The Heart of Treatment for Alcoholism

ALCOHOLICS ANONYMOUS:

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Ten years ago I was principal investigator on a massive, Federally-funded study of alcoholism in the elderly. A variety of research approaches were used to address questions which ranged in level and focus from government policy to individual case-handling. While a tremendous amount of useful and important information was developed in that study, none of it is as important or useful as what you are about to read in this article.

Health and social service providers who work with elderly people need to realize that about 10% of the elderly are likely to manifest varying degrees of health, psychological and social dysfunctions related to the excessive use of alcohol. The difficulty associated with detecting excessive alcohol use is inversely related to the chronicity and severity of the problem. About two-thirds of elderly alcoholics are severe, chronic alcoholics whose symptoms tend to be both obvious and profound. These symptoms are likely to include **physical signs of intoxication** (e.g. dysarthria, ataxia, impaired motor skills, attention and memory deficits, inappropriate behavior) **alcohol withdrawal** (e.g. tremulousness, nausea, vomiting, anxiety, tachycardia, hypertension, sweating, insomnia, loss of appetite, mild disorientation), **medical problems** (e.g. gastritis, cancers of the digestive tract, especially esophagus and stomach, pancreatitis, fatty liver, hepatitis, cirrhosis, organic brain syndrome, peripheral neuropathy, blackouts, atherosclerosis, hypertensive heart disease, cardiomyopathy, muscle pain and deterioration, weakness), **abnormal laboratory tests** (e.g. elevated uric acid, low levels of platelets and clotting proteins, decreased production of red and white blood cells, SGPT and SGOT elevations, low magnesium and potassium), and **psychiatric and emotional problems** (e.g. anxiety and depression, suicidal ideation, sleep disturbances, confusion and disorientation, frequent life crisis, disturbed interpersonal relations, and marked change in personality when drinking).

The remaining one-third of cases are likely to be less obvious. These people generally started drinking excessively later in life and their dependence on alcohol has no yet resulted in profound debilitation. Regardless of the obviousness or chronicity of the alcohol problem, "patients" are far more likely to present themselves as having medical problems than to walk in and announce that they have a drinking problem. **Denial** is the most basic and frequent psychological response to the suggestion that one has an alcohol problem. Thus, while you are well-advised to get some training in the recognition of alcohol problems, it is not likely to help you much unless you also have some idea about what to do

with older people who drink excessively once you have found them. This is where we get into the areas of intervention and referral for treatment the most delicate aspects of handling alcoholic clients.

A major difficulty in making referrals for alcoholism treatment is resistance on the part of the client. This may be augmented in elderly problem drinkers who were the youth and teens of the Prohibition era and who hold very negative and moralistic attitudes about alcoholics. This population is also poorly educated about alcohol and alcoholism, and their denial of alcohol problems is likely to be supported by their observations that they do not drink or act as their serotype of an alcoholic would.

Confrontation may thus be the first step in the referral process. Ideally, the counselor will have established a collaborative relationship with the client, and a mutual rapport. Generally, the best approach is for the confronting person to share his or her concerns, using the client's presenting complaints to bring up the subject of excessive drinking. The counselor may wish to point out destructive patterns of alcohol use; the relationship between drinking and symptom manifestation; or educate the client as to future problems he or she can expect if drinking is continued. The counselor should avoid the label "alcoholic" as well as judgmental, blaming, or punitive statements.

When the client has accepted the need for, or the reality of the referral, it will be necessary for the counselor to explore with the client his or her perceptions about treatment, and needs and preferences in regard to treatment. Fear is a common response to the idea of entering alcohol treatment, and the counselor should allow the client to express fears of being "locked up," socially ostracized, or financially ruined as a result of entering an alcohol treatment program. When the client has overcome the initial shock and its attendant anxieties, the counselor can explore those issues pertaining to the type of facility which is acceptable to the client.

The third step in the referral process is assisting the client in contacting the referral agency. This might include arranging transportation to the agency; contacting directly the person who will meet the client there; arranging a specific time for the appointment; obtaining signed releases for the transfer of information; and arranging for follow-up report(s) from the referral agency. Referrals to agencies with long waiting lists should be avoided, as research shows that the longer an alcoholic waits before entry into the treatment system, the less likely he or she is to enter or succeed in treatment.

There are a variety of existing programs for the treatment of alcoholism, ranging from in-patient, hospital-based programs to out-patient clinics and half-way houses. In choosing a referral for an elderly alcoholic or problem drinker, a number of factors must be considered. First is an assessment of the person's physical condition. Does he or she require detoxification or immediate medical attention? If this is judged to be the case, then referral to a hospital's alcohol program or to a detoxification center may be appropriate. Does the client have special health-care needs or disabilities which would bear on his or her eligibility of treatment? Before referring a client to any institution it is advisable to be aware of the organization's requirements and the

scope of its services.

The Most Important Things You Need to Know about Alcoholism Treatment

The variety of approaches to the treatment of alcoholic patients is mind-boggling in its diversity and this diversity constitutes a testimonial to the frustration and lack of success which caregivers have experiences. Once you move beyond standard medical remedies for the physical maladies associated with alcohol dependence, you enter the realm of actually treating the disease of alcoholism. After 20 years of clinical and research experience, I am convinced that the program provided by Alcoholics Anonymous (A.A.) has provided more help to more people than any other approach. Furthermore, I see no evidence that this reality is likely to change in the foreseeable future. The most important information in this article is what you are now going to read about A.A. and how it works.

Most caregivers in the elderly services network have only a superficial awareness of A.A. Unless they are members of A.A. or have a close relationship with an A.A. member, their knowledge of A.A. is likely to be deficient and their attitudes toward A.A. may be distorted. The notion that A.A. is a "religious program" which "has twelve steps" and "requires a lot of meetings in smoke-filled rooms" fails to do justice to a vast, sophisticated and free alcoholism recovery program.

The majority of alcoholism treatment programs in the U.S., including hospital-based in-patient programs, out-patient programs, and long-term residential care programs use the A.A. philosophy and encourage patients to become actively involved with A.A. While a period of hospitalization may be necessary for many alcoholics to detoxify safely and to stabilize medically, the real test of the efficacy of treatment does not occur until the patient is back out in the world and independently faces the challenges of abstaining from alcohol. Data from the AoA-funded study clearly indicated that elderly alcoholics who became actively involved with A.A. were far more likely to remain sober than those who did not. This research also clearly showed that group therapy and social support, whether related to A.A. or not, were the most important and effective elements of treatment.

The A.A. approach to recovery incorporates a "medical" model of alcoholism and a "moral-spiritual" model of recovery. The medical model of alcoholism asserts that alcoholism is a disease which, if not treated, is progressive and may lead to premature illness and death. The fundamental medical problem is that some people respond physically to alcohol in an abnormal way which leads to excessive use, dependence, "craving" and an inability to control intake.

The medical model of alcoholism has received some persuasive research support in recent years as evidence has been generated in support of the assertion that there may exist, in some people, a genetically inherited predisposition to become alcoholic. While it is true that there is a continuing scientific debate over the characterization of alcoholism as a disease, this debate has proven to be of more scientific interest than therapeutic value. In my opinion, the medical model of addiction has been valuable in therapeutic practice largely because it is more acceptable to the "patient" and to

society to view addictions as illnesses rather than as reflections of a personal failure of will-power or some other equally humiliating characterization.

The A.A. 12-step program of recovery begins with the practical observation that, for whatever reason, the individual has lost the power of choice with respect to alcohol consumption. The alcoholic's capacity to drink moderately is so impaired as to render the notion of "free-will" a fiction. Along with the inability to control alcohol consumption is a diminished capacity to manage one's health and life in general. The recognition and acceptance of this reality constitutes an enormously important psychological change from denial to awareness. It's like walking from darkness into light and it constitutes the foundation on which a program of recovery can be built. It is part of the wisdom of A.A. to know that this "awakening" is very much an individual matter which will not happen until the individual is "ready." Getting to the point of readiness may require that the individual "hit bottom" through considerable suffering. Sadly, some alcoholics never do reach a state of readiness and, other than intervention through some sort of confrontation, there seems to be little that outside agents can do to assist the process.

The second step of A.A. further reflects the genius of the program in that it provides hope and strength to replace despair and weakness. In this step the alcoholic acknowledges the existence of a power greater than self which can restore "sanity." The acceptance of a "Higher Power " is both a source of strength and inspiration to some people and an obstacle to be dealt with for others. The concept of a Higher Power in A.A. refers to "God" as we understood "Him" and it is the cornerstone of the spiritual foundation of A.A. Unfortunately, the "religious" nature of the A.A. program has been used by many alcoholics to justify their avoidance of the program. They complain or argue that this is a "turn-off" or that they can't relate to it. So profound is this phenomenon that in *Alcoholics Anonymous*, the A.A. "Big Book" which describes how the program works, there is an entire chapter entitled "We Agnostics" which deals with this issue. For some, A.A. becomes the higher power. For now, suffice to say that it is a gross distortion of the A.A. program to assert that one must be a highly religious person to benefit from the program.

The remaining 10 steps of the A.A. program also reflect the wisdom of those who have struggled to recover from alcoholism and while space limitations preclude an examination of each of them here, I will address a few points which they cover. In A.A. it is accepted that the cessation of drinking does not constitute recovery - it merely makes recovery possible. The need for profound life-style change is reflected by the individual's conscious decision to lead a less self-centered life and to accept one's place in the broader scheme of life. The alcoholic is asked to make "a searching and fearless moral inventory of self" and to share this with another person. Sound psychology is represented here in that exposure of the truth is consistent with a healthy orientation to reality and the emotional catharsis associated with relief from guilt and shame represents an unburdening of the self from negative, depressive emotions. Confession really does seem to be good for the soul.

Additional steps in the A.A.

program instruct and encourage the individual to take actions, both practical and spiritual, to facilitate the recovery process. Expansion of personal awareness, acceptance of personal responsibility, and sharing the program with others all serve to reinforce and integrate the process which the recovering person has made. Recovery is seen as being a life-long process which must be protected at all times. There is no "cure" for addiction to alcohol, only an ongoing program of recovery.

A number of features of A.A. make it especially appropriate for elderly people. First, it's free. Given limited funds and weak Medicare or other insurance coverage for out-patient treatment, A.A. represents an appealing alternative. Moreover, all the gold in Fort Knox cannot buy the support and commitment which is given freely by A.A. members. In A.A. you "work your program" with the help of a sponsor - a person who has "good sobriety" and who understands how the A.A. program works. Usually, these sponsors agree to be available 24 hours a day to assist you in case of crisis. Also, many A.A. meeting rooms are always open and this safe haven can be used by those who need it.

The support provided by A.A. goes beyond sponsorship in "working the program." It includes the provision of a sense of belonging, of being part of a group. This sense of connectedness can serve as a powerful antidote to the loneliness and isolation which is common among the elderly. If you need a ride to a meeting, someone will provide it - freely. Also, you can travel to just about any part of the country and many parts of the globe and you can find an A.A. meeting, a safe haven, a place where you know you will be welcome. You can't buy this.

In closing, it should be noted that A.A. is not the "answer" for all people - nor does it claim to be. Some alcoholics stop drinking with no assistance whatsoever but they are the minority and it is questionable whether their psychological and spiritual growth continues merely because they are abstinent. Some alcoholics find that they want or need psychotherapy or medical treatment for other psychological problems. Sometimes A.A. is only the beginning of the recovery process but it is the best program I know of and no one can argue about its cost effectiveness. If you really want to be helpful to elderly alcoholics, learn about A.A. Gat a copy of *Alcoholics Anonymous,* get a copy of a "where and When" booklet so you know the location and times of local meetings. Find out if there are any meetings in your area especially for older adults. Share what you learn.

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