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FACTORS IN OLDER ADULTS' RESISTANCE  
TO SUBSTANCE ABUSE TREATMENT

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A Project  
Presented to the  
Faculty of  
California State University,  
San Bernardino

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In Partial Fulfillment  
of the Requirements for the Degree  
Master of Social Work

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by  
Donnie Redl  
June 2003

FACTORS IN OLDER ADULTS' RESISTANCE  
TO SUBSTANCE ABUSE TREATMENT

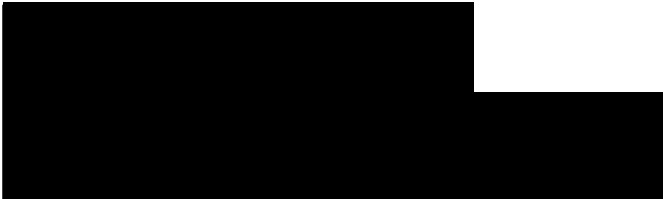
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by  
Donnie Redl  
June 2003

Approved by:

  
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5/22/03

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## ABSTRACT

Much research has been accomplished in the past in determining that there is a substance abuse problem in the older adult population (60+ years old) in this country. However, research has not addressed the reasons that older adults are resistant to treatment and participate in far less numbers than younger populations. This study investigates the relationship between stigma/shame and lack of social support as factors of resistance in older adults to drug/alcohol treatment. It hypothesizes that this population's shame associated with the moral stigma attached to their view of alcoholics and addicts along with a lack of social support are the major reasons that they resist seeking treatment.

## ACKNOWLEDGMENTS

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I would like to thank my wife Charlene for all her help in completing this study. The missed weekend get-aways, and special occasions that were taken up with continual proof readings were enough to test any marriage. Without her love, constant support and belief in what I was trying to accomplish I would never have been able to finish this project.

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## CHAPTER ONE

### INTRODUCTION

#### Problem Statement

Alcohol and substance abuse affects, by some estimates, up to 17% of the older population aged sixty years and older (U.S. Dept. of Health and Human Services, 1998). Substance abuse, particularly of alcohol and prescription drugs, is one of the fastest growing health problems in the country (U.S. Dept. of Health and Human Services, 1998). With the aging of the baby-boom generation this problem can only increase in the years to come. By the year 2050 the older adult population, 60 and over, will mushroom from the 1994's population of 33 million to more than 80 million (U.S. Bureau of the Census, 1996). It is important that as the population ages medical professionals, social workers and other social services providers become aware of this growing problem.

It is important for those in the helping professions to learn techniques for screening and identifying substance abusing clients. In addition, learning how to differentiate between normal aging and substance abuse is critical for medical personnel as well as social workers. Social service providers must be aware of what treatment



modalities are available for older adult substance abusers and how best to intervene. They require information on which substances are most widely abused and their presenting symptoms.

With services needed by older adults increasing on a daily basis (Gurnack & Thomas, 1989) social workers, substance abuse treatment providers, social service practitioners, doctors, hospitals, medical personnel as well as HMOs and insurance providers all have an interest in identifying and eliminating the causes of substance abuse in older adults. Adults 65 and older consume more prescribed and over-the-counter medications than any other age group in this country (U.S. Bureau of the Census, 1996a.) In the U.S. it is estimated that 2.5 million older adults have problems related to alcohol, and 21% of hospitalized adults over age 40 have a diagnosis of alcoholism with related medical costs as high as 60 billion dollars (U.S. Dept. of Health and Human Services, 1998). Currently, rates for alcohol-related hospitalizations among older patients are similar to the rates for heart attacks (Adams, Yuan, Barboriak, & Rimm, 1993). All service providers to older adults as well as funding sources have a vested interest in developing

treatment methods that not only work but also are cost effective.

For treatment programs to be cost effective they must be thoroughly tested, and these programs need to address the underlying reasons for why older adults abuse alcohol and other prescription drugs. The literature shows that most older adults that drink or abuse substances do so for many reasons (Brown & Chiang, 1983, Norton, 1998, Schonfeld & Dupree, 1990,). Some do so due to deaths of loved ones and resulting loneliness and break downs in their social network. Yet others drink because they started drinking early in life and their drinking continued to progress (Schonfeld & Dupree, 1990). Some abuse alcohol or prescription drugs because they have problems coping with the stresses and situations resulting from the aging process or the transitions that are required in later life (Gurnack & Thomas, 1989). Prescription drug abuse, however, is most often a case of misuse of the prescription drug and most have no intention of abusing them (Barnea & Teichman, 1994, Brown & Chiang, 1983). Often older adults are more likely to misunderstand prescription directions, a fact that is increased by the multiple prescriptions that they receive (Barnea & Teichman, 1994). Multiple prescriptions may be given by

several physicians that are unaware of other medications that are being prescribed. Discovering the reasons older adults abuse substances, developing treatments and screening instruments will be of no use if older adults refuse to use services provided.

Older adults tend to not enter treatment for substance abuse as younger groups do (Schonfeld & Dupree, 1990). In the state of California where this study will be conducted only seven-tenths of one percent of the 155,832 individuals entered into substance abuse treatment between July 1, 2000 and March 31, 2002 were over 60 years of age (California Department of Alcohol and Drug Programs, 2001). Numerous reasons have been put forth but not really studied thoroughly. Some explanations put forth say treatment programs, especially those publicly funded, are full of young people who are using illegal drugs. It is believed that older adults do not relate well to this population (Kofoed, Tolson, Atkinson, Toth, & Turner, 1987). Other treatment studies show that mixed aged treatment groups have better or equivalent rates of success with older adults (Janik & Dunham, 1983). To further complicate the problem there are the gender and cultural reasons for not seeking help (DeHart & Hoffman, 1995, Harrison, 1989, Kail, & DeLaRosa, 1998).

Throughout different studies (Brown & Chiang, 1983, Kauffman & Poulin, 1996, Schonfeld & Dupree, 1990) there appears to be an underlying sense that at least the present cohort of older adults views the subject of alcoholism and substance abuse as shameful behavior. To have a substance problem is a sign of weakness of character. To be unable to handle prescribed medications indicates individuals that cannot care for themselves and who might be better off in a home where others can care for them. It is hypothesized that older adults do not seek treatment for substance abuse because of the stigma and resulting feelings of shame attached to alcoholism and substance abuse. It is further hypothesized that lack of social support or sheer loneliness are factors in the older adult population not entering treatment programs. Identifying the causes for older adults' reluctance to seek help will allow those in the helping professions to break down the barriers to treatment.

With a problem that is getting bigger every day, treatment programs must be adapted to meet the needs of older adults and make it more acceptable for them to enter treatment. Ways must be found to remove the stigma attached to substance abuse. Social workers must reach out to those who are either unknowledgeable of treatment

programs or who lack that caring individual whose influence is required to help them seek treatment.

#### Purpose of the Study

The purpose of this study was to determine the factors that account for older adults' under-use of substance abuse treatment programs. With an older adult population that is growing rapidly the problem of older adult substance abuse will only increase (Gurnack & Thomas, 1989). Most current studies deal with the environmental factors and reasons for substance abuse as well as the physical and emotional consequences that abuse incurs. This study dealt with factors that prevent or make it harder for older adults to seek treatment and successfully improve their quality of life. It is hoped that this study as well as follow-on studies will enable health care workers to find ways of convincing this population that treatment is acceptable in the world they live in today.

#### Significance of the Project for Social Work

With an ever-growing older adult population, the problem of older adult substance abuse can only grow. The baby boom generation, those born between the years

1946-1964, will reach 65 years old or older adult status in the year 2011 (U.S. Bureau of the Census, 1996b). This is the generation that led the way in the use of illicit drugs in the sixties and seventies (Patterson & Jeste, 1999). The lack of sound treatment modalities and the social worker's inability to get older adults to access them could lead to unrivaled suffering amongst this population. To meet this challenge social workers must be able to identify the causes of older adult substance abuse and be able to break down their resistance to treatment.

## CHAPTER TWO

### LITERATURE REVIEW

#### Introduction

The literature review will discuss the size of the problem as well as the consequences both physically and emotionally involved in older adult substance abuse. The effects of the aging process will be identified and how they assist in masking the true problem of substance abuse. Ageism and stereotypes contribute to the problem and make it difficult to diagnose and treat. The effects of stigma, its resulting shame and guilt, and the lack of social support networks will be shown as major contributing factors in older adult substance abuse.

#### Behavior and Consequences

According to a study by Adams and Cox (1995) conservative estimates state that approximately 4% of the United States older adult population meets criteria for alcohol abuse or dependence. Of this population, ten percent are classed as heavy or problem drinkers. In one study of older adults at a teaching hospital clinic researchers interviewed 154 older adult primary care patients, which were 59% female. Sixteen percent met DSM criteria for life-long alcohol abuse or dependence (Adams

& Cox, 1995). The number of the older adults abusing prescription medications varies also, but looking at the number of older adults on medication might give an idea of how large the problem might be.

Eighty to 86% of older adults over age 60 have one or more chronic diseases requiring medication (U.S. Bureau of the Census, 1996). In addition, 83% of older adult patients over 65 years old take at least one prescription drug. Some studies show that approximately 30% of those 65 and older take eight or more prescriptions daily. Large shares of these prescriptions are for psychoactive, mood-changing drugs that carry the potential for abuse and dependency (U.S. Dept. of Health and Human Services, 1998). The numbers indicate that the problem is large and has the potential with the aging of the baby boomers to get even larger. The problem of substance abuse treatment for older adults is amplified by a lack of common agreement on how large the problem is and even what constitutes dependence and abuse in this population (Brown & Chiang, 1983)

Many definitions of alcohol and drug abuse in older adults are based on studies of younger individuals (Schonfeld & Dupree, 1990). When criteria such as found in The Diagnostic and Statistical Manual of Mental Disorders,



Fourth Edition (DSM-IV-TR) are used, terms like tolerance, withdrawal and persistent use despite adverse physical or psychological problems can become inaccurate yardsticks (American Psychiatric Association, 2000).

For example, tolerance changes with age (Fingerhood, 2000, Janick & Dunham, 1983). With the loss of lean body tissue an older adult client can quite accurately report that their drinking has not changed or has actually decreased over time (Adams & Cox, 1995). Yet the effects of the alcohol or drugs they use now are greatly increased and troublesome. When older adults are surveyed or screened, their problems and signs of abuse are often masked by their life situation.

Withdrawal symptoms such as depression and complaints of pain and discomfort can be misdiagnosed as the results of the aging process (U.S. Dept. of Health and Human Services, 1998). Worse yet, additional medications are quite often prescribed to eliminate these symptoms adding to the effects of the alcohol or drugs already being used. Physical ailments such as gastrointestinal problems as well as hypertension, sleep disturbances and insomnia become aging problems and older adult substance abuse goes unnoticed (Curtis, Geller, Stokes, Levine & Moore, 1989). Psychological problems, depression, anxiety and even

dementia are misdiagnosed as the results of aging (U.S. Dept. of Health and Human Services, 1998). Ageism creeps in with younger adults constantly assigning most problems that older adults have to problems of aging instead of substance abuse. The size of the problem is also hidden by the life style of a proportion of the older adult population.

The behavioral problems indicative of substance abuse or addiction are often seen openly in the young but not in older adults. As Adams and Cox (1995) stated, "Those adults who are unemployed or retired will not have problems at work, those who are widowed will not have marital problems and those who have stopped driving will not be cited for driving under the influence." For example, (Aunt Betsy having her daily nip does not bother anyone, except that Aunt Betsy nips all day and occasionally has a bad fall usually accounted for by her age. Common ageism comments such as 'she is up there in the years and won't be with us much longer' tend to lower expectations of older adult's quality of life and insure that the Aunt Betsys will not be with us long. Another reason for older adults not being diagnosed with a substance abuse problem is they are very good at hiding it (Brown & Chiang, 1983).

When talking to a doctor or care provider they complain often about psychological physical symptoms. They speak of anxiety, depressed mood, panic attacks, sleep disturbances, appetite and even hallucinations. Rarely do they complain about their drug or alcohol use (Solomon, Manepalli, Ireland & Mahon, 1993). With many older adults, problems with substance abuse involve feelings of shame, which causes denial of the problem to become very strong (U.S. Dept. of Health and Human Services, 1998). Add to this the attitudes of ageism found in family members and care providers and it becomes easy for the older adult substance abuser to go unnoticed. In the cases where substance abuse is identified, older adult substance abusers tend to use alcohol and drug abuse services at a much lower rate than younger cohorts (Schonfeld & Dupree, 1990).

#### Factors in Resistance to Treatment

As stated earlier many factors involved in older adult substance abuse have been discussed such as extent of the problem, treatment needs and why older adult substance abusers are misdiagnosed. The literature makes mostly assumptions of why older adults do not enter treatment for substance abuse. Some of the reasons that

have been given for the older adult's lack of treatment seeking seem very obvious yet they remain only assumptions and unproven (Gurnack & Thomas, 1989, Schonfeld & Dupree, 1990).

One of the reasons given is a reluctance to participate in treatment programs, especially publicly financed ones. These programs tend to have a large proportion of younger substance abusers (Schonfeld & Dupree, 1990). [The younger participants are often abusing illegal drugs while older adults abusing alcohol and prescribed medications are not doing anything illegal.] During the author's personal experience as a drug/alcohol counselor it has been observed that there is a tendency for drug abusers using different substances to look down on each other. An assumption could be made that this applies to the older adult's thoughts on younger substance abusers. For example, in group settings alcohol or marijuana users have a tendency to believe themselves as far better than methamphetamine users. So it is plausible that older adults believe they do not belong with these young lawbreakers because their drugs are legal. However, those older adults who enter treatment and are placed in age-integrated groups (groups containing members of different ages) are shown by studies to do just as well as

those in age-specific treatment programs (Janik & Dunham, 1983). Drug induced dementia or cognitive impairment is another plausible reason (Schonfeld & Dupree, 1990). Those older adults whose thinking is impaired are less able to make wise decisions about their condition and required treatment. It is the thrust of this study that while this problem has multifaceted reasons, two factors are most responsible for older adults not seeking treatment.

First is lack of a social support network or, as one study stated, loneliness (Finlayson, 1995). A study by Brown and Chiang (1983), which tried to determine reasons for substance abuse in older adults, found that abusers not in treatment were most likely to be living alone. It went further to find that the addition of a close friend living nearby significantly enhanced the chances that the individual would be in treatment. From this point it can be hypothesized that an individual lacking a significant other, spouse or family to intervene and prod the abuser toward treatment, will continue to abuse and refuse treatment. In another study, being unmarried was a contributing factor in older adult individuals who did not seek treatment (Kauffman & Poulin, 1996). The literature shows that the loss of loved ones and friends and the eventual loneliness is a contributing factor in older

adults starting to abuse substances (Norton, 1998). It may be that the loss of those very support networks leads to older adults being unable or unwilling to face their denial and seek treatment.

Second are the stigmas and the feelings of guilt and shame that often accompany substance abuse. In addition, not wanting to embarrass other family members could be factors for not using services. It must be remembered that the cohorts of older adult substance abusers now present in U.S. society base their thoughts on alcohol or drug abuse on a moral model (Kauffman & Poulin, 1996). The moral model held that the morals and personal character of the individual, and their will, or lack of, is the most important reasons for an individual's substance abuse (Kauffman & Poulin, 1996). Coming from this frame of reference it can be seen that older adults do not want to be seen as lacking in morals and possessing character flaws. It is not just the shame of older adults that contributes to the problem. The sense of shame felt by adult children of older adults contributes to the head-in-the-sand behavior that they sometimes exhibit. It is easier to see older adults as old and frail than to face that they have a problem that has to be dealt with.

In one study conducted by Barbara Barer, (1997) older adults were reluctant to even report theft and exploitation because of the shame involved in them being duped or considered incompetent by their families. Being judged incompetent may lead to the older adult being placed in a home where others can care for them and thus a loss of their independence. The shame and feeling of incompetence of not being able to handle medications properly or being able to control their alcohol intake could be another reason older adults do not seek treatment.

Cultural reasons have to be taken into account when considering shame as a factor in not seeking treatment. For example Latinos' views on respect for older adults and seeking help only within the family can be contributing cultural factors for not seeking outside help (Kail & DeLaRosa, 1998). In all cultures family can be part of the problem as well as part of the solution.

#### Theories Guiding Conceptualization

In the current study, Family Systems Theory is the guiding theory to determine the factors involved in older adults not seeking treatment for substance abuse. The literature shows (Finlayson, 1995, Kail & DeLaRosa, 1998,

Schonfeld & Dupree, 1990) that in most cases families and the systems around older adult substance abuser are interacting to either support the individual or degrade the situation. When shame, guilt or feelings of being judged incompetent break down the communications between family members and older adults substance abuse can go unnoticed or ignored. Lack or loss of significant others, spouses and close family ties contribute not only to older adults abusing alcohol and drugs but are factors in older adults not seeking treatment. These breakdowns can make it impossible for older adults to connect with or even find substance abuse services.

#### Summary

The problem of older adult substance abuse is not just one of developing programs to treat those in need. The uniqueness of this population and the stressors that they face in the aging process contribute to their denial and resistance to treatment. In a society that worships youth, older adults and their unique needs are sometimes ignored. To truly assist the older adult social workers must gain an understanding of the forces that motivate them. The literature shows that this is a large problem with many parts to the puzzle. This study will attempt to



take two factors, stigma/shame and lack of social support,  
and use them to explain older adult's reasoning and to  
empathize with their situation.

## CHAPTER THREE

### METHODS

#### Introduction

This chapter discusses the purpose of the study and the hypotheses and assumptions that were examined. It shows the makeup of the sample that was be used and the procedures that were followed to collect the data. In addition, methods used to obtain informed consent and providing protection of human subjects are discussed.

#### Study Design

The purpose of this study was to examine factors that prevent older adult substance abusers from seeking treatment. Specifically, the factors of stigma/shame and the lack of social support provided by family, friends and community were examined. This study explored the thinking of substance abusers prior to their getting treatment as well as their thinking now after years of recovery. It explored the reasons that they believe they resisted or put off seeking treatment. Prior literature involves studies examining factors leading to problem drinking or substance abuse but does not tend to concentrate on why substance abusers that are older adults do not seek treatment. The research question for this study was why do

older adult substance abusers resist seeking treatment. It was hypothesized that older adults do not seek treatment for substance abuse because of the stigma and resulting feelings of shame attached to alcoholism and substance abuse. It was further hypothesized that lack of social supports or sheer loneliness and isolation are factors in the older adult population not entering treatment programs. This study, which was qualitative in design, sought to explore not only the factors that have been hypothesized but also any other factors that are discovered during interviews and the gathering of data. The limitation of this type of study was that it did not examine older adult individuals that are right at that stage of having a problem but not as of yet seeking treatment. It was hoped that this study would give insight into the thoughts and feelings of those older adults who have a substance abuse problem and who have decided to seek help.

#### Sampling

The sample for this study was 10 substance abusing older adult individuals. For this study older adults was defined as individuals of both genders that are 60 years of age and older. Substance abusers were defined as

individuals that have abused alcohol or drugs of any kind either prescribed or illegal. All participants were presently involved with Alcoholics Anonymous (AA), Narcotics Anonymous (NA) or a California state recognized treatment program. Participants were drawn from San Bernardino County primarily from the San Bernardino and High Desert areas. There were no exclusions of participants based on gender, religion, ethnicity, socio-economic status or length of addiction or time in recovery.

#### Data Collection and Instruments

This study was qualitative in design utilizing face-to-face interviews with participants. A qualitative study was chosen since research in the area of treatment seeking for older adult substance abusers is limited. For the purpose of this survey the term treatment referred to any state-approved treatment facility, AA or NA program. This form of study allowed the factors of stigma/shame and social support to be evaluated. In addition, it provided an exploratory process that could discover any other factors that were present and affected the factors of treatment-seeking older adults.

All surveys that were completed by participants as well as the Informed Consent and Debriefing Statement were printed in large font (Arial 14). This was done to insure all older adult participants were able to easily read the information and questions. The researcher was present to assist any participant that required assistance in reading survey questions or information.

A 26-question survey was developed that had two parts. Part I (see Appendix A) was composed of Background Information (Demographics) with 9 questions including such variables as gender, ethnicity, age (measured by year they were born) marital status, religious affiliation, years of education, employment and who they reside with. The other section of Part I was Substance Use History. This section was composed of 6 questions that provided information on drug use, when the participant entered treatment, length of sobriety and how they entered treatment.

Part II was composed of 11 questions that were administered by the researcher and were provided so the researcher had a common starting point for every interview. This section provided questions that sought to explore the thoughts and feelings that were present at the time the participant entered treatment. This approach had strengths and weaknesses.

Its strength was in its open-ended question approach. This approach allowed for evaluating the study's hypothesis as well as any other variables that presented themselves. In addition, the semi-structured nature of Part II allowed for the participant to have a starting point for their thoughts and feelings to develop from.

A weakness was that an interview format relies on the participants' memories of the time just prior to them entering treatment. This period may be short for some but for others it could be many years. Reliance on memories of individuals that may have cognitive damage due to heavy drug/alcohol use may affect reliability.

#### Procedures

The first step in the data collection process was to make contact with recovering addicts that fit the study criteria to see if they would be willing to participate in the study. In addition, referrals from counselors were sought at drug/alcohol treatment facilities. Arrangements were then made for participants to be interviewed. Additionally, participants were encouraged to refer other participants to the study author so arrangements could be made to meet with them at meetings or other acceptable locations.

Participants were asked to participate in the study and informed that it would take approximately 30 to 45 minutes. Anonymity was explained, and the participants were instructed to insure that they did not provide their name or address or signature on any of the forms. Participants were informed that they may stop and withdraw from the interview at any time. They acknowledged their participation by reading and completing the Informed Consent Form (see appendix B). Once permission was granted the participant completed the survey (see appendix A) and interview questions face-to-face with the author of the study. The participants were asked to allow the interview to be audio taped making sure that they understood that they could refuse. In the event that permission to tape was not given all interview data was transcribed by hand. After the participant completed the survey and interview, all information gathered was placed in an envelope that was identified by a randomly assigned number. Participants then were debriefed (see appendix C) and were given referrals and telephone numbers to contact if they encountered any negative reactions or stress due to the interview. They were encouraged to contact the author of the study with referrals of additional individuals wishing to participate in the study. Participants were asked not

to reveal questions or in-depth information on the study to future participants.

#### Protection of Human Subjects

This study was designed to examine the thoughts of older adult substance abusers and what factors prevented them from seeking treatment. In order to protect this population the researcher obtained an informed consent (see appendix B) from all participants prior to administering the survey and questionnaire. No identifying data such as names or addresses were collected or maintained. All participants were briefed on anonymity and that participation in this study was voluntary and that they could stop their participation at any time. On completion of the interview all survey information, audiotapes and notes were placed in an envelope identified only with a randomly assigned survey number. All information was safeguarded with access provided only to my research supervisor and myself. Participants were provided with referrals and phone numbers of the researcher and individuals that could answer additional questions or provide assistance.



## Data Analysis

This study was qualitative in design involving face-to-face interviews. The researcher's notes and possible tape recordings were transcribed, and the researcher and his supervisor evaluated all data. Key concepts from each interview were transferred onto index cards and evaluated for similarity using interpretive Q-sort techniques. It was felt that categories would emerge as common themes and become apparent. In addition, the researcher examined differences and similarities in the qualitative responses in Part I. A process of comparing different factors as well as different categories was checked against the hypothesis to check for relevance.

## Summary

The methods and procedures of this study insured that the participant was protected at all times. Since this study was qualitative in nature its results may not be able to be generalized to the general population. It is hoped that this study provided information that could be used to generate further studies of this under-served population. In addition, it is hoped that social workers and substance abuse therapists, by using the data

presented, will be able to find effective ways to provide treatment for this population.

## CHAPTER FOUR

### RESULTS

#### Introduction

This study was composed of ten older adult alcoholics or substance addicted individuals. They ranged in age from 61 to 83 years old with an average age of 70 years old. Length in sobriety ranged from 11 to 32.7 years with an average length in recovery of 22.6 yrs. The ethnic make up was 80% Caucasian, 10% African-American and 10% Mexican-American. For further demographic information refer to Table 1 (see Appendix D).

#### Presentation of Findings

Each question in the taped interviews were used to gather statements that were then summarized as to responses that pertained to the question asked or were relevant factors in resistance. These responses to questions were then used to form important themes that pertained to why older adults resist drug/alcohol treatment. A total of four main themes were developed which either dealt with resistance to treatment, factors making it harder to overcome resistance and enter treatment or reasons given for entering treatment. The following is a list of the questions with some sample

responses and how these responses were used to either establish main themes or to aid in the identification of important factors.

Question 1 "At that point in time, did words such as alcoholic, addict, or substance abuser have a negative, neutral or positive meaning or feelings attached to them?". This question dealt with finding the individual's reaction to images or thoughts they had developed of what an alcoholic/addict looks like and the feelings or emotions evoked by those thoughts. All of the respondents produced negative statements to identify their thoughts and feelings. For example, "If I thought about an alcoholic it was some dirty old man in a raincoat... unwashed, unclean" (Jane 5) or "Negative, very negative. The feelings attached to it were essentially guilt, shame, no good, rotten, all of those things" (John 5). This question was used to establish the main theme of "Stigma/Shame" being a factor of resistance. The second part of the question, "How does that differ from your feelings or thoughts now?" was used along with question 11, "How do you feel now if the subject of your being in treatment or counseling is revealed or brought up while with friends, family or employers?" to determine if

treatment had been successful in changing or removing their prior stigma/shame-inducing thoughts.

Question 2 "Can you tell me what were some of your feelings or thoughts about yourself and your behavior at that time?" This question also was used to establish the main theme of stigma/shame. Responses to this question were used to compare thoughts and emotions in question 1 with their thoughts about themselves and the emotions that were evoked by those thoughts. All but one of the respondents identified their behavior prior to entering treatment as negative. "I felt very ashamed. I was full of guilt, full of fear. And I didn't know why every time I thought I'd just have a couple I ended up drunk. I couldn't understand. (Jane 5) and "Very low. Self-image, insecurities, hopelessness, no purpose in life. No direction. Just as a walking dead man. I had, I mean as a walking dead man and I mean it literally because that's the way I seen myself as hopeless. I was very selfish" (John 2).

Question 3 "What do you think the significant people in your life (family, friends, employer, physician) felt or thought about you prior to entering treatment or counseling?". This question helped to show imagined or actual feelings of shame that were felt by family members

and it was used to develop the main themes of stigma/shame and lack of social support. Shame and anger were indicated to be felt by 50% of the respondents' family members or significant people while 20% were totally isolated from significant people in their lives. Thirty percent indicated significant people just did not see anything wrong or were unaware of any unacceptable behaviors.

Question 4 "Did the significant people in your life (family, friends, employer, physician) know that you had entered treatment/counseling?" tied in with the major theme of lack of social support. "I mean once I got to A.A. and I told them, they seemed to be greatly relieved except my mother thought that I went to A.A. to talk about her" (Jane 5) and "I wasn't that close because I separated myself. You know, and I just didn't want to embarrass, well maybe even embarrass them" (John 2).

Questions 5 "Just prior to entering treatment or counseling, what was your marital status?" and Question 6 "Just prior to entering treatment/counseling, were you employed?" showed if the respondents were functional addicts or if the addiction had already taken everything in their lives. These questions were used in the formation of the main themes of lack of social support and reasons for entering treatment. Their answers broke down to 40%

married but only ten percent to some one who was not an addict. Another 40% were single with only one in a stable relationship and 20% were divorced with substance abuse being the primary reason.

Question 7 "Why did you enter treatment/counseling?". This question was used to attempt to show reasons for entering treatment and the mental emotional state of the respondents at the time just prior to entering treatment. All but one respondent's answer indicated that they were physically and emotionally at the low point of their addiction. Only one indicated that he was forced into treatment.

Questions 8 "How did you hear about the program you entered?" This question, along with comments made in other questions, established the major theme of "availability of services" as a reason for not seeking treatment and reinforced the theme of "lack of social support" as a factor in resistance to treatment.

Question 9 "Were significant people in your life (family, friends, employers, physicians) supportive of your entering treatment/counseling?" This question showed the social support obtained by the respondents after entering treatment and the level of stigma/shame just being in treatment caused family members. Of the

respondents 40% did not receive support from significant people in their lives even after entering treatment and 50% did receive support. One respondent was so isolated and feeling so much shame that he felt lack of support was mainly due to him. "I was so isolated from them because of my feelings about myself. You know, not that I was disowning them. It was just how I felt about myself, all those negative feelings about myself. That I was worthless" (John 2). Of those who did not receive support the majority showed shame that they had entered treatment, as the family members response, "my grandmother said something like how dare you disgrace our name" (Jane 5).

Questions 10, "When you entered treatment/counseling the first time did you relapse?", 10b "If you did relapse how many times did you relapse prior to maintaining your sobriety?" and 10c "Why do you feel you relapsed?" dealt with the major theme of lack of social support." In addition, this question identified relapse rates and some reasons for relapse, "Men. I left my husband and of course the next man was an addict. They were always addicts. I've been married to two addicts. And so I went back into the familiar relationship and I would get loaded with them" (Jane 2). Of the respondents approximately 60% relapsed



and relapsed numerous times before maintaining their sobriety.

#### Summary

The summary of responses and the percentages of responses were obtained from 62 pages of transcripts, which were derived from approximately 7 hours of recorded interviews. If additional information on responses is desired they may be found in Appendix E "Summary of Responses". The responses of the individuals in this study showed some common themes that are factors in their resistance to entering treatment. In addition, the responses helped to identify an additional theme that did not aid the respondents in their entering treatment such as their inability to find services. Lastly the theme of why people overcome the major factors of resistance and enter treatment evolved.

## CHAPTER FIVE

### DISCUSSION

#### Introduction

After analyzing the responses of individuals involved in this study four major themes became apparent. Two were factors that explained why older adults resist drug/alcohol treatment: stigma/shame and lack of social support. One involved a theme that makes it more difficult for older adults to enter treatment: the inability to find services. This theme, while not having to do with resistance, makes it more difficult for individuals to overcome resistance. The last theme involved factors that cause them to overcome resistance and enter treatment.

#### Discussion

All through the interviews the theme of stigma/shame appeared in almost every answer to questions that were posed. The source of this stigma/shame came from two major sources: the way this cohort thought or viewed alcoholism and addiction and the respondent's feelings about their behavior prior to entering treatment. As has been mentioned earlier this cohort was one that had not adopted the medical model of addiction but one that viewed addiction as a moral problem, (Kauffman & Poulin, 1996).

For example, the statement made by one respondent and echoed by others, "...in those days, that's a long time ago and in those days it was treated as more of a mental problem or moral problem than it was a sickness or disease" (John 1). The stigma of an alcoholic or drug addict was something that was viewed as someone of low character the lowest of the low, "An alcoholic was stereotyped as the old drunk laying down in the gutter sucking on a wine bottle" (Jane 1) and "It was negative just the way they looked at me. Right, as a, as a thief, as a liar, as a nobody in society". (John 2). This image of an addict made it very hard for someone trying to evaluate their behavior to accept that they were "one of those people". This lack of acceptance became a major factor in their resistance to treatment and led to denial of their problem. They rationalized that their behavior did not match the stereotypes or at best was not that bad, "Staying up to 3:00am cleaning my house. ...If my kids were spotless, my house was spotless and I was working everyday... then I didn't have a problem and how dare you say I do" (Jane 1). In addition to stigma, the respondents came to the point where they started to feel shame of their behavior. In those moments when they took an honest look at how they were acting their opinion of themselves

and their behavior became very critical, "Disgusting. I was totally out of control" (Jane 2). Stigma and shame were not limited to just feelings that were felt by the individual but also included stigma and shame felt by their families.

Families of these respondents also felt shame at the knowledge that their family members were addicts, "You know my mother was a little tiny woman, but she, it was a good family, and I was a disgrace. I was the only drunk that she knew in the family. I was a pretty low down woman" (Jane 5). This shame often led to denial and codependency by family members or an attempt to explain away the addicted family members behaviors, "Yeah, that and I had a lot of codependency in my family. My family used to tell me you're not an alcoholic you just drink too much" (Jane 1). This denial and codependency that infected the families and significant others of this population often led to another factor in resistance to treatment.

Lack of social support was another theme that became obvious during the interviews. Family members or significant others either denied the problem making it harder for the individual to accept that they needed help or they isolated the addict and had nothing to do with them. This isolation had the same result as if the

individual did not seek treatment. Without the pressure from family members or significant others the respondents were free to continue their behavior and wallow in the shame it produced.

Another form of social support that was lacking in some of the respondents was a family member being absent due to death or divorce. Now alone, their prior controlled substance use became unmanageable. Older adults while living longer face the reality that they may live those longer years alone. Again, without that significant person to point out their unacceptable behavior and force them to seek treatment their recovery can be delayed at best, (Brown & Chiang, 1983). While family members and significant others did not always have the ability to push a respondent toward treatment, their holding the addict accountable for their behavior was often a factor that led to recovery. During the interviews another theme became evident, the inability to find services by this group of respondents.

The inability to find services in the time period when they were facing their addiction was quite different from today. There were programs but they were less numerous because of the belief at the time that addiction was a character flaw. If it is not a disease why treat it?

Many respondents raised the issue of the increase in treatment facilities today versus those available in the past. As one respondent described it, "Back in the sixties, back in the fifties, there were no treatment programs like there is now. I mean there's a treatment program in every block. And A.A. and N.A. all over the place. Twenty-four hours a day. A.A. or N.A. wasn't there yet...maybe they were ready but there were no treatment programs" (John 2). Lastly, the respondents mentioned the importance of people other than significant others and family members.

They brought up the importance of doctors that they encountered during the years before they entered treatment. Some doctors recommended treatment and some while concerned pointed out their behavior but did not push them to treatment. The worst were doctors that either ignored their addiction or assisted in continuing their substance use, "Well, of course. My final dinner with the doctor was a martini lunch. He said I am not an alcoholic, but I have to watch what I do when I drink" (John 1). Those doctors that did discuss treatment were not always the turning point in the respondent's addiction but they quite often were the one who planted the seed that led to treatment.

The last theme that was obvious was why the respondents entered treatment. Practically all the respondents mentioned a complete loss of joy in their life. Many talked of being, "sick and tired of being sick and tired." Of the things mentioned that led to recovery was spirituality or belief in a higher power that they thought led them to treatment. Others spoke of a moment of clarity when they could look at their behavior and the thought that they needed help overcame their shame and led them to treatment.

#### Limitations

This study was limited by several factors. One was the ethnic composition of the respondents did not give a wide enough sample of different ethnicities views on addiction and treatment. Another limitation was the lack of input from those older adults who have just recently entered treatment. All the respondents in this study had been in recovery for a great deal of time and their memories could have been effected by their thoughts on treatment and their addiction that were formed recently and transposed on the past.

## Recommendations for Social Work Practice, Policy and Research

Social workers have to develop an understanding of older adults and the factors that cause resistance to treatment. They need to develop specific programs that take into account these factors and work to break down their sense of shame. In addition, they need to find ways to get the word out to this cohort about services that are provided. To do this they must keep in mind that many do not watch the same media formats or programs that younger adults may enjoy. Programs must be developed that educate other professionals, especially doctors, about the importance of awareness early detection of addicted behaviors in older adults. Further research in addiction of older adults in other ethnicities must be undertaken to determine different viewpoints on addiction and treatment to insure all receive the treatment they need.

### Conclusions

The respondents made it very clear that stigma/shame and lack of social support from significant others were major factors in their resistance to treatment. While other factors are undoubtedly present these two were evident in every respondent's memories of the time prior to entering treatment. The importance of involvement by



employers, doctors, judges and family members is critical. Their involvement was often that factor that either pushed them into treatment or planted the seed that led to treatment. Another conclusion that can be drawn was the lack of treatment programs or no knowledge of those that existed may have in the past led to an extended period of active addiction for many of this cohort. The most important conclusion was to reach this population programs have to be designed that take into account their sense of pride, independence and fear of stigma and shame.

APPENDIX A  
QUESTIONNAIRE

## Survey Questionnaire

This questionnaire is confidential. You do not need to write your name and you have the choice to not answer any questions that make you feel uncomfortable. This questionnaire comes in two parts. The first you will fill out by yourself. The second part is a series of questions that will be read to you by the researcher. Your participation is voluntary; there are no consequences if you choose not to participate in this study. There is no right or wrong answer to any of these questions. Please read each question carefully and answer it to the best of your ability.

Thank you for your participation in this study. I greatly appreciate your cooperation.

### Part I

#### Background Information

- 1.) What is your gender?  
Male \_\_\_\_\_  
Female \_\_\_\_\_
  
- 2.) What is your ethnicity?  
Native American \_\_\_\_\_  
African American \_\_\_\_\_  
Asian American/Pacific Islander \_\_\_\_\_  
Hispanic or Latino \_\_\_\_\_  
White/Caucasian \_\_\_\_\_  
Other (specify) \_\_\_\_\_
  
- 3.) In what year were you born? \_\_\_\_\_
  
- 4.) What is your current marital status?  
Never Married \_\_\_\_\_  
Married \_\_\_\_\_  
Divorced \_\_\_\_\_  
Separated \_\_\_\_\_  
Widowed \_\_\_\_\_  
Living together \_\_\_\_\_

- 5.) I presently reside with:
- Family \_\_\_\_\_
- Friends \_\_\_\_\_
- Live Alone \_\_\_\_\_
- 6.) What is your religious affiliation?
- Catholic \_\_\_\_\_
- Protestant \_\_\_\_\_
- Judaism \_\_\_\_\_
- Buddhist \_\_\_\_\_
- Islam \_\_\_\_\_
- Hindu \_\_\_\_\_
- None \_\_\_\_\_
- Other (specify) \_\_\_\_\_
- 7.) How many years of education did you complete? \_\_\_\_\_  
 (GED = 12 years)
- 8.) Are you currently employed?
- Yes \_\_\_\_\_
- No \_\_\_\_\_
- 9.) I work:
- Full time (32 hours or more per week) \_\_\_\_\_
- Part time (less than 32 hours per week) \_\_\_\_\_
- Disabled \_\_\_\_\_
- Retired \_\_\_\_\_

**Substance Use History**

1.) What is your drug of choice? (Check all that apply.) Age of first use?

Alcohol	_____	_____
Marijuana	_____	_____
Heroin/Opiates	_____	_____
Barbiturates	_____	_____
Amphetamines (speed)	_____	_____
Hallucinogens	_____	_____
Prescribed medication (specify)	_____	_____

2.) Age you entered treatment/AA/NA: \_\_\_\_\_

3.) Length of current period of sobriety?

Days	_____
Weeks	_____
Months	_____
Years	_____

4.) Was your entry into treatment/AA/NA voluntary or mandatory?

Voluntary	_____
Mandatory	_____

If mandatory, who forced you into treatment/counseling?

Family	_____
Friends	_____
Employer	_____
Court-Ordered	_____

5.) Was treatment/counseling recommended by a physician?

No	_____	
Yes	_____	Briefly describe. _____

6.) Have you suffered health problems because of your alcohol/drug use?

No	_____	
Yes	_____	Briefly describe. _____

## Part II

This part administered by researcher.

Researcher begins questioning by asking the participant to think back to that point in time just prior to their entry into treatment/counseling. Researcher defines treatment/counseling as any State of California recognized drug/alcohol treatment program, NA, or AA.

- 1.) At that point in time, did words such as alcoholic, addict or substance abuser have a negative, neutral or positive meaning or feelings attached to them?
  - How does that differ from your feelings/thoughts now?
- 2.) Can you tell me what were some of your feelings or thoughts about yourself and your behavior at that time?
- 3.) What do you think the significant people in your life (family, friends, employer, physician) felt or thought about you prior to entering treatment/counseling?
- 4.) Did the significant people in your life (family, friends, employer, physician) know that you had entered treatment/counseling?
- 5.) Just prior to entering treatment/counseling, what was your marital status?
- 6.) Just prior to entering treatment/counseling, were you employed?
- 7.) Why did you enter treatment/counseling?
- 8.) How did you hear about the program you entered?
- 9.) Were significant people in your life (family, friends, employers, and physicians) supportive of your entering treatment/counseling.
- 10.) When you entered treatment/counseling the first time did you relapse?
  - If you did relapse how many times did you relapse prior to maintaining your sobriety?
  - Why do you feel you relapsed?
- 11.) How do you feel now if the subject of your being in treatment/counseling is revealed or brought up while with friends, family, or employers?

APPENDIX B  
INFORMED CONSENT

## Informed Consent Form

### Study of Treatment Seeking in Older Adults

The study you are about to participate in is designed to explore the reasons that older adults may not seek substance abuse treatment. This study is conducted by Donnie Redl an MSW student at California State University, San Bernardino under the supervision of Dr. Tom Davis, Professor of Social Work. This study has been approved by the Department of Social Work, at California State University, San Bernardino. The university requires that you give your consent before participating in this study.

In this study you will be asked to respond to some questions exploring thoughts about substance abuse and reasons for not seeking treatment. This survey should take from 30 to 45 minutes depending on the length of your answers. The study will be given in two parts. The first part you will fill out on your own, and the second part will be a series of questions read to you by the researcher and recorded on audio tape or hand transcribed. All of your responses will be held in the strictest of confidence by the researcher. All data will be reported in group form only. You may receive a copy of the group results of this study upon its completion in June of 2003.

Your participation in this study is totally voluntary and anonymous. If you decide to participate, you are free to withdraw your consent and discontinue participation at any time without penalty. When you have completed the interview you will be given a debriefing statement.

If you have any questions about the study, please feel free to contact Professors Tom Davis or Rosemary MaCaslin at (909) 880-5507.

By placing a check mark in the box below, I acknowledge that I have been informed of, and that I understand the nature and purpose of this study, and I freely consent to participate. I also acknowledge that I am at least 18 years of age.

Place a check mark here  Today's date: \_\_\_\_\_

By placing a check mark in the following box I give my permission to allow this interview to be audio tape recorded. I am aware that I can refuse to allow the interview to be tape recorded and may ask that the taping be terminated at any time during the interview.

Place a check mark here  Today's date: \_\_\_\_\_



APPENDIX C  
DEBRIEFING STATEMENT

## **Debriefing Statement**

### **Study of Substance Abuse Treatment Seeking by Older Adults**

Thank you for your participation in this study. As stated in the informed consent form, the purpose of this study is to explore the reasons that older adults may not seek treatment for substance abuse. It is hoped that the results of this study will provide information that will be helpful in designing programs and services that will make it easier for those with drug/alcohol problems to seek help. All data included in this study will be reported in group form only. You may receive a copy of the group results of this study upon its completion in June of 2003 by contacting myself, Donnie Redl, at (760) 243-7151.

If in answering any of the questions in this study caused you to be distressed or uncomfortable please do not hesitate to contact myself, Donnie Redl, or Professor Davis at (909)880-5507 at the Department of Social Work, California State University at San Bernardino. Please do not discuss the questions or your answers with other possible participants so that they will not be influenced.

If you have knowledge of anyone who would be suitable for this study please do not hesitate to have them, or yourself if they give permission, contact me at the number provided.

APPENDIX D  
DEMOGRAPHICS

Table 1. Demographic Information

Demographic	N= (frequency)	% (percentage)
<b>Age</b>		
60 – 65	3	30%
66 – 70	3	30%
71 – 75	2	20%
76 +	2	20%
<b>Gender</b>		
Female	5	50%
Male	5	50%
<b>Ethnicity</b>		
Native American	0	0%
African-American	1	10%
Asian American/Pacific Islander	0	0%
Hispanic or Latino	1	10%
White/Caucasian	8	80%
Other	0	0%
<b>Current Marital Status</b>		
Never Married	3	30%
Married	3	30%
Divorced	2	20%
Separated	0	0%
Widow/er	2	20%
Living Together	0	0%
<b>Religious Affiliation</b>		
Catholic	2	20%
Protestant	7	70%
Judaism	0	0%
Buddhist	0	0%
Islam	0	0%
Hindu	0	0%
None	0	0%
Other	1	10%
<b>Years of Education</b>		
9 – 11	1	10%
12	2	20%
13 – 16	4	40%
17 +	3	30%
<b>Presently Resides With</b>		
Family	4	40%
Friends	0	0%
Live Alone	6	60%

APPENDIX E  
RESPONSE SUMMARY

## Response Summary

**Question 1** - At that point in time, did words such as alcoholic, addict, or substance abuser have a negative, neutral or positive meaning or feelings attached to them?

- Very negative feelings. (Jane 1)
- An alcoholic was stereotyped as the old drunk laying down in the gutter sucking on a wine bottle. (Jane 1)
- If I thought about an alcoholic it was some dirty old man in a raincoat...unwashed, unclean. (Jane 5)
- I was not an alcoholic. Alcohol was causing problems, but I was not an alcoholic. (John 1)
- It was negative just the way they looked at me. Right, as a, as a thief, as a liar, as a nobody in society. (John 2)
- At the time that I first, when I went into recovery it had a negative thing. (Jane 2)
- It was negative. (John 3)
- It didn't mean anything, because I didn't know. In my case, being an addict it took a long time for me to figure out I was an addict because I thought it was just weak people. Weak people use drugs. And I got hooked myself and I was what you would call a very strong-willed person. (John 4)
- Negative, very negative. The feelings attached to it were essentially guilt, shame, no good, rotten, all of those things. (John 5)
- It was a negative thing. I knew I was an alcoholic from the time I was young. I've known it for years, but I wouldn't admit it. It was negative. (Jane 4)

**1b** - How does that differ from your feelings/thoughts now?

- Far removed from how I look at it today. (Jane 1)
- Today I know that addiction is a disease, a mental, physical, and a spritual disease. (Jane 1)

- I look at myself now as a man of character, integrity, all because of working the program and turning my life over to the care of God, daily. (John 2)
- It doesn't bother me a bit because it doesn't apply. (Jane 2)
- It's completely different today because I go around telling people I am an alcoholic. (John 3)
- Actually, you know what, being an addict has changed my life so much. I'm an addict, I'm proud of it. Because I'm a recovering addict. (John 4)
- Mostly positive. And the sense that I have been through the trials and tribulations and it's empowering to a way. To be able to share that almost as a badge of courage to have survived is what it amounts to. (John 5)
- To know that I'm an alcoholic? Best thing in the world. Because I know what to do about it. (Jane 4)

**Question 2** - Can you tell me what were some of your feelings or thoughts about yourself and your behavior at that time?

- Staying up to 3:00am cleaning my house. ...if my kids were spotless, my house was spotless and I was working everyday....then I didn't have a problem and how dare you say I do. (Jane 1)
- I felt very ashamed. I was full of guilt, full of fear. And I didn't know why every time I thought I'd just have a couple I ended up drunk. I couldn't understand. (Jane 5)
- I was a disgrace to the family (Jane 5)
- I lost my driver's license for two years in the summer of 1979 and I actually lost my license in October...it was drinking and driving. I'd hit a telegraph pole, and I could have killed somebody. (Jane 5)
- Well, they were bad behaviors, but I blamed them on the alcohol consumption. I was not a bad person, it was making me do bad things. (John 1)

- Very low. Self-image, insecurities, hopelessness, no purpose in life. No direction. Just as a walking dead man. I had, I mean as a walking dead man and I mean it literally because that's the way I seen myself as hopeless. I was very selfish. (John 2)
- Disgusting. I was totally out of control. (Jane 2)
- My behavior, my thoughts were probably that I was a very successful type person. At the time I had a very large telemarketing organization going and I was making a tremendous amount of money. Of course, if somebody would call me an alcoholic, my answer was very simple. I don't have to attend those damn meetings. I'm just a drunk. And I accepted the fact that I was drinking a lot. (John 3)
- Well, you know, I always considered myself a hustler, not a dope dealer. A thief or whatever I was doing. Whatever it took for me to get money was what I did. I never said I was a pimp or a dope dealer. I was a hustler. It was business. (John 4)
- My thoughts, I recognized at that time that I was pretty manic and essentially I was using alcohol to medicate the mania, to bring myself down. And my thoughts essentially were I can do anything. I was just out there and nothing could slow me down or nothing could stop me. (John 5)
- The last two years that I drank, I drank alone because he had died. And I really was surprised I thought that I had better control of my drinking than that. I thought that I had a choice at that time. But then I drank two years alone so then I thought I'm not doing this by myself. I'm going to need help. But what scared me most was that I was getting to the point that one day I was going to retire. And I knew that when I worked I could control the drinking but I was afraid of what would happen when I stopped working. (Jane 3)
- I was lonely, insecure. Nobody would do what I wanted them to do. I wanted it done my way. I was angry. I was alone. I have never felt so alone. And I knew I was different, but I was alone. The loneliest feeling in the world is being an alcoholic. (Jane 4)



**Question 3** - What do you think the significant people in your life (family, friends, employer, physician) felt or thought about you prior to entering treatment/ counseling?

- nobody knew where I was because subconsciously I think I was on a suicide mission because I had disgraced my family. (Jane 1)
- my 13 year-old son, my oldest son at the time, stood flatfooted, looked me in the eye and said I hate your guts. I wish you would die. (Jane 1)
- I think several people that really knew me fairly well didn't realize how much I drank. I really don't believe they did, but my parents certainly did and they were desperately worried. (Jane 5)
- That I drank too much. (John 1)
- Actually I had no contact with my family so I did not know what they thought. (John 1)
- They just seen me as a drug addict, as a thief, and just kind of a, didn't want me to get near because they were afraid I might steal some valuable things of theirs (John 2)
- Totally disgusted, pretty disgusted. I went to my pediatrician and I was drunk, the same pediatrician that took care of my little girl that died. And he said don't you ever come into my office like this again. (Jane 2)
- I think that their opinion was that I was very successful, really. Because I had everything and anything any body could ever want. I don't think (they were aware) so. Not till the end. (John 3)
- Well, the only person I really cared about was my mom. She never knew. I had a son, and I think he knew about me, but he didn't come around. I'm pretty sure he thought pretty less of me. He never admitted it, but I'm sure he'd seen other addicts and said well my dad's an addict, too. (John 4)
- Most of them were alcoholic. Well, they thought I didn't have a problem because they were comparing themselves to how much they drank and how much I drank. The non-drinkers again they thought that I didn't have a problem. (John 5)

- I have two daughters and neither one of them said a whole lot about my drinking. They thought that if I didn't drink with their dad maybe he wouldn't drink so much. And that's the only comment that I had from one of them. And the other daughter didn't have anything to say about it. (Jane 3)
- My husband was very disgusted. He would have not left me I'm sure, but he was disgusted with me. He wanted me to go get help. And my children knew it and when they would call they'd want to talk with their dad. my mother because my uncle, her brother, was an alcoholic, and she hated it. She hated the idea that her daughter was an alcoholic. (Jane 4)

**Question 4** - Did the significant people in your life (family, friends, employer, physician) know that you had entered treatment/counseling?

- They didn't know where I was. (Jane 1)
- I mean once I got to A.A. and I told them, they seemed to be greatly relieved except my mother thought that I went to A.A. to talk about her. (Jane 5)
- I wasn't that close because I separated myself. You know, and I just didn't want to embarrass, well maybe even embarrass them. (John 2)
- No, the immediate, close people, secretaries, and stuff, they knew that I had gone to see a psychologist. And I didn't go because I had drinking problem. I went because of depression. (John 3)
- No, because I was three thousand miles away. (John 5)
- Oh, yes. In fact my husband took me to the hospital. I asked him finally when I had enough. I requested him to take me to the hospital and I went gladly. (Jane 4)

**Question 5** - Just prior to entering treatment/counseling, what was your marital status?

- Married. (Jane 1)
- Divorced. (Jane 5)
- Single. (John 1)
- I was already divorced. (John 2)
- I was married to an alcoholic drug addict. (Jane 2)
- I was single. (John 3)
- I was seeing a lady. I wasn't married. (John 4)
- I was single. (John 5)
- Married to an alcoholic. (Jane 3)
- Married. (Jane 4)

**Question 6** - Just prior to entering treatment/counseling, were you employed?

- We had our own restaurant and bar, which was very convenient. (Jane 1)
- Yeah, I was a school nurse, and I used to have to control my drinking. Just drink on the weekends, and not drink during the week. That was hard work. (Jane 5)
- Oh yeah. (John 1)
- Oh, no, no. I was a street addict. I could not keep a job. I tried. (John 2)
- No. Sporadically. But no, I always stayed at home with my children. (Jane 2)
- Yeah, I owned a business. (John 3)
- Yep. Every day. (John 4)

- Sporadically. I didn't work consistently. It was, I was going to school part-time and working part time so it was, you know, in between. (John 5)
- Oh yeah. (Jane 3)
- No. Not at the time I went into treatment. (Jane 4)

**Question 7 - Why did you enter treatment/counseling?**

- God loves you. It was that brief, very brief moment of clarity. (Jane 1)
- Because I needed help. I did not know how to stop drinking. I couldn't stop by myself. (Jane 5)
- If I didn't I wouldn't be employed, and I'd be turned out on the streets. ...it was pressured. (John 1)
- Because I was tired. I was just tired. I was just tired of the insanity of the whole thing. (Jane 2)
- I couldn't understand why I was so depressed. Why I was just totally through with everything. I had big homes in Canyon Crest, more cars than I could drive, more clothes than I could wear, more money than I could spend. But was totally, absolutely miserable. (John 3)
- I think basically because I was out there hustling and selling drugs, and doing whatever, and I was making this thousand dollars, and two thousand dollars a night but I was broke the next day. So basically I was ashamed because I was a damn trick. I was a damn prostitute. I was being prostituted. And that's what went through my mind and this guy was sitting behind that door and laughing the shit off. (John 4)
- I knew the alcohol was the symptom of some deeper problems that I needed to address and I had to get sober first so then I could address the other issues. I was also a psych major so I knew. (John 5)
- Because I knew the thought came to me one night that if I'm going to stop drinking, I'd better do it now. And I poured that last

drink out and I went to bed. I've always felt badly about drinking. That came from my upbringing. (Jane 3)

- Because I was sick and tired of being sick and tired and alone. (Jane 4)

**Question 8** - How did you hear about the program you entered?

- My doctor referred me the first time and I stayed sober about 9 months. (Jane 1)
- you knew about AA because originally you went to your first one. Yes. (Jane 1)
- A.A. From other people who showed me the way. I didn't know about A.A. I went to this woman because I needed help. I had no idea what the help might be. (Jane 5)
- Employers. (John 1)
- Word of mouth. (John 2)
- From my husband's aunt. She had been in recovery for several years. I knew that she was in the program so I just went. (Jane 2)
- the psychologist that I was going to, he made a suggestion that if I wanted to learn how to help an alcoholic, why don't you go to an A.A. meeting. Well he (psychologist) knew from the very start. At that time I think he had six years in the program. (John 3)
- You know, another dope thing. He mentioned to me about the cure. I didn't go in there to get clean. I just went in there to stop messing my profits up. (John 4)
- Through friends. And I was actually I started working in a treatment program, it was a, at that time it was a pilot program before I got sober. (John 5)
- I used to read about it, you know Alcoholics Anonymous, in Ann Landers. And once I went I was so impressed by the program and the people. I only went to three meetings. But I thought I will go back there some day and I hoped I could go back there and they would let me stay. (Jane 3)

- It was a hospital that I go to and they had a drug/alcohol facility which is wonderful. (Jane 4)

**Question 9** - Were significant people in your life (family, friends, employers, physicians) supportive of your entering treatment/counseling?

- ...my then-husband gave me such a bad time about going to AA and said if you want to hang out with a bunch of drunks just go to the tavern with me. (Jane 1)
- ...my grandmother said something like how dare you disgrace our name. (Jane 5)
- You know my mother was a little tiny woman, but she, it was a good family, and I was a disgrace. I was the only drunk that she knew in the family. ...I was a pretty low down woman. (Jane 5)
- I have one brother who I don't think has ever entirely accepted that I am a recovering alcoholic. ...apart from that everybody else seemed to be just fine with it, you know. (Jane 5)
- Absolutely. That I was worth saving, I think, was what they said. (Employer) (John 1)
- I was so isolated from them because of my feelings about myself. You know, not that I was disowning them. It was just how I felt about myself, all those negative feelings about myself. That I was worthless. (John 2)
- They weren't very supportive. I was just a bad person. I mean that's the way I felt that they, you know, like they looked down on me. Not that they didn't have problems. They were all prescription drug addicts, see. They were different. (Jane 2)
- Extremely so. At the time they disclosed to me that they were wondering if I was ever going to get help or was I just going to keep on struggling and fighting it. (John 3)
- I got a lot of support. They didn't know what to do because they figured after your thirty days you're cured. (John 4)
- They were all supportive. If I wanted to go, they were fine with that. And I have one friend that was really pleased. And she had

never said a word to me before but she was really pleased.  
(Jane 3)

- Yes, they were very supportive. My husband has supported me from day one. My children were so happy that their mother found help. (Jane 4)
- They continued to drink and I continued to be a crusader for sobriety essentially is what it amounted to. (John 5)

**Question 10** - When you entered treatment/counseling the first time did you relapse?

- Yes. (Jane 1)
- No. (Jane 5)
- Well, of course. My final dinner with the doctor was a martini lunch. He said I am not an alcoholic, but I have to watch what I do when I drink. (John 1)
- I went into A.A. and I never had to take a drink again. I am thirty-two years sober. But I smoked pot. I was eight years in A.A. and then I, I have been total abstinent ever since then. (Jane 2)
- No, I've never relapsed. (John 3)
- Yeah. (John 4)
- Yes, many times. (John 5)
- Oh, I drank for another ten years. See I went in 1965 but I didn't get sober until 1975.
- No. (Jane 4)

**10b** - If you did relapse how many times did you relapse prior to maintaining your sobriety?

- From the first time I was in AA in 1967 I stayed sober about nine months and from that point on I just drank periodically. And then in 1970 when I got sober I haven't drank since. (Jane 1)
- I don't consider any of it a relapse, because I was not an alcoholic. They said. So I had three treatments previous to my

fourth and fifth, which were together and after which I never drank again. (John 1)

- eleven times. (John 4)
- many times. (John 5)
- My husband and I both stopped twice for three months. We'd stop for three months because of his health; he'd have a hemorrhage, see. And then we'd have a drink and we were off and running again. (Jane 3)

**10c** - Why do you feel you relapsed?

- I thought it was a big joke. Well the bottom line is I wasn't. I wasn't done. I just wasn't done. (Jane 1)
- I had no reason to (quit). I got my job back. I got a clean bill of health. I got my check, everything else. (John 1)
- Because the drugs, the alcohol were still there. It was still available. I mean it was at my reach. And I didn't want to get into a program and take a stash with me. (John 2)
- Men. I left my husband and of course the next man was an addict. They were always addicts. I've been married to two addicts. And so I went back into the familiar relationship and I would get loaded with them. (Jane 2)
- Because I didn't do it the way the book says to do it. I went to the meetings, but I still was gonna do it my way. (John 4)
- I wasn't ready to get sober. I was just toying with the idea that I could just drink like a normal person. (John 5)
- Because I never went to meetings. Well, not enough. I was not in the program. (Jane 3)

**Question 11** - How do you feel now if the subject of your being in treatment/counseling is revealed or brought up while with friends, family or employers?

- I don't care who knows. I absolutely have no problem. (Jane 1)
- I announce that I am an alcoholic. (John 1)



- I'm not ashamed to tell people, or embarrassed to tell people now that I'm a recovering addict because I got hope. (John 2)
- It doesn't bother me at all. You know I don't feel the same about myself. And if other people, they do, that's their problem. (Jane 2)
- I'm not ashamed of it; right now I'm almost proud that I have it. (John 3)
- my feelings are I've been there, done that and don't want to go back. (John 5)
- I'm grateful to be an alcoholic. (Jane 3)
- it's hard for anyone that's been drinking for any amount of time, to consider even what your life would be without it. I mean if you're really addicted to it its not easy to give up. Its not easy and the fear of what's going to happen to me then. How am I going to cope with life if I don't have a drink? (Jane 3)
- It opens up the doors. No, it doesn't bother me. (Jane 4)

### **Factors and Additional Comments:**

- Yeah, that and I had a lot of codependency in my family. My family use to tell me you're not an alcoholic you just drink to much. (Jane 1)
- And I didn't know, I didn't know that alcoholism was a disease. (Jane 5)
- And I think because there's more knowledge around, and more information, a lot of people are saved from going down as far as that. (Jane 5)
- And I thought I was the only woman who was like that. You know, I really thought I must be the only terrible woman around. I don't know whether women or we people who are this old from my generation where you know you're brought up to be a lady not a drunk. (Jane 5)
- ...well I felt I was such a failure. (Jane 5)

- I was told by a doctor that I was not an alcoholic. Yes, three times. That I had to watch what I do, what I drink. (John 1)
- ...in those days, that's a long time ago and in those days it was treated as more of a mental problem or moral problem than it was a sickness or disease. (John 1)
- Alcoholism is a disease of defiance. How dare you tell me what's wrong with me. So I believe first of all its ignorance. They don't know that they are alcoholics. They know that alcohol causes problems, but they don't know alcoholism. (John 1)
- ...you know. I love my parents, I love my, I didn't want to go near them because I knew what I was and they knew what I was, too and I just felt ashamed. (John 2)
- He (the Judge) sent me into N.A. back in East L.A., a diversion program. He took me there to the meeting. He even bought me dinner. And he took me in that evening to an N.A. meeting. I didn't know it was N.A. because I was not that knowledgeable about treatment. (John 2)
- Back in the sixties, back in the fifties, there were no treatment programs like there is now. I mean there's a treatment program in every block. And A.A. and N.A. all over the place. Twenty-four hours a day. A.A. or N.A. wasn't there yet. It was either jail, prisons or institutions, insanity. And a lot of addicts and alcoholics died as a result of that. Because maybe they were ready but there were no treatment programs. (John 2)
- I had tried to stop, but when you live with somebody that drinks and uses, its very. Well, it was for me. Two addicts together don't make a well. (Jane 2)
- You know, working the steps. You know, just, you know getting rid of all the garbage. Getting rid of all the guilt, the shame, and you know. It's just a whole different lifestyle. (Jane 2)
- The fact that I was very functional. I could actually I could own companies, made a lot of money, buy anything that I wanted to buy. (why he felt that he didn't enter treatment) (John 3)

- You know what, I didn't know about treatment for one thing. The second thing, I didn't realize how bad it was, how bad I was. (John 4)
- Too proud. You know to get sober you have to get humble. (John 4)
- I didn't think I had a problem. (John 5)
- I had no idea I was saying that. I really believe that a higher power took over once I made that one move to pour that drink down that sink. (Jane 3)
- They're proud. I think that one of the main thing is they're proud. I think one of the main things is that they think that they can control it themselves. I think they don't want to admit it to their family. We're a proud generation. We were taught you do not discuss things outside your home. You don't let other people know you have problems. (Jane 4)

## REFERENCES

- Adams, W. L., & Cox, N. S. (1995). Epidemiology of problem drinking among elderly people. International Journal of Addictions, 30(13 & 14), 1693-1716.
- Adams, W. L., Yuan, Z., Barboriak, J. J., & Rimm, A. A. (1993). Alcohol-related hospitalizations of elderly people: Prevalence and geographic location in the United States. Journal of the American Medical Association, 270(10), 1222-1225.
- American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders, (4th ed.). Washington, DC, Author.
- Barer, B. M. (1997). The secret shame of the very old: "I've never told this to anyone else". Journal of Mental Health and Aging, 3(3), 365-375.
- Barnea, Z., & Teichman, M. (1994). Substance misuse and abuse among the elderly: Implications for social work intervention. Journal of Gerontological Social Work, 21(3/4), 133-147.
- Brown, B. B., & Chiang, C. (1983). Drug and alcohol abuse among the elderly: Is being alone the key? International Journal of Aging and Human Development, 18(1), 1-12.
- California Department of Alcohol and Drug Programs. (2001). California alcohol and drug data system reports. (CADDs Report July 30, 2001) Sacramento, CA: Office of Applied Research and Analysis.
- Curtis, J. R., Geller, G., Stokes, E. J., Levine, D. M., & Moore, R.D. (1989). Characteristics, diagnosis, and treatment of alcoholism in elderly patients. Journal of the American Geriatrics Society, 37, 310-316.
- DeHart, S. S., & Hoffmann, N. G. (1995). Screening and diagnosis of alcohol abuse and dependence in older adults. International Journal of Addictions, 30(13 & 14), 1717-1747.
- Fingerhood, M. (2000). Substance abuse in older people. Journal of the American Geriatrics Society, 48(8), 985-995.

- Finlayson, R. E. (1995). Misuse of prescription drugs. International Journal of the Addictions, 30(13 & 14), 1871-1901.
- Gurnack, A. M., & Thomas, J. L. (1989). Behavioral factors relating to elderly alcohol abuse research and policy issues. International Journal of the Addictions, 24(7), 641-654.
- Harrison, P. A. (1989). Women in treatment: Changing over time. International Journal of the Addictions, 24(7), 655-673.
- Janik, S. W., & Dunham, R. G. (1983). A nationwide examination of the need for specific alcoholism treatment programs for the elderly. Journal of the Studies on Alcohol, 44, 307-317.
- Kail, B.L. & DeLaRosa, M. (1998). Challenges to treating the elderly Latino substance abuser: A not so hidden research agenda. Journal of Gerontological Social Work, 30(1/2), 123-141.
- Kauffman, S., & Poulin, J. (1996). Coherency among substance abuse models. Journal of Sociology and Social Welfare, 23 (3), 163-174.
- Kofoed, L. L., Tolson, R. I., Atkinson, R. M., Toth, R. L. & Turner, J. A. (1987). Treatment compliance in older alcoholics: An elder specific approach is superior to mainstreaming. Journal of the Studies on Alcohol, 48, 47-51.
- Norton, E. D. (1998). Counseling substance abusing older clients. Educational Gerontology, 24, 373-389.
- Patterson, T. L., & Jeste, D. V. (1999). The potential impact of the baby-boom generation on substance abuse among elderly persons. Psychiatric Services, 50(9), 1184-1188.
- Schonfeld, L., & Dupree, L. W. (1990). What triggers their drinking? Aging, 361, 5-10.
- Solomon, K., Manepalli, J., Ireland, G. A., & Mahon, G. M. (1993). Alcoholism and prescription drug abuse in the elderly: St. Louis University grand rounds. Journal of the American Geriatrics Society, 41, 57-68.

- U.S. Bureau of the Census. (1996a). 65+ in the United States. (Current Populations Reports, Special Studies, No. P23-190) Washington, DC: U.S. Government Printing Office.
- U.S. Bureau of the Census. (1996b). Populations and housing characteristics of baby boomers 26-44 years old: 1990 United States. (Current Populations Reports, No. 1990 CPH-L-160) Washington, DC: U.S. Government Printing Office.
- U.S. Department of Health and Human Services. (1998). Substance abuse among older adults (DHHS Publication No. (SMA) 01-3496) Rockville, MD: Author.