, the cause may be misread. The aim of combating diseases or at least maintaining them is finding the cause. (Merrick et al, 2008)

Consequently, they might still continue with their alcohol habits which may interact with the medication causing over doses and at times defeating the purpose of the medication. Furthermore indulgence in alcohol to a level of misuse has effects on one's brain and functionality in everyday life. Health is also a concern, in the sense that alcoholics are bound to not eat well. All of the above results can have from short to long-term implications on the particular individual.

According to Dyson (2006), the carers for the older people have little if any education about alcohol and its misuse. Awareness on the subject will help in the future to incorporate educational packages and training for the carers. This would be relevant to

both local need and available support and treatment even in earlier years of the alcohol dependent individuals.

The lack of suitable care models for the elderly and of information on ageing is also seen in deficiencies in care. 'Mini interventions' by a doctor works for some elderly people. Others may require long-term psychotherapy to come to terms with traumatic experiences. After the first stage of recognition, most elderly people remain committed to treatment. For this to be well accomplished it requires close cooperation among care providers and efficient coordination of services. (Dyson, 2006)

Over the decades alcohol dependency has not been an outspoken subject. It is not easy for the elderly demographic to admit to having alcohol problems. Should there be any disease that may be brought about by alcohol over indulgence, the effort to either maintain the condition or even treat it may be inhibited if the elderly individual is not advised to cut down on the drinking habits or stop all together.

The following chapter gives the aim and purpose, as well as the questions the author hopes to answer at the end of the paper.

2 AIM AND RESEARCH QUESTIONS

The aim of this study is to get sufficient information on alcohol misuse among the elderly. This in turn assists create awareness on the subject and helps unfold the problems and the repercussions of too much alcohol intake on the welfare and health of the elderly. Models used in accessing alcohol dependency and implementation of necessary help. The purpose of the study is to contribute awareness of alcohol misuse among the elderly to the healthcare givers and enlighten them on how to dispense the necessary measures and help to the elderly.

To achieve the aim and purpose of this study, it is necessary to answer the following research questions:

- What does alcohol misuse among the elderly mean?
- What are the signs and consequences of alcohol misuse among the elderly?
- How can alcohol misuse among the elderly be assessed?

3 BACKGROUND

In the addiction cluster there are two groups. The first group is early onset drinkers who have always used alcohol since early years of their lives in high concentrations. The other group involves the late-onset drinkers who started drinking in the later years in life. This may have been brought about by several reasons including: loss of loved ones, retirement, and regression in terms of ability to perform their daily activities.

According to Ålstrom (2008), alcohol use amongst the elderly is an increasingly important area to understand. In many western societies the number of older people has greatly increased. This is expected to keep increasing as the years go by. Alcohol as an industry has also grown increasing variety to choose from. The baby boomers are drinking more than their parents' era.

High income, well-educated seniors are more likely to engage in heavy drinking. Older men who are separated or divorced have higher rates of alcohol problems than other groups with marital disruption. In men it is common to get dependent on alcohol after the loss of a spouse or in the case of a negative event occurring. For females however, alcohol problems are correlated with marriage, especially when married to a man with an alcohol addiction. (Arizona department of Health Services 2011)

Elderly people are a particularly vulnerable group where excessive alcohol use is concerned. Their alcohol tolerance, behavior when intoxicated is and hazards due to alcohol intoxication are different than those of young ones. Age-related illnesses, limitations and medications are unquantifiable risk associated with the use of alcohol. (Päihdelinkki, 2009)

The lack of suitable care models for the elderly and of information on ageing is also seen in the deficiencies in care. A 'mini intervention' by a doctor works for some elderly people. Others may require long-term psychotherapy to come to terms with a traumatic experience. After the initial stage of recognition, elderly people generally remain committed to the treatment. (Päihdelinkki, 2009)

Even when the habit has spread into many and varied social situations and changed the relationship to alcoholic beverages, cultural habits and layered, and have not changed accordingly. At the core of the Finnish drinking culture, there is still the idea of drinking to get drunk; this idea still lives on and is adopted early on along with the first experiences with alcohol. Becoming intoxicated has remained the central characteristic of Finnish drinking habits. The difficulty of changing these habits is also evidenced by the fact that it is still rare to drink alcohol with meals. (Päihdelinkki, 2009)

Limited research suggests that sensitivity to alcohol's health effect may increase with age. One reason is that the elderly achieve a higher blood alcohol concentration than younger people after consuming an equal amount of alcohol. This is as a result of an age- related decrease in the amount of body water in which to dilute the alcohol. Therefore there is an increased risk for intoxication and adverse effects. (National institute of Alcohol Abuse and Alcoholism, 2000)

Ageing also interferes with the body's ability to adapt to the presence of alcohol (that is tolerance). Through a decreased ability to develop tolerance, elderly subjects persist in exhibiting certain effects of alcohol (e.g. in coordination) at lower doses than younger subjects whose tolerance increases with increased consumption. Thus, an elderly person can experience the onset of alcohol problems even though his or her drinking patterns remain unchanged. (National institute of Alcohol Abuse and Alcoholism, 2000)

While there appears to be a rising incidence of problem drinking among the elderly, there are also reports that low drinking may provide benefits to the elderly populations. Low to moderate alcohol consumption may be associated with better cognition, psychological wellbeing and improved quality of life in elderly populations. (Institute of Alcohol Studies, 2010)

3.1 Drinking Prevalence among the Elderly

Observation of different age groups in the community, suggest that the elderly, generally defined as persons older than 65, consume less alcohol and hence have fewer alcohol related problems in comparison to the youth. However, survey tracking individuals over

long periods of time suggest that a person's drinking pattern remains relatively stable with age, reflecting societal norms that prevailed when the person started drinking. (National institute of Alcohol Abuse and Alcoholism, 2000)

Additionally, some people increase their alcohol consumption later in life, often leading to late-onset alcoholism. In contrast to most studies of the general population, surveys conducted in health care settings have found increasing prevalence of alcoholism among the older population. (National institute of Alcohol Abuse and Alcoholism, 2000)

Studies indicate that 6-11 percent of elderly patients admitted to hospitals exhibit symptoms of alcohol misuse as do 20 percent of elderly patients in the psychiatric wards and 14 percent of elderly patients in emergency room. In acute care hospitals, rates of alcohol related admissions for the elderly are similar to those of heart attacks. Yet hospital staff is significantly less likely to recognize alcohol misuse in an older patient as opposed to a younger patient. (National institute of Alcohol Abuse and Alcoholism, 2000)

Generally, alcohol consumption decreases with age and the proportion of non-drinkers increases. The reasons for the decline are presumably connected to the changes in life circumstances and attitudes and, in the late middle aged and older ill health. There is evidence, that today's population of the elderly people may be relatively heavier drinkers than earlier generations. This could be the result of the effect whereby a generation which has had its formative years at a time of high social availability and acceptability of alcohol may be more likely to maintain the habit of drinking. Higher disposable income in retirement could also be a factor. (Institute of Alcohol Studies, 2010)

3.2 Types of Elderly drinkers

There are three types of elderly drinkers as shown below:

Early-Onset drinkers

Otherwise known as 'survivors', are those people who have a continuing problem with alcohol which developed in earlier life. It is thought that two thirds of elderly problem drinkers have had an early onset of alcohol misuse. However, because of health risks

connected with heavy drinking and dependence on alcohol, the chances of reaching old age are reduced- one estimate is that the life span of a problem drinker may be shortened by ten to fifteen years. (Institute of Alcohol Studies, 2010)

Late-Onset drinkers

Also known as 'reactors', begin problematic drinking later on in life, often in response to traumatic life events such as the death of a loved one, loneliness, pain, insomnia and retirement. (Institute of Alcohol Studies, 2010)

Intermittent or Binge drinkers

These users drink alcohol occasionally and at times drink to excess which may cause them problems. It is thought that both late-onset and intermittent drinkers have a high chance of managing their alcohol problems if they have access to appropriate treatment such as counseling and general support. (Institute of Alcohol Studies, 2010)

3.3 Effects of Alcohol and Ageing

Despite many medical and other problems being associated with both ageing and alcohol, the extent to which these two factors may interact to contribute to disease is unclear. Some alcohol- ageing interactions include the following:

- Hip fractures increase with alcohol consumption. This increase can be explained by falls while intoxicated combined with a more pronounced decrease in bone density in elderly persons with alcoholism compared with elderly non-alcoholic.

- Moderate alcohol consumption may confer some protection from heart diseases. Although the research on this issue is limited, evidence shows that moderate drinking also has a protective effect among those older than 65. Because of bodily changes among the elderly, it is recommends that persons older than 65 consume no more than one drink per day.

- Depressive disorders are more common among the elderly than among the younger people and tend to co-occur with alcohol misuse. Studies have shown

that persons older than 65 with alcohol misuse are approximately three times more likely to express major depressive disorders than those without alcohol problems.

- Long term alcohol consumption activates enzymes that break down toxic substances, including alcohol. Upon activation, these enzymes may also break down some common prescriptions medications. The average person older than 65 takes two to seven prescription medication daily. Alcohol-medication interactions are especially common among the elderly, increasing the risk of negative health effects. (National institute of Alcohol Abuse and Alcoholism, 2000)

4 THEORETICAL FRAMEWORK: THE SUFFERING HUMAN BEING

The suffering human being finds herself in a sort of universe of suffering, an infinite number of happenings that at last despite all, are shown to have connectedness. Suffering is appropriate for the human being. To live implies, among other things, to suffer. Suffering is in its deepest meaning, a form of dying. Yet, where life triumphs, suffering has constituted a source of energy for new life. The meaning of life and the meaning of suffering seem to belong together. When life has a meaning, suffering also can be given meaning. (Eriksson, 2006 pg.2)

Suffering has often been pictured as a mystery or a riddle, but its immensity results in wanting to call it a universe. That likeness accords every age and every person a given place in relation to suffering, since we are forced to try to understand suffering in relation to our own life and our own becoming. (Eriksson, 2006 pg.2)

Suffering is a struggle between good and evil, between suffering and desire. Without all of this, life would be empty and without movement. Suffering is a struggle for one's dignity and one's freedom to be a human being. Every human being tries to master her suffering through sacrifice, to perform an act of reconciliation. Suffering lacks a specific language but in its infinite silence there are forms of expressions that we can perceive with our innermost and most sensitive movements, our mutuality and our compassion. (Eriksson, 2006 pg.2)

I chose this theoretical concept because the subject of the paper relates to suffering. Suffering in one's life may lead to indulgence in alcohol. Misusing alcohol causes suffering in almost aspects of an individual's life. This may even sometimes unfortunately lead to death.

The suffering human being is discussed in more depth in as we progress. The concepts, dimensions and suffering in relation to health care and caring will also be looked into.

4.1 The Concept of Suffering

A concept refers to definite thought content and every concept can be expressed in a number of ways. The terms can eventually replace the concept and lead to a change in the original thought content. Over the last century, the concept of suffering has shown signs of disappearing and has been replaced by a number of terms for example: pain, anxiety, and illness which represent different thought content. (Eriksson, 2006 pg.12)

The concept of suffering has been desubstantiated; it has lost its original meaning both in health care and in general contexts. The concept of suffering and pain are not synonymous; there is suffering where there is no pain, just as there is pain that exists without suffering. The dimensions of suffering are presented in figure 1. Suffering has both positive and negative dimensions. The opposite of suffering is desire. Our concept supports that suffering is a form of dying. (Eriksson, 2006 pg.12)

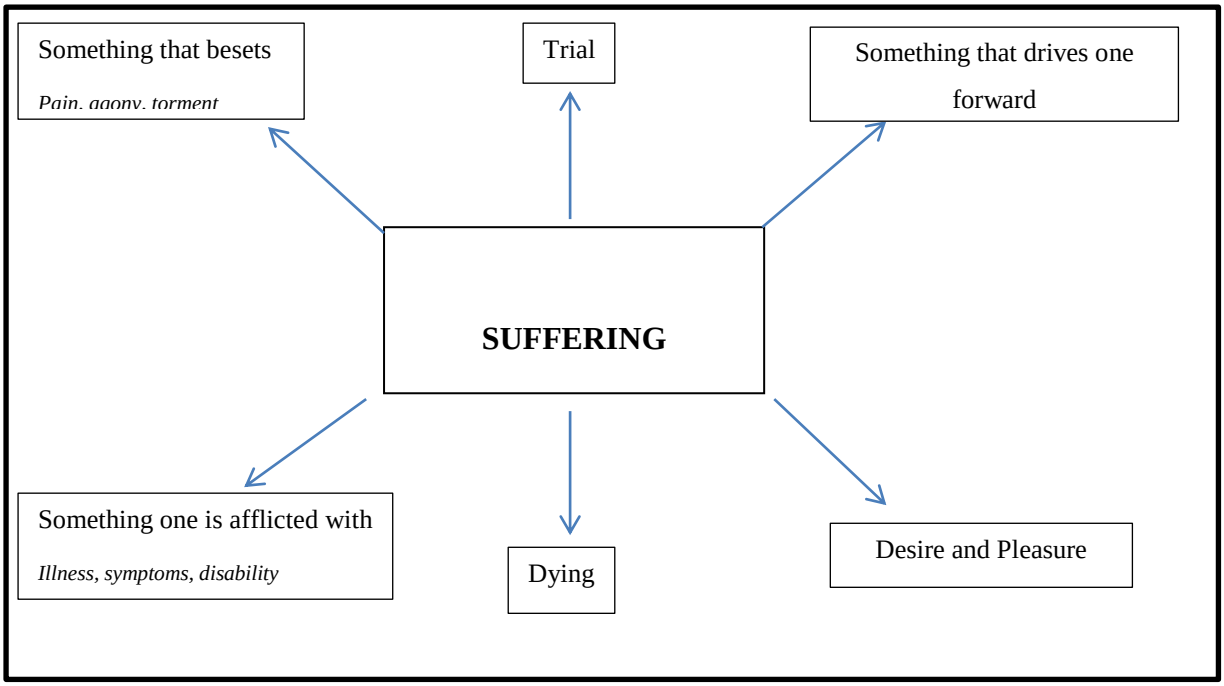

Figure 1: Dimensions of Suffering (Eriksson, 2006pg.13)

To Suffer and Suffering as Desire

This is to be tormented and to suffer agony. It is also to struggle and to endure. It could also mean to be reconciled. In summary, one can differentiate the following main dimensions for the concept to suffer:

- Something negative or evil.
- Something someone has to live with, something to which she is subjected.
- A struggle.
- Something constructive or carrying meaning, reconciliation.
- Suffering as compassion, that is, to suffer with and for someone else.
- Suffering as the expression of something that people lack.

Desire can be said to be something which drives a person; it can be compared to a need. It can also be a deeper longing for something; a craving, a wish or a will. Desire could also be something life giving and positive; life, joy and calling. It is also devotion and love for someone. (Eriksson, 2006 pg.14)

Suffering and pleasure belong together. They require each other in order to have any understandable significance and in reality, they constantly merge into each other. There

is much evidence in the literature that suffering gives birth to an unsuspected life power that is not seen as having any other source than suffering itself. (Eriksson, 2006 pg. 14)

The Patient- The Suffering Human Being

The concept patient originally meant the one who suffers, the one who patiently accepts and endures something. It is interesting to note that the concept patient did not originally refer to illness. The patient was someone who suffered, had to endure something, was passive and could be patient, but also had passions, sufferings and desires. (Eriksson, 2006 pg.16)

Later on it was given the meaning of one who is ill, has a diagnosis or an infirmity and who is receiving care. In recent years, the concept has also been given the connotation of a social-political or administrative concept by being linked to the official right to receive care and get financial support for treatment. (Eriksson, 2006 pg.17)

One can link today's care with the fact that a system that originally was intended to give care to the suffering human being, in many instances causes suffering. To be a patient today one has to give evidence of objective and socially acceptable symptoms for a named ailment, which can be treated and which does not cost too much. Suffering may have disappeared as a concept but still remains a part of human reality. (Eriksson, 2006 pg. 17)

4.2 The what of suffering, Inability to Suffer

This is an attempt to describe the nature of the suffering. It is a characteristic of each separate suffering. Suffering will presumably always appear as a riddle since each person's suffering is unique and bears the name of the sufferer. For people to recognize the *what* of their suffering, we must help them recover their ability to suffer. (Eriksson, 2006 pg.6)

The inability to suffer is probably of the greatest and cruelest of all suffering. Seen objectively, one should suffer and express the pain and misfortune expected of her. A real inability to suffer is easily confused with other forms of expressions, for example, contempt and arrogance in the face of suffering. These in themselves are examples of human suffering, but must be dealt with differently than the expression of the inability to

suffer. In the deepest meaning, no person presumably wants to suffer. (Eriksson, 2006 pg.7)

Passion in Suffering, Suffering as Temptation and a Form of Dying

Passion is conceptually related to suffering. It is as if the person in her seemingly hopeless situation sometimes expresses her pain or suffering through passion. In passion there is a creative force, and by giving in to it the person may forget suffering for a period of time. It could be said that, passion in suffering, is a way of giving suffering meaning. Through giving suffering the signature of passion, one can at least for a while make it endurable. (Eriksson, 2006 pg.7-8)

In the face of temptation, this in its deepest meaning is obsession, the struggle increases. Resisting temptation requires courage. To yield the temptation, can at least for a time, give the person satisfaction and experiences of desire, only to have it changed into suffering momentarily. When suffering becomes a temptation, it easily creates bitterness and indifference for everything and everyone. This makes the person lose courage, weakens her in every respect and leads to premature ageing. (Eriksson, 2006 pg.8)

In each suffering, something definitive is taken from us in concrete or symbolic meaning. Each suffering can be likened to a struggle with death. Suffering implies that the human being can be transformed, created or disintegrated. In dying, there is a possibility for a new life; i.e., reconciliation. In suffering that causes death, the human being is obliterated as a person and a whole human being. In the absence of confirmation of her worth as a human being, she enters a world that is far beyond all relationships and thus beyond all suffering. (Eriksson, 2006 pg.8-9)

In the world where the human being is no longer a person, suffering does not exist. The suffering, the guilt, and the pain may be found in the next of kin or the people who stand in a close relationship to the 'dying' human being. A person who suffers and grieves is tired. This means that the person needs rest and calm but not necessarily solitude. Having lost a person she loves and who has been important to her, she experiences a great loneliness. This feeling is perhaps not to be seen by anyone. Unfortunately, there are many living-dead among us. We encounter these suffering fellow human beings daily,

but we fail to see them. We meet these people in the hospitals, but they are also in the midst of us. (Eriksson, 2006 pg.9)

4.3 The Why of Suffering

Human beings have always had a need to try to explain the world they inhabit and the events of which they are a part. What they cannot explain or understand, they often to refer to as an external power, fate, or something evil or good. Everyone who is a victim of suffering positions themselves in some phase of the question why? Sometimes we are given an answer, but just as often, it is not given. (Eriksson, 2006 pg.28)

Suffering as has been indicated is a part of life. Suffering is related to the levels on which one lives. For the person whose primary relationship is social, suffering can be the exclusion from friendship or not to experience that one has a place in life. For a person who strives for freedom or to satisfy her own needs, and be allowed to be what she wants to be, suffering can consist of loneliness where she experiences that she is not understood and that no one can give her what she needs. (Eriksson, 2006 pg. 29)

People express their suffering in several ways, but often we lack a language to express what we really experience. We are forced to give our suffering an explanation. Our human suffering is transformed to pain, anxiety or a physical expression that can be observed. (Eriksson, 2006 pg.30)

There is, to be sure, a suffering caused by natural catastrophes, and situations for which human beings apparently cannot be responsible. The suffering which we human beings cause one another is frequently concealed. Evil and good are related to one's freedom. Freedom means at the deepest level to be responsible. A human being who has suffered and has experienced suffering and has been reconciled to her suffering has a difficulty consciously causing suffering to another. To cause suffering for the other always implies violation of the dignity of the other, failure to confirm his human being's full worth. The history of suffering belongs together with the history of compassion and the responsibility we are prepared to assume for each other. (Eriksson, 2006 pg.30-31)

4.4 Suffering – A Struggle between Good and Evil

A common conception is that suffering belongs together with evil. An analysis of the concept revealed that suffering is the opposite of desire. In desire there is movement, striving and craving after the good, but desire can also be used in the struggle against evil. To suffer always involves a struggle. Suffering is not the same as anxiety; however, a person who suffers can experience anxiety. The struggle of suffering is a type of torment in which a person fights against the feelings of shame and humiliation. In the struggle four basic positions emerge, they are represented in figure 2. (Eriksson, 2006 pg.2)

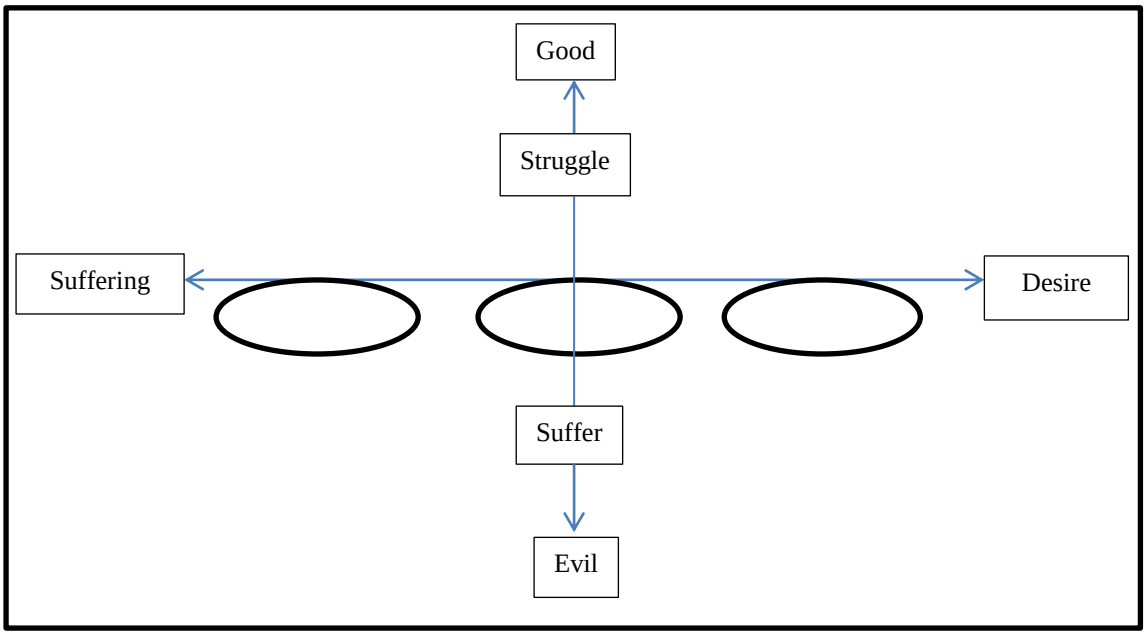

Figure 2: Suffering as Struggle-A Position Model (Eriksson, 2006 pg.23

In good suffering the person is in a struggle for meaning and growth toward a higher degree of integration in order to be a whole person. It is certainty beyond unrest and fear that makes a person strong. In good desire there is genuine joy in life, meaning and strength. In desire that is evil, the person is captive to her passion and is unable to decide about her life; rather she is driven. Depending on the different positions and on the person's actual life situations and life view, suffering takes different forms. Suffering is

therefore always a unique blending of desire and suffering, good and evil. (Eriksson, 2006 pg.22)

Each time a person suffers she is violated. This violation of human dignity is as a result of the person's hesitance to discuss her suffering, especially when she finds herself in the middle of it. A person suffers because of guilt, but at the same time she may want to suffer in order to atone her guilt. All persons carry guilt because of various faults, large or small, for which in some way they feel responsible. The experience of guilt becomes a suffering the moment that the person becomes conscious of failing herself. Through suffering, one can expiate her guilt. (Eriksson, 2006 pg.33)

By condemning another and acting as a judge of the other we cause much suffering. How quick are we to condemn those who are different, those who do not share our thoughts and values? The task of the human being is not to condemn but to understand and to forgive. Condemning is declaring the other invalidated and to obliterate her as a human being. Condemnation is to the contrary loveless and in all respect, evil. (Eriksson, 2006 pg.34-35)

A human being's deepest desire is the desire for love and confirmation. To not receive and not be able to give love involves a limitless suffering. Lack of love hinders us from feeling compassion and from entering a deep relationship with another person. (Eriksson, 2006 pg.35)

To experience that no one reckons with me, can cause unendurable suffering. It can give us a feeling that we do not exist for others. It becomes a hopeless situation because any effort to make contact is meaningless. To not be taken seriously is to be questioned about one's identity and to be deprived of all possibilities to affirm one's own identity. The aloneness that implies being excluded from all communions can cause serious suffering, yet all aloneness is by no means suffering. Aloneness becomes suffering when a person is too alone in her alone-suffering. Not to be allowed to be alone or have privacy can also involve suffering. (Eriksson, 2006 pg.35)

There are people who live totally alone who do not feel lonely or deserted. They have communion with existence itself. There is an intolerable loneliness where a person feels

that she is deprived of something she once had as her own or that she would wish to have as her own. (Eriksson, 2006 pg.35)

All human beings want to experience that they are invited and welcome to a communion that someone waits for them and longs for them. To feel not welcome, regardless if the situation is an individual, concrete one or if it is life in its entirety, deprives the person of hope and the joy of living. To welcome someone means to show respect, to confirm the other. A person can endure loneliness, lack of love, guilt etc., as long as it does not violate her as a human being. Suffering can be experienced as different conditions, feelings and situations, but at the deepest level of suffering is caused by deprivation of a human being's dignity in its objective and/or subjective meaning. (Eriksson, 2006 pg.36)

4.5 The Meaning and Drama of Suffering

The meaning in suffering emerges when a person reconciles herself with the situation and thereby finds possibilities and meaning. The experience of suffering seems bound to an experience of different possibilities in the actual life situation. Suffering can be transformed to desire and joy by the help of an insight of new, unsuspected possibilities. It is a gleam of hope that enters a situation that previously seemed hopeless. If the person cannot change circumstances, she must change her attitude toward the circumstances. Faith, hope and love can alter our attitude in spite of the fact that the concrete circumstances have not been changed. (Eriksson, 2006 pg.40)

The threat lies in not seeing the suffering and its possibilities or to see it and to seek to eliminate it or to explain it away without making it a part of life. This should not be interpreted as an effort to beautify suffering or not to see the evil in it. (Eriksson, 2006 pg.40)

There is suffering in caring created by the expectations experienced when one enters a human encounter or a caring relationship. This is called the drama of suffering. Every person's suffering is played out in a drama of suffering. To try to alleviate the suffering of a fellow human being involves daring to be a fellow actor in the drama. (Eriksson, 2006 pg.46)

Confirming the suffering of another person implies conveying to the other, 'I see.' That another person sees my suffering implies a comfort, an assurance that someone will come to meet me. Confirmation of suffering can happen in a number of ways; a look, a touch, a little word. This means that one will not abandon the other, that one is available, gives an invitation to the sufferer, and provides time and space to undergo the suffering. (Eriksson, 2006 pg.46-47)

We can deprive a person of the possibility to suffer through arguing away or by too rapidly finding reasons for her suffering. To be in suffering means to oscillate between suffering and desire and hope and hopelessness. A person who suffers prefers to be alone despite the fact that she wants to experience a feeling of communion. To be reconciled means finding a new life and forming a new entity in that life where something has definitely been lost. It means creating a new wholeness that includes the evil which is now included in a new wholeness and holiness. A person who has attained reconciliation can often assign a meaning to the experienced suffering. (Eriksson, 2006 pg.47)

If a person cannot play along in the drama of suffering that leads to a true reconciliation, she experiences an intensified suffering, which eventually leads to contrition and a form of dying. The person literally dies, first as a person and a human being in spirit and soul, and little by little even in body. (Eriksson, 2006 pg.47-48)

4.6 Suffering in Relation to Health, Caring and Health Care

This constitutes the essential content, the substance in the struggle of the suffering and in the person's battle to survive. There is a proverb that says that a person cannot appreciate health before she has encountered illness. Regardless of the perspective there is a common denominator in all suffering: the person is in some sense cut off from herself and her wholeness. Suffering and love are the deepest and most intimate movements of our soul and spirit and for that reason constitute the most fundamental of the life and health processes. In the deepest sense, health is wholeness through its association with suffering. If we consider suffering as a natural part of the human beings, suffering is also a part of health. (Eriksson, 2006 pg.56)

Courage is born in trials. A person needs courage to confront life and its trials. Through becoming courageous and using one's courage, a person can come to terms with her

destiny. Joy breaks out when a person wins over her own destiny. The ability to accept one's own destiny is related to the person's maturity. (Eriksson, 2006 pg.60)

The Suffering of Illness, Care and Life

There are many situations within health care where the person is exposed to shame and humiliation. These can involve different events in illness and treatment or the patient's own experience of feeling a failure as a patient, not being able to cooperate in her treatment. Suffering among the elderly is especially obvious within institutional care. The worst time is when the older person seeks to adjust to the institution. Suffering is interpreted as losses of various kinds. One loses one's personal abilities; close a friends and associates, participation in social groups, one's home and one's full value as a human being. (Eriksson, 2006 pg.78)

Violation of a patient's dignity and worth as a human being constitutes the most frequently occurring form of suffering of care, and all other forms can be derived from this one. To violate a patient's dignity implies taking from her the possibility to be a whole and complete person. (Eriksson, 2006 pg.80)

Condemnation and punishment are closely linked with the violation of human dignity. Condemnation has its origin in the understanding that it is the caregiver's task to decide what is right and what is wrong with respect to the patient. One way to punish is to omit caritative care or be indifferent toward the patient. (Eriksson, 2006 pg.83)

To assert power is to deprive the other of her freedom, since one forces her to do things she would not choose to do her own free will. Assertion of power means forcing patients to do things that they are actually unable to do. This is also true when caregivers want to hold to established routines and find it difficult to share the patient's thinking. (Eriksson, 2006 pg.83-84)

Omitted caring can be due to lack of ability to see and determine what the patient needs. There are many forms of omitted caring, from minor kinds of oversight and carelessness to conscious direct acts of neglect. Non-caring, is a situation where one perhaps does not perform caring or where the caring dimension is absent. (Eriksson, 2006 pg. 84)

Illness, poor health, and the situation of being a patient affect the total life of a person. The life one is accustomed to is disturbed and suddenly more or less taken away. The

suffering of life can include everything from a threat to one's total existence to a loss of the possibility to pursue varied social tasks. It is related to everything included in what it means to live, to be human being among other human beings. (Eriksson, 2006 pg.85)

Suffering Can Be Alleviated

It is important to strive to eliminate unnecessary suffering, but there is suffering that cannot be eliminated and which we must do all we can to alleviate. The prerequisite for being able to alleviate suffering is to create a culture of caring in which the patient experiences the right and the space to be a patient. (Eriksson, 2006 pg.87)

The need to show respect and to confirm a patient's dignity is apparent in situations where the patient must carry out her most intimate needs in the presence and with the help of others. Even the most difficult suffering can be alleviated for a time by a friendly look, a word, a caress or something else that expresses an honest feeling of compassion. In all suffering there is also a glimmer of delight that can increase through our ability to play and laugh together. Play and suffering, if artistically applied, can be expression of love and can alleviate suffering. (Eriksson, 2006 pg.87)

4.7 Conclusion

Suffering is somewhat a way of life. Its existence can be to enlighten, strengthen and at times it just causes pain. It can be found in almost all aspects of life. To suffer could mean by affliction or by experiencing pleasure or even having a desire. It is difficult to find a definite position regarding suffering. It is possible to experience pain and not suffer and could also be lonely and not be suffering. The healthcare system suffering aspect could be inflicted by the care givers on the patients. Not listening to what they are saying, paying attention to body language and cues given could enhance one's suffering. The patient if of sound mind should be allowed to exercise their rights to decide what they would prefer and what they wouldn't like. In the case where a patient cannot speak for him or herself, it is important to maintain privacy and avoid violating them intentionally.

5 METHODOLOGY

The method of data collection used for this paper was literature review. This was made possible reading through research conducted within the past decade. The information obtained was carefully read through several times in order to acquire the necessary information best suited for the author's interests. The subject of interest was alcohol, its use and misuse with the focus being the elderly people.

Literature by credited researchers and scholars on alcohol and the implications it has on the elderly was used. Statistical databases and books on theories were also useful in writing this paper.

Literature review is an account of what has been published on a topic by accredited researchers and scholars. The purpose of a literature review is to convey to the reader the knowledge and ideas that have been established on a topic and what their strengths and weaknesses are. It must be defined by a guiding concept and not just a descriptive list of material available. (University of Toronto, 2011)

Database used during the research process were EBSCO and the keywords used was *alcohol misuse, *alcoholism, *alcohol dependence and the *elderly.

Sample Process

To initiate the search process the author had to find a database for information retrieval. EBSCO was one database used accessed via the Nelli Portal from the Arcada web page. The keywords *Alcoholism search yielded 8703 results. The author was only interested in recent research work and full text articles. Therefore the results were refined by limiting the search to the past decade; between 2001 and 2011 and full text, which yielded to 2997 results.

Further refinement was required and the author used the subject term * elderly which in the database, gave *older people to mean the same. Search results were reduced to 49 results. The author then went through the results to pick the articles that were of relevance to this paper. From these 12 articles were chosen:

Location	Name of Article	Author	Year	Content
Background	Alcohol use and problems among older women and men: A review	Salme Ålstrom	2008	The article talks about alcohol among the elderly people and how that has become a growing area of interest. It also talks on the problems faced as a result. The focus is mainly Europe.
Content Analysis	Alcohol Intake and the Risk of Dementia	Jose A. Luchsinger, Ming-Xin Tang, Maliha Siddiqui, Steven Shea, Richard Mayeux	2004	The article discussed alcohol and how it could be used to reduce the onset or decrease the risk of dementia.
Content Analysis	Alcohol abuse, Cognitive impairment and Mortality among Older People	Vince Salazar Thomas Kenneth J. Rockwood	2001	The article relates alcohol abuse to cognitive impairments and independently with short-term mortality.
Content Analysis	Alcohol use and mortality in older men and women	Kiearan A. McCaul, Osvaldo P. Almeida, Graeme J. Hankey, Konrad Jamrozik, Julie E. Byles, Leon Flicker	2010	The article relates level of alcohol intake to mortality. It looks into the health risks and benefit posed by alcohol intake at different levels.
Content Analysis	Alcohol Consumption Among Older Adults in Primary Care	JoAnn E. Kirchner, Cynthia Zu-	2006	The article discusses alcohol misuse as a growing public health concern. Focus is on the prima-

		britsky, Eugenie Coakley, Hongtu Chen, James H. Ware, David W. Oslin, Herman A. Sanchez, U. Nalla B. Durai, Keith M. Miles, Maria D. Llorente, Gluseppe Costantino, Sue Levkoff		ry care patients.
Content Analysis	Older adults' alcohol consumption and late-life drinking problems: a 20-year perspective	Rudolf H. Moos, Kathleen K. Schutte, Penny L. Brennan, Bernice S. Moss	2009	The article talks about guidelines on alcohol consumption. It gives amount recommendable with age among the elderly group.
Content Analysis	Alcohol misuse and older people	Jane Dyson	2006	The article discusses how common alcohol intake is. The reasons for alcohol misuse, benefits and harm and assessment and intervention.
Content Analysis	Unhealthy Drinking Patterns in Older Adults: Prevalence and Associated Characteristics	Elizabeth L. Merrick, Constance M. Horgan, Dominic Hodg-	2008	The article looks into unhealthy drinking among the elderly. It relates it to sociodemographic and health characteristic.

		kin, Deborah W. Garnick, Susan F. Houghton, Lee Panas, Richard Saitz, Frederic C. Blow		
Content Analysis	High-Risk Alcohol Consumption and Late-Life alcohol Use Problems	Rudolf H. Moos, Kathleen K. Schutte, Penny L. Brennan, Bernice S. Moos	2004	The article talks about high risk alcohol consumption. Gender difference and alcohol intake is among the factors discussed in this article.
Content Analysis	The Alcohol-Related Problems Survey: Identifying Hazardous and Harmful Drinking in Older Primary Care Patients	Arlene Fink, Sally C, Morton John C. Beck Ron D. Hays Karen Spritzer Sabine Oishi Alison A. Moore	2002	This article talks about how alcohol intake can be harmful. It discusses interaction between level of alcohol, diseases and medication use.
Content Analysis	Alcohol's Effects on Brain and Behavior	Edith V. Sullivan, R. Adron Harris, Adolf Pfefferbaum	2010	This article relates alcohol use and changes within the brain including cognitive capabilities. It further shows how behavior is altered as a result.
Content Analysis	Substance Use, Misuse and Abuse Among Older Adults: Im-	Wanda P. Briggs, Virginia A.	2011	This article discusses the changes in the elderly that may prompt alcohol

	plications for Clinical Mental Health Counselors	Magnus, Pam Lassiter, Amanda Patterson, Lydia Smith		use and dependence. It also looks at the various ways the individuals can be helped.

Table 1: Articles List

5.1 Content Analysis

Content analysis is a method of analyzing written, verbal or visual communication messages. Its history dates back to the 19th century, where it was first used for analyzing hymns, newspaper and magazine articles, advertisements and political speeches. (Elo and Kyngäs, 2007)

Content analysis as a research method is a systematic and objective means of describing and quantifying phenomena. It is also known as a method of analyzing documents. It allows the researcher to test theoretical issues to enhance understanding of the data. Throughout content analysis, it is possible to distil words into fewer content categories. It can be used to develop an understanding of the meaning of communication and identifying critical processes. (Elo and Kyngäs, 2007)

Content analysis is a research method for making replicable and valid inferences from data to their context, with the purpose of providing knowledge, new insights, a representation of facts and practical guide to action. The aim is to attain a condensed and broad description of the phenomenon and the outcome of the analysis its concepts or categories that describe the phenomenon. (Elo and Kyngäs, 2007)

An advantage of the method is the large volumes of textual data and different textual sources can be dealt with and used in corroborating evidence. It has been an important way of providing evidence for a phenomenon where the qualitative approach used to be the only way to do this, particularly for sensitive topics. One challenge of content analysis is the fact that there is no simple 'right' way of doing it. Researchers must judge the variations that are most appropriate for their particular problems and this makes the analysis process most challenging and interesting. (Elo and Kyngäs, 2007)

The main category has been derived from the research questions as in the tables below.

Question 1: What does alcohol misuse among the elderly mean?

There are various factors to consider when in relation to alcohol intake which could lead to misuse. There are three categories that can be included to give meaning to what alcohol misuse; gender difference, harmful drinking and social and emotional factors. They can be categorized as shown below:

SUB CATEGORY	GENERIC CATEGORY	MAIN CATEGORY
-Men tend to consume more alcohol than women. Women drink slower than men and prefer alcohol with meals compared to men. -Male gender, more active lifestyle living alone, better health and functional status, smoking, divorced or unmarried.	Gender Difference and Harmful Drinking	What alcohol misuse among the elderly means
Bereavement, mental stress, isolation, loss of income, skills, occupation, function. Less social encounters, legal and occupational	Social and Emotional Factors	

Table 2: Research question 1

Question 2: What are the signs and consequences of alcohol misuse among the elderly?

They are divided into signs and consequences. Under consequences there is falls, nutritional and sleep problems and psychological problems and diseases as shown below:

SUB CATEGORY	GENERIC CATEGORY	MAIN CATEGORY
Confusion, memory loss, isolation from social surroundings, change in eating habits, neglecting one's appearance, estrangement from family.	Signs	Signs and consequences of alcohol misuse among the elderly
Hip fractures, postural mechanism loss, osteoporosis gait and balance, death	Consequences (Falls)	
Foliate and thiamine deficiencies, lack of nutritional foods, restlessness, insomnia, suppression of rapid – eye movement	Consequences (Nutritional and sleeping problems)	
Cognitive decline, anxiety, self-harm, alcohol-drug interaction, dementia syndromes, stroke, Parkinson's disease, cancers (mouth, esophagus, larynx, pharynx, liver) cirrhosis	Consequences (Psychological problems and diseases)	

Table 3: Research question 2

Question 3: How can alcohol misuse among the elderly be assessed?

Help can only be given if the problem has been recognized. Alcohol as a problem has to first be noticed and for this to happen assessment must be applied. There are three assessment tools in this paper; the AUDIT, CAGE and MAST test tools. They have been sub categorized as shown below:

SUB CATEGORY	GENERIC CATEGORY	MAIN CATEGORY
13 question questionnaire that depending on how one responds can show whether one has an alcohol misuse problem	Alcohol Disorder Identification Test (AUDIT)	Assessing alcohol misuse among the elderly
This is a 4 question yes-no questionnaire. 2 yes responses indicate alcohol problems. It may also mean not dependent but still have problems	The CAGE Questionnaire	
22 questions yes-no self-test designed to show a lifetime alcohol misuse problem.	MAST-G test	

Table 4: Research question 3

5.2 Problems encountered during the study

The nature of the topic only limited the author to reviewing articles as opposed to going out there with questionnaires and attaining fresh information. The subject is sensitive and getting information first hand is that much harder.

The article results in the databases were many which meant that the author needed to take a lot of time to go through them for relevance. Some of the articles did not have

sufficient information to match the requirements for the paper. The information retrieved does not however give an exact picture of the situation in the current times. It is also not a reflection of alcohol misuse among the elderly internationally. There is still not enough research done on the subject.

5.3 Validity and Reliability

The articles were chose with relevance to the interests of the author. They were carefully used to answer the problems the author was seeking to respond to. The articles used in writing this paper have been refined to the last ten years. In the paper itself any information from articles has been quoted in the text. The years of publication have also been included in the quotes.

The author also used books in the paper and the author of the book, year of publication as well as the page number the information was retrieved have been quoted in the text. Content in this paper is therefore reliable and valid.

5.4 Ethical Consideration

The author read through the 'Good scientific practice in studies at Arcada' guidelines. Information acquired from research articles and books has been written in truth throughout this paper.

High standard of professional conduct was maintained during the data search process. Respect for the researchers and scholars and their work was observed throughout the research process. Privacy and causing no harm to others and the ethical principles were also adhered to. Ethical consideration was applied and personal bias or opinions did not interfere with the writing of this paper.

6 RESULTS

In this chapter the author further discusses the results that come forth from the articles below. The results are in three parts in relation to the three research questions as reflected below.

6.1 What does alcohol misuse among the elderly mean?

(Results for Research Question 1)

Defined by the World Health Organization (WHO), harmful drinking is use of alcohol that causes physical or psychological complications, whereas hazardous drinking is the use of alcohol that places an individual at risk for such complications. (Fink et al. 2002)

Misuse of alcohol by older adults is a serious problem and is under identified and under-treated. Alcohol misuse has been defined as encompassing risky use, problem drinking, and alcohol disorders including abuse and dependence. (Merrick et al, 2008)

Gender Difference and Harmful Drinking

Gender differences in the absorption of ethanol and its probable effects suggest the desirability of lower consumption guidelines for women. Compared to men however, women may drink at a slower pace and prefer drinks with meals and with less alcohol content, so that a comparable number of drinks may have less influence on women than on men. (Moos et al. 2009)

Compared to women, men may drink more rapidly, consume more drinks served to them, be less likely to drink with meals and concentrate their drinking over a shorter interval. The rate of drinking is lower among the 75-85 age group compared to when they were between 55-65 years. (Moos et al. 2009)

Alcohol related health problems among older people may be significantly under attributed. This can occur because alcohol-related illness is difficult to distinguish from other illnesses and from adverse reactions to medication; symptoms of alcohol problems may defer from those observed in younger patients; and older people show a greater reluctance than younger people to self-report alcohol abuse. (Thomas, 2001)

The top two indications for harmful drinking include alcohol use in combination with medical conditions that may be caused or worsened by alcohol. The top two indications for hazardous drinking include the use of alcohol with medication that may adversely interact with alcohol or whose efficacy may be diminished by alcohol. (Fink et al. 2002)

It has been found that 38% of women and 52% of men aged 55-65 consumed three or more drinks per day or seven or more drinks per week. Adults over 55-60 who consume five or more drinks in one day or more than seven drinks per week are more likely to experience alcohol-related symptoms than are the older adults who consume less alcohol. (Moos et al. 2009)

Currently defined risky drinking amounts for people aged 65 and older is more than seven drinks per week or more than three drinks on any single given day. Among elderly people exceeding these limits is associated with significant interpersonal and functioning problems. Factors found to be associated with a higher likelihood of unhealthy drinking in older adults includes male gender, more active-lifestyle, better health and functional status, and smoking. Studies have found that, living alone for men and women or being divorced or unmarried predicts unhealthy drinking. (Merrick et al, 2008)

A striking feature of alcohol misusers is their continued drinking despite their knowledge of the untoward physiological or psychological consequences of their behavior. (Sullivan et al 2010)

Heavy drinking is associated with depression and anxiety, less social support and heavy drinking combined with binge drinking is associated with depressive/anxiety symptoms and perceived poor health. (Kirchner et al, 2007)

Social and Emotional Factors

There tends to be two types of drinking in later life. The first is where the drinking is a continuation of an existing chronic problem and the second is where the problem drinking developed later in life. Around 40 to 46 percent of older drinkers fall within this second type. Triggers to problem drinking are fairly self-evident and include bereavement, mental stress, physical ill health, loneliness and isolation, and loss, including loss of occupation, function, skills, income and important people in their lives. (Dyson, 2006)

Elderly people lose social and emotional support systems as they age. The ageing process often results in social isolation due to death of a spouse or partner, other family members and close friends. Similarly, retirement, altered activity levels, disability, relocation of family and friends and family dissonance may produce feelings of isolation and depression that exacerbate substance abuse in older adults. (Briggs et al, 2011)

Social factors also contribute to under detection of the problems. Older people may have reduced social contact and therefore their behavior may not be as noticeable to others. They are also less likely to encounter social, legal and occupational complications resulting from alcohol misuse, thus making the commonly used screening tools and definitions of alcohol misuse inapplicable among the elderly drinkers. (Dyson, 2006)

6.2 What are the signs and consequences of alcohol misuse among the elderly?

(Results Research Question 2)

Alcohol use problems specifically relevant to the older adults, some of the problems might be considered to be relatively minor, such as neglecting one's appearance because of alcohol use. (Moos et al, 2004)

Signs of alcohol misuse

- Unstable and poorly controlled hypertension
- Recurrent accidents, injuries or fall
- Frequent visits to the emergency department
- Unexpected delirium during hospitalization
- Gastrointestinal problems
- Estrangement from family
- Cognitive decline or self-care deficits
- No adherence with medical appointments and treatment
- Memory problems
- Change in eating habits
- Lack of interest in usual activities
- Isolation from their social surroundings

Presentation of elderly people with alcohol problems may be atypically masked by other illnesses. Older people may present to the healthcare services with for example: confusion, depression where alcohol may not be high on the list of causative factors. Like-

wise, non-specific health problems such as gastrointestinal problems and insomnia may be misdiagnosed. (Dyson, 2006)

Consequences of alcohol misuse

Misuse of alcohol comes with various consequences and they have been discussed further below:

Falls

Alcohol use can lead to falls leading to hip fracture, a leading cause of death in this group. Older adults' higher sensitivity and poorer ability to metabolize alcohol contribute to higher risk at a given level of use. Alcohol can also exacerbate medical disorders that are common among the elderly people, including congestive heart failure and hypertension. (Merrick et al, 2008)

Older people are prone to falls when postural mechanisms are lost. Alcohol impairs balance and judgment and the diuretic effect of alcohol may cause orthostatisis. Some of the alcohol misusers develop myopathy and strength is often impaired. Osteoporosis, combined with the detrimental effects of alcohol on gait and balance, result in a higher rate of age-adjusted hip fractures among older alcoholic patients. (AAFP, 2000)

Nutrition and sleep problems

Nutritional deficiencies, particularly of foliate and thiamine occur when food intake is reduced because calories are derived from alcohol, or when access to nutritional food is limited. Alcohol misusers also experience disturbed sleep, with insomnia, restlessness and suppression of rapid-eye movement. (AAFP, 2000)

Psychological problems and Diseases

Alcohol misuse has also been implicated in cognitive decline. Various forms of dementia syndromes have been described, for example, Wernicke's encephalopathy and Korsakoff's psychosis and alcohol-related dementia has been reported as the second most common cause of dementia among institutionalized older people. (Thomas et al, 2001)

With the aging population, the prevalence of dementia is expected to increase significantly. There are no known treatments but delaying its onset could significantly de-

crease its prevalence. Moderate alcohol intake has been associated with a decreased risk of dementia. It is possible that the risk is decreased at the expense of increasing other comorbidities, including forms of cognitive impairments. (Luchsinger et al, 2004)

Psychological and psychiatric problems are associated with alcohol misuse in old age and may include; memory loss and depression, anxiety, self-neglect and self-harm. Mixing alcohol with prescribed drugs is particularly significant in the older population. Alcohol is contraindicated by many of the drugs regularly used to alleviate degenerative disorders and its consumption may result in for example; increased sedative effects, increased danger of falls and accidents and increased incidence of psychological side effects. (Dyson, 2006)

According to Moss et al (2009), the limit of two drinks per day is consistent with the association between consumption of more than two drinks per day and a higher risk of impairment in activities of daily living and of injuries and several cancer (mouth, esophagus, pharynx, larynx, liver) related conditions.

Another disease that could result from alcohol misuse is stroke. There is an increased risk for accidents which are a significant cause of mortality and ill health in older people. It could also increase likelihood of incontinence and gastrointestinal problems. The brain damage resulting from high levels of alcohol consumption can also contribute to dementia and alcohol can provoke the onset of Parkinson's disease. (Dyson, 2006)

High levels of alcohol have been considered detrimental to older people have been implicated in cirrhosis of the liver, specific cardiovascular condition (hypertension, cardiomyopathy), gastrointestinal problems (gastritis, acute pancreatitis, gastrointestinal bleeding) and mental health problems. It however remains unclear what level of alcohol contributes to this health outcomes. (McCaul et al, 2010)

6.3 How can alcohol misuse among the elderly be assessed?

(Results Research question 3)

A variety of issues need to be addressed to accurately diagnose alcohol abuse in older adults. For example, many diagnostic criteria for alcohol misuse may not apply or may mimic signs of physical or mental impairment common in old adults. Among many other barriers to assessment and treatment of older adults with alcohol misuse problems are limited transportation, denial and stigma associated with alcohol misuse, lack of social support and inadequate financial resources. (Briggs et al, 2011)

Alcohol Disorder Identification Test (AUDIT)

Developed by the World Health Organization for screening excessive alcohol drinking, AUDIT was in particular to help practitioners identify people who would benefit from reducing or ceasing drinking. The majority of excessive drinkers are undiagnosed. Often they present with symptoms or problems that would normally not be linked to their drinking. (Babor et al, 2001)

Check Appendixes, appendix 2

The CAGE Questionnaire

This is a short and simple four question test to administer. The answers are either yes or no. Two or more positive answers are correlated with alcohol dependence in 90% of the cases. When used with alcohol misuse, both dependence and initial associated problems may be identified as well as those who are not dependent but still have some problems.

This instrument may not pick up problems in those who are fearful of negative consequences of disclosure such as those looking for accommodation, people who are fearful of child protection agency staff and those with mental health problems. (DrugNet, 2010)

Check Appendices, Appendix 3

The Michigan Alcohol Screening Test- Geriatric Version (MAST-G Test)

It was designed for those people 65 and older. The 24 questions take into account the special needs of alcoholism and the elderly. These needs may include medical problems that may not be present in younger people and differences in social and employment situations. To every question one responds with a yes or no. An evaluation is made based on the responses given. (The Alcoholism Guide, 2010)

Health professionals can then be better fit to know what treatment or recommendation to give.

Check Appendices, Appendix 4

Treatment Approaches

Foremost, appropriate treatments require empathic care and concern when a problem has been identified. Many older adults will deny or minimize problems because of stigma, shame, perceived moral failure and even fear of losing their independence. They respond better to age-specific treatment that is supportive, adaptive, creative and less confrontational and that addresses needs associated with the ageing process. (Briggs et al, 2011)

Cognitive behavioral and brief interventions

Initially, least-restrictive treatment options have been found to be beneficial, and older adults respond better to age-specific group treatment and cognitive behavioral therapy based programs. In particular, two brief therapies, motivational interviewing and brief advice, have helped decrease alcohol consumption. One to five brief sessions of advice and education, motivational interviewing is required and then referral to treatment as needed. (Briggs et al, 2011)

Another successful cognitive-behavioral approach is the Gerontology Alcohol Project (GAP). These treatment modules (thoughts, activities and people) provide multi-dimensional interventions, such as motivational interviewing, teaching components of behavior change and methods of increasing social interactions and personal efficacy when refusing alcohol. At all levels of interaction, education is central to helping older adults with alcohol misuse problems in terms of harm reduction, identification of causes

of noncompliance, medication management and health and functional consequences of misuse. (Briggs et al, 2011)

Engaging Families

Family members often collude in denying that an older relative has alcohol misuse problems because they are embarrassed by the relative's behavior. They may attribute the behavior to getting older and justifying it as an understandable response to stressors associated with ageing. The fundamental premise is that an alcohol misuse problem does not reside solely within the individual but within the context of a larger system. Alcohol misusers have reported that family members exerted more influence on their decision to begin treatment and even legal pressure. (Briggs et al, 2011)

Two primary reasons for using family-focused interventions are as valid for older adults as younger ones: family members have stress-related symptoms that deserve help in their own right and involvement of family members has shown to improve treatment outcomes. (Briggs et al, 2011)

Support and self-help groups

Counselor support for older client engagement in ancillary programs such as 12-step fellowships may help relieve isolation and loneliness. Preparing clients by demystifying the program, being informed about local meetings and their appropriateness for older clients, and encouraging clients to commit to attending a number of meetings before deciding on their usefulness to the recovery process is important. (Briggs et al, 2011)

To effectively address the needs of ageing adults with alcohol misuse problems, it is therefore vital that counselors understand the challenges of assessing and diagnosing alcohol misuse problems in light of the unique presentations of older clients. When offered treatment, older adults seem to benefit from age-specific interventions that can reduce unhealthy alcohol misuse and its adverse effects on health and well-being.

Alcoholic Anonymous 12-step Program (AA)

This in its simplest is a fellowship of men and women their experience, strength and hope with each other that they may their common problem and help others to recover from alcohol misuse.

The only requirement is the desire to stop drinking. AA is concerned solely with the personal recovery and continued sobriety of individual alcohol misusers who turn to the fellowship. Traditionally AA does not accept or seek financial support from outside sources and members preserve personal anonymity in print and broadcast media and otherwise at the public level. (Alcoholics Anonymous Great Britain, 2010)

Check Appendices, Appendix 5

7 RELATION BETWEEN RESULTS AND THEORETICAL FRAMEWORK

As the author stated earlier, suffering if a part of life. The elderly have suffered in their earlier years when they were productive. The struggles of making ends meet an creating a life for themselves and the generations to come. These efforts have their rewards through triumphs and salaries. As they age, they experience suffering in terms of loss and changes in their lives. It is a huge adjustment from working on a daily basis for between five to seven decades.

Suddenly they have no place to be or deadlines to meet. Adjusting can be very testy, because then they have to find things to do that can fill up there time during the day. Those who drunk in their years may increase the level of alcohol intake and those who did not drink at all may start just as a coping mechanism.

The feeling that one is not as productive in society and the unfortunate existence of ageism do not help the elderly people in adapting to the new lifestyle after retirement. Under the suffering as a struggle between good and evil all human beings want to feel like they belong and accepted in a community. This is mostly not the reception the elderly get among societies. The male gender in specific has a bigger problem with alcohol because it is more a social indulgence. Men generally tend to go to bars to just pass time

with their mates. More time in their hands means increase in the alcohol consumed daily.

People often want to express their suffering but there lacks a language that can best explain what a person is undergoing. Being human one can only bear too much and engaging in alcohol to a level of misuse is an example of a way to deal with what is going on underneath.

Due to alcohol misuse, the elderly may lose touch with their family member as well as be in accidents that may lead to hospitalization or worse. Diseases may be a result of alcohol misuse for a long period of time. That in itself is suffering because then estrangement from family in most cases means loneliness for the elderly. This is because more often than not they have lost their friends and loved ones. Suffering in that way is a form of dying for the elderly people.

In order to get help there has to a realization of the problem. This means giving the suffering meaning by reconciling with the situation. This suffering can then be transformed into desire and joy. When the elderly seek the help and the health care givers are empathetic most time they commit to treatment. The desire becomes abstinence or regulating alcohol intake.

Alleviation of suffering is applicable when the health care professionals are compassionate with the elderly individuals and give the treatment necessary without making the elderly feel ashamed. In some cases the elderly drinkers will open up about their experiences. It is important that their suffering is confirmed. This is a major step toward the healing process. It is important that they feel validated and that they belong. This is where the age-specific treatment and general groups come to play. Meeting other people with whom they have a lot in common brings about comfort. Family members should also be encouraged to participate in these interventions.

8 DISCUSSION, CONCLUSION AND SUGGESTIONS

The age-group 65 years and older has increased and is expected to continue doing so in the years to come. This means that more attention needs to be paid among these individual. More research and information needs to be compiled to broaden the scope of knowledge on the subject.

The idea is to increase mortality among the ageing, this means being able to enable them in all aspects of their lives. It is true that when certain areas of the elderly suffer, the stress incurred could lead to indulgence in alcohol use. The problem with alcohol use is that frequents use could lead to overuse which in itself becomes misuse.

In Finland alone education on alcohol misuse should be an issue to be looked into. The alcohol drinking trend mostly starts in early years and most times continues often to old age. This consequently has a negative impact on the life mortality of Finns. Deaths related to alcohol have increased and if nothing is done could continue to rise.

Cardiovascular disease, strokes and cancers related to alcohol continue to be on the higher numbers. Independence of the elderly people could also be inhibited due to alcohol misuse. Memory disturbances and cognitive impairments mean that the elderly people cannot be able to handle activities of their daily living. Depending on the severity of the psychological problems, they may be a danger to themselves and even others.

According to research triggers could cause individuals who had never used alcohol to start, those who had stopped to relapse and those drinking increase the level of drinking. Unfortunately this could lead to accidents whose magnitude range from fractures to emergency situations and even death.

Conclusion

The aim of the study was to understand the level of alcohol misuse among the elderly. The situation as has been researched in earlier years and the consequences of misusing alcohol and ways to access and treat the problem.

In Finland alcohol misuse has grown over the past four decades. It is approximated that 5-10% of elderly Finns problematic or risky alcohol misuse at least on an occasional. Of this group 1% has had a long-term alcohol misuse problem. Majority of the elderly peo-

ple with alcohol problems have not openly admitted to it. This means that the extent of the problem on a national and even global scale has not been fully realized.

Since alcohol misuse is sometimes not detected among the elderly who even visit the hospitals or emergency rooms, it is very hard to give the necessary advice and administer treatment. Health problems that come with ageing are at times exacerbated by alcohol misuse. Despite administering treatment, if the cause is not established properly it means that the problem may not be solved to totality.

As the population ages there are many changes that are inevitable. Some of the changes are in form of experiences. The most frustrating bit of it all is lack of control in most of those changes. There are no known ways of dealing because it is a very individual thing. Consequently the elderly might not know how to handle the pressures that come with these big changes that at times come too many at a time. Loss of loved ones and friends, retirement, and regression of body function can be great stress factors. This might push the elderly to use alcohol as a way of dealing with these pressures.

Assessment of alcohol misuse is a difficult task and might be hard to go about. The alcohol subject is very sensitive especially among the elderly who need empathy as they open up to alcohol misuse problems. Appropriate measures should be taken and involvement of family helps intervention and treatment outcomes.

Suggestions

Effort on how alcohol is a cause of various diseases should be observed. Alcohol should be regulated by the government from the younger generation so that alcohol misuse as a problem decreases. Combating the problem is a big goal to achieve for any given country but small measures should be implemented to pave way to the bigger changes.

The other big problem is use of drugs when under the influence of alcohol. It may be easier to reduce this when using prescription drugs because then health care professionals can keep an eye out for alcohol misusers. Over the counter medication however, can be bought at any time by anyone. This with alcohol could also have adverse effects and this becomes another area of interest.

Above everything else education and awareness on alcohol misuse as a growing problem should be encouraged. Help centers and help lines should always be available in

case anyone needs to talk or consult. Anonymity should always be observed at all times and family should be encouraged to speak up and support their relatives with the treatment

9 APPENDICES

9.1 Appendix 1 Alcohol and Drug Interaction

Alcohol Drug Interaction		
Drug	**Prescribed Purpose**	**Interaction**
Anesthetics (ex: Diprivan, Ethrane, Flouthane)	Administered prior surgery to render a patient unconscious and insensitive to pain.	-Increased amount of drug to induce unconsciousness -Increased risk of liver damage
Antibiotics	Used to treat infectious diseases	-Reduced drug effectiveness -Nausea/Vomiting -Headaches -Convulsions
Antidepressants (ex: Elavil)	Used to treat depression and other mental illnesses	-Increased sedative effects -May decrease effectiveness of antidepressants -Potential for dangerous rise in blood pressure
Antidiabetic Medication	Used to help lower blood sugar levels in diabetic individuals	-Reduced drug effectiveness -Nausea -Vomiting
Antihistamines (e.g. Bena-	Used to treat allergic symp-	-Intensified sedation

dryl)	toms and Insomnia	-Excessive dizziness
Antipsychotic Medication (e.g. Thorazine)	Used to diminish psychotic symptoms such as delusions and hallucination	-Intensified sedation -Impaired coordination -Potentially fatal breathing difficulties
Antiseizure Medication (e.g. Dilantin)	Used to treat epilepsy	-Decreased protection against seizures -Increased risk of drug-related side effects
Antiulcer Medication (e.g. Tagamet, Zantac)	Used to treat ulcers and other gastrointestinal problems	-Increased presence of drug; increased risk of side effects
Cardiovascular Medication (e.g. nitroglycerine, Aproseline, Ismelin, Inderal)	Wide variety of medications used to treat ailments of the heart and circulatory systems	-Extreme dizziness or fainting -Reduced drug effectiveness
Narcotic Pain relievers (e.g. Morphine, Codeine, Darvon, Demerol)	Used to alleviate moderate to severe pain	-Intensified sedation -Increased possibility of a fatal over-doze
Non-narcotic Pain relievers (e.g. Asprin, Ibuprofen, Acetaminophen)	Used to alleviate mild to moderate pain	-Increased risk of stomach bleeding -Increased risk on the inhibition of blood clotting -Increased effects of consumed alcohol acetaminophen (Tylenol) taken dur-

		ing or after drinking may significantly one's risk of liver damage
Sedative and Hypnotics (e.g. Valium, Dalmane, Ativan, sleeping pills)	Used to alleviate anxiety and insomnia	-Severe drowsiness -Depressed cardiac and respiratory functions -Increased risk of a coma and fatality
Adapted from the National Institute of Alcohol Abuse and Alcoholism		

9.2 Appendix 2: Alcohol Disorder Identification Test (AUDIT)

The AUDIT test questionnaire contains the following:

1. How often do you have beer, wine or other drinks containing alcohol?
    - Never
    - Monthly or less
    - 2-4 times a month
    - 2-3 times a week
    - 4 times a week or more
2. How many drinks containing alcohol do you have on a typical day when you are drinking?
    - 1-2 drinks
    - 3-4 drinks
    - 5-6 drinks
    - 7-9 drinks
    - 10 or more drinks
3. How often do you have 6 or more drinks on an occasion when you are drinking?
    - Never

- Less than monthly
- Monthly
- Weekly
- Daily or almost daily

4. How often during the past year have you found that you were not able to stop drinking once you had started?
    - Never
    - Less than monthly
    - Monthly
    - Weekly
    - Daily or almost daily
5. How often in the past year have you failed to do what was normally expected of you because of drinking?
    - Never
    - Less than monthly
    - Monthly
    - Weekly
    - Daily or almost daily
6. How often during the past year have you needed a first drink in the morning to get you going after a heavy drinking session?
    - Never
    - Less than monthly
    - Monthly
    - Weekly
    - Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?
    - Never
    - Less than monthly
    - Monthly
    - Weekly
    - Daily or almost daily

8. How often during the past year have you been unable to remember what happened the night before because you had been drinking?
    - Never
    - Less than monthly
    - Monthly
    - Weekly
    - Daily or almost daily
9. Have you or has someone else been injured as a result of your drinking?
    - No
    - Yes, but not in the past year
    - Yes, during the past year
10. Has a relative, friend or a doctor or other healthcare worker been concerned about your drinking or suggested you cut down?
    - Never
    - Yes, but not in the past year
    - Yes, during the past year
11. Sex?
    - Man
    - Woman
12. Age?
    - 15 or less
    - 16-17
    - 18-24
    - 25-30
    - 31-40
    - 41-50
    - 51-64
    - 65 and more
13. Whom are you testing?
    - Yourself
    - Partner
    - Child
    - Relative

- Client

9.3 Appendix 3: The CAGE Questionnaire

The CAGE questions appear as follows:

1. Have you ever felt you need to **C**ut down on your drinking?
2. Have people **A**nnoyed you by criticizing your drinking?
3. Have you ever felt **G**uilty about drinking?
4. Have you ever felt you needed a drink first thing in the morning (**E**ye opener) to steady your nerves or to get rid of a hangover?

9.4 Appendix 4: The MAST-G Test

The questions are as follows:

1. After drinking have you ever noticed an increase in your heart rate or beating in your chest?
    - Yes
    - No
2. When talking with others do ever underestimate how much you actually drink?
    - Yes
    - No
3. Does alcohol make you sleepy so that you often fall asleep in your chair?
    - Yes
    - No
4. After a few drinks, have you sometimes not eaten, or skipped a meal because you didn't feel hungry?
    - Yes
    - No
5. Does having a few drinks help decrease your shakiness and tremors?
    - Yes
    - No
6. Does alcohol sometimes make it hard for you to remember parts of the day or night?

- Yes
- No

7. Do you have rules for yourself that you won't drink before a certain time of the day?
    - Yes
    - No
8. Have you lost interest in hobbies or activities that you used to enjoy?
    - Yes
    - No
9. When you wake up in morning do you ever have trouble remembering parts of the night before?
    - Yes
    - No
10. Does a drink help you sleep?
    - Yes
    - No
11. Do you hide your alcohol bottles from family members?
    - Yes
    - No
12. After a social gathering have you felt embarrassed because you drank too much?
    - Yes
    - No
13. Have you ever been concerned that drinking might be harmful to your health?
    - Yes
    - No
14. Do you like to end the evening with a night cap?
    - Yes
    - No
15. Did you find that your drinking increased after someone close to you died?
    - Yes
    - No
16. In general, would you prefer to have a few drinks at home rather than go out to social events?

- Yes
- No

17. Are you drinking more now than in the past?
    - Yes
    - No
18. Do you usually take a drink to relax or calm your nerves?
    - Yes
    - No
19. Do you drink to take your mind off of your problems?
    - Yes
    - No
20. Have you increased your drinking after experiencing a loss in your life?
    - Yes
    - No
21. Do you sometimes drink when you have had too much to drink?
    - Yes
    - No
22. Has a doctor or nurse ever said they were worried or concerned about your drinking?
    - Yes
    - No
23. Have you ever made rules to manage your drinking?
    - Yes
    - No
24. When you feel lonely does having a drink help?
    - Yes
    - No

9.5 Appendix 5: Alcoholics Anonymous 12 steps

The twelve step program has the following?

1. We admitted we were powerless over alcohol- that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God as we understood him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly ask Him to remove our shortcomings.

8. Made a list of all persons we had harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to make personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God, as we understood Him, praying for knowledge of His will for us and the power to carry that through.

12. Having had a spiritual awakening as the result of these of these Steps, we tried to carry this message to alcoholics and to practice these principles in all our affairs.

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