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Aftercare following treatment for aging alcoholics

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Abstract

Throughout the last fifteen years the realization of a problem with alcoholism in the elderly population has come to the attention of many Americans. Following heart disease and cancer, alcoholism ranks as the third leading cause of death (Benshoff & Roberto, 1987). Approximately one out of ten people over 60 years of age {27.5 million) fall into the category of alcoholics but only 15% of that number actually receive treatment {Kelley, 1991).

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Throughout the last fifteen years the realization of a problem with alcoholism in the elderly population has come to the attention of many Americans. Following heart disease and cancer, alcoholism ranks as the third leading cause of death (Benshoff & Roberto, 1987). Approximately one out of ten people over 60 years of age (27.5 million) fall into the category of alcoholics but only 15% of that number actually receive treatment (Kelley, 1991).

Many researchers did not clearly establish a definition for alcoholism during their studies, causing concerns about the validity of their studies (Maypole, 1989). Therefore, it is important to look at some of the different characteristics of alcoholism to establish a basis for a definition. According to the same article by Maypole, the following characteristics are often noted, or ascribed, to alcoholics in the United States:

*An alcoholic has a disease (disease perspective).

*An alcoholic is a sinner (moral perspective).

*An alcoholic's drinking causes problems in any facet of his/her life (social functioning perspective).

*An alcoholic is emotionally and physically dependent on the drug alcohol (dependency perspective). (p. 44)

According to Simon (1980; cited in Teague, 1987, p. 138) an alcoholic is, " a person whose dependence upon alcohol has reached such a degree as to interfere with his or her health, interpersonal relationships, social adjustment, or economic functioning." A different definition by the Funk & Wagnalls New Encyclopedia (1986) states that, "alcoholism is a chronic and usually progressive illness involving the excessive inappropriate ingestion of ethyl alcohol, whether in the form of familiar alcoholic beverages or as a constituent of other substances." (p. 361)

There are two main classifications of the elderly alcoholic agreed upon by Dupree and Schonfeld (1989); Teague (1987); Dupree, Broskowski and Schonfeld (1984); and Abrams and Alexopoulos (1991). The first classification consists of the "elderly alcoholic" (aging alcoholic), who has been identified as having

alcoholic difficulties throughout most of adulthood. The second classification consists of the "late alcoholic" (geriatric alcoholic) who developed a problem with alcohol later years and who has not had any serious problems throughout adulthood.

Two types of adults develop into the geriatric alcoholic (Benshoff & Roberto, 1989):

> The "early onset" individual presumably suffers from a disease process whose roots lie in long term difficulties and who probably has benefitted in lifesaving advances in medical science and participation in treatment. The "late onset" individual is more often thought to have alcohol problems whose roots lie in recent age-related environmental events such as loss of spouse, retirement, isolation, and loneliness. (p. 5-6)

There are two types of treatment for the elderly alcoholic, short-term and long-term. The first one that will be discussed is short-term treatment which consists of either inpatient or outpatient treatment. Inpatient consists of a person being placed in a residential facility and usually lasts from 21 to 48 days in length depending on the needs of the client.

This form of treatment is very structured for the client and every day is filled with group sessions and/or individual sessions with a counselor. Persons going through inpatient treatment are usually so out of control (such as engaging in lying, stealing money to get the alcohol and/or not able to control their drinking without people around 24 hours per day) that structure is necessary for success because they will most likely use alcohol if they have the urge or if it is in "eye sight."

The other form of short-term treatment is outpatient, which consists of a less-structured environment for the client. The client is required to come to the treatment facility on an outpatient basis and is usually involved in an outpatient treatment group plus weekly/biweekly sessions with a counselor. Persons going through outpatient treatment are not as out of control as are persons in inpatient treatment in that theses types of alcoholics do not act upon urges all of the time. However, the alcoholics still need guidance in maintaining sobriety.

The second type of treatment for elderly alcoholics is long-term which consists of either

inpatient or outpatient treatment plus continuing care known as aftercare. Aftercare is similar to support groups such as Alcoholics Anonymous (A.A.) in that after a person has gone through treatment they continue to be involved within the agency in therapeutic group (Mackay & Mariatt, 1991; Ornstein & Cherepon, 1985).

Studies done by Filstead (1990), reported that among young people recovery rates are much lower for persons who only go through short-term treatment than they are for those who go through long-term treatment (inpatient or outpatient treatment plus aftercare and other self-help groups). According to this study, the longer young adults are involved in treatment their recovery rate; therefore increases. Whereas, the possibilities, should also be considered, that this also holds true for the elderly alcoholics.

It is hypothesized that the elderly alcoholic population will show a higher recovery rate among those who go through long-term treatment as compared to those who go through short-term treatment. The purpose of this study is to investigate, through a literature review, possible benefits of aftercare for elderly alcoholics. Barriers placed on the alcoholic for

prevention of early treatment and the etiologies of alcoholism will be taken into account of how society views an alcoholic. This paper will also examine short-term and long-term treatment and the benefits of aftercare.

Theories of Etiology

Alcoholism has become of more concern in the aging adult population in the last decade, resulting in an increase in the number of studies examining long and short term effects in the elderly (Kofoed, Tolson, Atkinson, Toth & Turner, 1987). Theories throughout generations have given some guidance in determining some type of etiology of elderly alcoholism. Despite these remains a lack of agreement regarding etiology.

One theory of the etiology of alcoholism in older adults is from Sigmund Freud (Maypole, 1989). Freud believed that people who developed alcoholism were actually "stuck" back in their first phase of development which is the oral stage. This has been characterized by pleasures resulting by stimulation of the mouth. Freud believed that because alcoholics were "stuck" in the oral stage they would replace their mother's breast with a "booze bottle." Psychoanalytic

treatment would include working on issues surrounding difficulties at that age of development. Because psychoanalysis is a very lengthy process, this type of therapy would be inappropriate for elderly alcoholics.

A second theory of the etiology of alcoholism is the "loss theory" (Gomberg, 1982; cited in Maypole, 1989). The theory views an adult who has come to the stage of "old-adulthood" and has experienced losses. The loss could include death of a spouse, menopause, retirement, etc. Elderly adults experiencing loss and finding themselves unable to cope with the stress and/or other emotional/physical effects from the loss may turn to drinking as a coping mechanism. Treatment, according to the loss theory, would involve looking at different patterns of coping mechanisms and how effective they are for the adult.

A third theory of etiology is that there is a specific "personality type" of alcoholics. According to this theory, men and women need to fulfill dependency needs through drinking, "while men attempted to feel 'macho' and women 'effeminate'" (Maypole, 1989, p. 50).

"Learning theory," based on B. F. Skinner (Maypole, 1989), is a fourth theory. According to Skinner's theory, learning is instilled by a stimulus followed by a response which is usually a reward. People experiencing anxiety, frustration, etc., (stimulus) take in the alcohol (response) which produces a "high" for that person (reward). When this develops, learning has taken place. A person continues this pattern until addiction develops. Once this has occurred, the feelings of frustration and anxiety are replaced by bad feelings from withdrawal; therefore, continuing the cycle.

Treatment designed to fit the "learning theory" approach to alcoholism has consisted of replacing the "good feelings" as a result of the high with more unpleasant situations such as shock or by disturbing visual imagery. Treatment that has consisted of unpleasant consequences has been found to only work for a short duration of time regarding abstinence. Therapy may be of more benefit by replacing the "good feeling" with some different type of reward, rather than punishment (Maypole, 1989).

Another theory of etiology cited in Maypole (1989), is the "genetic-constitutional." This theory states that certain people have a genetic predisposition to develop alcoholism. Theorists who believe in this theory state that once the gene that develops alcoholism is located certain people carrying the gene can be warned of the consequences of drinking.

The "social pathology" theory of etiology (Maypole, 1989) consists of the idea that "sick" people such as delinquents are the ones who have caused problems for society. The reason for their "sickness" is that they were never taught the moral norms of society. In dealing with alcoholics, society places this absence of morals on the alcoholic and categorizes them as pathological. Treatment for these types of alcoholics would consist of learning the morals and values of society.

The "social disorganization" theory of etiology (Maypole, 1989) came into use after World War I when the United States society started changing with increased migration, urbanization and industrialization (just to name a few). Maypole stated that during this period of change, societal rules became unclear, gave a

feeling of abnormality and put individuals in bewilderment. Unable to cope, some individuals turned to alcohol and became dependent. These individuals who turned to alcohol after the war are now elderly adults. According to the theory of social disorganization, treatment would include teaching society's rules to the confused individuals. However, this should be done early to prevent alcoholism from occurring later in life. This theory also will hold true for any social disorganization that society has such as Desert Storm.

Another etiological aspect of society in general is that there are groups in conflict trying to seek both control and power (Maypole, 1989). Conflict theorists' "conflicting values" theory states that struggle is a part of a group's process to uphold their interest. This theory stated that alcoholics may have lost the struggle and do not gain the power and control. Therefore they turn to alcohol as a coping mechanism to deal with defeat and negative feelings (Maypole, 1989).

The "deviant behavior" theory (Maypole, 1989) states that individuals have not had proper socialization and their behavior goes against the

"normative rules" of society. Thus, using alcohol excessively is a deviant behavior that is not a norm of society. Treatment would consist of learning the "proper" behavior that is acceptable to society.

The last etiology theory elaborated on by Maypole (1989) is "labeling." Labeling involves society giving persons certain labels such as "delinquent" or "alcoholic." Caught in these roles placed on them by society, the alcoholics develop an increase in this behavior and become alcohol-dependent. In order to help these individuals, elimination of the labeling would need to take place.

Regardless of how or why alcoholism has developed, one needs to consider possible indicators leading to early diagnosis that could lead to earlier treatment and prevent severe alcoholism.

Barriers in Detecting Alcoholic Indicators

Barriers may develop which could cause difficulty in determining the indicators of alcoholism. Therefore examining and removing them increases the chance for alcoholics to identify signs of alcoholism (Benshoff & Roberto, 1988).

In a study by Dupree, Broskowski and Schonfeld (1984), including 48 elderly clients with a mean of 64 years of age five factors were found that may or may not indicate possible addiction.

Physical Health

The greater number of symptoms in this area occur after a drinking period. Symptoms such as blackouts, hand tremors and "inner" shakes appear most often (Dupree, Broskowski & Schonfeld, 1984). Other physical risks include fragility due to aging (Amodeo, 1990). Safety issues are a concern with the elderly due to physical changes in balance, coordination, vision, color and sound perception. These changes may lead to an increase in accidents such as burns, falling down stairs, slow reaction time or broken bones. Drinking added to these aging factors may increase these physical changes making safety more of a concern for the elderly, thus indicating physical problems for the elderly (Dupree, 1984). Another factor discussed by Curtis, Geller, Stokes, Levine and Moore, (1989) is that elderly alcoholics on an average are apt to drink less in both quantity and frequency, making detection more difficult because they are not drinking at high-

risk levels (two or more drinks daily). Most elderly adults do not recognize alcoholic symptoms until it is too late and they have passed their trigger level into alcoholism. Another barrier is that physicians may treat alcoholism as a minor issue such as depression (Gambert, Newton & Duthie, 1984; cited in Benshoff & Roberto, 1988). Some doctors may purposely misdiagnose the elderly population to "save them" from embarrassment (Blazer & Pennybacker, 1984; cited in Benshoff & Roberto, 1988).

Mental Health

A study by Funkerhouser (1978), found that alcoholism produces problems psychologically, such as anxiety being expressed overtly. Although there is no specific "personality" for alcoholics, there are some personality traits common among alcoholics. According to the Minnesota Multiple Personality Inventory (MMPI), (Skinner, 1974; cited in Funkerhouser, 1978), anxiety and depression were found among most alcoholics. However, Blane (1968; cited in Funkerhouser, 1978), found it difficult to determine which was a primary issue, the alcoholism or depression. Blane also noted that most alcoholics expressed a feeling of

worthlessness and preoccupation of self-destruction. In recent studies and assessments by Dupree, Broskowski and Schonfeld (1984), with elderly adults, severe behavior/psychological problems were not found, thus creating another barrier in detecting alcoholism in the elderly.

Financial Problems

The majority of adults at a later age have fewer financial obligations such as bills or payments, therefore, they have more money to spend on alcohol. This creates an illusion that there is not a problem with alcohol because of the assumption that most alcoholics have financial difficulties and are unable to pay their bills (Dupree, Broskowski & Schonfeld, 1984).

Legal Problems

The fact that older adults do not drive as much as younger adults decreases their chances of being caught by the legal system (Dupree, Broskowski & Schonfeld, 1984). This absence of legal involvement creates a picture of alcoholics not having a drinking problem (Dupree, Broskowski & Schonfeld, 1984).

Social/Interpersonal Problems

Many adults spend much of their time drinking in isolation which creates problems for persons trying to assist the individuals with seeking professional help (Sherouse, 1983; cited in Benshoff & Roberto).

It was found that with an increase in alcohol use in the elderly, the amount of socialization with peers tends to decrease (Dupree, Broskowski & Schonfeld, 1984). The Gerontology Alcohol Project (GPA), which was a study of elderly individuals age 55 and older whose onset of alcoholism was at 50 years of age or older noted that the elderly social network for the elderly is relatively poor. On an average, they had contact with .88 people (non-relatives) and 1.3 relatives per day. Following treatment, an increase was observed in the total social network for the elderly recovering alcoholics.

Health Issues

There are many factors affected according to Benshoff (1987), Amodeo (1990) and Abrams and Alexopoulos (1991), in the aging process that alcohol affects in elderly bodies. These include:

The Metabolism of Alcohol

According to Amodeo (1990) and Abrams and Alexopoulos (1991), as adults grow older their metabolism rate slows down and the process of filtering the alcohol out of the body through the liver takes a longer amount of time compared to that of younger adults. This creates a "high" in older adults with a much lower amount of alcohol.

Physical Fragility Due to Aging

As noted earlier by Amodeo (1990), normal aging factors such as coordination, balance, eyesight, hearing and reaction time are affected even more when alcohol is added to the system. The addiction of alcohol leads to further physical injuries because falling, burns or accidents. Many times these injuries go undetected because the alcohol affects the nervous system, thereby creating some numbness. a further difficulty is that because the effects of alcohol are undetected, the affected individual lacks the involvement with "professionals." At times when injuries are ignored the possibility of complications increases and sometimes may lead to death.

Medication

Many elderly persons take a variety of medications which, when taken in combination with alcohol, can create numerous side-effects or serious problems (Amodeo, 1990, and Abrams & Alexopoulos, 1991). Other problems may include alcoholics forgetting to take the medication or forgetting they have taken it and therefore taking it again. Lastly, certain combinations of alcohol and medication may intensify the medication's effects and result in an overdose.

Other Effects on the Body

According to Benshoff and Roberto (1988), detrimental effects on the health of alcoholics increase with progressiveness of the disease. Korsakoff's disease is one of the largest detrimental effects alcoholics may develop (Beaumont, 1983; Kolb & Whishaw, 1985; cited in Benshoff & Roberto, 1988). Korsakoff's is due to poor nutrition and vitamin deficiencies through years of drinking, which causes dementia in older adults. Elderly adults suffering from Korsakoff's disease are unsuitable for "traditional" alcoholic counseling and therapy because of the large amount of memory loss they suffer.

Through massive doses of vitamin B-1, Korsakoff's can be arrested and most memory restored. However, this disease can never be reversed and with severe cases persons will have a very low chance of survival in a non-protective environment (Beaumont, 1983; Kolb & Whishaw, 1985; cited in Benshoff & Roberto, 1988).

Other neurological problems include: "Peripheral neuropathy, cerebellar degeneration, sleep disturbances, and sexual dysfunction" (Este & Heinemann, 1982; cited in Benshoff & Roberto, 1988, p. 8-9). "Physical problems consist of difficulties with the gastrointestinal and cardiovascular systems, possible problems with the liver (cirrhosis of the liver) and pancreatic difficulties, resulting in disabling pain, nausea and vomiting" (Gambert, Newton & Duthie, 1984; Mishave & Kastenbaum, 1980; cited in Benshoff & Roberto, 1988, p. 8-9). "Upper and lower gastrointestinal problems include an increase of fatal esophageal hemorrhage, irritation to the stomach and duodenal area of the colon" (Gambert, Newton & Duthie, 1984; cited in Benshoff & Roberto, 1988, p. 8-9). "The cardiovascular system includes the exacerbation of existing age-related cardiovascular disease as well as

the direct cardiotoxic effects of the consumption of larger amounts of alcohol" (Sherouse, 1983; cited in Benshoff & Roberto, 1987, p. 8-9).

Throughout all of the problems and effects alcohol has on the body, one positive thing has been found. In moderate use of alcohol (approximately one ounce of 100% alcohol), numerous studies have found a decrease in cardiovascular disease (Benshoff & Roberto, 1988). However, one positive effect in the use of alcohol cannot negate all of the negative effects on the elderly, therefore, treatment is an option to prevent problems with the physical health, mental health, the financial problems, the legal problems, and the social/interpersonal problems of the elderly.

Treatment

Once barriers to the diagnosis of alcoholism are overcome and the need for treatment is recognized, elderly alcoholics must decide what form of treatment would best fit their situation. The options are: "inpatient or outpatient, public or private, expensive or free, hospital-based or social model" (Benshoff, 1987, p. 5).

In considering the elderly population, Zimberg (1989; cited in Dupree, Broskowski & Schonfeld, 1984) believed that older alcoholics should be in a treatment area that is familiar to them rather than in a treatment center. However, treatment failure or success will depend on the appropriateness of the skills acquired by recovering alcoholics (Dupree & Schonfeld, 1989). Some examples of this were shown in a study by Dupree, Broskowski and Schonfeld (1984). The first area of treatment was "designed to teach clients the components of behavior chains (from general to specific, individualized drinking behavior), second was methods for dealing with personal 'general' antecedents typically associated with abusive drinking and relapse, and the last area was the consequences of alcohol abuse" (p. 511).

The first stages of treatment include the most difficult and important steps: diagnosis and implementation (Benshoff & Roberto, 1988).

Diagnosis

One reason diagnosis is difficult is that the denial process must be broken not only in alcoholics

but in their families as well. Factors that add to the difficulty in overcoming denial in the elderly are:

1. The recognition that disease requires outside involvement with society such as being picked up for drunk driving and having the legal system require them to have an evaluation for chemical dependency. Because most elderly alcoholics are not extensively involved in society difficulties in distinguishing between alcoholism and age-related changes shields the alcoholics from becoming aware of the problem (Abrams & Alexopoulos, 1991).

2. Retirement takes the responsibility of going to work sober off the elderly alcoholics. If they have no job to lose, their motivation to seek help to keep their position is no longer there (Abrams & Alexopoulos, 1991; Gordis, 1988).

3. Family and friends are more likely to not be around enough to realize there is a problem (Curtis, Geller, Stokes, Levine & Moore, 1988).

4. They no longer drive so they will not be involved in the legal system and not be recommended to seek help because of an O.W.I. (Abrams & Alexopoulos, 1991) and,

5. Agencies visited by the elderly population may not recognize the symptoms of alcoholism, or may attribute the symptoms to different problems thereby, underestimating its severity, and unintentionally looking at the option of referral and preventing elderly alcoholics from entering treatment. Once these steps of diagnosis have been accomplished, the option for treatment can be looked at and a decision can be made regarding what method of treatment will best fit the needs of individual alcoholics (Benshoff & Roberto, 1988).

One group that has been found beneficial is aftercare, which is a continuing care group (support group) that follows inpatient or outpatient treatment (Wegscheider-Cruse, 1989). Aftercare will be discussed in its own section.

Aftercare

A study done by Mackay and Mariatt (1991) sums up what exactly is aftercare. "Aftercare is the step following cessation of drinking that focuses on maintaining the change; it provides therapeutic and

social support and a place where recovering alcoholics can get helpful feedback from other participants" (p. 1266).

According to Wegscheider-Cruse (1989), only ten percent of the work for recovery and treatment is done in primary care such as inpatient or outpatient treatment. When persons are trying to recover aftercare creates an opportunity for higher rates of recovery and abstinence for alcoholics.

The focus for aftercare therefore is to look at the process of how alcoholics and family members are communicating and processing issues that come up. It is not a goal of aftercare to "solve" the alcoholic's problems.

"The major goal of aftercare is to open up the family system" (Wegscheider-Cruse, 1989, p. 188). This consists of opening communication that has been lost because of fear, denial and the unwritten rule of silence. They must learn how to express feelings and to communicate them to the families.

Another goal of Wegscheider-Cruse (1989) is:

to make sure that families are in touch with their own delusions, defenses, and compulsive behaviors,

> and is motivated to change them. Until family members are ready for this step, alcoholics are powerless to function in an honest and flexible way a healthy family system demands. (p. 188)

Once the families and alcoholics are ready for change and start to learn how to communicate within the family, the pain that alcoholics and family members have suffered comes to the surface (Wegscheider-Cruse, 1989). Through this, the families and alcoholics find that not only were they themselves impacted by their drinking but other members of the family were impacted as well. Through this sharing of pain comes the sharing of happiness and growth.

Everything involved in aftercare is to help the alcoholics and their families to become more healthy, happier individuals. It is a time where alcoholics can start to feel like new individuals and find new ways to interact with their families and other individuals. The alcoholics can stop the role-playing of a dependent and work on developing their life as recovering alcoholics.

Other studies

In a study by Filstead (1990), it was found that out of 6,521 clients who had gone only through inpatient or outpatient treatment in 83 different facilities, over 2,800 were interviewed by phone approximately 11 months after discharge. Fifty-seven percent had a one-hundred percent abstinent rate from alcohol and drugs and 64% were defined as "recovering" which meant they were either abstinent or had one slip.

In the same study, Filstead (1990) gathered data from 2,800 clients after an 11-month discharge period. Clients going through treatment plus aftercare had a higher percentage rate of recovery than did those who had only treatment The aftercare group soared to a 79% abstinence rate and a 86% rate in "recovery" (definition same as above). That is a difference of 22% higher for abstinence and recovery for elderly alcoholics going through treatment plus aftercare.

In a different study done by Christner (1989), it was stated that, " The most consistent predictor of successful outcome for therapeutic community research has been the length of stay in treatment" (p. 16.8). Filstead (1990) also stated that clients who follow

through with recommendations of involvement in self-help groups such as A.A. "demonstrated the therapeutic benefit of these components" (p. 16.12).

In a study by Ornstein and Cherepon (1986), measuring outcomes of inpatient treatment in 1210 expatients, it was found through the use of a two-year follow-up that the longer the length a program is for alcoholics the higher the rate of abstinence. Ornstein and Cherepon also stated that clients in the hospital were found to have higher abstinent rates when going through a 90 day program as compared to a 30 day program.

A study by De Leon (1988) found that the success rates for any alcohol treatment program for recovery were about 50% - 75%, depending on the length of stay. The longer clients stayed in a program the higher the percentage of recovery was for alcoholics. This also included the "total" change individuals made to become more healthy persons. If clients did not work in treatment, such as not doing assignments, not sharing information about themselves or giving feedback to other clients, no matter how long they were in treatment their recovery rate was not high.

In 1991, Kelley conducted study on relapse prevention for alcoholics and reported that the longer a client is in treatment, the lower the relapse rate for the client. Therefore, longer involvement in aftercare would increase the alcoholic's recovery rate.

Outcome in treatment is promising for the elderly due to their strong foundation of coping skills (Toft, 1992). It was found by Kofoed, Tolson, Atkinson, Toth and Turner (1986), that the elderly (54-76 years old) had a higher rate for staying in group and maintaining sobriety than did younger (20-53 years old) alcoholics. Groups that were developed specifically for the elderly population were found to have an even better outcome due to treatment surrounding age-related issues in self-management and in maintaining goals.

When considering prevention for the elderly to try to avoid dependency and later treatment, older adults as a whole should be considered "high risk," due to the likelihood that the elderly population already has problems with developmental issues. Education is a good method for awareness of a problem, if it is presented as helping people deal with problems rather that just educating the elderly on prevention. One

population with which education is needed is with the medical community, including physicians, clinics and other professionals that deal with the elderly. However, in the United States few prevention programs are available for the older adult, with the result that a great deal of unnecessary suffering takes place.

Group Treatment

Group involvement accompanies treatment and in most settings is a requirement (Amodeo, 1988). Benefits from group work consist of being able to identify with other alcoholics, to realize that they are like other alcoholics, and opportunities to develop more social interactions. Only under certain circumstances such as the presence of serious hearing or speech impairments should alcoholics going through treatment be permitted to drop participation in a group (Amodeo, 1988).

Implications for Counselors:

Counselors and therapists could find the different theories of etiology helpful when looking at forms of treatment for elderly alcoholics. Some etiologies are inappropriate for the elderly due to time and effort required.

Another area that is helpful for the professional is the barriers and indicators for identifying elderly alcoholics. Due to many factors that are not common for alcoholics in general, those listed in the barriers section of this article will make the professional more aware of possible indicators when assessing elderly individuals. If indicators for developing alcoholism are not detected a client may be misdiagnosed and unintentionally prevented from getting treatment.

Once a diagnosis is made it is important for the professional to know the outcome probabilities for long and for short-term treatment. It has been found in different studies reported throughout this paper that long-term treatment, which included either inpatient or outpatient treatment plus aftercare or self-help groups increases the recovery rate both for young persons and for older adults. It has also been shown that recovery rates are increased by as much as 22% more for the elderly population going through long-term treatment than short-term treatment.

A clear implication for counselors is to be able to select the most appropriate treatment form for

different clients and to have requisite skills in treating alcoholism.

Summary

This study consisted of a literature review looking at the possible benefits of aftercare following treatment for the elderly population. Barriers and indicators of treatment were concerned along with the etiologies of alcoholism through society. It was hypothesized that long-term treatment for elderly alcoholics would be more beneficial than compared to short-term treatment.

Options for treatment are laid out for alcoholics, either inpatient or outpatient, short-term or long-term treatment. Short-term treatment consists of inpatient or outpatient treatment only for the elderly alcoholic. Inpatient treatment consists of a 21 to 48 day stay in a residential facility which involves a very structured program. Outpatient treatment consists clients coming into the facility only for outpatient groups and/or to individual sessions with their counselor and are still able to live outside the residential facility. Aftercare consists of either inpatient or outpatient

treatment plus aftercare (continuing care) and/or a support group such as Alcoholics Anonymous.

The review of literature revealed three major benefits of aftercare following treatment among elderly alcoholics ages 55 and older. They were:

1) An increase of up to 22% higher for recovery in long-term treatment compared to short-term treatment (Filstead, 1990).

2) All studies found that the longer elderly alcoholics were involved in some form of treatment, the longer their abstinence rate lasted (Ornstein & Cherepon, 1986; De Leon, 1988; & Kelley, 1991).

3) Overall, treatment outcome was better for older alcoholics than for younger, and even better when clients went through aftercare and a treatment specifically designed to fit the older alcoholic population.

The following theories regarding the etiology of alcoholism among the elderly were found in the literature: The "stuck in development" theory, the loss theory, the genetic-constitutional theory, the social

pathology theory, the social disorganization theory, power and control theory, the deviant behavior theory, and the labeling theory.

The review also considered indicators of alcoholism, including mental health problems, financial problems, legal problems, physical health and social/ interpersonal problems. Most of these problems were found not to indicate a possible problem however, this did not mean that there was not a problem.

Although there are some indicators for persons to tap into for the elderly, persons may still find barriers to overcome in receiving or providing treatment. Some barriers include late recognition, attribution of the disease to other disorders or lack of societal involvement. Once the problem is recognized, health issues play a part on determining how far along the disease has progressed.

It was found by many studies that the benefits for aftercare in long-term treatment far out-weigh the success rate for alcoholics going through only short-term treatment.

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