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Understanding older problem drinkers: The role of drinking to cope

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HIGHLIGHTS

- Problem drinking is highly prevalent in older adults.
- Problem drinking measures that do not assess quantity and frequency of drinking may be more suitable for older adults.
- Specific drinking to cope motives were associated with problem drinking.
- Drinking to cope motives that have a social context are more associated with problem drinking
- It may be important to ask older adults about their reasons for drinking.

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ABSTRACT

Introduction and aims: Despite a common perception that older adults drink less than younger adults, drinking frequency increases with age. The aim of this study was to examine the types of coping motives associated with problem drinkers in addition to the types of specific drinking problems most commonly endorsed by older drinkers. The study also sought to investigate the role of individual drinking to cope motives in problem drinking.
Method: Participants were 288 community dwelling older adults aged who consumed alcohol, and were drawn from a larger study of health and aging in rural areas of Australia. Participants completed a postal questionnaire comprising the Drinking Problems Index, Drinking Motives Questionnaire, The AUDIT-C, and the Centre for Epidemiological Studies Depression Scale.
Results: Overall, 22.2% of the sample were problem drinkers, with a higher prevalence for men (30.4%) than women (15.6%). Problem drinkers were significantly more likely to consume alcohol according to several indices of risky drinking. The most common drinking problems experienced were becoming intoxicated, spending too much money on drinking, feeling confused after drinking, and skipping meals. Drinking to cope motives to relax, to manage physical symptoms and to feel more self-confident increased the odds of problem drinking.
Conclusions: Problem drinking is highly prevalent in older adults. Given the potential adverse consequences of problem drinking on the health of older adults it is imperative that health professionals pay attention to drinking behaviours as part of routine practice.

1. Introduction

The study of alcohol consumption in older adults is particularly important because of the greater impact of alcohol-related consequences among older people compared with those in younger age groups (Anderson & Scafato, 2010). With age, the body's ability to metabolise alcohol decreases as a result of physiological changes, such as decreases in body mass and higher levels of fatty tissue, leading to a higher blood alcohol concentration for a given dose compared with younger adults (National Institute on Alcohol Abuse and Alcoholism [NIAAA], 1998). This also means that older adults may experience certain effects of alcohol at lower doses than younger people, whose tolerance increases with increasing consumption (NIAAA, 1998). Furthermore, the higher consumption of pharmaceutical drugs and prevalence of diseases or health conditions in which concurrent alcohol use is not recommended, exacerbate the potential risks of alcohol use in older people (Anderson & Scafato, 2010). In the US it is estimated that up to 78% of older adult drinkers use medications that interact with alcohol (Blow et al., 2005; Breslow, Dong & White, 2015). This greater vulnerability to the effects of alcohol necessitates a better understanding of drinking practices in older adults.

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1.1. Problem drinking

Community-based studies across Europe and the US show that 50–70% of older adults consume alcohol (Frischer et al., 2015; Leon-Munoz et al., 2015; Satre, 2015). Gilson, Bryant and Judd (2014) studied a sample of 370 community dwelling older adults in Australia and found evidence of frequent drinking, with 46% of the sample drinking weekly, of whom 27% drank four or more times per week.

The prevalence of problem drinking within older adults has been difficult to establish, and estimates range anywhere from 1 to 15% and higher (Moore et al., 2006). A number of factors contribute to this variation, however it is largely because different methods of assessment are used and there is a lack of consistency in the definition of problem alcohol consumption in older adults. It has been argued that such definitions need to be age-specific because of older adults' increased sensitivity to low levels of alcohol. A 2013 National Drug Strategy Household Survey in Australia identified 23% aged 60–69, and 9% aged 70 and above consumed levels of alcohol that put them at-risk of injury and harm on a single occasion of drinking (>4 drinks on one occasion) in the previous year. Nearly 20% of 60–69 years olds and 12% of aged 70 years and above had more than two standard drinks a day (Australian Institute of Health and Welfare [AIHW], 2014). Draper and colleagues (2015) found that 17.1% of their sample of 200 older Australians within geriatric community health services screened positively for hazardous alcohol use on the AUDIT-C. In contrast, Towers et al. (2011) surveyed over 6000 older New Zealanders aged 55–70 years using the AUDIT-C, and identified between 42 and 56% as being hazardous drinkers. A study by Gilson et al. (2014) found that risky drinking in older Australian drinkers ($N = 292$, Mean age of 71 years) was prevalent in 6.6 to 31.7% of women and 21.6 to 44.8% of men, depending on the criteria applied to define risky drinking. Higher estimates were identified with the AUDIT-C screening instrument compared to applying safe alcohol guideline recommendations.

One particular area that has received little research attention is the type of drinking problems that older adults may experience from drinking alcohol. Examples of drinking problems include physical problems (e.g., craving for alcohol), psychological difficulties (e.g., feeling confused after drinking), interpersonal problems (e.g., family members' complaints about participant's use of alcohol), and functioning problems (e.g. whether alcohol use had caused the individual to have a fall or accident). A recent study on an older alcoholic treatment sample, found that the drinking problems most endorsed were becoming drunk, having family members worry or complain about drinking and going to someone for help about drinking (Kopera-Frye et al., 1999). Given the clinical nature of this sample, further work is warranted to examine the drinking problems experienced by community dwelling older adults. Understanding the types of problems that older adults commonly experience may guide primary care health professionals in their discussions with older adults about their alcohol use. This is especially relevant for older adults, given that talking about alcohol use with professionals can be heavily stigmatised in this age group (Blow, 1998). Therefore, asking about the broader drinking problems that stem from alcohol use might be more acceptable than directly enquiring about the quantity and frequency of drinking. The current study seeks to investigate the specific types of drinking problems that older adults report to experience in a non-clinical sample of community dwelling older adults.

Only one measure is currently validated to assess the frequency of drinking problems in older adults (Drinking Problems Index; DPI, Finney et al., 1991). This measure also classifies individuals as problem or non-problem drinkers. However, given the absence of quantity and frequency of alcohol information in this classification, and that an individual only needs to respond positively to one or more of the DPI items to be classified as a problem drinker, this study sought to examine several indices of alcohol consumption across problem and non-problem drinkers classified according to the DPI.

1.2. Coping motives

In addition to investigating the drinking problems that older adults experience, it is important to understand why they drink alcohol. Individuals differ widely in their reasons for drinking, with some drinking for social reasons and others to enhance positive emotions or to seek relief from negative emotions. These differences are important because different drinking motivations for drinking alcohol have been shown to predict distinct patterns of alcohol consumption and alcohol-related problems. Thus, drinking behaviour is motivated by different needs or serves different functions. Cooper, Russell, Skinner and Windle (1992) developed the Drinking Motives Questionnaire (DMQ), which represents a theoretically derived three-factor structure of drinking motives encompassing coping (with negative emotion) social (e.g., to improve social gatherings), and enhancement (of positive affect) motives.

Drinking to cope refers to the use of alcohol to escape, avoid, or otherwise regulate unpleasant emotions (Cooper, 1994). In this sense alcohol consumption is considered a reactive process that is preceded by the experience of negative emotion; hence, motivation to engage in alcohol use to alleviate negative emotional states. In terms of alcohol-related consequences, drinking to cope predicts drinking problems both directly and indirectly through alcohol consumption (Holahan et al., 2001; Abbey et al., 1993; Carpenter & Hasin, 1998; Cooper et al., 1992).

Drinking to cope motives have been studied extensively in youth, but there is a lack of research investigating how these motives relate to older adults' drinking behaviours. Studies that have investigated why older adults drink alcohol have used various non-standardised measures of reasons for drinking rather than theoretically driven constructs such as the DMQ. This body of research has found that older adults drink alcohol to help cope with sleep disturbances, symptoms of cardiovascular disease, mental problems (Aira et al., 2008) and to seek relief from negative affect (Khan et al., 2006; Immonen, Valvanne, & Pitkala, 2010). Immonen et al. (2010) found that drinking to relieve depression and anxiety was a powerful predictor of at-risk drinking. Similarly, drinking for pain relief is also associated with this outcome (Gilson, Bryant & Judd, 2014; Brennan et al., 2005). More recently, Gilson et al. (2013) validated the DMQ for older adults and found that the drinking to cope dimension was associated with greater quantity of alcohol use. Together, these studies suggest support for the association between drinking to cope and problem drinking in older adults. The current study aims to build on these findings to examine which drinking to cope items of the DMQ differ across problem and non-problem drinkers and which drinking to cope items are most predictive of problem drinking.

The novel contribution of this study is in the examination of individual coping items which can provide insight into which drinking to cope items are most endorsed in older drinkers, in addition to problem and non-problem drinkers. To reflect the previous research findings, this study will also include additional coping items in relation to seeking relief from physical symptoms and to aid sleep, which are not included in the coping dimension of the DMQ. Furthermore, the study seeks to examine which of the individual coping items are most predictive of problem drinking. This information has relevance to preventative strategies focusing on coping motives. To our knowledge, no previous study has investigated coping motivations for drinking from a theoretically based instrument, and in relation to problem drinking that is not defined by the quantity and/or frequency of alcohol consumption.

1.3. Aims

The aims of the current study are to: 1) examine the alcohol use profile of problem and non-problem drinkers, 2) examine the specific types of drinking problems most commonly endorsed by older drinkers, 3) examine differences in the endorsement of individual drinking to cope motives between problem and non-problem drinkers, and 4) investigate which drinking to cope motives are the strongest predictors of problem drinkers.