

Alcohol Use Among Community Dwelling Older Adults

by

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Abstract

Alcohol use among community dwelling older adults is fast becoming a major health concern in Canada. It is fast becoming a major precursor for social dysfunction as many have experienced destructive relationships, financial despair, and social isolation. This population often falls victim to ageist views held by health care providers, delaying recognition and assistance in relation to alcohol misuse. Perhaps the most important gap is the lack of qualitative research that will study the experience of alcohol misuse in older adults from their perspective and try to understand their readiness for change.

This critical ethnography explored the attitudes, beliefs, behaviours, and experiences of alcohol use among community dwelling older adults within their social, cultural, or political context with an aim to elicit a change during the process. Data were collected through semi-structured interviews with a total of eighteen individuals; 1) study participants (N=11) that were older adults and dwelled in an urban center in the Interior of British Columbia, and who used alcohol, and 2) key informants (N=7) who had extensive experience with substance use issues working in a variety of fields within the community. Audio-taped interviews were transcribed and analyzed. Using Carspecken's framework of analysis, three main themes and thirteen subthemes were identified.

This study examined the role of environmental factors early in older adults' life and their influence in forming beliefs, attitudes, and behaviours, related to alcohol use later in life. It examined the older adults' drinking patterns, consequences of alcohol use, additional substance use, and barriers to seeking assistance.

Findings in this study indicated that early adverse life experiences increase the chances of alcohol misuse later in life. Adjunct use of other substances indicated the changing characteristics of this population and the potential increase in health care costs as baby boomers become a predominant faction of the older adult population. Results of the study indicated improved access to nursing services at the primary health care level, a change of physicians' attitudes, increased resources, and community support would encourage this population to seek out help. These themes have implications for nursing practice, education, nursing administration, and further research.

Preface

Ethics approval for this study was obtained from the University of British Columbia and Interior Health Authority. The ethics numbers are as follows: University of British Columbia #1200147 and Interior Health Authority approval-2012-13-017-E.

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Chapter One: Alcohol Use Among Community Dwelling Older Adults

1.1 Introduction

There has been an exponential increase in the number of adults who are 65 years or older in Canada (Statistics Canada, 2013). The term ‘older adults’ is used throughout this research to describe a population who are 65 years or older. As of July 2013, older adults make up 15.3% of the country’s population (Statistics Canada, 2013). Moreover, this number is estimated to increase to 18.9% by 2021, and to 24.9% by 2041 (Statistics Canada, 2002). The growth to this population has been accelerated as baby boomers have recently entered this cohort of 65 years or older (Statistics Canada, 2013). It has been observed that with baby boomers joining the older adult population, there will be an increase in the number of older adults that use alcohol, which may place a heavier demand on health care and social services (Johnson & Sung, 2009). Rogers and Wiese (2011), report alcohol misuse in 16% of Canadian adults who are fifty-five or older. It is important to note however, that the prevalence rate of alcohol use in older adults is complicated by the fact that there are large differences in alcohol intake between age cohorts (St. John, Snow, & Tyas, 2010). Those who are young-old (65-74), use alcohol more frequently than the oldest-old (85 and older). Nevertheless, the problem of alcohol misuse has been on the rise in this population, and is fast becoming a major health concern in Canada. As increases in disposable income, improved health status, and more lenient attitudes towards alcohol use continue, all are likely to increase utilization of alcohol in older adults (Schofield & Tolson, 2001). In addition, media messages about alcohol being beneficial to health may influence consumption (Schofield & Tolson, 2001).

According to Cummings, Bride, and Rawlins-Shaw (2006), older adults who misuse alcohol are at a higher risk for increased morbidity and mortality. Alcohol misuse can lead to falls with a risk of hip fracture, a leading cause of death in this age group (Merrick et al., 2008). It additionally can exacerbate medical disorders such as stroke, hypertension, and congestive heart failure. This misuse of alcohol is also associated with increased risks of common cancers. Prolonged alcohol use may lead to poor nutrition, vitamin or immune deficiencies, and is a known risk for dementia. Alcohol use is associated with a number of mental illnesses, depression being the commonest associated mental illness (St. John et al., 2010). The co-morbidity of alcohol misuse and depression in older adults is vitally important due to increased risks of suicide in relation to undiagnosed depression (Cummings et al., 2006).

The ill effects of alcohol on health and the cost associated with the treatment are substantial, and the magnitude is expected to grow as baby boomers join this age group (Han, Gfroerer, Colliver, & Penne, 2009). The large size of baby boomers' cohort, and their greater life time rate of substance use will undoubtedly impact health care and other community resources significantly as diverse needs for health care will increase. It is predicted that increasing number of older adults will be entering treatment centers from complications of poly substance use (Lay, King, & Rangel, 2008).

The experience of alcohol misuse by older adults is a not a static occurrence. It is important to note it is not something that happened overnight, rather it is a series of events and occurrences that transpire over a lengthy period of time and are dependent on a large number of variables such as their environment, family structure, socioeconomic status, social interaction, cultural background, moral principles, personal beliefs, attitudes, and experiences about drinking

(Immonen, Valvanne, & Pitkala, 2011; Mechanic & Tanner, 2007). Therefore, the motive for all types of drinking can be different for different people (Immonen et al., 2011). The concept of motive for drinking is based on the assumption that people use alcohol in order to attain a certain outcome. For example, it has been observed that young people drink for social motives, whereas older people consume alcohol for many reasons other than social (Coulton, 2009). However, alcohol does play an important social role for older adults; for example, social gatherings tend to reduce social isolation for a large number of them. This population may also misuse alcohol in response to a lack of social support, challenging health problems, or experiences of major life changes such as losses (Balsa, Homer, Fleming, & French, 2008).

In the younger population, misuse of alcohol has received plenty of attention in modern society, whereas it largely goes unnoticed, undiagnosed, and untreated in the older adult population. A number of factors are implicated in the under-diagnosis of alcohol misuse in the older adult population. First, older adults often do not present with a clear clinical picture as their younger counterparts do. Usually the primary reason for their visits to their family physician or emergency department pertains to falls, delirium, cardiovascular, or gastrointestinal complaints (Loukissa, 2007). According to Coulton (2009), 60% of older adults who are admitted to acute care with repeated falls, delirium, heart failure, or chest infection have undiagnosed alcohol issues. Secondly, many of the social systems such as employers, friends, or the legal system that could help identify alcohol use problems, may not be as relevant in this population (Sattar, Petty, & Burke, 2003). In some instances, simple physical limitations, such as transportation, are a barrier. Other factors that act as barriers to accessing help may be a lack of social support or a shrinking circle of friends (Sorocco & Ferrell, 2006).

At the primary health care level, alcohol misuse by older adults in the community is not being recognized or diagnosed by their physicians due to a number of factors; time constraints, lack of appropriate training, and lack of age appropriate screening tools. Perhaps the most crucial contributing factor to the under-diagnosis and under-treatment of alcohol use in older adults is the attitudes and perceptions of primary care physicians regarding screening for alcohol use in older adults (Sharp & Vacha-Haase, 2010).

1.2 Significance

Although alcohol misuse in older adults represents a major public health concern, little attention has been focused either on the problem, or the potentially effective interventions to address this need within this population (Cummings et al., 2006). By and large, the majority of the initiatives on the part of health services, public health, or government policies have been directed towards younger adults. The issue of alcohol misuse in older adults often goes undetected or misdiagnosed. At an individual level, an unawareness of problem drinking being an issue, or worse, the denial on the part of an older person often appears to be a hallmark feature. There may be feelings of shame, guilt, or stigma attached acting as barrier in accessing help (Menninger, 2002). More importantly, at a broader level, society seems to tolerate older adults who may have alcohol use issues. This thinking often starts with family members who are either ashamed or may adapt a more tolerant view of a drinking issue as a justifiable response to the stresses of aging. Physicians at the primary care level, either do not have time, or consider it a waste of time trying to address this issue with older adults as they are difficult to treat, or the attitude that drinking may be one of the few pleasures left, and not wish to deprive them of it

(Culbertson, 2006a). These pervasive and persistent ageist messages can create feelings of low worth or a lack of utility which, combined with the shame and isolation that comes with alcohol use can be devastating for an older person, further discouraging them from seeking assistance (Morgan, Brosi, & Brosi, 2011),

At an even higher level, the dominant policy decisions center on individuals rather than populations, and the emphasis is on seeking to change individual behaviour or lifestyle rather than seeking to identify vulnerabilities of people or why they use alcohol (Mechanic & Tanner, 2007). These observations clearly show that the issue of alcohol use in older adults needs to be examined at a broader level. Social hierarchies, such as income distribution, public policies on housing and education, social relationships (social network or discrimination), and cultural norms are all important features of social environment that affect an individual's health and well-being (Galea & Vlahov 2002). These social factors, or social determinants of health, shape both micro level and macro level risk factors as well as health outcomes (Mechanic & Tanner, 2007). For older adults who misuse alcohol, these social factors may impact their ability to gain adequate recognition of their concerns, or to access therapeutic or social assistance because of age inequitable standards or policies.

As the population of older adults continues to grow in number, there is an increasing need for health care providers to examine and understand alcohol use in this population, particularly from the older adults' perspective. Identifying alcohol use may be more difficult in older adults as compared to their younger counterparts, due partly to the reticence of this population to seek help. Additionally, alcohol related pathology may likely be obscured by concurrent health challenges and medications (Menninger, 2002). Finally, it is extremely important for health care

providers to “understand ageism and the resultant narrative both from a personal and a professional perspective.” (Morgan et al., 2011, p. 448). There exists a need at the policy level to develop care pathways that would not only allow equitable access to various treatment options for the older adult population, but also provide education at the personal and community levels resulting in older adults being understood and supported in their homes and in the community (Coulton, 2009).

There has been a significant amount of research on alcohol misuse and its negative outcomes among older adults; however, this issue has not been explored at any significant length at broader societal, political, cultural, or historical levels. Older people’s own reasons for drinking, their attitudes, and experiences have received little attention. It is critical for health care providers to understand alcohol misuse in the older adult from their perspective. In recent years, much of the nursing research has focused on health disparities by exploring relationships between health and social factors such as age, gender, race, socio-economic positions, or educational attainments (Mohammad, 2006). Nurses are situated in an excellent position to study alcohol misuse at a much broader societal level by studying the social environment within which individuals interact and function.

1.3 Problem Statement

Alcohol use by people 65 years and older is a serious problem and one that is under-identified, under-treated, and poorly understood (Merrick et al., 2008). Besides exacerbating medical disorders that can result in multiple hospital admissions, it can also be the main contributor to falls leading to hip fractures, a leading cause of death in this age group. The

overall cost and ill effects of alcohol on health are substantial, and the magnitude is expected to grow as baby boomers transition into this age group (Boyle & Davis, 2006; Patterson & Jeste, 1999). Early identification and understanding of older adults who use alcohol inappropriately is essential for timely and appropriate clinical intervention (Merrick et al., 2008).

I believe that nurses are in the frontline to detect alcohol related problems among community dwelling older adults. In order to have a true understanding of alcohol misuse in older adults, nurses need to understand this behaviour from the clients' perspectives. A clearer understanding of their beliefs, attitudes, and their reluctance to access help will allow planning for timely and appropriate intervention/prevention strategies.

1.4 Statement of Purpose

The purpose of this study was to gain a greater understanding of older adults' use of alcohol within their social, cultural, and political context.

1.5 Research Objectives

The following objectives guided the research process to:

1. Explore attitudes, beliefs, behaviours, and experiences of alcohol use among older adults.
2. Explore factors that influence or shape alcohol use among older adults.
3. Use findings to inform nursing practice, education, and research.

1.6 Chapter Summary

In this chapter, I have explained the background and significance for my research study on alcohol use among community dwelling older adults. I have explained the problem statement

and presented three research objectives that guide this study. The next chapter provides a synthesis of the current literature on alcohol use in older adults that includes effects of alcohol use and misuse, clinical picture, drinking patterns, reasons for under-diagnosis, screening instruments, barriers to treatment, and treatment options noted thus far in the literature.

Chapter Two: Literature Review

2.1 Introduction

In this chapter, I present a review and synthesis of current literature on alcohol use among community dwelling older adults to outline the context for my study. The literature review includes an analysis of current literature on prevalence, effects of alcohol use and misuse, clinical picture suggestive of alcohol misuse, drinking patterns and drinking categories, under-diagnosis, screening for alcohol use, barriers to treatment, and treatment options for older adults with alcohol use issues.

2.1.1 Inclusion criteria for selection of studies.

Both qualitative and quantitative research studies were selected and included for the literature review. Experimental designs as well as non-experimental design studies were included. The importance of including qualitative studies was to gain a deeper understanding of alcohol use in older people who live in the community. The publication dates of the research articles and the countries they were conducted in were not specified as inclusion criteria. Only peer reviewed articles were included for quality and credibility purposes.

2.1.2 Identification of studies.

I used CINAHL, Psycinfo, Pubmed, Medline, and Academic Search Complete databases for my research study. Key phrases used to initiate the search were ‘alcohol use in older adults,’ ‘older adults with substance use issue,’ ‘baby boomers,’ ‘impact of alcohol on older adults,’ ‘community dwelling older adults,’ ‘alcohol use disorders,’ and ‘outcome of substance use issues in older population.’ As my research is on alcohol use among community dwelling older adults, I

chose those key words to gather articles on alcohol use in older adults and examine various issues that are related to it. Additional terms used for search were; older adults, alcohol use, concurrent disorders, depression in older adults, dementia, marginalization, stigma, and childhood adversities.

2.2 Review of Literature

2.2.1 Prevalence.

The concept of alcohol use as a distinct phenomenon among older adults was introduced as early as 1964 (Sattar et al., 2003). Community surveys in the American older adult population show a range from 6% to 16% depending whether it is the older adults in outpatient clinics, retirement communities, living in remote areas, or dwelling in the cities (Menninger, 2002). According to Merrick et al. (2008), the 2005 National survey on Drug Use and Health in the United States found that 8.3% of people aged sixty-five or older indulged in binge drinking and 1.7% were heavy drinkers. In another study conducted in the United States, in which they employed logistic regression modeling, Han et al. (2009) determined that the prevalence of alcohol use in older adults will become more than double in 2020, resulting from combined effects of a 39% population increase, and a 44% increase in the rate of alcohol misuse. In Canada, as mentioned earlier, the prevalence rate is 16% for individuals fifty years and older (Rogers & Wiese, 2011).

Alcohol use in older adults is influenced by factors such as gender, socio-economic status, living arrangements, ethnicity, co-morbid illnesses, or genetics. Men are more than twice as likely to exceed recommended guidelines as women in the age group sixty-five and older

(Dar, 2006). Merrick et al. (2008) report a prevalence rate of unhealthy drinking in men aged sixty-five and older ranging from 10% to 15% as compared to 2% to 5% in women of the same age group. In a cross sectional study carried out in Manitoba, Canada, men were more likely to misuse alcohol in older adult population (St. John, Montgomery, & Tyas, 2009). This gap is shrinking however, as women from the younger cohort of baby boomers may be more prone to the adverse effects of alcohol as they grow older (St. John et al., 2010).

Across genders, higher levels of drinking are more prevalent among the higher social classes, the more educated, and the more affluent (Dar, 2006). Merrick et al. (2008) found in their study conducted in the United States that a higher level of education and income was associated with higher prevalence of drinking within the guidelines, as well as unhealthy drinking. Among older men, those who are married are less likely to drink heavily (Dar, 2006). According to Merrick et al., living alone for older men, whether being divorced, unmarried, or losing their partners predicts unhealthy drinking.

Any change in personal or social dynamics predisposes this population to alcohol misuse. For example, besides their partners, older adults begin to lose other family members and friends as they age, which can lead to a loss of social support systems as well as depression (Sattar et al., 2003). Similarly, moving to a new location upon retirement, or family or friends moving away, or loss of contact with co-workers may also cause social isolation (Best Practices, 2002).

People with depression or other psychiatric illnesses have a higher propensity for alcohol use (Sattar et al., 2003; St. John et al., 2010). It may be difficult to determine which condition came first. Furthermore, one condition may lead to the other, and/or they may co-exist. A positive family history of alcohol misuse is an important predictor of developing alcohol-related

problems later in life. There is substantial evidence that genetic factors play a significant role in the development of alcohol-related problems (Dar, 2006). Older adults who use psycho-active substances and nicotine are more likely to use alcohol as well (Sattar et al., 2003).

Benzodiazepines are the most commonly abused psycho-active medications.

In other parts of the world, comparable prevalence rates have been reported for people sixty-five or older. Dar (2006) reports a prevalence rate of 17% in men and 7% in women in the United Kingdom. In the Mexican older adult population, again, alcohol misuse has been reported as a serious health problem. It is estimated that prevalence rate in this population varies from 15% to 72% (Castillo, Marziale, Castillo, Facundo, & Meza, 2008). Kim et al. (2009), report that with a rapid increase in the South Korean older adult population, alcohol use has been reported as a major health issue; they report a prevalence rate of 13.6% for social drinking in older adults. In general, Caucasian older adults tend to drink alcohol more regularly, but African American and Hispanic tend to binge drink more often (Sorocco & Ferrell, 2006).

The prevalence rate for in-patients is higher than community dwelling older adults with alcohol misuse history, with 14% for emergency departments, 18% for medical in-patients, and 23% to 44% for psychiatric in-patients (O'Connell, Chin, Cunningham, & Lawlor, 2003). Older adults are hospitalized for conditions associated with alcohol at approximately the same rate as myocardial infarction (Merrick et al., 2008; Weintraub et al., 2002). It is important to note that older adults that use alcohol are more likely to be hospitalized with non-alcoholic diagnoses, leading to under-identification of alcohol misuse (Weintraub et al., 2002). According to Culberson (2006a), true prevalence of alcohol related hospital admission rates may be considerably higher than is reported. Emergency physicians are known to diagnose fewer than

50% of older adults who misuse alcohol with estimates as low as 20% for in-patients and emergency departments combined (Culbertson 2006a; Weingtraub et al, 2002).

In summary, alcohol use and misuse is a growing problem in people who are sixty-five and older. Prevalence rate appears higher in males, people with higher education, higher socio-economic status, those who live alone, have co-morbid psychiatric illness, use psycho-active substances, or in-hospital patients as compared to community dwelling older adults. Thus, overall, alcohol use/misuse is going to become a much bigger issue with an exponential growth in older adult population as baby boomers join this cohort. This is also a global issue as the rates are comparable in other parts of the world.

2.2.2 Effects of alcohol use and misuse.

Alcohol use/misuse has different consequences in older adults as compared to their younger counterparts. This difference is related to older adults' frailty, age-related altered physiology, presence of concomitant physical and mental illnesses, vitamin and immune deficiencies, and frequent use of multiple medications.

Alcohol use has been identified as one of the main reasons for falls in older people (Dar, 2006; Merrick et al., 2008; Sattar et al., 2003). It can affect balance and judgment. Age related changes in bone density and decreased muscular strength can all contribute to bone fractures (Best Practices, 2002). Older adults who consume alcohol have a 2.6 fold increased risk of fracture as compared to patients without a history of alcohol misuse (Menninger, 2002). In older adults, alcohol related falls causing hip fractures, lead to significantly higher admissions to long-term care facilities as compared to those older adults who sustained hip fractures without alcohol

use being a factor. According to Health Canada, 12% of hip fracture patients with alcohol use problems were discharged to long-term care facilities as compared to only 5% of patients without alcohol use concerns (Statistics Canada, 2002).

In older people, lean body mass and proportion of body water decrease, whereas total body fat content increases. Consequently, body's total volume of distribution decreases that leads to higher blood alcohol levels even when no change occurs in the amount or rate of alcohol consumption (Sacco, Bucholz, & Harrington, 2014; Sattar et al., 2003).

Besides frailty and age related physiological changes, heavy alcohol use in older adults is associated with increased health risks. Some of these risks result from lifelong alcohol use, but even drinking that begins later in life, can be associated with negative health consequences (O'Connell et al., 2004). Excessive drinking puts older adults at risk for coronary heart disease, hypertension, and stroke (Dar, 2006). It can also increase the risk of cardiac arrhythmias or cardiomyopathies (Culberson, 2006a). In fact, even moderate amounts of alcohol can exacerbate or intensify pre-existing medical conditions in older adults such as diabetes, hypertension, and congestive heart failure (Loukissa, 2007; Merrick et al. 2008). According to Menninger (2002), alcohol is a direct myocardial depressant. Its chronic use exacerbates hypertension, hyperlipidemia, and angina pectoris; all of which lead to a greater risk of myocardial infarction.

Alcohol causes many gastrointestinal disturbances, notably gastritis and peptic ulcer disease (Culberson, 2006a; Menninger 2002). Elevated liver enzymes, an indication of hepatitis, fatty liver or cirrhosis are often present in older adults who misuse alcohol. According to Menninger (2002), half of the older adults with cirrhosis die within one year. Long-term use of alcohol also puts this population at an increased risk for pancreatitis. Older heavy drinkers are

also at a higher risk for developing cancer of the liver, colon, oesophagus, and nasopharynx (Dar, 2006).

Besides the acute confusional state that may occur with acute intoxication, alcohol causes global cognitive impairment and cerebral atrophy in the older adult population (Menninger, 2002; Oslin & Cary, 2003; St John et al., 2010). It leads to a pattern of impaired executive functioning and impaired memory, which can be detected with neuropsychological testing. Cerebro-vascular accidents are more common in older adults who misuse alcohol. Subdural hematoma resulting from falls is one of the most common presentations in emergency departments within the older adult population (Menninger, 2002), again, often as the direct result of misuse of alcohol.

It has been observed that there is an increased incidence of all types of dementia, except Alzheimer's disease, in older adults who consume alcohol (Dar, 2006; Menninger, 2002; Thomas & Rockwood, 2001). Although the relationship between alcohol and dementia is complex, according to Oslin & Cary (2003), it has been generally accepted by researchers that alcohol dependence can lead to a syndrome of dementia that is commonly known as 'alcohol related dementia' (ARD). ARD accounts for 5% of dementias and may result from direct effects of alcohol, thiamine deficiency, or both (Culberson 2006a). Alcohol misuse may also exacerbate Parkinson's disease in older adults.

Prolonged heavy drinking may also lead to self-neglect, poor nutrition, poor hygiene, and hypothermia in older adults (Culberson, 2006a; Dar, 2006). Inadequate nutrition may result in a number of vitamin deficiencies and metabolic changes. Vitamin B12 malabsorption can cause megaloblastic anemia, folate deficiency can lead to sideroblastic and haemolytic anemia, and

thiamine deficiency can lead to both Wernick's encephalopathy and Korsakoff's syndrome (Menninger, 2002). Decreased hydroxylation of vitamin D can cause osteoporosis (Culberson, 2006a; Menninger, 2002). Chronic upper gastrointestinal bleeding may result in iron deficiency anemia. Alcohol misuse is also the most common cause of thrombocytopenia in the older adult population (Menninger, 2002). Chronic misuse of alcohol in older adults leads to an impaired immune system, exposing them to the possibility of repeated infections (Sattar et al., 2003).

Alcohol misuse not only impacts physical health negatively, it is associated with mental illnesses as well. Incidence of primary mood disorders may vary from 12% to 30% in older adult population with alcohol use (Dar, 2006). In a cross sectional study conducted in Manitoba, Canada, the researchers found a significant association between alcohol use and depression in older people (St. John et al., 2009). The researchers further hypothesized that a feedback loop may exist between alcohol use and depression. Clinicians should inquire about depressive symptoms in older adults who present with alcohol use, and about patterns of alcohol use in older adult population presenting with depressive symptoms. Older people with an alcohol use history and who suffer from depression have an increased risk of suicide according to Dar (2006). Additionally, a history of alcohol use is an indicator of a poorer response to treatment of late life depression. More rarely, schizophrenia may co-exist with alcohol problems in older adults and complicate the treatment of both (Dar, 2006). Research has shown a strong association between alcohol and co-morbid affective disorders (Blow, Brockman, & Barry, 2004). Late life drinking or problem drinking can strain existing relationships and threaten social network that may become a risk factor for suicide.

Perhaps the most concerning aspect of alcohol use in older adults is their concomitant use of over-the-counter and prescription medications. Older adults are uniquely vulnerable to effects of alcohol use because of their high risk for drug and alcohol interaction (Sorocco & Ferrell, 2006). Around eight out of ten older adults, aged sixty-five and older, regularly take prescribed medications. According to a cross sectional analysis conducted by Pringle, Ahern, Heller, Gold, & Brown (2005) in the United States, 77% of the prescription medication users used at least one medication that interacted with alcohol. Furthermore, cognitive impairment in older adults that may or may not be related to alcohol use, can easily lead to a drug overdose in this population (Culberson, 2006a; Morgan et al., 2011). Older people are also the major users of over-the-counter medications (Schofield & Tolson, 2001). Alcohol is contraindicated in the majority of these medications (Dar, 2006). Slower metabolic rate and clearance mechanism delays the clearing of these medications and makes this population more susceptible to adverse drug and alcohol interaction (Sorocco & Ferrell, 2006).

A significant number of older adults take a benzodiazepine at night (Schofield & Tolson, 2001). Alcohol potentiates the sedative effect of these drugs leading to slower reaction time and an impaired balance that predisposes these people to falls, automobile accidents, or even death (Pringle et al., 2005). A combination of alcohol and non-steroidal anti-inflammatory drugs (Aspirin) increases the risk of gastrointestinal bleeding. Also, antihypertensives, another commonly prescribed group of medications in older adult population, can interact with alcohol and cause severe drop in blood pressure (Schofield & Tolson, 2001). According to Schofield and Tolson (2001), 78% of older adults receiving medications for which alcohol is contraindicated had no recollection of this information being given to them by their physicians.

In summary, older adults are sensitive to the effects of alcohol due to age-related physiological changes, as the same intake causes higher blood alcohol concentrations in their bodies as compared to younger people. Alcohol misuse exposes this age group to higher risks of cardiovascular diseases, gastrointestinal diseases, or liver damage. It may also exacerbate existing illnesses. Excessive alcohol use is one of the leading causes of falls in older adults. Also, alcohol-drug interaction may lead to falls, accidents, and even death. It can cause global cognitive impairment and is associated with most dementias, except for Alzheimer's disease. Chronic alcohol use leads to nutritional, vitamin, and immune deficiencies. Alcohol use in older adults is often associated with depression, or even suicidal tendencies. Concomitant use of prescribed or over-the-counter medications and alcohol by older adults puts them at considerable risk, particularly as majority of them are unaware of the relevant information.

2.2.3 Clinical picture suggestive of alcohol misuse in older adults.

One of the first signs that physicians may observe in older clients who misuse alcohol is that therapy is not working on normally treatable condition such as hypertension (Sorocco & Ferrell, 2006). Frequent complains of insomnia, fatigue, weight loss or malnutrition, complaints of anxiety with frequent requests for anxiolytics, sedatives or hypnotics, unexplained post-operative agitation, confusion or new onset seizures, diarrhea, urinary incontinence, or memory loss should alert physicians that they may be encountering alcohol misuse by their clients (Sorocco & Ferrell, 2006).

Difficulty performing activities of daily living (ADL), such as eating, grooming, toileting, or transferring from chair to bed are often impaired in older adults who misuse alcohol

(Culbertson, 2006a). Up to 20% of older adult drinkers report difficulties with instrumental activities of daily living (IADL) such as using telephone, buying groceries, or paying bills. Impairment in functioning “increases the likelihood of injury, institutionalization and health care use” (Culbertson, 2006a, p. 25).

2.2.4 Drinking patterns & drinking categories in older adults.

According to National Institute on Alcohol Abuse and Alcoholism (NIAAA, 1995, as cited in Sorocco & Ferrell, 2006, p.455) individuals who are sixty-five and older should not consume more than one standard drink per day, or seven standard drinks per week. A standard drink consists of 12oz of beer, 1.5 oz of hard liquor, 5oz of wine, or 4oz of sherry, liqueur, or aperitif (Sorocco & Ferrell, 2006).

Drinking patterns vary in older adults; they can be low risk, moderate, heavy, problem, or binge drinkers depending on how much or how often they consume alcohol (Sorocco & Ferrell, 2006). Moreover, alcohol use/misuse in older adults can be categorized as being of early onset or late onset depending on whether they started to drink before or after the age of forty, and whether they are continuous or intermittent drinkers (Sattar et al. 2003).

2.2.4.1 Definitions of different drinking patterns.

One of the challenges for researchers who conduct studies on alcohol related issues are the definitions and measurements. There are variable definitions for ‘alcoholism,’ ‘heavy drinking,’ or ‘problem drinking.’ Furthermore, most of the definitions for variable drinking patterns are based on studies conducted on a younger population and are often inappropriate for older adults (Sorocco & Ferrell, 2006). For the sake of clarity and for my study, I will use

following operational definitions as described by some of the researchers: a) low risk or abstinent drinkers are those that follow standard guidelines of no more than one drink per day; b) moderate drinking: more than one drink per day, or more than seven drinks per week; c) problem drinking: when drinking leads to adverse medical, psychological, or social consequences; d) heavy drinking: five or more drinks on the same occasion on each of five or more days in the past thirty days; e) binge drinking: five or more drinks on the same occasion, on at least one day in the past month (Sorocco & Ferrell, 2006). Risky drinking is defined by Merrick et al. (2008) as more than seven drinks per week, or more than three drinks on any single day. Alcohol misuse and abuse are often used interchangeably by researchers. Alcohol misuse or “abuse is characterized by continued drinking, despite adverse effects on family, or work, trauma or negative health consequences” (Barrick & Connors, 2002, p.584).

2.2.4.2 Early onset versus late-onset drinkers.

Studies over the years have identified two distinct categories of older adults who misuse alcohol; early versus late-onset drinkers (Sorocco & Ferrell, 2006). Early onset refers to people who started to drink before the age of forty. Early-onset older drinkers comprise two thirds of the older adult drinking population (Menninger, 2002). They start their alcohol related problems in their twenties or thirties. Socioeconomic decline, estrangement from family, antisocial behaviour, and family history of alcohol use is common in this group. In a qualitative study on motives for using alcohol in early mid-life, most of the participants viewed their alcohol use as a social activity, first and foremost, as they associated with friends who came from similar backgrounds and who also used alcohol (Emslie, Hunt, & Lyons, 2012). Besides considering it a

social activity, they also used alcohol to escape from problems, or to simply get intoxicated (Abbey, Smith, & Scott, 1993). According to Culbertson (2006a) another reason may be that a number of these individuals started the use of alcohol to self-medicate for a range of psychosocial or medical issues, and continued to drink as they aged. They are the ones who suffer from chronic alcohol related problems such as co-morbid psychiatric disorder, cirrhosis, or cognitive decline, as, according to Sattar et al. (2003), alcohol misuse often progresses with age. On the other hand, a subset of this group includes older adults who have been successfully treated and have had extended periods of abstinence. However, as the disease of alcohol use is chronic and progressive, any change in their lives such as poor health, loss of support mechanism, or isolation can lead to previous drinking patterns (Culbertson, 2006a).

Late-onset drinkers are usually the older adults who began problem drinking after the age of forty (Sorocco & Ferrell, 2006). This problem seems to occur more frequently in females (Barrick & Connors, 2006). They “have generally attained a higher level of education and income” (Menninger, 2002, p.168). They comprise one third of the total drinking population aged sixty-five and older. They appear physically and psychologically healthier due to their limited period of use (Culbertson, 2006a). A number of these individuals have drunk socially for much of their adult lives, only to change to harmful pattern of drinking in response to life changes experienced with aging such as retirement, loss of spouse, increasing disability, or any chronic illness (Culbertson, 2000a; Menninger, 2002; Sattar et al., 2003). This group is also more amenable to treatment and to have a positive recovery, but is also more likely to be overlooked by health care providers according to Menninger (2002).

Despite the above differences, some similarities exist between early and late-onset drinkers. Both groups lead isolated lives, drink almost daily, and the reasons for drinking are almost the same; to relieve the depression, loneliness, or anxiety secondary to major life changes (Sattar et al., 2003).

2.2.4.3 Continuous versus intermittent drinking.

Often, “continuous” drinking older adults are not impacted in their day to day drinking by external stimuli such as loss of job, loss of spouse, or any kind of change in their living circumstances (Sattar et al. 2003). They may even have developed tolerance over a period of time and may have increased the amount of their drinking. They may suffer from alcohol related problems and yet tend to minimize or even deny their alcohol dependence (Sattar et al., 2003). On the other hand, intermittent drinkers exhibit different patterns. They may have long periods of abstinence, sometimes lasting many years and any change in circumstances may cause them to resume drinking. Generally they are healthy and present well (Sattar et al., 2003). However, emotional and social problems such as bereavement, loss of friends and social status, retirement, impaired ability to function, altered financial circumstances, family conflicts, and reduced self-esteem can once again, trigger problem drinking (Dar, 2006; Sorocco & Ferrell, 2006). Anxiety, menopause, assuming care-giving role, children leaving home, physical disabilities, chronic illnesses, insomnia, reduced mobility, and cognitive impairment are some of the other triggers for problem drinking (Dar, 2006; Sorocco & Ferrell, 2006).

In summary, older adults exhibit a variety of drinking patterns. They can be categorized into early onset or late onset, depending on the age they start to drink and whether they drink continuously or intermittently.

2.2.5 Under-diagnosis of alcohol use among older adults.

2.2.5.1 *Social context.*

Problematic alcohol use among older adults is also called the “Invisible Epidemic” (Benshoff & Harrawood, 2003; Sorrocco & Ferrell, 2006). A number of factors contribute to this term. First, an alcohol problem is difficult to diagnose in the older adult population due to presence of other chronic illnesses. Schofield and Tolson (2001) point out that the effects of heavy alcohol use may be mistaken for insomnia, depression, dementia, or falls due to other causes. Second, problematic alcohol use is sometimes overlooked by health care providers because of their own personal biases (Sorrocco & Ferrell, 2006). For example, physicians are less likely to screen for alcohol use in older adults, women, the educated, or those with higher socio-economic status. Third, there is a tendency for both patients and clinicians to avoid the topic of alcohol use as it can be an uncomfortable subject (Culberson, 2006a; O’Connell et al., 2003). Additionally, older adults may not even consider it to be an issue to be discussed with their physician. In a study on older adults’ own reasons for drinking, the majority of the participants disclosed that they drank for social reasons, usually before and with meals. They described their alcohol use as a part of their daily lives (Immonen et al., 2011). Fourth, in the older adult cohort, self reported alcohol use is likely to be underestimated as they consider it to be “medicinal”, but also due to their fear of stigmatization. Therefore, the patient and their

families are often reluctant to seek help because of stigma, as well as shame. Fifth, in some minority older adult populations, alcohol use is considered a private matter, preventing them from seeking help (Sorrocco & Ferrell, 2006).

2.2.5.2 Health care context.

In examining the issue of under-diagnosis of alcohol use among older adults through a critical social theory (CST) lens, it becomes apparent that social structures such as the images of older people, women, or ethnic minorities projected by the media, the kinds of resources and funding that are available and to whom, the availability of health care, and/or the distribution of wealth define how privilege, powerlessness, or exploitation are distributed among persons and groups (Stevens, 1989). For instance, looking deeper into the ageism issue, “[a]geism as a set of social practices, and its embodiment the *aged body* are central concepts for understanding the way we treat people of different ages” (Laws, 1995, p.112). Such concepts capture the active oppression of the older adult population. One of the assumptions of CST is that oppressive structural relations such as ageism pervade modern society without being questioned or examined. Ageism is one of the few fundamental dogmatic ideologies that is internalized in social structures and thus operates in an unexamined way (Stevens, 1989). This kind of ideology both limits the concrete alternatives open to individuals and maximizes the life opportunities of some groups by minimizing those of others. In this case, the younger generation being the preferred group as compared to older people. “Ageism, like racism and sexism, is a form of prejudice, a form of oppression that not only limits people who are the object of that oppression but also shapes perceptions of people, both young and old, who hold ageist attitude” (Laws,

1995, p. 113). For example, it is often thought by clinicians that it may be a waste of time trying to address alcohol use issues with older adults as they are difficult to treat, or that drinking may be one of the only pleasures left in their lives so why deprive them of it (Culberson, 2006a; Schofield, & Tolson, 2001; Sorrocco & Ferrell, 2006). But even more important is the “progressive shortening of the doctor-patient interaction time as patients age” (Sattar et al., 2003, p.745). As the age of the client increases, the amount of time physicians spend with them decreases, “making it less likely that alcohol-related problems would be identified during visits to physicians’ offices as ‘more important’ medical or psychiatric issues compete for time” (Sattar et al., 2003, p. 745). It may have to do with ageist belief among some of the health practitioners that the needs of older adults are less important than those of the young and that older people will benefit less from treatment. This belief also has possible ethical implications if treatment or care given or denied is on the basis of age (Ward, 2000).

Again, the ideology of ageism may be the reason behind existing diagnostic criteria and screening instruments; often these are not specifically designed for older adults and consequently may fail to identify an older person with alcohol use issues (O’Connell et al., 2004). This is despite the fact that alcohol use in older adults has been acknowledged as an important public health problem. They are less likely to encounter legal, social, and occupational complications associated with excessive alcohol use (O’Connell et al., 2003). Finally, as all the screening tools are self-reporting, often older adults are embarrassed or ashamed and may not answer correctly. Lack of disclosure of alcohol use may place older adults at high risk of complications and even death (Loukissa, 2007).

Under-diagnosis of alcohol use in older adults is particularly unfortunate because the risks associated with alcohol use and a possible relapse can be significant (Barrick & Connors, 2002). Any change in their life circumstances such as loss, social isolation, loneliness, depression, or interpersonal conflicts can lead to excessive drinking or relapse in this population. By helping clients monitor these high risk situations and identifying strategies to cope-up with them may go a long way in not only avoiding poor physical or mental health outcomes, but also in saving a substantial cost to health care (Barrick & Connors, 2002).

Often alcohol use in older adults is under-identified and under-diagnosed. Reasons could exist in a social context, such as, older adults present differently than younger people, physicians' reluctance to address this issue with this population due to their own personal biases, reluctance on the part of the older adults or their families due to feelings of shame, stigma, or their cultural background. Historically, the older members of age cohort of over sixty-five lived through the prohibition years in North America where temperance was popular (Benshoff & Harrawood, 2003; St. John et al., 2010). Many states had prohibition laws. These morality-based laws tended to restrict alcohol consumption and, as a consequence, many older adults view alcohol use as a moral failing and are ashamed to acknowledge it. The other reasons for under-diagnosis are often observed in a health context. Ageist beliefs or attitudes lead to not-so-meaningful visits to health care providers, inappropriate screening tools, and inappropriate diagnostic criteria. It is important to identify alcohol misuse in this population to avoid high morbidity and mortality associated with this problem (Menninger, 2002). CST further assumes that in order to bring a change, one has to reject the universalizing scholarship that denies differences.

2.2.6 Screening for alcohol misuse in older adults.

Although more than 80% of older adults with alcohol issues see physicians regularly, almost half of them that are most in need of intervention do not seek it. Secondly, physicians often miss alcohol misuse and other related problems despite the frequent contact (Sattar et al., 2003; Sharp & Vacha-Haase, 2010). To minimize this oversight, it is recommended that primary health care physicians screen these individuals routinely.

There are several screening tools for alcohol misuse in the younger population, but there is a lack of information on age specific criteria for older adults (O'Connell et al., 2004). Screening tools that are commonly used for older adults are: CAGE questionnaire, geriatric version of the Michigan Alcoholism Screening Test (MAST-G), Short version of MAST-G (SMAST-G), the Alcohol Use Disorders Identification (AUDIT), and the two questions of Cyr and Wartman (Beullens & Aertgeerts, 2004).

CAGE is a screening tool with four questions: 1) 'Have you ever felt that you should cut down on your drinking?' 2) 'Have people annoyed you by criticizing your drinking?' 3) 'Have you ever felt bad or guilty about your drinking?' 4) 'Have you ever had a drink first thing in the morning to steady your nerves or to get rid of the hangover?' (Beullens & Aertgeerts, 2004). 'CAGE' is an acronym and formed by the words 'Cut-down,' 'Annoyed,' 'Guilty,' and 'Eye-opener.' A score of two or more on this yes/no questionnaire indicates alcohol misuse. This is the most widely used screening tool as it is easily remembered and can be applied quickly (O'Connell et al., 2004). It carries specificity between 82% and 99%, and sensitivity between 48% and 70% according to Dar (2006). The drawback of CAGE is that it does not have high validity with older people, particularly with women. "It is also limited in that it assesses only life

time alcohol use and does not ask specifically about current drinking habits” (Dar, 2006, p. 176). It is also not suitable for detecting daily alcohol intake below 80 gms., thus may be valid for dependent drinkers only (Gomez et al., 2006). It may give false negative results as many of the older adults may not be aware that their current level of drinking may be hazardous, and as such, have never felt ‘guilty’ or tried to ‘cut down’ (Culbertson, 2006b).

MAST-G is a screening tool that specifically addresses older adults. It contains 24 yes/no questions. A score of five or more suggests alcohol misuse or dependence (Beullens & Aertgeerts, 2004). It has a sensitivity of 94% and a specificity of 78%.

The 10 item Short MAST-Geriatric Version (SMAST-G) is a shorter version of MAST-G. It was developed for busy clinical practice (Moore, Seeman, Morgenstern, Beck, & Reuben, 2002). It was specifically developed to identify older people with alcohol use issues and to include a larger number of women. This screening tool may detect persons whose alcohol consumption is relatively small and thus may be superior in identifying older adult drinkers, particularly women (Moore. et al., 2002). SMAST-G is found to have a sensitivity of 85% and a specificity of 97%, however, neither SMAST-G nor CAGE can distinguish between current alcohol problems and the lifetime misuse (O’Connell et al., 2004).

AUDIT was developed by World Health Organization (WHO) to detect actual drinking problems in the young adult in a primary health care setting. It contains 10 questions: three concerning amount of alcohol and frequency of drinking, three concerning alcohol dependence, and four concerning problems caused by problem drinking (Beullens & Aertgeerts, 2004). Each item receives a score of zero to four. A score of eight or more identifies alcohol misuse or dependence. Even though AUDIT has not been evaluated for use with older adults, it is the only

screening instrument that has been validated cross-culturally (Culberson, 2006b; Dar, 2006).

Unlike other screening instruments, the AUDIT is not a true/false test. It takes into account the frequency and quantity of alcohol consumed (Culberson, 2006b).

The two questions of Cyre and Wartman are: 'Have you ever had a drinking problem?' and 'When was your last drink?' They showed a sensitivity of 92% and a specificity of 90% in identifying an alcohol misuse issue with the MAST score as the chief criterion in a hospital setting (Beullens & Aertgeerts, 2004). However, these two questions are not sensitive as the second question is about alcohol consumption in the past 24 hours and alcohol consumption is not a reliable measure in the older adult population. Older people can drink a reduced amount and less frequently and still obtain the same level of mood state as younger people consuming substantially larger amount of alcohol.

In using any of these screening instruments, particularly in older adults, it is important to remember that factors that impact the performance of alcohol screening instruments include patient characteristics, culture, clinical setting, and the prevalence of alcohol use in the population under study (O'Connell et al., 2004).

Most existing screening instruments were developed for young and middle aged population (Beullens & Aertgeerts, 2004). The items on the questionnaires belong to the following domains; 1) alcohol related social and legal problems; 2) level of consumption; 3) symptoms of drunkenness or dependence; 4) self-recognition of the problem. Older adults do not have the same parameters. Majority of this population are no longer employed, and in most cases, they often drive less or not at all (Loukissa, 2007). Level of alcohol consumption is not a reliable measure in older adults as, due to age related physiological changes, smaller amount of

alcohol can produce significant blood alcohol concentration (Beullens & Aertgeerts, 2004). Moreover, many older adults are unaware that the amount of alcohol they are consuming is unusual or harmful to health (Schofield & Tolson, 2001). Compared to younger population, they may find questionnaire very judgmental and may not report correctly. Furthermore, due consideration should also be given to cognitive impairment, an important part of geriatric-specific morbidity (Gomez et al., 2006). Cognitive impairment could easily lead to a misunderstanding of any of the test items, thus increasing recall bias. Additionally, stigma around alcohol consumption may cause under-reporting in older adults.

In considering and comparing various alcohol screening instruments, most researchers contend that different screening instruments capture different aspects of harmful drinking in older adults and that a combination of screening instruments such as CAGE and SMAST-G may identify a larger number of older adults that use alcohol than either of these instruments alone (Moore et al., 2002). Although the most commonly used screening instruments are CAGE and MAST-G as they are more age specific, there is no consensus on the combination of screening instruments that could be most useful for the older adult population with drinking problems. Also, no study has focused on older adults with the possibility of cognitive impairment, a particularly vulnerable group where a valid screening instrument is essential and needed ((O'Connell et al., 2004).

While existing alcohol screening instruments are generally useful in the older adult population, the crucial difficulties with screening for alcohol use in the older adults “remains the lack of age-specific criteria” (O'Connell et al., 2004, p.1079). In older adults, the criteria should include “reducing the recommended ‘sensible’ limits of alcohol for older people and de-

emphasizing the role of social and occupational complications” (O’Connell et al., 2004, p.1082) of alcohol use as they are less relevant for older people. Until this issue is addressed, older adults with drinking problems will continue to be missed on screening.

2.2.7 Barriers to treatment.

Besides barriers to diagnosing alcohol misuse, older adults may also face barriers to treatment (Sorocco & Ferrell, 2006). Physical limitations such as hearing or vision problems, arthritis, incontinence, falls, and reduced mobility can all interfere with a person’s ability to participate in a treatment program (Morgan et al., 2011). Many older people do not drive, therefore, making it to their appointment with a physician, and/or reaching an alcohol treatment program can be challenging for them. In addition, a number of these treatment programs are held in the evenings. Older adults who live in rural areas may have difficulty with public transportation. Also, older clients may experience feelings of shame and embarrassment when accessing services, particularly if they are expected to participate in programs that put them with younger adults (Morgan et al., 2011).

On the part of the health care system, models that are generally used by policy makers are designed for the younger population (Ward, 2000). As Canales (2000) points out, cultural mores in any society are maintained through its economic, educational, political, or religious institutions, and are reflective of that society’s dominant values that define how privilege, exploitation, or powerlessness are distributed among different groups. Thus, looking through a CST lens, one can observe that in case of alcohol misuse treatment availability for older adults, it is clearly the ageism ideology that impacts policies and how health care is distributed (Stevens,

1989). In the absence of treatment modalities geared specifically toward older adults, they are offered services, often group therapy with young people where they may feel intimidated, frightened, or anxious (Best Practices, 2002). Also, health care providers who hold ageist beliefs, assume that older people are unable to change, learn, or develop new coping techniques in addition to their belief that the needs of older adult population are less important than those of the young (Ward, 2000). Finally, cultural differences between clients and their clinicians may pose a barrier to treatment if the health care provider is unaware of these differences (Best Practices, 2002).

2.2.8 Treatment options for older adults with alcohol use problems.

Most recommendations for treatment of alcohol misuse in the older adult population lack empiric justification (Sattar et al., 2003). Instead, the majority of treatment recommendations are derived from general substance use treatment guidelines, geriatric medicine, or psychiatric medicine. According to Sorocco and Ferrell (2006), when alcohol misuse is identified in an older person, the least intensive treatment options should be explored first. Older adults can be particularly receptive to their physicians' advice about their drinking habits. Lin et al. (2010) determined that "patients' perception of physician involvement was found to be the most important predictor of early change" (p. 232). They further determined the strongest influence on early reduction of drinking was the drinker's perception of whether their physician had discussed the risks of excessive drinking and advised changes in their drinking patterns. They determined that although physicians gave advice to patients who screened positive for problematic alcohol use, very few provided any additional information, advice, or gave supportive statements.

According to Sorocco and Ferrell (2006), patients should be involved in the referral decision and in setting specific drinking goals.

Training and awareness among health care providers is crucial to change attitudes and identify alcohol misuse in older people (Dar, 2006). At a policy level, it is important that the needs of this age group are highlighted in strategies and national service framework.

Commonly offered treatment options for community dwelling older adults with drinking problems are; brief interventions, family interventions, motivational counselling, and cognitive behavioural therapies (Sorocco & Ferrell, 2006). Brief intervention has proven to be extremely effective with older adults (Dar, 2006; Menninger, 2002). It is cost effective and can be delivered in a primary care setting by a general practitioner or a trained health care provider. In some instances, education to significant people in the life of a person about alcohol use and its prevention proves to be beneficial (Sorocco & Ferrell, 2006). The other technique found to be effective in this population is motivational counselling. Contrary to the medical model where counsellors offer information and education about risks of excessive alcohol use, motivational interviewing techniques allow a client to digest the information, evaluate the risks themselves and take responsibility for their own change. It may be more effective for clients who are not ready for action-oriented intervention (Sorocco & Ferrell, 2006). Cognitive behavioural therapies have also been found to be effective in the older adult population as clients learn new skills to cope with their drinking problems, such as initiating adaptive behaviours and challenging unhelpful thoughts (Cummings et al., 2006). In older people, rates of relapse will decline significantly if medical and psychiatric morbidities are treated alongside (Menninger, 2002; Sattar et al., 2003).

Regardless of which treatment approach is used, health care providers need to be aware of the age appropriate treatment plan for that individual (Sorocco & Ferrell, 2006). Age-specific treatments are more effective for older adults where non-confrontational and individualized techniques are used and where they feel respected and cared for.

2.3 Chapter Summary

In this chapter, I have presented a review and synthesis of the existing literature on alcohol use among community dwelling older adults. The review of literature identified quantitative, qualitative, and mixed method studies. To understand alcohol use in older adults holistically, studies that were conducted in different parts of the world were included in the literature review.

It is evident that there has been a significant growth in adults who are sixty-five and older and this growth is expected to continually grow significantly over the next few years. In Canada, the number is estimated to reach 18.9% by 2021, and 24.9% by 2041 (Statistics Canada, 2002). People are living healthier and longer lives. Their attitudes have changed towards drinking, particularly as baby boomers have joined the age group of older adults (Han et al., 2009). Certainly media messages about alcohol being beneficial to health may influence consumption (Schofield & Tolson, 2001). Alcohol consumption by older adults is fast becoming a major health problem in Canada. Prevalence rates as high as 16% in older adults are significant enough to focus on this subject (Rogers & Wiese, 2011). Furthermore, despite the awareness of under-diagnosis and different barriers, not much progress has been made to address these issues (Benshoff & Harrawood, 2003; Sorocco & Ferrell, 2006).

Ageism, ignorance, personal biases, and lack of time continue to cloud health care providers' ability to make a timely diagnosis and prevent morbidity and mortality in their clients, as well as save health care dollars that could be used in a more suitable manner (Culberson, 2006a; Schofield & Tolson, 2001; Sorrocco & Ferrell, 2006). The same barriers of ageism are often the reason that emergency physicians fail to diagnose alcohol misuse in older adults in up to 80% of admissions (O'Connell et al., 2003). It is an important observation, as, unless identified and dealt with; it will continue to cost the health care system heavily in terms of dollars without dealing with the underlying cause (Culberson, 2006a; Schofield & Tolson, 2001; Sorrocco & Ferrell, 2006).

In terms of barriers from the clients' perspective, there appears a need for education of the community, family, and health care providers that will create awareness about this issue as well as decrease associated stigma (Best Practices, 2002). Information sessions in the comfort and privacy of older adults' own homes can go a long way to dispelling ignorance about alcohol use and its ill effect on their health.

While existing alcohol screening instruments are generally useful in the older adult population, the crucial difficulty with screening for alcohol use in the older adult is the lack of age-specific screening instrument (O'Connell et al., 2004, p.1079). Until this issue is addressed, older adults with drinking problems will continue to be missed on screening.

As far as intervention is concerned, over the years, researchers have described various treatment modalities for older adults, but none of them is developed specifically for this population. In most instances, the recommendations are derived from general substance use treatment guidelines, geriatric medicine, or social gerontology literature.

Acquiring an understanding of alcohol use in older adults' from their own perspective will contribute significantly towards education of the health care providers, families, and the general public. It will help towards developing age specific screening tools and interventions. It will also help towards developing specific health and social policies to address the issue holistically.

2.4 Gaps in the Literature

Over the years, there have been studies that have examined many different aspects of alcohol misuse in older adults such as the prevalence rate, effects of alcohol use and misuse and the impact on the health care system, different screening tools, management strategies and such. However, these studies have mostly been systemic reviews or cross-sectional studies that are time limited. (Sattar, et al., 2003). There have been very few qualitative studies that have examined alcohol use among community dwelling older adults from their own perspective. This gap in the literature may be one of the main reasons for the under-detection of this issue.

I believe it is essential for researchers to further examine alcohol misuse in older adults from their own perspective and attempt to understand their readiness for a change. Acquiring an understanding about attitudes, beliefs, behaviours, and experiences of the older adults about their alcohol use will pave the way towards successful and lasting interventions for this population. A successful intervention depends on the readiness of an individual for a change, but also that they are treated in a supportive, respectful, and dignified manner, and where they are assured of confidentiality and discretion.

Chapter Three: Research Methods

3.1 Introduction

In this chapter, I describe the research methods employed in this study. The purpose of this study was to gain a greater understanding of older adults' use of alcohol within their social, cultural, and political context. I chose a critical ethnographic method of inquiry to explore the attitudes, beliefs, and behaviours of older adults' alcohol use from their perspective. I begin by describing the two theoretical perspectives used to guide the study, followed by a description of the method of inquiry, an explanation of the population of interest, criteria for inclusion, recruitment methods, and procedures used for data collection. I explain the approach to data analysis and describe various strategies used to ensure rigor in this research project, then concluding the chapter by describing ethical considerations.

3.2 Theoretical Framework to Support the Research Question

The two theoretical perspectives used in this study are postcolonial nursing scholarship and critical social theory. Postcolonial theories are a family of theories that share a social, moral, and political concern about the history, and importantly, legacy of colonialism in that, how colonialism continues to shape people's lives, health, and life opportunities even today (Browne, Smye, & Varcoe, 2005). Furthermore, what sets this theory apart from other critical theories is its ability to shed light on the unequal power relationships that are the legacy of colonization and focuses on uncovering and disrupting structural and health inequalities that have emerged through this practice of colonization. Baumbusch (2010) illustrates that the postcolonial

perspective is characterized by an intersectional analytical framework that examines class, race, culture, history, and age, to name a few intersections.

In essence, this scholarship provides a theoretical lens allowing access to everyday experiences of marginalized groups, which in this study are older adults who misuse alcohol. This lens includes an analysis of the micro politics on one hand, and the macro dynamics of the structural intersecting oppressions on the other (O'Mahony & Donnelly, 2010). Older adults who misuse alcohol experience marginalization in many facets. At an individual level, there is often reluctance to access assistive services due to feelings of shame and guilt combined with social isolation. On a broader level, this attitude is further fuelled by the negative age-based messages received from society in terms of government policies, family members, or their physicians (Morgan et al., 2011). The ageist belief held by a large number of health care providers that older adults are unable to change, or that they are an economic burden influences how they (older adults) receive health care (Ward, 2000). This ageist view is pervasive and persistent at all levels. It impacts social and political systems, educational program, and eventually the individuals themselves (Morgan et al., 2011).

To truly make a difference, nursing scholarship needs to look beyond individual experiences of health or illness towards the broader, social structures that determine the health status of a person. Through a postcolonial lens, nurses are able to meet the social mandate of addressing social aspects of health and illness, particularly in older adults with alcohol use issues, and then situate the experience within a larger social context (Kirkham & Anderson, 2002). By uncovering social and health inequalities, experiences of marginalized groups (older adults) can obtain an equal stance with the dominant group. According to Browne et al. (2005),

researchers and practitioners who work within a paradigm of postcolonial scholarship have an obligation to “disseminate knowledge to policy-makers, health authorities, leaders in health care organizations, and community members, with the aim of shifting social attitudes, correcting past and current injustices, reducing health disparities, and mitigating inequities to access to health and health care” (p. 27-28). Postcolonial perspective is an important analytic lens from which to explore the attitudes, beliefs, behaviours, and experiences of alcohol use by community dwelling older adults within their broader social, cultural, and political context.

The second theoretical lens used in this study is critical social theory (CST). This theory has its roots in Marxism. It originated in Germany in the 1920s as a response to developments in Europe’s economic and political environments (Bevan et al., 2012). Its purpose is to provide a lens through which to analyze differences between the actual and possible (Campbell & Bunting, 1991) and to facilitate changes in structural conditions that limit life options (Stevens, 1989). As a method of inquiry, CST calls us to examine relationships of power and underlying societal structures that produce inequalities such as the type of employment and wages that are made available to a certain population, distribution of wealth, availability of health care, and access to health care. According to Mohammed (2006), these misrepresentations of social processes are made to appear natural, constant, and inevitable and yet, they serve to reinforce interests of the dominant group. In a critical theory paradigm, the researcher attempts to expose hidden power imbalances. Empowerment is the central tenet of CST and seeks to challenge these power imbalances and moves beyond from ‘what is’ to ‘what it could be’ according to Mohammad. Using critical theoretical lens, questions arise; has substance use issue in the older adult population been adequately addressed? Are there effective age specific screening tools available?

Why is health of older adults not being considered at par with other age groups? Do they have equitable access to resources? Whose interests are being served as a result of the way things are (Stevens & Hall, 1992). The inequalities of the political structures of society impact the physical, social, emotional, and intellectual health of older adults. By identifying this population's needs and concerns, nurses situate clinical efforts to empower this population rather than impose a biased point of view. Nurses can evoke change by asking critical questions with the intent of creating knowledge that would allow older adults to reflect and obtain a clearer understanding of their own health damaging situations (Stevens & Hall, 1992). Thus a critical theoretical lens is orientated towards a transformation process.

3.3 Study Design

Qualitative studies focus investigations on studying human experiences in a holistic and in-depth way which is well suited to exploring the complex health issues that nurses encounter in their practice (Vishnevsky & Beanlands, 2004). Qualitative research is a way of exploring the different experiences held by an individual within their social context, and what they mean for that person.

There are different approaches to a qualitative research design. Essentially, it is the research question that dictates what method is going to be utilized for a particular study (Allen, Chapman, Francis, & O'Connor, 2008). As this research was about exploring attitudes, beliefs, and behaviour of older adults who use alcohol, critical ethnography was considered the most suitable method of inquiry for this study.

3.3.1 Critical ethnography as a method of inquiry.

It is not enough for a critical researcher to simply describe a phenomenon; rather they should attempt to change the existing social, cultural, or political conditions of the phenomenon under study (Smyth & Holmes, 2005). Thus, critical ethnography as a research design, combined with the two theoretical frameworks mentioned above, are all steps towards a transformation process. Critical ethnography is a change-oriented approach to understand social structures within a community. It is a method of inquiry that can disrupt the status quo and empower vulnerable populations (Polit & Beck, 2012). The use of critical ethnography emphasizes a holistic human experience and offers an opportunity to examine issues such as health challenges, inequitable health access, limited opportunities, or oppressive conditions from the perspective of those who live them daily (Harrowing, Mills, Spiers, Kulig, & Kipp, 2010). It is a form of research that seeks not only to describe and interpret a culture and cultural phenomenon, but to change it by investigating and analyzing hidden agendas and examining the power relations. Critical ethnography provides an avenue for meaningful health promotion practice (Cook, 2005).

According to Polit & Beck (2012), critical ethnography is very well suited to researchers that promote health, as they are concerned with enabling people to take control of their own situation. In the past, health promotion research studies focused on individual life style factors such as exercise, smoking, and diet which implied that individuals were responsible for their own health. However, the focus of health promotion research has now shifted onto broader social, political, and economic factors such as income and social status, education, employment, and social network. These are the fundamental resources that enable a person to achieve optimal health (Cook, 2005).

Critical ethnography, as a health promotion approach, allowed me to develop a dialogical relationship with participants, allowing me to observe and analyze social, political, cultural, or material elements that may have influenced their drinking habits. It has been my hope that this knowledge will help to change their attitudes and beliefs about using alcohol. It has also been my ambition that my inquiry may raise participants' consciousness and open up a venue for emancipatory change (Allen et al., 2008).

3.4 Sampling Plan

3.4.1 Setting and sample.

To study the experience of alcohol use in community dwelling older adults, my target population consisted of two groups: 1) older adults (participants) who were either presently using alcohol, or had extensive experience with alcohol use, 2) Individuals (key informants) who had worked with people with substance use issues in the community in a variety of roles and gained extensive experience in that domain.

This was a young sample, except for one person over eighty-five. All of the eleven older adult participants lived in an urban center in the Interior of British Columbia. Two individuals were still actively employed in the workforce with stable finances. Of the nine other participants, six lived in low income housing and were on a limited income. Five of them lived alone. A majority of the participants were recruited from the local community mental health and substance use center that is being operated by the local health authority. This community resource offers a variety of services; general and substance use counseling services, psychiatric consultation and follow up, and case management that includes social support and support with

activities of daily living for individuals with chronic mental health illnesses and substance use issues. An outreach program for older adults (65 and older) with mental health issues is another service offered by this center. The mental health and substance use center partners with other non-profit organizations in the community that address other social determinants of health such as food, socialization, and housing. This center provides services to both the urban area and nearby rural areas as well. The participants recruited from this program were accessing substance use counselling services, attending group therapies related to substance use issues, or being provided support with basic needs of daily living at the time the interviews were conducted for this study. The key informant participants selected were situated in the same urban center in the Interior of British Columbia and serve the community in the roles of substance use counsellors, social workers, general practitioners, or community nurses.

3.4.2 Inclusion and exclusion criteria for participants.

The inclusion criteria for older adults participants were that they: 1) dwell in the community, 2) had the ability to converse in English, and 3) age. It was assumed that all of the participants had experience with alcohol use whether they were currently not using.

3.4.3 Inclusion criteria for key informants.

The inclusion criteria for key informant participants were their knowledge and extensive experience as professionals with substance use issues among the community dwelling older adults.

3.4.4 Sampling strategy.

The aim of most qualitative researchers is to gain a rich understanding of the phenomenon under study; therefore generalizability is not considered a criterion (Polit & Beck, 2012). Participants are chosen for their ability to provide rich information relating to the phenomenon under study, which in this case, was to study the experience of alcohol use in community dwelling older adults.

I used purposive sampling for this study. Ethnographic studies can often be labour intensive as the goal of an ethnographer is to obtain the most comprehensive and holistic perspective of the phenomenon under study. An ethnographer seeks to identify the culture and the 'lived experiences' of a population under study in order to understand a certain phenomenon. Deciding on whom to interview or observe is of critical importance. Consequently, purposive sampling is often the technique utilized by ethnographers (Stahler & Cohen, 2000). Purposive sampling is a judgemental sampling method where the researcher selects the participants who best represent the population under study (Molefe & Duma, 2009). It includes individuals on the basis of their personal experience in relation to the phenomenon, as well as their ability and willingness to communicate personal experiences to others (Sandelowski, 1995).

For the purpose of this study, sample size consisted of a total of eighteen participants. There were eleven older adult participants and seven key informant participants. Ten older adult participants were chosen through a purposive sampling technique. They were recruited through the local community mental health and substance use program, operated by the local health authority in an urban center in the Interior of British Columbia. When I visited one of the older adult participants for our scheduled interview, she introduced me to a friend of hers. This

individual had learned of the proposed study from her friend and wanted to participate in the study. Thus, one participant was recruited through a snowball sampling technique. All of the key informant participants were chosen through a purposive sampling technique.

This study maintained value due to the focus on the older adult participants' experiences with alcohol use/misuse within their social and political, and cultural context.

3.4.5 Recruitment methods for the older adult participants.

Recruitment can be difficult especially when the research deals with sensitive issues (MacDougall & Fudge, 2001). I utilized a number of strategies to overcome this challenge. For example, recruitment of the older adult participants was carried out through a third party. I started by asking my professional colleagues if they could recommend any suitable participants. I sent letters (Appendix K) to different substance use team leaders explaining about my research and requested their assistance in locating suitable clients within their client load that may agree to participate in my research. The substance use team members assisted me by mentioning my study to the appropriate clients. Those clients who appeared willing and interested were then provided detailed information about the nature and purpose of the study, expectations of participants, information about the researcher, and guarantee of confidentiality and anonymity to those clients who were agreeable by my colleagues. My colleagues also provided the written invitation letter that contained my name and contact number (Appendix A) to potential participants, and instructed them to contact me so I could answer questions and explain the research project in more depth. People who agreed to participate were requested to give their verbal and written consents (Appendix D).

A total of eleven older adult participants were recruited. Seven of the older adult participants were recruited by the above mentioned recruitment method. Three older adult participants were family members of my colleagues who volunteered after learning about the research. One older adult participant was recruited through a snowball sampling method. Upon agreeing to participate, I obtained a verbal and written permission from older adult participants prior to starting the interviews (Appendix D).

Of the eleven older adult participants, four were males and seven were females. Their ages ranged between fifty-six and ninety years. Five older adult participants had not consumed alcohol within the last two years, two participants were abstinent for a period of two months at the time of interview, and four were actively consuming alcohol (Appendix F). All the older adult participants had experimented with alcohol in their teenage years. Six had never stopped drinking, three re-started in their late twenties or early thirties due to life circumstances, and two older adult participants started in their fifties and sixties respectively, again, due to life circumstances. All the older adult participants were able to articulate their attitudes and beliefs about why they used or still use alcohol. I was friendly, honest, and assured each participant that the study was not to judge them, or to humiliate them, but rather to acknowledge, and substantiate their experience (Allen et al., 2008).

Challenges were encountered while trying to put up posters in community clinics, public health units, or walk-in-clinics requesting older adults (65 or older) who use alcohol to participate in the study (Appendix I). Managers for two of the services expressed their discomfort about having these posters up on the walls in their clinics. They expressed their concerns that older adults tend to be private and may feel embarrassed or ashamed to

acknowledge that they have a drinking problem (Merrick et al., 2008). Additionally, at one community clinic, the physicians did not feel comfortable to allow me to put up the posters.

3.4.6 Recruitment methods for the key informant participants.

As a result of their personal skills, experience, and position in the society, the key informants are able to provide detailed information and insight on the given subject (Marshall, 1996). According to McKenna and Main (2013), key informants' world views about how they perceive community strengths, weaknesses, needs, and potential in context with a certain phenomenon makes them extremely valuable to ethnographic research. Key informants for this study consisted of a group of individuals who had worked with substance use issues in the community in a variety of roles such as substance use counsellors, social workers, general practitioners, or community nurses, and had gained a good insight into the issue of alcohol use among community dwelling older adults (Appendix E). Recruitment of key informant participants was carried out through a third party. I drafted out letters of invitation (Appendix B) for potential key informants inviting them to participate in the study. I arranged with the team leader of the substance use team to have her forward these letters to individuals who she thought could be most suitable for my study. Of the seven key informant participants who agreed to participate in the study, four were colleagues, working within the same program as myself. Three colleagues were substance use counsellors and one was a multicultural counsellor. Besides these four key informant participants, a general practitioner with a speciality in substance use, an executive director of a community treatment center, and an acute care nurse agreed to participate

as key informants. I provided further detailed information about the study to these individuals over the telephone.

3.5 Procedures and Data Collection

Open ended conversations are an integral part of critical ethnography as they facilitate a trust between the researcher and the researched and allow the researcher to have an understanding of the way the researched view their own world (Mahoney, Donnelly, Este, & Bouchal, 2012). The advantage of semi-structured interview is that it allows all research participants to be asked the same questions within a flexible framework (Polit & Beck, 2012). During the research, data were obtained utilizing multiple data collection techniques pertaining to the understanding the attitudes, beliefs, behaviours, and experiences of older adults who live in the community and use alcohol. I followed the self-report technique, utilizing both open-ended conversations and semi-structured interviews with the study participants using an interview guide (Appendix H) for the study participants and (Appendix G) for the key informants.

3.5.1 Semi-structured interviews.

I conducted the in-depth individual interviews from September of 2012 to May, 2013. I encouraged participants to share their experiences on alcohol use using a semi-structured interview technique. The length of each interview was between sixty to ninety minutes. Although I had stated in my letter of information that I might require three interviews, only two participants were visited twice. One participant admitted at the time of the first interview that he did not feel well and asked to reschedule the interview. I rescheduled the appointment after a couple of weeks. In the second instance, the participant terminated the first interview after

twenty minutes when she remembered she had another appointment. She readily agreed to book another appointment within the same week. I was very mindful of the generosity displayed by the participants by giving their time and sharing their experiences with me. I offered to meet with them at their choice of venue. Three participants chose to visit me in my office. The rest of them preferred to be visited in their own residences. The visit to participants' homes added richly to my understanding of these participants. I collected data at a pace that was least stressful to the participants and also offered to end the interview at any time they deemed necessary. All the interviews were audio-taped and were later transcribed by myself. Following the transcription, I listened to all the recordings a second time to cross check for transcription accuracy, which proved to be a lengthy process. However, as Batch (2012) notes as an outcome of this kind of activity, by the end of this stage, I was closely acquainted with the data that assisted me in the next phase of data analysis.

Similarly, I met with the key informants in person at the place and time of their convenience for a one time interview. Six of the key informants agreed to meet me in their offices at a time that was convenient for them. I interviewed one key informant at home at a time convenient for them. All of the key informants were very willing to share their knowledge and experience about the alcohol use issue in older adults with me. The interviews ranged between thirty to sixty minutes. I obtained informed written consent (Appendix C) from them prior to starting the interview. I utilized semi-structured interview technique as well as open ended conversation technique. All the interviews were audio-taped and were later transcribed by myself.

3.5.2 Demographic information.

Basic demographic data were collected at the beginning of each interview. Specifically, for the older adult participants, information was gathered about their age, sex, highest level of education, status of employment, active state of drinking, and a weekly estimate of the money spent on alcohol. The demographic questionnaire was formulated in consultation with my supervisor. It took five to ten minutes to complete the questionnaire as some participants took time to recall about how long they had been using alcohol, or how much money they spent on alcohol weekly (Appendix L). The demographic information on key informants included their positions in the health care system or the community and their experience with substance use by community dwelling older adults.

3.5.3 Reflective journaling.

Throughout the study, field notes and reflective memos were recorded in a journal. Field notes (Appendix J) included observations of the physical setting, body language, and other behavioural cues that lent meaning to the words of the participant. They were written as soon as possible after the observation to allow accurate recording (Groenkjaer, 2002). I utilized reflective journaling to explain my own views or insights about the interviews and how they might have impacted the research process.

3.6 Data Analysis

Ethnographic analysis is an iterative process where cultural ideas that arise during research are transformed, translated, and represented in a written process (Thorne, 2000). It also involves continuous searching for inconsistencies and contradictions, as well as sifting and

sorting through pieces of data to detect and interpret thematic categorizations (Thorne, 2000). Thus, throughout the analysis, the researcher attempts to gain a deeper understanding of what they have studied and to constantly refine their interpretations (Basit, 2003). In-depth individual interviews, field notes, and reflective journaling have been major data sources of this study.

Transcribing the interviews myself was advantageous, as it was not just a data processing, but rather a data analysis as I listened to the audio tapes repeatedly for accuracy of the interviews. Reviewing the audiotapes allowed me to discover a visual recall that took place at the time of the interview adding meaning to the content. It also helped me to learn more about the participants and brought new insight each time that I listened to an interview. Deliberate or accidental alteration of data and unavoidable alteration of data (transcription will inevitably miss nonverbal cues) are the main categories of error I was careful about (Polit & Beck, 2012).

I followed Carspecken's critical qualitative research framework that advocates for simultaneous data collection and analysis (Hardcastle, Usher, & Homes, 2006). Thus data collection and analysis occurred concurrently with interviews and observations which later became more focused with time.

3.6.1 Stage one and two.

For stage one and two, preliminary steps included formulating a list of three research questions in order to gain a greater understanding of older adults' use of alcohol within their social, cultural, and political context that guided the research process. I then gathered relevant data to answer these three questions.

In order to be reflective, I explored my values and biases on this subject matter before entering the field (Carspecken, 1996). This was accomplished by journaling and debriefing with my supervisor. These activities kept my biases in check. Journaling on my personal feelings, thoughts about interviews, my reactions and values, as well as peer debriefing was maintained throughout the research process. Prior to moving to stage three, I created a list of ‘low level’ codes aiming to provide basis for my dialogue with the participants (Carspecken, 1996). One should begin with low level codes as low coding requires very little abstraction and then move onto high level coding which involves a high level of abstraction and is based on “explicit meaning reconstruction and horizontal analysis” (Carspecken, 1996, p. 148).

3.6.2 Stage three-dialogical data generation.

This is the interview stage. Research questions had already been formed before starting the interview to avoid influencing the data collection in the interviews. Stage three was conducted over a period of eight months. Out of the eleven interviews conducted, two participants were re-visited. The interviews were conducted using open-ended conversations and semi-structured interviews. The importance of stage three is that it is considered the main catalyst stage to potentially transform social practices through a dialogue between the researcher and the researched (Carspecken, 1996). I engaged in conversations with the participants at this point to generate dialogical data (Carspecken, 1996). I was able to maintain respectful and supportive atmosphere such that participants felt comfortable and on equal footing with me. This was evident by the way they spoke and interacted during the interviews. This atmosphere also facilitated emancipation by allowing all the participants to describe the world within their own

understanding, talking about their life stories and experiences (Batch, 2012). All the interviews were audio-taped and later transcribed. Transcribed interviews were reviewed many times to familiarize myself with the subjects and to create a better understanding of the content. Field notes were revised and checked multiple times. Initial data including a list of 'low level' codes was compared with the responses of participants. Emergent codes were added to a code list. It is during this stage where researcher has the capacity to act and transform practice (Hardcastle, 2004), thus, I was able to collapse various codes into categories and then into themes.

Members of the research committee challenged, illuminated, and/or verified the findings throughout the research process. The previous two stages were repeated after compiling of the data, as Carspecken (1996) advises to loosely follow the framework and that the stages can be visited back and forth.

3.6.3 Stage four and five-conducting system analysis.

Stages four and five require data to be reviewed in broader socio-political term as the researcher moves in and out of etic and emic perspectives. This process requires the researcher to continually check and recheck the information and link the findings with participants' responses, thus creating a solid foundation to build upon. (Hardcastle, 2004). The researcher often revisits stage one to three during this process. My analysis began with process of data coding. The object was to break down data into general categories that were later used to expand data in order to formulate new levels of interpretations. According to Thorne (2000), a good coding scheme steers the researcher towards collecting data into groups with similar properties. Some of the initial codes I developed were; denying substance use, blaming circumstances, or feelings of

guilt, peer pressure, same social circle, loneliness, or familial substance use. This process helped me to truly see the data even in the initial period of coding. Based on the codes, some of the categories developed were; attitude about drinking, beliefs about drinking, or contributory factors. Provisional findings were compared with secondary data sources in order to challenge my analysis and interpretation of the data.

I speculated on how these themes and subthemes exist in context with broader societal, political, and environmental factors. Connections were made between reconstructions and the macro level factors such as physical, environmental, social, level of education, financial situation, access to health, or level of support/help and how these may have impacted on older adult participants' attitudes, beliefs, or experiences on use of alcohol.

3.7 Rigor

The criteria for establishing integrity in critical ethnographic studies can be challenging. Critical ethnographers require techniques to discuss how researcher and participants contribute to a study result and yet minimize researcher bias. In my research, I utilized reflexivity, reciprocity, and rationality to assess rigor and establish trustworthiness.

3.7.1 Reflexivity.

Reflexivity is an important concept in a qualitative study during data collection process (Polit & Beck, 2012). It is an open reflection about a researcher's beliefs and values during a particular research project (Vandenberg & Hall, 2011). Researchers need to be aware of the part they play within their own study. They can question how they query for details or clarity in order to become conscious of how they construct data. Vandenberg and Hall (2011) emphasize that

building on reflexivity with participants enables critical ethnographers to acknowledge biases, and to also give an opportunity to participants to critique the researcher's view. Before starting to conduct interviews, I spent time in self-reflection to explore my own biases, values, and beliefs about the population I was going to study. This process of self-reflection proved to be of extreme value as I realized I really wanted to understand the experience of alcohol use by older adults from their stand point; their beliefs and attitudes about using alcohol, and how it had influenced their lives. I was ready to enter the field with an open and eager mind. I was able to keep my objectivity by ongoing reflective journaling. I was conscious of my social positioning as a nurse working in the community, and also as a colleague of the substance use counsellors who referred most of the participants to me. I additionally considered how it might affect my position in the field as a researcher and eventually my interpretation of the data. Reflexivity is not only about being conscious and setting aside biases or personal beliefs, but it also applies to creating a new understanding through a process of critical thinking (Mahoney et al., 2012). Besides reflective journaling, I had frequent discussions with my supervisor about the research process, ideas, and themes arising from data analysis. During these discussions, insights were raised that confirmed, challenged, or raised additional questions about clarification of my concepts. I found these discussions extremely useful as they constantly forced me to step outside of the field and view myself objectively, as well as look at the research process from the point of view of another person who was not as intimately involved in the process.

3.7.2 Reciprocity.

A reciprocal relationship consists of trust and support between a participant and a researcher and is founded on the elements of equality. It therefore builds on the process of reflexivity where researcher is constantly engaged in self-reflection and their social positioning in relation to participants (Baumbusch 2010; Kirkham & Anderson, 2002). Unless a relationship of trust is built with participants, it is questionable whether the research findings accurately represent what is significant to the participant. I tried to foster reciprocity by encouraging active involvement of the participants in the stages of data collection and data analysis of the research process, thereby promoting equal partnership. I was friendly and honest with them. At the outset, I explained the purpose of my study and reassured them that the study was not to be judgemental, or to humiliate them, but to observe, acknowledge, and report their valued experiences in the hope, my study could be used to reduce the social, political, historical, or economic structures that may have been contributing factors to social inequities (Vandenberg & Hall, 2011). I also encouraged them to speak openly, ask questions, and provide feedback, thus creating mutual trust, support, and equality of power which are all hallmarks of reciprocity.

3.7.3 Relationality.

“Relationality is defined as the responsibility of researchers to share power with participants in decision making and social action” (Vandenberg & Hall, 2011, p. 29). Sometimes researchers may be unaware of the position of privilege they occupy in their research project. Researchers who contemplate predicting and controlling other people’s lives through their explanatory theories have a moral obligation to emphasize equity in their power relationship with

the participants (Hall & Callery, 2001). If there is a power imbalance, the participants may be unwilling to challenge the researchers about the validity and relevance of their proposed analytic framework. Relationality is a very important element in a research such as a critical ethnography, as critical ethnography is about uncovering and reducing the social, political, economic, and historical structural inequalities. Relationality is an emerging criterion for rigor in a qualitative study. The researcher has to be extremely careful of the power relationship while contemplating possible outcomes of their research and the impact on participants and larger communities (Vandenberg & Hall, 2011). It is the responsibility of the researcher to share power with participants on equal ground in any decision-making and social action. Throughout the research process, I was extremely conscious of maintaining a consistent power balance between the participant and myself. In order to make participants feel comfortable and at ease, I left the choice of venue for the interview to be theirs. I always started the interview with trivial matters until the participant appeared at ease, and with their permission started to audio-tape the interview. I was very open about any queries they had about my background. A couple of the participants inquired about my religious affiliation. I was able to satisfy their curiosity and let them know at the same time that I was very respectful of other people's religious beliefs whatever they may be, thus I was able to form good rapport with all of the participants. I encouraged them to voice their thoughts and opinions frankly. It was empowering when participants reflected upon their lives and the impact that alcohol use had on their lives. In many instances, they did not want me to leave, rather they wanted to continue conversing, and most of them thanked me for coming to their homes and listening to their stories.

3.8 Ethical Considerations

Ethical issues were addressed through a research proposal that was presented to the University of British Columbia's Behavioural Research Ethics Board and the Interior Health Authority Ethics Committee for review and approval prior to recruiting the participants. Letters (Appendix A) were sent to different substance use team leaders explaining the research and requesting them to ask suitable clients if they would agree to participate in the research. Those clients who showed willingness to participate in the study were then provided with a written invitation letter that had my name and contact number (Appendix B). When potential participants contacted me over the telephone, I was able to answer any further questions and explained the research project in more detail. I then screened them to ensure they met the requirement of the proposed study.

I conducted the interviews with sensitivity and provided a thorough description of the research anytime it was sought during the interview. I was extremely diligent in explaining to the participants that it was not my intent to judge them or try and force them to access help in giving up or using alcohol, rather, only to have an understanding of why they use alcohol. I did not manipulate or force them to participate in the research. Every effort was made by me to ensure that each participant was aware that they could withdraw from the study voluntarily and were not obliged to respond to any of the questions that made them uncomfortable.

Each participant was provided with a full explanation of the study and their right according to the Tri-Council Policy Statement. I further emphasized on the voluntary and confidential nature of the study. People who agreed to participate were requested to give their verbal and written consent (Appendix C). It was emphasized that participants may refuse to

answer or stop the interview at any time. I advised all participants that resource in terms of counselling was available to them if the interview upset them in any way or if they wanted to talk further pertaining to this matter. I ensured anonymity was preserved and protected the privacy and confidentiality of each participant. Anonymity was protected as follows: 1) data were identified by pseudonyms and coded only; 2) all the data, including audiotapes and transcripts were kept secured in a locked cabinet and locked environment. This data will be retained for any future research with written consent from the participant. No identifying information was included in presentation or publication; 3) consent forms are stored in a locked cabinet separate from the interview tapes and transcribed data.

Computers where the data was stored were password protected. To maintain confidentiality, I used code numbers with no identifiable information on transcripts and interview questionnaires. At the close of the study, none of the reports will include any identifying information. Five years after the completion of study, all data will be destroyed.

3.9 Chapter Summary

A critical ethnographic research design was used to answer the following objectives:

- 1) explore attitudes, beliefs, behaviours, and experiences of alcohol use among older adults; and
- 2) explore factors that influence or shape alcohol use among older adults.

Postcolonial theory and critical social theory were the theoretical perspectives that guided this study. Critical ethnography was the method of inquiry chosen for the study. A purposive sampling technique was used to select older adult participants who provided in-depth

information on their attitudes, beliefs, behaviours, and experiences on alcohol use. The participants for the study were recruited from the community mental health and substance use health unit in an urban center in the Interior of British Columbia. I also recruited key informant participants to enrich the information on the phenomenon under study. Data were collected by using semi-structured interviews. These interviews were later analysed using Carspecken's framework of analysis. Reflexivity, reciprocity, and relationality were utilized to enhance the rigor of the study. Finally, careful attention was paid to the ethical considerations in the study.

Chapter Four: Findings

4.1 Introduction

In this chapter, I will present findings from my study that was conducted to gain a greater understanding of older adults' use of alcohol within their social, cultural, and political context and how these factors may have influenced their alcohol use over the years. I will describe the themes that emerged using Carspecken's model of data analysis for this study. Themes allow us to progress from the diversity of data to general concepts and their inter-relatedness (Bradley, Curry, & Devers, 2007). Three major themes emerged from the data analysis of my research; 1) narratives of drinking, 2) barriers to help seeking, and 3) changes to promote help seeking. Several sub-themes emerged within each major theme that illustrated the uniqueness and similarities within the group. I have described each theme and subthemes using direct quotations from the participants as necessary. Pseudonyms were used to protect the identity of the participants.

4.2 Narratives of Drinking

I begin by describing the factors that shaped the research participants' earlier years and life experiences in the later years that may further have influenced their drinking. I next describe the different drinking patterns and drinking behaviours of the study participants which, for some individuals were highly risky or inappropriate. A number of participants also experimented with substances other than alcohol during their drinking years. The last two subthemes describe the various consequences the research participants experienced through their use of alcohol and what

has been helpful to them through their journey of alcohol use. Thus, a total of six subthemes emerged under the main theme of narratives of drinking.

4.2.1 Factors that shaped early years of life.

Early years of life are considered extremely important as they lay the foundation for the future. The experiences and relationships of early years contribute significantly towards building the attitudes and behaviours of adulthood. When environmental influences are positive, they help to maximize an individual's full potential. On the other hand, negative environmental factors in early years can become obstacles to healthy developments (Loke & Mak, 2013). In my research, a number of participants encountered adverse environmental factors in their childhood; a background of drinking, problematic family relationships, sexual abuse, or loneliness. It is well documented that childhood adversities increase the risk for substance use that often starts early in life (Dube, Anda, Felitti, Edwards, & Croft, 2002). Therefore, it is not surprising that most of these individuals experimented with alcohol in their teenage years, considering it to be a 'social thing to do' or even 'a way of life.'

Alcohol in the background during the childhood years of an individual certainly plays a role in influencing their alcohol use. For example, parents or other family members who drink and view drinking favorably, may have children who not only start at an early age, but also drink heavily (Loke & Mak, 2013). In my study, seven out of eleven older adult participants grew up in an environment of alcohol misuse. Tim, Jill, Kate, and Pam grew up with both parents misusing alcohol. Pam, Kate, and Anna grew up in an environment where besides parents, other family members drank. Pam recalled:

I got with him (husband) when I was fifteen, and I got married at 18. And I lived with him....before...and then we had two children....and for me....I grew up with an alcoholic father. And there is a lot of alcoholism in my family.

I: Like.....besides your dad...?

Pam: Ummm.....And his sisters were alcoholic, my grandparents were alcoholic....uhmmm.....I had six kids in my family, everyone has struggled with alcoholism except for one, she is a social drinker. She is the oldest.

Kate also grew up in a background of alcoholism; her parents drank, all the friends in the neighbourhood drank, and so drinking for her was almost a given:

“Well, both my....my father was alcoholic...and my mother was alcoholic, and the kids I was hanging out with, they all drank....from school....high school.”

Sheri’s father was an alcoholic and so was Dora’s step-father, in her childhood years.

Anna grew up in a small community. She believed that living on the reserve, where everyone drank, definitely contributed to how her life turned out:

I: “Do you think that your cultural background has affected...impacted your alcohol use?”

Anna: Oh yeah. You come from a small, isolated reserve like that; everybody drank. It was...just a way of life, you know.”

A background of alcohol in early childhood often involves other adversities such as dysfunctional families, or physical and/or sexual abuse (Dube et al., 2002). Childhood sexual abuse is a well documented risk factor when substance use is in the background (Sartor et al., 2013). Besides being raised in an environment of alcohol misuse, three women participants had also experienced sexual abuse in their childhood. Dora grew up in a difficult environment. She was put in a foster home by the child protection agency at a tender age of thirteen and had experienced sexual abuse by a foster parent. Anna and Pam were both sexually abused by family members in their childhood. Anna shared that being a First Nations’ person, being a girl, and living in a small rural community made her feel extremely vulnerable. She felt that her

background, sexual abuse first in her childhood, and again later by her husband had a great impact on what happened later on in her life:

And I found out that some of my actions were.....in part because....of the sexual abuses in my life; starting at three. I remember once, and I don't remember if it was 2-3-4-5 times, I have no....recollection of that. And then, there was the....my brother-in-law. He was a wicked-wicked man. Uhm....was one older boy from school. When we were going to school – he'd grab one of the girls and....take us under the apple tree there, on the way to school and uh....fondle us....you know. So, there has been.....

Children, who grow up in an environment of multiple negative circumstances, often have difficulty forming relationships as they mature (Schaefer, 2011). The teenage period can be challenging for teenagers with a difficult background; a lack of desired social inclusion can be even more challenging. Sheri, who grew up in a background of parental alcohol misuse, mentioned she drank in her teenage years because she was lonely:

I: Did you not have lot of friends?

Sheri: No, I never did, no, (pauses) and I didn't have boyfriends either.

I: So you were kind of lonely.

Sheri: I was....very much so, and I think that has a lot to do with why....and I was very young...at fourteen I started to drink.

Almost all of the older adult participants had experimented with alcohol in their teenage years; it was a social thing to do, hanging out with friends who drank, because that is what all teenagers did. None of them appeared to connect their early years of drinking to their alcohol use later in life. When Penny was asked about how the drinking started, she reported:

I: "So.....uhmm...what.... like it's just going out with friends that started it, like social drinking?"

Penny: "uhmm....just teenagers...you know.... on a Friday night, we all...went and did stuff like that..."

Ron did not think there was anything wrong with these behaviours either. In fact, he emphasized that he grew up in a very stable neighbourhood, growing up with the same friends, all doing the same things. He said drinking beer in their teenage years was one of the many ‘fun things’ he did with his friends:

Uhmnn....just the odd beer here and there. Uhn.....some friends would steal it from their parents or....or we get it some other way, and we would have the odd beer....uhmnn.....it was always sneaking, because we were....under-age of course..... it was just a social thing..... We all lived in the same neighbourhood, we grew up together, unlike most kids today are very fractured in their relationship. We grew up, the parents had jobs, and they stayed at their jobs till 35-40 years. And no one moved from the neighbourhood. So, it was a very cohesive group.

Several of the other participants reported that it was always a ‘way of life’ for them in their teenage years. Jim, who is ninety, reminisced that drinking on the weekends was a way of life for him as well when he was growing up. He said everybody worked hard during the week and then partied on the weekends. Their only source of entertainment was gathering at the town tavern for dancing and drinking on the weekends.

In summarizing ‘factors that shaped early years of life,’ four subthemes emerged; 1) a background of drinking, 2) sexual abuse in childhood or younger years, 3) loneliness, and 4) ‘drinking as teenagers.’ I found all the subthemes to be interconnected. Most of the participants were raised in a background where their parents or other family members used or misused alcohol. Three of the individuals, besides having alcohol in their background, also experienced sexual abuse in their childhood or in later years. Most of the participants also experimented with alcohol in their teenage years, considering it a ‘way of life.’ It appears from most of their stories that they ‘hung out’ with friends who shared similar backgrounds. It is also likely that factors such as alcohol misuse in the background and abuses such as physical or sexual may have

contributed to these individuals experimenting with alcohol early in their lives, and for most of them, also in their later years.

4.2.2 Life experiences influencing alcohol use in later years.

In my study, nine older adult participants either continued to misuse alcohol or started misusing it in their early twenties or early thirties (early-onset drinkers), and two older adult participants started to misuse alcohol in their fifties and early sixties respectively (late-onset drinkers).

Brook et al. (2013) note that a background of adversities in childhood such as alcohol misuse by parents or family members, childhood abuse, poor family relationships, or isolation, are risk factors for its continued use, or escalation of it in adult life. Early-onset drinkers in this study named destructive relationships, loneliness, physical or sexual abuse by partners, financial stress, or depression as some of the reasons for their continual misuse of alcohol into their adulthood. The most common reason for these individuals was loneliness created by destructive relationships.

For the two late-onset drinkers, retirement, and a combination of stress and sudden multiple losses led to alcohol misuse in their early fifties and sixties respectively.

4.2.2.1 Destructive relationships leading to loneliness.

Loneliness means different things to different people. According to Routasalo and Pitkala (2003), it is generally a negative and distressing feeling signalling social isolation, often due to loss of some kind; for example, a spouse, intimate relationship, friend, relative, or employment. In my study, loneliness surfaced again for most of the participants later in life, in most instances,

because of broken relationships. They had been either divorced or separated, and used drinking to cope with their loneliness when they lived on their own. Sheri reported going to pubs to compensate for the loneliness she experienced after her divorce:

....I didn't go out to the bar to look for a guy. I went out to have fun. And when I say fun...I mean laughing and dancing, and music and....you don't.....lots of people around me and.....lots of fun you know, laughter and jokes, and....I guess....because I didn't have that in my life and....that...alcohol kind of brought that somewhat in life. It didn't fulfill it, but it did help bring it in....so.

Adam, an American, who immigrated to Canada about ten years ago, said that although he had continued to drink from his teenage years, one of the stressors for escalating alcohol misuse was the break-up of his marriage and his wife removing his daughter from him. Adam reflected that his drinking caused the break-up in the first place, but the detachment also caused him loneliness that led to him drinking excessively.

Dora had been sober for twenty-seven years before her life circumstance changed. She had a rocky marriage for some years, but did not succumb to drinking again until her husband left her and she was alone. She stated it was her loneliness that not only started her drinking again, but it was also the reason she found herself in another destructive relationship:

...but in(acute psychiatric ward) I had met a sick NA (Narcotics Anonymous) person, and I thought he could help me...plus he had the...baby blue eyes my husband had. And...in my sick head I figured, you know this...he was living at the(center for homeless)...so he was looking for a place to stay because his time was up there, and I needed somebody to mow the lawns, etcetera, and I was alone in the house, so...

Tim mentioned he used alcohol as a way of coping with loneliness when he was on his own. He admitted he has lived a lonely life, which was not what he desired, but because of the choices he made (of drinking- alone). Of the eleven participants, six still live alone.

Additionally, some of the key informants expressed their views on loneliness. Carol, an experienced multicultural counsellor talked about some of her First Nations' older clients. She stated they often feel lonely, neglected, and uncared for:

They.....they often come to me – when I see them anyway, and they....that's a big part. There is nobody that cares what they think, or how they feel, or....whether they've had a meal that day or....you know, so when somebody gives them that attention and really listens, you know, often that's all that they really need....

Robin agreed that socialization becomes a very important factor, particularly for older adults. He said, “....*And if you are feeling stuck in your apartment, or bored, and you are all alone - why wouldn't you want to go out and gamble?.... why wouldn't you want to go to casino or get some alcohol?*” He pointed out there were gathering places for seniors such as the Legion where you can get an alcoholic beverage cheaper and also have a bit of socialization:

...You are going to see familiar face! So why wouldn't you go back? You are going to be comfortable, you are welcomed. Chances are, you might pay a little bit less money. So that whole social factor is real big for a lot of these older people, particularly if they have access to the legion. You know, it's a job for them, it's a place... to go and relax, talk to old friends, tell war stories, whatever you do at the legion....

To summarize, nine individuals expressed that loneliness was one of the main reasons for their drinking. For a majority of them it was the loneliness created by broken relationships due to alcohol misuse by one or both partners.

4.2.2.2 Physical or sexual abuse.

Trauma such as an abuse of any kind, particularly perpetrated by loved ones, can have lasting effects leading to depression, low self-esteem, substance misuse, or thoughts of self-harm (Orzeck, Rokach & Chin, 2010). Some of the women participants talked about abuse they had

received at their partners' hands. Sheri mentioned that in her second relationship, her partner was 'bossy' and was physically abusive towards her. She said one of the reasons for her drinking during her second relationship was because she knew she was going to get a beating that night and to escape that horror and numb the pain, she drank:

....and I think that's why I did get beat up a lot of the times, is because I knew that he was going to beat me up anyways when he was drinking, when we got home. So, I kind of...when got out in the public...I kind of....used the public to have my fun and not him. I kinda put him in the background, because I just had to get away, like....and have fun because.....Because everybody knew that I would....that I would get beat up. And I guess I was hoping that if that part would be over....somehow and....yea...over...uhnn....overlook...or..uhmmm...keep me high enough so that I didn't totally breakdown you know from the beatings eh!

Kate, another older adult participant, who had stopped drinking for a number of years, spoke of starting again during her second relationship. Her second husband drank and also sexually abused her, contributing to her heavy drinking again:

.....In AA (Alcoholics Anonymous), I met my second husband; got married to him in 1985, and.....uhmnn....it was uhmnn....we were out to [a small town in the Interior of British Columbia], had about five acres. I just loved it. Had couple of horses, had seven dogs, and ducks, and a goat. It was wonderful! Marriage.....was really crummy. He was....ahmmnn...sexually abusive to me, and 'course my drinkings. I should....

Anna also talked about the sexual abuse she had experienced at her husband's hands:

Humn....humnn...and....the other abuse was....the kids' dad. He got drunk one time, and he raped me and.....while he was in the process of doing that, he was slapping me back and forth – Is that what you want? Is that what you want? That was the end....

Pam, who grew up in an environment of alcohol misuse by family members and sexual abuse in her younger years, was married to her first husband very young. They both drank heavily. She felt he was controlling. The fact that she did not drive, contributed to his controlling nature. She said he encouraged her to drink; *“he liked me drinking cuz then he could control me, right?”*

Dr. A, one of the key informants, endorsed that it was not that uncommon for her to see clients who had experienced abusive relationships that had led to alcohol misuse. She received these referrals mostly from physicians when they experienced time constraints or could not figure out the underlying cause for drinking. In one case, she received a referral from the Insurance Corporation of British Columbia where a woman was involved in an alcohol related motor vehicle accident. Dr. A was able to determine that the underlying cause was long-term physical abuse by her husband and thus made appropriate recommendations.

Poor and abusive relationships surfaced as very important reasons for alcohol misuse in early-onset drinkers. Four of the women participants in this group had experienced physical or sexual abuse in their childhood. They experienced abuse again later in their lives. It was an important observation that these women married men who misused alcohol and were abusive towards their wives. This speaks to the problem at a higher societal level.

4.2.2.3 *Depression.*

Sometimes, it can be difficult to determine if depression is the cause or the effect of alcohol in people with ongoing alcohol misuse issues, as alcohol is a known depressant. In this study only three participants had carried a clinical diagnosis of depression prior to their drinking where depression could be named as one of the causes. During the conversations, it became clear that all three women, Sheri, Kate, and Dora were diagnosed with depression in their teenage years. Sheri was reluctant to admit she was diagnosed with depression back in her youth. Kate was also diagnosed as having depression when she was very young. She described she had been

participating in self-harm behaviour at a young age and had also received treatment for this behaviour:

.... like I had been under psychiatric care since I had been a kid...uhmmnn....seventeen- eighteen years old.

I: What....was that for? What was the diagnosis?

Kate: Ahh....just depressive. But....have you ever heard ofVancouver? No? I was burning myself and cutting myself, and.....anyways so I started drinking again.

Similarly, Dora suffered from depression in her youth. She had even tried to commit suicide in her teenage years:

Dora: “So I went....(cries) I lived the last six months of school with a girlfriend....coz....of teen problems.....(sniffles)...you know I had been out drinking.....and....(very softly) tried to commit suicide, and.....”

In later years, she still suffered from depression because of her drinking.

Dr. A, one of the key informants, noted that although depression is a common occurrence as a reason to start drinking in the older adult population, it is likely missed at the primary care level because of ageism:

And...and, you know, for some reason they....if you are forty and then going to the doctor all the time, they go...you know...why are you coming to the doctor all the time...there is something there; whether it's depression, or something. But when you are sixty and going to the doctor all the time, you don't really think about it.

Carol, the multicultural counsellor, talked about trauma during the life span and that any trauma or significant change in people's life can easily lead to depression, which can often lead to excessive drinking. Robin, another key informant, talked about the mood altering properties of alcohol:

Robin (continuing): You know, we are still looking at one of the basic factors of drinking in the first place and that's for its mood altering effects. So if you are old and lonely, what is alcohol then going to do for you? It is going to alter your mood? You won't feel that loneliness. So, I mean it doesn't matter if you are 20 or 70, you

are still going to be, in one way or the other, drawn to alcohol, perhaps, to some degree, because to its mood altering effects.

In summary, depression stood out as a cause for their drinking for only three older adult participants, although it is one of the most common reasons why older adults start to misuse alcohol.

4.2.2.4 *Financial stress.*

Financial stress as a reason for drinking was noted by only one participant. Adam informed me that one of the main reasons for ‘going overboard’ with drinking was the financial stress he experienced:

No. The end is not like that....uhh.....I got married and....uhh...moved to.... ...(a city in the United States).... ... I had a daughter and....a....bunch of things happened.....and all of a sudden, I owed like....a lot of money, and, you know, and I ended getting two full time jobs;..... one I had to pay for life, and the other one to pay the debts off and....and I started...uh...not just drinking alcohol, but using speed to stay awake and work, and.....

Although none of the other participants had held a regular job for any length of time, only one participant identified financial stress as one of the major reasons for drinking.

4.2.2.5 *Stress and sudden multiple losses.*

Two participants, Jill and Anna, started misuse of alcohol into their early fifties and sixties respectively. Jill noted that her husband’s job required frequent relocation, causing stress in her life. It was compounded by sudden losses of close family members:

Jill: Yeah, but I had drank before, but I was able to stop drinking for days, and I stopped drinking for....but I drank....the last five years. It’s been a....family....my father died, uncles and aunts died, my husband went away out of country for thirteen months. I...moved three times in that process, that time. I felt like I lost my identity, and.....grip on some of the reality that came with it, and it just became for

me....mental stress. Just have my dad die, being alone in...Northern Territories, Yellow Knife, and not have any support up there.

4.2.2.6 Retirement.

Anna gave retirement as the cause of her drinking heavily in later years. She had used alcohol in her earlier years, but did not feel that it had ever become problematic. She said she felt useless after retirement; suddenly there was nothing to do:

I: “So your real problem started after you retired?

Anna: I would think so, because I felt....uhmn.....useless...there wasn't.....

I: Anything to do?

Anna (nodding): There wasn't anything else for...me to do that was productive.....”

In summarizing life experiences influencing alcohol use later in life; bad or abusive relationships, depression, and financial stress were some of the reasons noted by early-onset drinkers. For four of the participants bad relationships that turned abusive was noted to influence their alcohol misuse. The second important cause noted was depression. Three individuals identified their misuse of alcohol was related to depression; all three of these participants had experienced a difficult childhood. For one early onset drinker, financial stress was the cause of an escalation to his drinking. Within the late-onset drinkers' group, one participant found that retirement led to the misuse of alcohol, another experienced alcohol misuse due to multiple relocations and sudden multiple losses.

4.2.3 Drinking behaviours.

Alcohol use in older adults is considered to be an 'invisible epidemic' (Sorocco & Ferrell, 2006). To make it more visible, it is important to have knowledge about older adults' patterns of drinking behaviours and how they view themselves with regards to alcohol use.

I will first describe the drinking status of my study participants at the time the interviews were conducted. I will then describe the different patterns of drinking behaviours based on: 1) the frequency of their drinking, and 2) their view of what kind of drinker they consider themselves to be. In the last section of the subtheme, I will describe drinking behaviour as narrated by some of the participants that were risky as well as inappropriate.

At the time of the interviews, two older adult participants had been abstinent for ten years and three participants had not used alcohol for two years. Four participants readily admitted that they were actively drinking and two were not sure about their drinking status. One participant stated she was trying to quit, and another participant had not drunk for one month but was not sure if she was going to be able to remain sober.

Three different patterns of drinking behaviour emerged based on the frequency of drinking and what kind of drinker the participants considered themselves to be; 1) week-end binge drinking, 2) steady drinking, and 3) social drinking. For six of the older adult participants, five of them women, drinking started as a 'social thing' on weekends with friends. Over time, this 'social thing' progressed to week-end binges. Four women participants disclosed that their week-end binge drinking was done with their husbands. For all five women, gradually, the week-end binge drinking progressed to daily excessive drinking at home.

Dora and Pam, both of whom were abstinent at the time of interview, had somewhat similar beginnings. Dora and her husband partied every weekend and drank heavily. At one point in her life, drinking was a major part of their socialization:

Dora:so....then we got married. And....I was 21, and he drank a lot. And we just carried on with our lives, had kids, drank a lot, and partied every weekend. Uhhn.... joined a jeep club and met people.
I (coughs): Joined a what...club?

Dora (repeats): A jeep club and...a four -wheeled drive club ...had lots of fun, had three kids, had a wonderful life and....Uhhh we just drank, and drank...and drank.....

Dora grew tired of this life style, especially as she felt responsible for her three little girls. She had a period of sobriety that lasted twenty-seven years, but when she started drinking a second time, it was at home, by herself. Pam, like Dora, started drinking in her teen years on the weekends. This pattern continued into her early married life as her husband drank as well. Her week-end drinking soon progressed to being a heavy drinking at home. Pam does not drive so she depended on her husband to bring in liquor, who, she noted, encouraged her drinking. She said she drank till she blacked out. Pam continued to drink even after she separated from her husband. She worked part time jobs and drank at home while raising her two little children. She took pride in the fact that although she drank, she was “always home for them and made meals.”

Penny’s drinking started as weekend binge drinking with her friends, but it changed to steady and heavy drinking at home after a major motor vehicle accident. She needed a drink to carry out any activity, such as paying the bills and doing chores around the house. Penny still drinks and likens her heavy ‘drinking – hospital – detox’ drinking cycle to a revolving door.

Anna remembered that her husband came home on the weekends and forced her to go with him to the pub, marking the onset of weekend drinking. She divorced her husband and over the years drank on and off, but noted that drinking only became an issue after her retirement. At present, Anna is working on ‘non-drinking windows’ with the help of her substance use counsellor.

For three of the older adult participants, drinking did not start as weekend binges. Except for Jill, who is a late onset drinker, the other two started drinking early in life and just carried on until drinking became a major issue in their lives. The common thread running through the older

adult participant's lives was loneliness. Tim noted that he has always been a loner. He started drinking in his teenage years and continued. He said he drank between six to twelve beers every day. He often drank alone. Initially Tim noted that drinking was an 'on and off thing', but then he started to drink on the job. Matters became worse and he quit the job and just drank:

“Well, things got from bad to worse. After divorce and separation, I...went... right off the deep end. I quit working altogether...just drank. Went on a point where just drank and drank...and drank. When money ran out –went back to work.”

Similar to Tim, Kate started early in life and carried on. She never stopped drinking. She worked part time jobs, came back home, and drank most evenings, even when her children were small. She still drinks. She lives alone and finds it hard to fill time. She said she tries to not drink, and may go without drinks for a week, but it has not been very successful. For her, pay day is a difficult day:

Kate: You know how it isone day at a time. Today I am not going to drink, and tomorrow is my pay day....and I am not going to drink, I just know that.

I: Okay, that's great!

Kate (cuts in): But see....I've done that before. I could, but, at this point there is no reason....

Jill, who only started misusing alcohol only five years ago, said it was not a gradual progression. She said a combination of factors pushed her over the edge and she started to drink. It did not matter what day of the week it was, she drank almost every day. She soon reached a point where she needed a drink to function.

For Jim and Ron, drinking has always been only a 'social thing.' Jim said he worked hard during the week as a logger, but when he came home on the weekends, drinking was the main social event. He lived in a small community in the Interior of British Columbia. Their focus of socializing was a week-end gathering in the town tavern for dancing and other entertainments. I

tried to ask him if drinking was not considered an issue. He insisted drinking was strictly a social event in those years and that he did not have a drinking issue although he spoke of the weekend binges often.

Ron also insisted that drinking has always been a 'social thing' for him. When he was younger, he went out with friends to socialize, and now it (alcohol) relaxes him. Throughout the interview, Ron insisted he enjoys a drink, but that he does not have an issue with drinking, rather, other people have a drinking problem:

Ron (cuts in): Not a problem at the minute, as I say I try to limit myself, uhhh....I....I....because I don't want it to become a problem, because I enjoy it. Now, you run into people that have.....had to stop drinking, but you know, these are the people that....that drinking first thing in the morning....all day long, may be a twenty-sixer....for years.....well, they....they are hooped...they've ruined their body. So, not that I have the desire to drink first thing in the morning, I am....kind of an afternoon guy, and I don't drink too much in the evening, coz it affects my sleep. So, you know, I....I pretty limit myself to when I consume alcohol.

Jay, one of the key informants said that a lot of the older adults view themselves as 'social drinkers.' When stress level or anxiety levels go up for any reason, they may drink heavier, but then they go back to being social drinkers:

So, majority of them, that I saw, I don't think would fit the criteria for an alcoholic, you know. But what's an alcoholic? (laughs) you know...you know what I mean, like it's just....ahhh...if they are looking at having problems drinking...that....and they can't do abstinence for whatever reasons, then, quite possibly, they could be alcoholic. You know...but if it's a problematic drinking and they get themselves back on track, then don'tthey don't view themselves as having a big problem.

In summarizing the patterns of drinking behaviour, three categories emerged; week-end binge drinking, steady drinking, and participants who viewed their drinking as strictly a 'social thing.' Six of the older adult participants admitted to week-end binge drinking. A common thread for five of them (all women), was that their drinking started off as a way of socializing, but

changed to steady drinking with time and circumstances. Four of them had started out week-end binge drinking with their spouses who drank equally heavily; all of these relationships ended bitterly, alcohol being the main cause. Of the three individuals who drank almost daily, Tim and Kate drank steadily their whole lives, but Jill started late in life due to a combination of factors.

Two older adult participants, Jim and Ron looked upon their drinking as purely a ‘social thing.’ Neither of these participants considered alcohol to be an issue for them.

Behaviour after drinking can be very different in every circumstance. In this research study, I discovered that some of the older adult participants lived a risky life while drinking. On numerous weekends, when younger, Sheri reported that she wandered out on the streets, was picked by the police and thrown in the ‘drunk-tank.’ As she grew older, she exhibited a unique and highly risky behaviour. After drinking, she used to get out, walk to the nearest highway and hitch-hike. It did not matter who she got ride with, or where she got dropped off:

Yeah, because when I’m drinking and not on my med.....when I drink, I don’t take my meds eh! And I...I hitchhike all over the place....like I’ve hitched hiked from (a town in B.C.....,to Trail, B.C. I’ve hitched hiked from Trail, B.C. to... ahhh....where my other daughter is. And you know, and I don’t think of any dangers.....(pause)...thank goodness I was never ever hurt, or raped, or...or anything like that, when I was traveling and hitchhiking....

This risky behaviour stopped when she stopped drinking about twelve years ago.

Kate and Adam admitted that at the time they were drinking, they felt they would have done anything for a drink. When asked what ‘anything’ meant for her Kate became wary and said she would rather not talk about it:

Kate: “Ahh...(pauses) uhmnn.....lost kids....well, that was devastating. Uhmnn.....so I drank more. And...I lived almost round the street uhh....did anything I could to....uhhhhh get alcohol. Uhmnnnnn....I lived in different areas; basement suites, apartments, and then.....uhh....at about.....”

Kate drank while she was pregnant:

“...let me think....actually the birth of my ssss..son – it became ahh....really a problem, I drank very much, a lot. Ahmmm when I was carrying my daughter, I was drinking the whole time.”

She is relieved that her children did not suffer the consequences of her drinking during that time.

Her children were removed from her due to her excessive drinking. Kate still drinks but is trying to quit. She indicates she lives from pay cheque to pay cheque and tries not to drink, but sometimes loneliness overpowers her, and she finds herself heading to the liquor store.

Adam became extremely desperate at one point in his life. From having a family and a job, he became a destitute during the drinking period of his life:

...And uhh....then I realized she (wife) wasn't going to come back, you know. So when I figured that out, I....started drinking again, and....and uhh....the next....about six years of my life – I really spent living on the streets ofunder a bridge and....pushing a shopping cart, climbing in and out of dumpsters for food and clothes, and....you know....

One older adult participant admitted to inappropriate sexual behaviour when drinking.

Pam stated she used to act out sexually when drinking. She blamed it on the sexual abuse she had experienced in her childhood; “... *and....I used to act out sexually sometimes when I drank....touching other men and stuff because of the abuse I suffered (crying)...and I only found that out through counselling that's why I would do that.*”

Her biggest regret is inappropriate behaviour with her brother-in-law after drinking; something that was witnessed by her son:

And....my husband's brother was an active alcoholic, and we used to drink together, and....one night, when my son was....I think he was thirteen years old at the time (sniffing)....I was laying on the couch with my brother-in-law...kissing him, and stuff, and my son came up....to go to the bathroom....and...(difficulty in continuing) he saw us (sighs)...

After this particular episode, she lost credibility with her two sons as well as with her husband and went through a difficult period. She stopped drinking for nine years after this traumatic experience. She reminisced that all it took for her to re-start drinking was one drink. She has not had a drink for two years now.

To summarize drinking behaviour, five of the older adult participants shared about their drinking behaviours that were dangerous and inappropriate. Two participants admitted that at one point in their lives, they would have done anything for a drink; one woman participant admitted to inappropriate sexual behaviour that was related to her drinking, and one woman participant shared a uniquely dangerous behaviour of going out on the highway and hitch-hiking after drinking.

In summary, three distinct patterns of drinking behaviours were identified in the study; the steady drinking, week-end binge drinking, and the strictly social drinking. It was a point of interest that the largest group (six) consisted of the weekend binge drinking. Besides the different patterns of drinking behaviour, some dangerous and inappropriate drinking behaviours were identified in five of the individuals. Another notable point was that the individuals that started drinking early in life were also the ones whose pattern of drinking was week-end bingeing. As well, the same group of individuals talked about their inappropriate, and in one case, dangerous behaviour after drinking.

4.2.4 Additional substance use issues.

It has been noted time and again that baby boomers have now joined the ever increasing population of the older adults who are sixty-five years or older. This new cohort brings its own

values and life style different than the generation before them (Immonen et al., 2011). They have experimented with other substances and some of them still continue to do so. In my study, seven of the older adult participants had additional substance use issues along with alcohol misuse. It was noted, that except for one participant (Joe) who is ninety, the rest of the participants fall under the baby boomers age group.

The most common additional substance used was tobacco. Four of the older adult participants agreed that they found it difficult to stop smoking while trying to quit drinking at the same time. They gave up drinking, but still continue to smoke. Tim has attempted to quit smoking for a couple of years. Sheri has a similar difficulty. She quit drinking, but still rolls her own cigarettes. She said this is the only enjoyment left for her and she is not yet ready to give it up:

Oh, Yesss....I don't think I want to quit that (smoking). I....sometimes I would like to quit, but, I...really...it doesn't really bother me that much..... Some days it's...I smoke very heavy and other....it just depends how upset I am, or what I am in I guess eh!

Dora said she started to smoke in her younger years to stop hunger pains. She and her husband went through a period of hardship as they had just started their own business. Similarly, Pam, who is now sober, finds it very hard to give up smoking. She said she would love to give it up, but that is all she has for now. Jim, who is ninety, happily said that he 'drank and smoked like a chimney.' He noted that in his time, it went without saying that people both drank and smoked socially.

Four older adult participants used substances other than tobacco. Adam, who is fifty-eight, went through a difficult and a dangerous period in his life. He said he was drinking and

using amphetamines. He said he was under heavy financial pressure, so he worked and drank, and then did 'speed' to keep awake. For years, he used intravenous routes to inject himself:

...you know, and all of a sudden, I owed like....a lot of money, and, you know, and I ended getting two full time jobs; one I had to pay for life, and the other one to pay the debts off and....and I started...uh...not just drinking alcohol, but using speed to stay awake and work, and.....

He was quite candid about sharing his experiences of the period in his life when he lived under the bridge and had multiple encounters with the law when he was caught with paraphernalia for injecting drugs.

Penny who is fifty-six, spoke about her smoking tobacco and marijuana as 'a normal thing to do' with her friends while she was still in high school. Later in life, she had to give up both these habits as she could not smoke anymore.

Dora, who is a heavy cigarette smoker, blamed her partner (her second relationship) for her additional substance use issues. She said her partner was doing cocaine and that he also introduced her to it. She insisted that she did not realize at the time that she was using crack cocaine. Her friends tried to warn her, but she did not heed to their advice. She said she was afraid of her partner. This relationship broke up only when she had a stroke a few months later and her family intervened. She still smokes heavily:

...uhmmn...for a while, and then he was smoking drugs, and I think he even gave me some and I didn't know it. I was that ignorant, stupid, that I didn't realize he was...it wasn't just marijuana, because I couldn't figure out this strange smell; he was back on crack cocaine. And his other friends kind of told me - said 'we think he's back on crack cocaine and Dora, we don't want him taking advantage of you'. Well, I didn't believe it.

Pam, who still smokes cigarettes; for a period of time, used methamphetamine. Like Dora, she blamed her husband for introducing her to crystal meth:

It was very dangerous. I was so afraid and.....uhmm....he was actually selling meth and hooked on meth. And then.....he introduced me to meth, and I had never even seen it before, and I knew (wipes tears)...I know in my heart that if it wasn't for him, I never would have tried....

In summary, seven older adult participants reported to having additional substance use issues. All seven older adult participants smoked tobacco. Four participants went through a period in their lives when they used substances other than tobacco, such as amphetamine, marijuana, cocaine, and methamphetamine. All of these four participants belong to the baby boomers' age group. At the time of the study, four older adults were actively smoking cigarettes. This is an example of future implications that could be a burden on the health care system in general, and on substance use treatment and prevention policies in particular (Colliver, Compton, Gfroerer, & Condon, 2006).

4.2.5 Consequences of drinking.

It is unfortunate that misuse of alcohol impacts all aspects of life. It affects not only the individual, but the immediate family, friends, and society as a whole (Morgan et al., 2011; Schaefer, 2011). It starts to have an impact on the health care system and other social institutions (Boyle & Davis, 2006). Within this study, alcohol misuse impacted personal lives of the study participants; relationships broke up due to drinking, participants experienced loneliness, missed out on family life, and some felt remorse upon learning that their children had started to use alcohol. Alcohol misuse also impacted the social lives of most of the individuals, where they felt not only socially isolated, but stigmatized as well. Some of the other participants described physical health issues when they were actively consuming alcohol. Some individuals experienced mental health issues, and for a number of participants, ongoing alcohol use

significantly impacted their finances. The most impacted aspect of participants' lives was their personal lives.

4.2.5.1 *Impact on personal life.*

Nine older adult participants stated that alcohol misuse had significantly impacted their personal lives, in most cases, a divorce or a separation. The single most devastating consequence of this impact on their personal life was the loneliness in the aftermath of separation or divorce. Other consequences of separation or divorce included losing custody of their children and in some families, children began to misuse alcohol.

Eight of the participants' marriages broke up as a direct consequence of their alcohol misuse. In the case of four participants, it was drinking excessively that destroyed the marriage. Tim had no hesitation in verbalizing that it was alcohol that caused his family to disintegrate, leading to his lonely life. His wife divorced him twenty-six years ago and he has lived alone since. He regretted that he did not see his sons grow up because of his alcohol use. He noted that at the time, drinking seemed more important than anything else.

Three other individuals spoke frankly about their alcohol misuse that broke up their own families. For example, Kate said that in her first marriage, it was her drinking that broke up the marriage; she noted that her husband did the right thing by divorcing her and moving their two young children to another town.

For the other four individuals, all women, both partners drank, and they socialized with individuals that misused alcohol as well. When they reflected on their drinking period, they all

agreed that drinking broke up their marriages. Sheri shared with me that her first marriage broke up because of drinking, as both partners misused alcohol:

“Uhhumn....it wasn’t just me or just him; it was both of us. We always drank...pretty much always drank together. Yea... (pauses)....pretty much, it has always been like that in my life. It never was just one of us.”

Her second relationship broke up again due to drinking. For Dora, Pam, and Anna their husbands drank as well. They also blamed alcohol as a major cause of their divorce.

Many of the participants never sustained marital relationships. Six of these individuals live alone as a direct consequence of their drinking. They reported they feel lonely and if they could reverse time, things would be different.

Kate had similar circumstances; her marriage ended in divorce and she lost custody of her two children. She expressed that her husband made the right decision, even though she was heartbroken at the time:

“...I lost my children because of my drinking. Uhmnnn.....and I believe my husband at that time did the right thing. Looking back in retrospect, it was best thing ...for my kids.”

She lives alone in low income housing. Her sister lives close by, but does not have much contact with her, again because of her drinking. For Adam, a big regret was he did not see his daughter grow up as his ex-wife did not allow him to visit.

Three older adult participants felt remorse that their children began to misuse alcohol. Dora’s family fell apart because of drinking, as both partners drank. She felt terrible that her children were exposed to drinking; one of her daughters had started to drink excessively. Jill, another participant, was worried that her drinking issues may have somehow contributed to her

youngest son's drinking issues. She hoped her children would not go down the same path as she did:

“I think my youngest son had some problems...with drinking. And because I was pretty blunt. Because I am suffering, you don't want to be me (pause), you don't want to get down that road. He stopped drinking”

Sheri described the pain she experienced when she realized that her son may be going down the same route as she once did. She added that it was this realization that was instrumental in her ceasing to drink alcohol.

In summary, the impact of alcohol misuse appeared to have been significant in personal/family relationships of my research participants. In some cases, marriages ended bitterly, individuals faced loneliness, missed out on children growing up, and in some instances, children of participants engaged in alcohol misuse. There appears to be a common thread across participants; many grew up in a drinking and abusive background, met and married another person with a drinking problem, drank excessively, were caught up in a cycle of abuse, and then had children who began to misuse alcohol.

4.2.5.2 Impact on social life.

Substance use is still looked upon as a moral weakness in society, creating negative feelings of guilt, shame, or stigmatization by those who experience substance use issues. It also creates a definite impact on a person's social life, particularly in an older adult's life. For example, it can cause social isolation leading to loneliness.

Five older adult participants expressed negative feelings at the time they were drinking. Tim experienced not only isolation, but also stigmatization because of his drinking. He stated it

was because of his drinking and that he isolated himself, but at the same time he also felt stigmatized:

Tim: "Actually there were people did judge me through my drinking.

I: In the community...In the society?

Tim: Yea, yeah, friends that said 'Tom you are going overboard'.

I: "They did...and that was not nice?"

Tim: "No, it hurt."

Penny led an active social life prior to getting involved in a major motor vehicle accident, one of the major contributory factors towards her starting to misuse alcohol. After a period of time she felt embarrassed and ashamed to talk about her drinking issues with her family members or even close friends:

I: Yeah. No, perhaps what...perhaps what I meant was- when you did realize there is a problem, like when you were going through detox and all...did you think...did you feel that your family was not judging you...not judgemental in their support?"

Penny: "Never thought about it. I just told them. First few times into....into, you know, through detox through one of the places I am staying; I didn't tell them because of....shame or...whatever, right...."

Adam, who has been abstinent for twelve years certainly felt stigmatized in his darkest moments. He was able to rationalize the reasons why people shunned him, however, this still hurt him:

Adam: Uuhhmn.....sometimes. Uhm....I can remember pushing my shopping cart down the street, and people coming towards me and...and they would cross the street- it used to hurt.

I: Oh, that's tough.

Adam: You know, I mean, it was not, I didn't never hurt anybody, you know.

I: But you were still drinking?

Adam: Oh, yeah, you know. I can understand....today...I mean, I totally understand, they would shun me. And, I was a mess and dirty, and I was pushing a shopping cart with a million cans and...."

Kate also narrated her experiences when she felt being shunned by family or friends. She blamed herself for a lot of her isolation and loneliness because she had let people and family down so often. She reflected that she may have pushed friends away because of her drinking:

Oh...my family....I had alienated them....my sister....we talk through... email....but she is very nervous about trusting me....being around. Because I....I've fallen down so many times or let her down. But it's...it's getting better, but I've lost....I don't have any friends anymore. Uhmnn....after J. my husband died...sort of people (pause) went away and.....that's probably may be because he passed away, and partly because.....I was drinking...again.

A number of the older adult participants such as Sheri, Pam, and Dora went out drinking with their spouses and socialized with those who also drank. When circumstances changed in their lives such as divorce and separation, they felt isolated and lonely. Sheri, who has been abstinent for some years now, does not have a social network as she and her husband, and later her partner, socialized only with people that drank. When she broke away from her second relationship, Sheri found herself alone. She noted that she does not have many friends, although her son and one daughter who live in town are close to her and she helps out with her daughter's children. Sheri commented that her daughter unfortunately, has developed a drinking problem.

While Jill's husband was away in another country, she started to drink. She felt socially isolated from her friends and family. She also felt that it was not her friends that stopped communicating; she blamed her loneliness and isolation on herself:

Jill: For me it was loneliness, but I made myself lonely by drinking and isolating.

I: So it's not that people stopped, it's you who isolated.

Jill: Yeah, I...I did it to a big degree to myself. And I....at the time did not realize I was doing it so much so, but....because....but I could see myself doing it, but I couldn't effectively....I did not want to stop doing what made me feel good, but I didn't want to continue doing what was making me inept.

Elvis, one of the key informants, observed that drinking is more of a stigma for women:

Elvis (sighs): We see more men than women because women have much more shame in their addictions.

I: And they may not know about them, the other family members, like they are secret....

Elvis: They are 'closet drinkers'.

I (nodding): Closet drinkers, so that may be the reason.

Elvis: Right, well, that is the reason, is that, they have to maintain the appearance of being okay. And, you know, so you might start seeing, you know, just aberrant behaviour, we might think it's just aging process, you know, Old timer's disease – or whatever- Alzheimer's, they are just, you know, mild senility- that sort of thing. But that could be alcohol use and quite often, these women die from falls. And..they have a fall, and they break a hip, and then they go to hospital.....

Quite often stigma, shame, or embarrassment prevents older adult population from seeking help. Most of the key informants agreed that it is uncommon for them to see older adults come through their offices of their own volition. Often, the referral came from the physician, and although uncommon, at times, the family members brought the client in for counselling. Most of the key informants agreed that quite often, families are ashamed, particularly in ethnic communities, and would seek help only when the problem becomes unmanageable. Dr. A commented that the lack of resources in our health care system, and the attitude that somehow it is their (older adults) own fault, adds to the stigma experienced by this population. Elvis, an experienced substance use counsellor, pointed out that, sadly, deep rooted feelings of shame and stigmatization in our community about drinking in the older adult population can stretch out even in death:

..... and they will be...you know, you'd see them in the paper- died of...of heart disease or died of stroke, or died of...you know, because the family won't even address the fact that they died of alcoholism. It is still is- died of old age, or....died of complications to the thrombosis or....coronary disease.

Thus, it is apparent that stigmatization about older adults' misuse of alcohol exists at multiple levels and can become a barrier in asking for help.

In summary, stigmatization, feelings of shame or being shunned, and social isolation were voiced by all of the older adult participants except the two ‘social drinkers’, Jim and Ron. They all experienced some levels of social isolation at the time they were drinking. Four of them voiced that their drinking caused not only their isolation, but they also felt ashamed, shunned, or stigmatized by their friends or society. Four individuals live alone and still feel isolated; two of these, Penny and Kate still drink, but Tim and Sheri have been abstinent for some years.

This observation forces our attention at how broad determinants of health such as social isolation, lack of education or training, economic status, and discrimination or a perception of discrimination can affect individuals’ lives. It is only then, by having an understanding of their thoughts and views from within the context of their lives, that we can direct their attention on the above mentioned social determinants of health and help empower them.

4.2.5.3 Impact on physical health.

Four older adult participants talked about how alcohol misuse impacted their physical health. Kate suffered multiple falls over the years and said she has broken almost every bone in her body. She now suffers from frequent black outs and memory loss, which she attributed to her repeated falls. She also lost a significant amount of weight over the years. She said her poor health keeps her isolated.

Penny has had repeated hospital admissions due to her drinking. About one year ago, she developed obstructive jaundice, for which she underwent a surgical procedure, as a direct consequence of drinking. She was warned not to drink again. She lasted only a few months without drinking. For Dora, it took an admission to the hospital with a stroke that stopped her

drinking almost two years ago. She has not used alcohol after the stroke because she was warned by her physician that if she drinks again, she will die. Jill, who started drinking later in life, said drinking caused hypertension. She did not eat very much while she was drinking and lost about thirty pounds.

In my study, most of the older adult participants denied frequent visits to the emergency department and were not admitted often to acute care, the only exception being Penny. Connor, one of the key informants, who is an acute care nurse, estimated that 20% to 30% of the older adults on acute care wards are admitted with alcohol misuse as the underlying cause for their admission:

Connor:They will be questioned in the emergency department, or even questioned once they reach the ward. Uhm....do you drink daily?...Sometimes that question kind of gets skewed, or missed- perhaps in the emergency department. They'd come up to the ward and it's discovered that they drink a bottle of wine every day. And so that would warrant them to be on the alcohol withdrawal protocol.

Only four individuals talked about health concerns at some point during their active drinking period. In fact, three of the older adult participants even expressed surprise that despite the heavy drinking, they were in good physical shape. As Jill put it:

.....I wish I had Bible on my hand right now, because I went and had....MRI...or CAT....scan on my...my organs and they are all fine. And I figured I had abused myself more than enough to ...have a little rotten liver there, and a little pancreas problem and....

The two 'social drinkers', Jim and Ron denied alcohol causing any negative physical impact. Jim laughed:

I: "...So did it ever impact your health?"

Jim: "Eh?"

I (louder): "Health – drinking? Did it ever have any impact on your health?"

Jim: "I didn't want to live past ninety, but I did (laughs)"

In summary, at the time of study, except for one older adult participant for whom failing health was obvious (due to multiple falls), participants denied suffering any serious or lasting negative physical consequences as a direct result of their drinking. This is somewhat in contrast to the high percentage of acute care admission of older adults with alcohol misuse noted by one of the key informants. Penny was the only participant who reported frequent hospitalization as a direct consequence of drinking.

4.2.5.4 Impact on mental health.

Although alcohol is a known depressant, it can also trigger or unravel any underlying mental illness. In my study, five of the older adult participants, all women, suffered from various mental health issues along with their alcohol use. Dora, who had a traumatic childhood and was diagnosed with depression in her younger years, was later on diagnosed with manic depression while still drinking heavily. She was certified under mental health act and hospitalized in a psychiatric unit on more than one occasion. Four other women suffered from depression and anxiety at the time they were drinking. Pam admitted that she suffered from depression and anxiety because of her drinking and a combination of other factors. Her anxiety and fear of her husband contributed to a hospital admission. Penny and Jill suffered from depression and anxiety as well. They both knew their depression and anxiety stemmed from misusing alcohol. Anna worked as a counsellor for First Nations' students at a Canadian University for a short period. After attending workshops on trauma and recovery, she discovered that trauma, at any age, if not dealt with, can show up in any form. She went through a series of trauma from her childhood to

adulthood, and realized that depression and anxiety that followed drinking are somehow related to her trauma.

On the subject of alcohol misuse and mental health issues, Elvis, one of the key informants, reported that women tend to have a higher incidence of concurrent disorders than men, at least in his experience:

...many of the women that we work with, are much deeper into their disease of addiction, and much more deleterious effects from the alcohol than men do. And...they have more often, a concurrent disorder uhh....than the men do....The water content and all that....hormonal issues as well. So we know that it does impact women much more significantly, specially in seniors. And....they....well, quite often have depressive disorders, and the...the anxiety disorders at that point. Quite often, these women will also be getting diagnosis of.....of Axis 2 – cluster B traits...

Rather than be embarrassed or self-conscious, all of the participants were quite forthcoming about their mental health issues.

In summary, five older adult participants, all women, suffered from some sort of mental health issues that were likely brought on as a consequence of drinking. One was diagnosed with manic-depression, and four women suffered from depression with anxiety. One of the key informants concurred that a higher percentage of women suffer from concurrent disorders.

4.2.5.5 *Impact on finances.*

Alcohol misuse, particularly if has been an ongoing issue, can impact anybody's finances. In older adults, it can become more of an issue as majority of older adults have limited income. Drinking on regular basis can cause a significant 'dent' in their finances. In my study, seven of the participants suffered significant impact on their finances as a consequence of drinking.

Tim is a heavy duty mechanic by profession. His drinking impacted his job as well as his finances:

Well, things got from bad to worse. After divorce and separation, I...went..... right off the deep end. I quit working altogether...just drank. Went on a point where just drank and drank...and drank. When money ran out –went back to work.

He retired at the age of fifty-one because of drinking. He lives in a group home on a very limited income. He regretted bitterly, but only in hindsight, his lifelong drinking. Two other older adult participants volunteered that alcohol had cost them heavily financially. Adam talked about being homeless and living on the streets for six years:

“...and uhh....the next....about six years of my life – I really spent living on the streets ofunder a bridge and....pushing a shopping cart, climbing in and out of dumpsters for food and clothes, and....you know....”

Adam has done well for himself since he stopped drinking and re-married.

Some of the other participants were not so forthcoming about their financial impact. They were willing to talk about it, but only when I asked a direct question. Five individuals live in low income housing and have limited income. Tim lives in a group home, and four women, live in low income rental apartments. Sheri lives in a low income rental apartment with a low monthly income. She admitted to having restricted finances only after being asked a direct question.

Anna, on the other hand, was quite candid about money. She lives with a partner and feels she does not have a lot of options:

I:Has it impacted you financially?

Anna: “Oh, definitely. I don’t get that much. If it weren’t for B’s (partner) uhhm...three pensions, we wouldn’t be able to make it. That’s why we have been struggling whether to separate or stay here, and uhh.....”

Four of the older adult participants in the study declared that drinking did not impact them financially. Two women, Penny and Jill are quite well off financially so their drinking did not have a significant impact on their finances.

The 'social drinkers,' Jim and Ron also maintained that alcohol had not had any major impact on their finances. Jim, the ninety year old logger, would not admit that alcohol could have caused financial hardships. Whenever the question came up, he was either defensive or simply ignored the question:

“Oh yeah, we were loggers and slobbers and yeah.....but in all....there was always food on the table and.....”

Ron at some point during the interview, admitted that the money he put in alcohol, could have been used elsewhere, he also complained of the rising cost of liquor over the years, but that was the extent of any financial worry for him:

Ron: Oh...of course, if I put the money I put into booze, into savings account, my retirement would look pretty good. But the same with the smoke, you know, it's dollar a day you could have been putting away, but now it's 12 dollar a day. Yes.....but I've always been able to afford alcohol. It hasn't taken food out of my family.

To summarize, the impact of long-term misuse of alcohol on the participants' finances was clearly visible in seven of the older adults. It not only impacted their relationships, but also their quality of life. Five of them live alone, in low income housing, and are on a very limited income. Anna lives with a partner, but has very limited options in how she wants to live her life. Adam, the only older adult participant who went through a period of homelessness, was able to pull his life together and is presently financially stabilized.

Notably, the participants that suffered financially had either traumatic and unstable childhoods, or troubled relationships later in life. Also, four of them did not complete their grade

school education. It was noted that only two of these seven participants had any training or education that enabled them to get good paying jobs; Tim trained to be a heavy duty mechanic and Anna studied to become a counsellor, but neither of them held jobs for any significant length of time.

In summary, negative impact of drinking on older adult participants in my study was noted on their family/personal relationships, social life, physical health, mental health, and financial life. Impact on their personal or family relationships seemed to be most significant, as most of them talked about it almost right away. Nine out of eleven participants talked about the issues in their personal lives such as divorce, loneliness, losing custody of children, or children drinking. The second important impact appeared to be on their social life or the lack thereof. Again, nine individuals shared their experiences of feeling isolated, ashamed, shunned, or stigmatized at some point during their drinking period. They were not embarrassed to talk about it, in fact, were rather forthcoming. Almost all of them appeared to have insight into the reasons for their isolation. They readily admitted that the isolation was created by them and not the other way around, regardless, they felt isolated, ashamed, shunned, or stigmatized within the society.

Financial impact appeared to be the third significant factor in this group as seven older adult participants experienced the stress on their finances because of their drinking. One individual was able to overcome it, but the other six participants still suffer from the consequences of drinking heavily for many years. They still live with financial restraints and struggle to make ends meet.

It was disclosed during the interviews that five older adult participants suffered from various mental health issues. Depression, depression with anxiety, or manic depression were the

three mental health issues mentioned by the participants. Alcohol misuse most likely was the cause, or unmasked the underlying illnesses.

It was noted, with interest, that only four of the older adult participants experienced any negative physical consequences, and only one participant suffers from long-term poor physical health as a consequence of drinking. The other three were in good physical health at the time of interview. Most of the participants expressed surprise that despite their prolonged drinking, they were in good physical health.

In summarizing life experiences of older adult participants in later years, each individual had a story to tell about their drinking, some of them being quite unique. However, they all had one common thread, all these individual stories were centered on their alcohol use; factors that influenced their drinking, their drinking patterns and behaviours, and consequences of drinking on their lives.

4.2.6 What has been helpful.

Thus far, there has not been sufficient research evidence to support what treatment modality or approach would help this population the most (St. John et al., 2010). However, older adult participants in my study narrated what has helped them in their journey of alcohol misuse. Under the subtheme ‘what has been helpful’, I have related their experiences about 1) an awareness of drinking as an issue, 2) family support that some of the more fortunate participants were able to receive, 3) support from the local mental health and substance use center, and 4) positive experiences with Alcoholics Anonymous (AA). For every individual these positive experiences were different.

4.2.6.1 *An awareness of drinking as an issue.*

A person will access help only when they are convinced that they need help, therefore, first, there has to be an awareness of an existing problem or issue. Several participants talked about having developed awareness of drinking as an issue because of the life experiences each one had while drinking actively.

Tim, who has drunk since his teenage years without any abstinence, did not seek out any help on his own as he did not consider it to be a problem. He agreed that it was his family that created awareness of the issue for him and then a warning from his physician added to it. For Sheri, unstable and abusive relationships created the awareness that her drinking may be the cause and this has helped her keep sober. She was quite open about it:

“...But it was drinking that broke us up and that’s how come a lot of the times I got abused too. If I wouldn’t have been drinking, I wouldn’t have got beaten because he never beat me up during the week, never...”

Three women participants reflected that one of the main factors causing awareness of drinking as an issue was when they realized their children began to misuse alcohol. Sheri is one of these women. She indicated she felt guilty that one of her daughters has started to misuse alcohol and that somehow she (Sheri) may have influenced her. For Dora, besides a broken marriage, it was the worries about her children following her suit that was a big contributory factor towards seeking the help:

“...I thought, I was sick and tired of my actions and embarrassments...things I do when I drink. And I had three kids, and I didn’t want to give them the same life (cries)....that I had....they deserved more (cries)....”

Unfortunately one of her daughters suffers from alcohol misuse issues.

Besides these two women, Jill was dismayed to learn that one of her sons had started to misuse alcohol at the time when she was drinking heavily. Kate, who has misused alcohol throughout her life, realized that drinking has impacted all aspects of her life negatively. She lost her children to her husband, lives almost on the poverty line, and has an extremely poor physical health as a direct consequence of drinking. She reported she has broken almost every bone in her body due to frequent falls.

I: But sometimes you must feel like drinking...

Kate: "Not, not lately. I mean it goes through my mind but I follow..... through....now....because I know what the consequences are going to be. Because I black out....really fast now and....I get so ill and I am scared of falling down again. I am breaking something....I deal with a lot of pain....physical pain...and.... ahh to deal with that. Uhh....my eyes are really bad. Uhn.....just different things I have to deal with and....and I don't want to drink, but I want just....."

For Pam, it was the shocking realization of her inappropriate behaviour with her brother-in-law that finally stopped her from drinking.

In summary, there were a number of factors identified by different participants that created awareness that drinking has become an issue. For one individual it was the awareness of instability in relationships, and yet for another, it was his family that created the awareness. Three women became aware that their children had started to misuse alcohol. One participant was wary of continual drinking because of broken bones acquired during intoxication and another expressed extreme remorse that her drinking had led to sexually inappropriate behaviour, which eventually also became the deciding factor for her wanting to stop misusing alcohol.

4.2.6.2 Family reconnections.

Most of the older adult participants talked about having a better relationship with their loved ones when they stopped using alcohol. Most voiced a desire to continue these behaviours. Tim's motivation to remain sober stems from his wish to have better relationships with his sons and grandsons:

I: That's tough eh?.....because I am thinking that you would need some kind of support or counselling and all that....What do you think though...what may have helped you not drink....other than the part of seeing grandchildren?"

Tim: "That was mostly...seeing the grandchildren over the next while....see the grandchildren grow up....."

Pam has developed a good relationship with her two sons and even baby sits her grandchild, which makes her very happy:

But I am so happy to be drug and alcohol free, and living a clean, sober life for my kids, and for my grandchildren (voice quivering)...because.....uhmmm my grandchildren are so young that they....they will never know that I drank or used drugs (voice breaking).

For Dora, her family too is a reason to abstain from alcohol:

I: But when you were with AA, I think.....was it only the AA that helped you? Or was it like a friend, or some social support, or family support?"

Dora: "Well.....no, it was family support, it was everybody around me too they were.....damn proud I wasn't drinking anymore."

Additionally, Jill also stated she feels supported by her spouse and children now that she is trying to quit drinking.

It is apparent that family reconnections appear to be meaningful for those older adult participants, for those who were lucky enough to sustain them.

4.2.6.3 Accessing resources from local mental health and substance use center.

Eight out of the eleven older adult participants were connected to the local mental health and substance use center at some point during their active drinking period. Five of these suffered from concurrent disorders and were being followed by substance use counsellors. Six had been under a psychiatrist's care infrequently, and three individuals still saw a psychiatrist on regular basis. According to most of the participants, the time for individual counselling by substance use counsellors has been reduced significantly in the last few years due to financial restraints, but none of them expressed concerns. Those who wished to have more structured help were involved with various group activities. They did not appear to mind coming to the mental health and substance use center or other designations for these group activities.

Those individuals who were provided with basic needs such as housing, food, and other social determinants of health along with addressing their substance use issues by local mental health and substance use center, fared better. Tim's counsellor not only counselled him for his alcohol misuse, but helped him with finding housing as well. The counsellor had been trying to connect him with other community resources at the time of our interview. Kate lived a lonely life and still struggled with drinking issues. Her substance use counsellor assisted her by being instrumental in finding her low income housing, and she was also being supported by a life skills worker for other activities. Sheri is another person who was helped by her counsellor to move to an affordable apartment. She indicated that she felt valued and supported by her counsellor. Additionally, Sheri is supported by life skills workers as well, who provides transportation and accompany her to various activities such as swimming or other self-efficacy groups.

4.2.6.4 Help from Alcoholics Anonymous.

Out of the eleven older adult participants, eight talked about their involvement with Alcoholics Anonymous (AA) at some point at the time they were drinking. For three individuals, the biggest and lasting support came from AA. Dora, who has not touched or used alcohol since her stroke two years ago, has a very interesting story:

Dora: No....ahhh....some weird things happened. First time I ever know about AA was in And I was ...our friends and our neighbours were Christian ministers, and she knew my husband and I were having a turmoil in the marriage, was drinking all the time. And all of a sudden, an AA book landed in my backyard, and I opened it, what's this God thing (laughs).

I: (softly): And that was the beginning?

Dora: That was the first. That was the first time, and that was probably the beginning, and I got down on my knees with them and....ask....asked Jesus into my heart....and I think my life started changing from then..I was able to quit ahh.....by....AA. I have to give...them....all the credit...and knowledge in the book.

Pam, who was introduced to me by Dora, also gave all the credit to AA for supporting her and helping get over alcohol misuse. She does not have friends outside of her sponsor and other AA friends, similar to Dora, and does not seem to mind:

Pam:and then I had a friend that I used to work with, and she was in AA. And she told me about a meeting made by my house so went by myself that night and....I don't remember much of the meeting and I was in a....heck of a state. I didn't weigh very much because I wasn't eating properly, using nat and nap and drinking, and.....I was really... really skinny and I looked just awful but I knew I needed help so I went to AA by myself, it was close to my home, and I've stayed with that group. I've got a good sponsor.

Adam is another older adult participant who has been abstinent for many years. His initial involvement with AA proved to be short lived as he went back to drinking. He lived a difficult life on the streets for the next six years, misusing alcohol and injecting self with methamphetamines. His re-involvement with AA as a part of the rehabilitation that he was

mandated that he attend has proven to be lasting. He admitted it was not easy; he has become an advocate for AA and is quite open about the positive impact AA has had on his life. He also sponsors a number of people. He thinks that keeping connected to AA and people who have had similar experiences is the key to keeping sober.

Two older adult participants, Jill and Penny, admitted that AA has been useful for them, but that it was just one part of their rehabilitation. Kate became involved in AA some years ago in an on and off capacity, but indicated it did not really help her. In fact, ironically, she met her second partner at one of the AA meetings, a relationship that proved to be extremely destructive for Kate. While talking about AA, she said she does not like to go to AA now, primarily because of her deafness.

In summary, four positive outcomes emerged under 'what has been helpful': 1) family reconnections, 2) an awareness of drinking as an issue, 3) accessing resources from local Mental Health and Substance Use center, 4) help from Alcoholics Anonymous.

Those participants who reconnected with their families felt strongly that they wanted their relationships to become stronger rather than lose them because of drinking again. They already regretted the years that they lost. Support from AA to all those who accessed it, had been a pleasant surprise, as it is often assumed that older adults do not feel comfortable with younger people around them. However, point to be noted here is, all those individuals who accessed AA were part of the 'baby boomer' age group, therefore their outlook may be slightly different. Three of the older adult participants gave full credit to AA to help them stop drinking and not relapse. They have continued to go to AA and have become sponsors themselves. Two individuals accessed AA, but not as their primary or the only resource, but rather, as a part of

their rehabilitation process. Most of the older adult participants accessed resources from the local mental health and substance use center for their substance use issues, psychiatrists' follow up, group activities, or help with the social determinants of health.

4.3 Barriers to Help Seeking

Older adults often come across difficult situations that create barriers for them in accessing health care or seeking help. These barriers may be physical, psychological, or emotional. The second theme I identified is about experiences or situations that my study research participants perceived as barriers to health or help. The first barrier identified was a denial or an unawareness of drinking as an issue for some of the participants at the time they were using alcohol. The second important barrier experienced by most of the study participants was the feelings of discrimination at the primary care level, at substance use treatment level, and at the policy level. A third important barrier presented itself in terms of older adult participants' beliefs about drinking. Most of them blamed their circumstances for their alcohol use rather than accepting the responsibility, and also, they believed that alcohol was in their genes, so the outcome (alcohol use) could not have been any different. The last barrier experienced by the research participants was their feelings of resentment, shame, or pride, again, in a large part, due to their age.

4.3.1 Denial or unawareness of substance use issues.

When inquiring about their beliefs with regards to their alcohol use, it was apparent that a number of older adult participants had no awareness of drinking as an issue while drinking excessively. At least five participants, at the time of the interviews, denied they had an issue with

substance use. Two of these were abstinent at the time of interview. Sheri, abstinent for almost twelve years, believed that although she went to the bars, drank excessively, and exposed herself to dangerous situations such as hitchhiking, she did not have substance use issues. Tim, who is presently not drinking, reminisced that despite a warning from his physician, he did not consider drinking to be an issue, at least not for a number of years. For two participants, Ron and Jim, alcohol use has always been only a 'social thing.' Ron, sixty-five, still actively engaged in the workforce, did not think he has a problem with alcohol use despite the concerns voiced by his partner:

Ron: (raises a hand)...call me an alcoholic as I drink every day.

I: I'm not sure....it is what you think about it. Do you think you are an alcoholic?

Ron: I knew this was coming...

I: No, no, no. Excuse me Ron. No, not at all.

Ron(cuts in): Do I think I am an alcoholic? Well, I guess...

I: That's the most important thing.

Ron (continues): Yea, I don't think I am. However, in terms of....the terms of being an alcoholic, I could be concluded that I am an alcoholic. If you have a....have...have a cigar around the campfire one time....two times a year, and if you go for Life insurance and they say to you 'do you smoke?', and you say 'well, I have the odd....cigar...maybe when I am camping...' all of a sudden, you are a smoker. There is no fine line. So....two or three beer a day...could make me an alcoholic, but I don't feel that I am...I don't wake up craving booze...I....I don't need it, but I enjoy those different flavours that I'd go to the liquor store and buy.

Jim, ninety, and still living in his own home (with the help from his daughter), was happy to be interviewed by me, but appeared genuinely perplexed whenever I broached the subject of alcohol as an issue. He was happy to be engaged in conversation with me, and recited several poems that he had written and had recited for most of his life in any social gatherings. In fact, sometimes, those poems were often the only source of entertainment for that evening's social gathering. The content of every single poem was on binge drinking and the after effects. And yet, he was clearly bewildered when I inquired if there ever was a concern around drinking. On a

couple of occasions, he just ignored the query; instead, he started to recite another poem. At one point, he explained to me that according to his physician, drinking was good for his health.

Robin, one of the key informants has been a substance use counsellor for over twenty years. He endorsed Jim's view about drinking that, in good old days, drinking was a way of life. He reminisced that his uncle and aunt whom he liked very much, drank routinely, sitting in front of the television:

...But that was a pretty normal routine for them, to sit in front of the TV at night, and just relax and have a few beer. But you try to take it away from them and they would be very upset. If you tried to indicate to them that may be that was getting to be too habitual, they would get pretty upset as well...that was just part of their life style.

Unawareness of drinking as an issue, at some level, allows an individual to drink as much as they would without feeling guilty as in case of Ron and Jim. Neither of them wanted to be labelled as an 'alcoholic'. However, where Ron was quite willing to talk on the subject, Jim was uncomfortable talking about it. However, he was defensive just as Ron was.

Anna, who currently uses alcohol, did not think she has a substance use issue. She had used alcohol in her younger days, but since she retired, has started to drink heavily. When I asked her if she had considered going to AA she said she was not sure if she has a problem or not; *"Yeah, I still haven't.....committed myself to saying that I have a problem and....."*

On the subject of denial, some of the key informants had very important information to share. Robin explained denial has little to do with age, as there is denial of substance use in any age group. He further explained that denial works as a coping mechanism for people, in fact, this is how they (older adults) deal with stressful and difficult times. Jay, one of the key informants

explained that if a person is not even willing to admit there is an issue with their drinking, there is no motivation to change.

Several of the key informants felt strongly that, unfortunately, denial of alcohol use in this age group exists not only at an individual level, but even at a higher societal level. Family members, friends, and health care providers tend to avoid identifying or simply fail to identify drinking issue in older adults. Elvis gave an example:

.....So, you know, I have worked with some Indo-Canadian men that....were alcohol abusers and they were going to....They go for the walk, they go out for the morning walk and not come home. And they start to get that Alzheimer's diagnosis, but they are just so grossly intoxicated – they just don't know how to get back home, right. So, everyone says, 'oh, you know, we've got to keep, you know, better - you know, control at grandpa there, because he is wandering and getting lost all the time. Oh, no....he is drinking.....

In Elvis' opinion, society seems to have a tendency to want to protect the older adults because of their age. He feels this tendency is a matter of concern as there is a big element of ageism involved. Robin talked about the attitude of law towards older adults:

I: (laughing) you know I was just picturing this senior gentleman being stopped by cops and picked up on drunken charge and thrown in drunk tank.”
Robin: “You know...a little bit more. You know age brings in another aspect; I think we are a little bit more patient, a little bit more mercenaries toward elders. So if you were a policeman and stopped...you know a senior that was in his late sixties or seventies, going down to liquor store to pick up a bottle of sherry for example, chances are, you are not going to be as quick to haul him off to a drunk tank (laughs), you do want to make sure he gets home safely, but you are going to be a lot more patient and compassionate towards him...I suspect.

Robin further pointed out:

Because of their age, you know it is....and maybe we are not clear on that, It is like we....have a different perspective on seniors. We tend to overlook the fact that may be they do have a drinking problem, and we are also colored by the fact that sometimes we have an attitude that perhaps they deserve to have a few drinks....you know.....they worked all their lives, so they deserve it. But you know we don't necessarily stop to look at some of the consequences.

Dr. A, a physician with a speciality in substance use issues, commented; *“I think a lot of the time, it just goes unrecognized because nobody asks grandma why she drinks so much at Christmas.”* She also observed that, at times, substance use issue may go completely un-noticed by the family. She gave an example of an East Indian gentleman:

.....He moved towhere there are no dode (opium). And then he was using T3s and he was taking them out of the medicine cabinet at home, and then he started drinking. And when I saw him, he was in the emergency room in severe withdrawal from dode (opium) and.....T3s, because he ran out. But his blood alcohol level was quite high, and he is a frail old man, and you know, not anybody that you would see at the Gurdwara (Sikh temple) and say, you know Oh my goodness this guy must be an alcoholic or on methadone. No, why would you think that? He is seventy five.

She further commented that often alcohol issue never comes up in the primary care setting. At times, she may get a referral after a patient has had a seizure in the recovery room after an elective surgery, as no one has even asked the person about their drinking. It is quite evident that older adults, their families, or society as a whole may not acknowledge or recognize that a problem exists.

Summarizing, a denial of substance use issue exists at several levels; at an individual level, at the family level, and even at the societal level. According to some of the key informants, there may be an element of ageism in how an older adult’s alcohol use is viewed by the society in general. It is often observed that the society holds a different view of older adults who have alcohol use issues as compared to their younger counterparts. This distinction starts at home, and then goes up to higher levels where we, as a society, indulge our older adults. One can see because of this indulgent or ageist view, alcohol use as an issue with an older adult can be easily missed at a primary health care setting, as Dr. A has pointed out.

4.3.2 Feelings of discrimination.

Most of the participants felt discriminated on several accounts. They voiced their physician's lack of time and interest in their concerns. They reminisced about the change in health care policies in their region several years ago that diminished the importance of services to older adults regarding their substance use. Some of the participants, who voluntarily or otherwise entered various treatment centers to get over their substance use issues, found they did not have any support or services to sustain their abstinence once they returned to their community.

4.3.2.1 Physicians not interested.

Ron, one of the older adult participants, felt that physicians are not interested enough to pick up and discuss an issue such as alcohol use with their older clients. They may see their patients often, but the subject of alcohol misuse does not come up:

Ron (emphatically): No. No one has said that (addressing drinking). My physical check-ups are generally pretty good. I think, I...my blood pressure is getting up there as I get older and with my last exam which...was three years ago, uhh...but no one has said that you've got to cut booze out."

I: "Your doctor hasn't said that?"

Ron: "No, he has not.

Ron felt sad that the 'good old days' of physician visiting people at homes is a thing of the past.

He said nowadays there are no 'family doctors', what you have is a doctor:

Ron: Well, you know who has got a doctor these days. I had a doctor when I lived in...when I was working in New Westminster. No one has really got a doctor these days. It's not like the guy comes to your house when you are sick, with the black bag and....

I (adds): 'Asks you all kinds of questions...

Ron: Yeah, yeah. Now, now...doctors....doctors don't know you. They may ask you a question and you could tell the truth or you may tell a lie, but they don't know who

you are. Yes. A doctor – J. when I was growing up – he was the family doctor, lived in the...worked in the shopping plaza – on the other side of where I lived. And he knew...he knew people. He'd come to the house when you were sick. Nowadays, nobody has a family doctor. You have a doctor you see, but they don't know you.

Dora felt her physician was not supportive of her and even seemed to distrust him. None of the other participants mentioned having any conversation with their physician about alcohol use or misuse.

A number of key informants admitted that alcohol misuse in older adult is not being identified at the primary care level. According to Dr. A, the reasons are multifold; family physicians feel uncomfortable broaching the subject of alcohol misuse with their older clients and they feel they do not have time to document or communicate with other specialists about this particular subject:

I: So the problem really lies at the primary care level.”

Dr. A: “I would say that's one of the reasons it is hidden. It's because family doctors don't know what to do then when they open that can of worms...right? They don't want to open up that can of worms.”

I: (nodding) Yes.

Dr. A further explained that one of the other reasons is physicians are not trained to screen for alcohol misuse or how to broach the delicate subject with their older clients:

....Because the physician doesn't know that you should screen, and that one should do talk to them. He says you know what you should really stop drinking...because physicians are not trained in what to do. We don't learn in....we are starting to now, but we don't learn it in medical school. We don't learn it in residency, because most of our training is done in hospital, right? It's done in hospital and even in a family practice residency, if you are interested in addictions, you will go and get an elective....or do whatever....

It was voiced equally by the older adult participants and the key informants that there is a lack of physicians' involvement in addressing the alcohol use issue in older adults at the primary

level of care. This may be due to a lack of proper training and/or age specific assessment tools besides a lack of time.

4.3.2.2 *Changes in health care policies.*

Adam, one of the older adult participants commented about the changes that occurred a few years ago in the health care system in British Columbia, and how those changes impacted him and other recipients receiving services:

Adam: I've been here long enough to see some things happen. I...I've been here long enough to see some of the changes in health care as they've happened."

I: "Like?"

Adam: "Oh, several years back, health authorities took over addictions from....people that were really knowledgeable and skilled with addictions, and all these people who don't have knowledge about addictions, took it over, and a lot of the programs that were there to help addicts and alcoholics went away.

At least two of the key informants, both of whom have worked with substance use issues for over twenty years, were critical of the changes that occurred at the policy level. Both of them strongly felt that substance use portfolio should never have been integrated with mental health services. Jay, who worked for years as a substance use counsellor before the merge, felt that older adults who have substance use issues may feel stigmatized or embarrassed to access these services, as now there is an additional stigma of 'mental health' attached.

Robin, another substance use counsellor, brought up a very important observation while talking about the policies and cut backs in the health services. He pointed out that the limited resources are causing an impact at the community level where the services to older adults are not being offered:

Because, by large, I think there has been cut back in the resources, and probably there are not a number of home visits, whether through us or some other

caregivers, there aren't probably the home visits that used to be carried on. So, I think it is a lot easier for seniors, particularly who are living alone to be back there and are not getting the attention that they need, particularly if there is a drinking issue and may be....maybe they are not getting out to their doctors as often as they ought to because of the drinking. I think they are afraid or ashamed of talking to their doctors of this possible addiction issue, so they tend to just stay home. And if they have health issue, they probably tend to avoid it for far too long.

Hanna, who is a substance use counsellor, also acts as case manager for a number of older adults who have alcohol misuse issues. She not only counsels the clients, but also helps them find appropriate housing and other community resources. She expressed her concerns that funding is not adequate for the key resources such as the social determinants of health:

Or.....it....and this is unfortunately where I step into my new role of harm reduction – is all of our resources, and this is the policy part or the government part. If we are putting seventy percent of our....resources, and our funding, and our money into....things like protection, and RCMP, and jail systems, uhm....we are absolutely putting the funding in the wrong places...

It was strongly voiced by both the participants, as well as the key informants, that substance use and mental health should never have been merged under one portfolio as it somehow negated the importance of substance use issues. This change was felt to be a cause of diminished funding, expertise, and resources that were much needed for older adults. Two other key informants also felt strongly that there is not adequate funding or policies around addressing the substance use issues as a whole. At the policy level, government needs to address not only the issue of more age appropriate resources such as individual counselling, but also the health determinants such as basic needs of food and shelter, social support networks, and education specific to community dwelling older adults with substance use issues.

4.3.2.3 Treatment centers did not help.

Four older adult participants disclosed that they had entered treatment centers on more than one occasion in an attempt to ‘clean themselves up.’ None of them were successful, as they all went back to drinking. Tim disclosed that the only reason he entered the treatment programs was because of the pressure from his family, but it did not help:

“I stayed in one (treatment center in Vancouver) for a year, and I stayed in another for a year....oh seventeen months. But when I got out, I went back to drinking again.”

Kate, who has been drinking since her youth, was admitted to a treatment center in Vancouver when she was a teenager as she used to cut herself. Later, when she was drinking excessively, she went through detoxification center on several occasions. These multiple admissions obviously did not help her as she still uses alcohol. Jill talked about going into a three-month treatment program, but she went back to drinking after a few weeks. The other participant who entered treatment centres on a couple of occasions is Penny. She found it to be expensive and the treatment did not appear to help. All those participants that entered treatment program felt that it was too costly, and secondly, there were no services or follow ups in the community to sustain their abstinence when they returned back home. They all went back to drinking.

4.3.3 Beliefs about drinking

The participants in this study expressed certain beliefs about their drinking that may depend on a variety of factors such as their upbringing, background, or education. Above all, these beliefs were formed by their individual life experiences. Two beliefs about alcohol use that

emerged were; 1) blaming the circumstances or not accepting responsibility, and 2) (alcohol misuse) an inevitable outcome due to genetics.

4.3.3.1 *Blaming the circumstances, or not accepting responsibility.*

Not uncommonly, people with substance use issues find it easier to justify their actions by blaming their circumstances, or events that happened in their past. Five individuals blamed their drinking on their own circumstances. Penny blamed it on her chronic pain after a major motor vehicle accident, Dora stated she drank to stop the pain from her traumatic past, and three of the older adult participants blamed their spouses for their excessive drinking. Tim actually blamed his ex-wife for his excess use of alcohol because she did not stop him; *“If she had put her foot down it probably would have helped.”*

Anna divorced her husband when her children were very young as she could not handle her husband’s alcohol misuse and the abuse that followed. She disclosed in her interview that she did not have any desire to go out and drink and that she was quite content looking after her two boys, but that her husband forced her to go to the bars with him:

Yeah...(still laughing)...and I told....my...my...The kids’ dad was a heavy...heavy drinker. He worked out of town. He would come home for five days or so and....(sighs)...uhnnn....he hit the bars first and....pretty soon he started asking me to go with him, and I kept saying ‘no’; children were still small. And he would say to me –why...why? Do you think you’re too good or something? Like that.....you know, put me down for not drinking. So I started to drink with him...

Pam stated her husband was her enabler. As she did not drive, she would ask him to go out and grab a bottle of beer; he would go to the liquor store and bring back a six-pack of beer. She would always drink it all:

Pam: ...and ...in the end of my marriage, uhmm....I was drinking heavily. He'd keep bringing me alcohol and...

I: Who? Your husband would keep bringing you alcohol?

Pam: Yeah, every time I asked him for some beer, he would go out to his car and bring me in an eight pack, or case...and I would drink them all, and then he was leaving alcohol in my home, and then I was drinking whatever....there was after the beer was gone, and blacking out.

4.3.3.2 *An inevitable outcome due to genetics.*

At least four older adult participants believed they never had a chance, as drinking was in their genes. They grew up where drinking was a part of their daily lives. Their parents or other family members drank, so, to them, it was natural that they would follow in the same path. Pam, who is abstinent at present, is convinced that the course of her life could not have been different as she has the 'alcoholic genes.' She gave me the explanation about how she knew this 'to be genetic because she blacks out whenever she drinks':

Pam: Yeah...I could have....uhmmnn...I don't know like....for me, I always knew I was alcoholic right? Just because I blacked out, and everything...in my teens.

I: How do you mean that you knew that you were an alcoholic?

Pam: Because if you black out....that makes you an alcoholic.....

Anna, who has had a university education, worked as a counsellor for youth in Vancouver, facilitating workshops such as 'self-esteem', was convinced that her alcohol use issue was something that was inevitable because of her genes:

"Well, my family began to think I was having a problem. I...we come from a dysfunctional family and many of them...uhmnn....and many of them used to drink...."

Dora and Kate also believed that their misuse of alcohol is due to genetics and that it would have led them to the same fate, no matter what. Beliefs such as above create barriers to accessing any kind of help. Looking at these individuals' background, it is evident that these

beliefs were not formed overnight, but are rather a culmination of variables such as being raised in an unhealthy (drinking) environment, lower socio-economic status, low priority on education, poor family structures, lack of social resources, and limited life opportunities which carry on from one generation to the next. These variables contributed to shaping these individuals' thinking process, attitudes, and the life choices they made.

4.3.4 Resentment/pride/shame.

Two women participants were resentful of their husbands as they did not support them in their decision to access AA. Both of them had the same complaints that their husbands were jealous of other people shaking hands or hugging them. Dora blamed her husband for her relapse the first time. She said that her husband did not want to socialize with her AA friends, and that he was jealous:

Dora (emphatically): Yes, and he wouldn't socialize, he wouldn't mix with them, he wouldn't do family events, (continues): ... plus my husband was very jealous....and everybody shaking hands and hugs, and the warmth...and he was jealous and he...his fear....it was just too much.....so I chose...(difficulty to continue)... to quit AA. But I...I didn't choose to go back drinking. I stayed sober for twenty seven years (voice breaks).

Pam had similar experience. When she wanted to join AA, her husband took her there for the first few times, but then he did not want to drive her there anymore. Neither of these women has ever had a driver's licence:

“... He (husband) took me to one AA meeting, and then he told me that he would never drive me. He didn't want other people hugging me and....he didn't want me involved in AA....”

At least three other women participants expressed feelings of pride, shame, or resentment that was a barrier to their asking for help or accepting it. Jill readily agreed that when she did

realize there was a problem, it was hard to admit it, and even harder to accept help. She explained it:

“And...and it took me a long time to say I can’t do it, and I need help, and I...I am very.... realizing I am a very proud. I never asked for help”.

Penny, who still uses alcohol, said she found it hard to ask for help from her friends or family for support even though she was close to them and they were aware of her issues with alcohol use. In her conversations, it appeared that it was a combination of pride, shame, and embarrassment:

.....So, right at the moment, I have actually kind of pushed my friends away....because of the shame, and they don’t.....you know, it’s like....after a while they don’t want to hear when I am drinking, sober or drunk, right? So, yea, because, you know like; what’s Penny up to now? Is it a sober week or is it a drunk week, right?...

Anna also felt it was difficult for her to ask for help because of pride and shame. Jay, one of the key informants, supported the barriers experienced by the above participants. He said that his experience about substance use issues in older adults has shown that often older adults like to keep their problems to themselves:

....The other barrier is....I think....is the stimulus, or the belief system that, you know, when you hear all the time don’t....you don’t air your dirty linen in public, you know. And if they come out of that kind of a structure, you know, where.... or say their parents were alcohol addicts, know they work on; don’t trust, don’t feel, you know, don’t talk.....rule, and they’ve kept that all their life, so they’ve kept all the stuff bottled up inside them, so I mean there are all kinds of things, like that.

Five of the older adults, all women, talked about pride, resentment, and shame as the barriers they experienced in accessing or accepting any sort of help.

In summary, four subthemes emerged under the theme ‘barriers to help seeking’; 1) an unawareness of drinking as an issue, 2) feelings of discrimination, 3) belief about drinking, 4) and pride/resentment/shame.

The most voiced concerns were around the physicians’ role, or rather the lack of it, pertaining to older adults. One of the key informants commented that the physicians do not have the time, but also, they do not feel comfortable broaching the subject of drinking with their older adult clients. This obvious gap at the primary health care level points at a possible ageist view. It was strongly voiced by the participants, as well as the key informants, that there is a need for primary health care providers to have knowledge about substance use, have age appropriate tools for screening, and have a useful dialogue with older adults around these issues.

Another significant barrier observed was the change of policies at the provincial health care level some years ago when it was decided to merge substance use, which used to be an independent portfolio, with mental health. According to the participants and some of the key informants, this change significantly decreased the access and resources for clients with substance use issues. They also felt that this change in policy undermines the importance of adequately addressing substance use issue and that the government needs to revisit this situation again in order to provide better resources for substance use issues, particularly for the older adult population. Those participants that accessed treatment centers felt there was no follow up for them when they returned to their communities, often resulting in a return to misusing alcohol.

The two beliefs about drinking expressed by some of the participants indicate their lack of education among other factors. Looking at this issue through a critical lens, it is evident that in order for this population to make any informed choices, first and foremost, there needs to be

education and information available not only to the individual, but to the community at large, creating an awareness about these issues, as well decreasing stigma (McCabe, 2011). For example, the belief by some participants that because problematic drinking is genetic, their outcome could not have been any different, the battle is lost for them even before it started. It is apparent that there is already an existence of power imbalance and social conditions of inequity that were likely created through generations, which generates the feeling of inevitability or non-desire for a change in their (participants) lives. A nurse's role here is not only to educate the individual, but to question the social order and serve as a catalyst to empower the individuals in order to bring a change.

The other barriers mentioned were more at personal levels such as the older adult participants' own feelings and views about their drinking issues that included pride, resentment about not being supported by family, and shame. These feelings were expressed as the reasons that created barriers for them to access help or health. Lastly, it is definitely a barrier to accessing help when one is not ready, or can even acknowledge that they are drinking excessively, and that their drinking may be considered an issue. Some of the older adult participants in my study did not acknowledge their drinking as problematic, therefore, they did not feel the need to access any help. Certainly an unawareness of drinking as an issue is a barrier to accessing help of any sort that again speaks to people's attitude at a personal as well as at a social level. Thus, as in Jim's case, the ninety year old logger, it was a combination of the region, era, and culture of that particular grouping that did not consider alcohol use to be an issue.

4.4 Changes to Promote Help Seeking

The third theme was developed around what could be beneficial towards helping the older adults who have alcohol use issues. The participants in my study were quite vocal about the changes they look forward to that would help themselves and other older adults in the community. Three main subthemes that emerged under this main theme were; 1) more support from the community in terms of helping with their social determinants of health, more social activities, and support with issues such as decreased mobility, etc 2) education to primary health care providers that is specifically geared towards dealing with older adult population with substance use and providing age specific screening tools for the same, and 3) more resources should be available at the level of the health authority that are specific to the older adults with alcohol misuse issues.

4.4.1 Support from the community.

Two older adult participants, Anna and Penny live with room-mates. They both mentioned that living with someone not only makes the loneliness tolerable, but also helps them to abstain from drinking, as their roommates do not drink. They both attend various groups related to their alcohol use issues and mentioned there could be more support available to them in the community. Tim, who lives in a supported housing, mentioned that support from the community would be beneficial.

Some of the key informants impressed upon the importance of having more support in the community as well. Hanna, a substance use counsellor and case manager, stressed the

importance of a community network to support people who suffer from substance use issues and who are lonely:

Uhm...isolation...I think...unfortunately...is a lot of times - if they don't have healthy family,..... So, that lack of support in the community, that isolation....that lack of connection with community organizations, family members, other people. Uhm...and then the substance use basically consumed all of their life style, and then their health, and then they ended up at my place. So, a lot of them had nothing – food, nutrition is the other big thing. So, they didn't have proper....ability to...make meals for themselves which would deteriorate their cognitive functioning as well.

She also stressed the importance of addressing the social determinants of health in the older adult population that misuse alcohol, as well as connections among various organizations to accomplish the same. She admitted that she worked unconventionally and helped her clients obtain housing, food, and connections in the community. She discovered that she was 'headed in the right direction' as far as helping substance use issues were concerned:

....it's not appropriate that they (older adults with alcohol use issues) are in.... the hospital. So, that's where the larger system needs to look at that prevention. Like, I...I firmly believe its a lot cheaper to provide subsidized housing than to have someone in acute care, or the jail system. So, unfortunately, our resources are all divvied up and....uhm...unfortunately, we don't have that preventative kind of housing mechanism right now. But that's where, potentially, I think things will help a lot. And it would be cheaper, and the prevention investment..... traditionally, working with substance use, what I should have been doing is counselling for the substance use, treating the substance use, and....and....focusing on the substance use. Uhm...I was doing...just what you said – the social determinants of health – addressing those. And what happened is when you start addressing those, then....the substance use went away, or wasn't a primary concern anymore because you are linking them with other things. But uhm...result in health. So, with health care system, I'd say you....you can't do it alone...

It was observed from the above conversations that older adults whose basic needs are met and who are supported in the community, fare better, and have better chances of being abstinent.

4.4.2 Improved access to health care providers/age specific tools.

Most of the older adult participants felt their physicians were not interested or did not have time to discuss an issue such as alcohol use with them. It was expressed by most of the older adult participants that they should be able to have easier access to a primary health care team in the community where they feel respected and valued. Two of the key informants addressed the issue of screening at the primary care level. Carol, the multicultural counsellor, said she often struggles with how to start the conversation around alcohol use. Having a screening tool at hand avoids those awkward moments:

Carol (cuts in): I think when we do our initial assessments....to....have that...you know, that CAGE (one of the screening tools for alcohol use). That would be one suggestion – to have that as a part of an initial assessment.

I: For all health care workers?

Carol (nodding): “For all health care. Yes, because then, you, right away.....you are asking....you know, how many drinks have you had...rather than.....

Dr. A also talked about the need to have a screening tool for substance use issue in older adults leading to an early detection and intervention. She talked enthusiastically about a screening tool that is called SBIRT (screening, brief intervention, referral to treatment) that is being used in the United States. She noted this tool would be very useful for physicians at primary care level. She also addressed the need to start the education on substance use issues at least at the residency level:

Because the physician doesn't know that you should screen, and that one should do talk to them. He says you know what you should really stop drinking...because physicians are not trained in what to do. We don't learn in.....So I think there is movement...but we are not there. We need to be starting at this....rather than....at the...the residency level.

If the primary health care team is better equipped about substance use issues, particularly in older adults, and have the screening tools available, a much larger number of drinking issues in older adults could be identified.

4.4.3 More resources should be available.

Most of the older adult participants who have accessed various services offered by the health authority did not comment on how they felt about participating in group activities, except for two individuals who voiced their opinion that they would have liked one-on- one counselling. Anna expressed she is not happy that she cannot have individual counselling.

Jay, one of the key informants admitted that for a large number of older adults, group activities do not work:

I: “But you lose them quickly because we don’t have right now....real ability for one to one....one-on- one counselling?”

Jay (nodding) “For addiction, yes, we don’t have that.”

Elvis, another key informant, had a lot to say about the government policies on services for older adults with alcohol use issues:

“For seniors? (sighs), well, having been involved in the whole policy part of it.....for many years hmmn...and knowing the numbers of men and women that have problems with..... addiction....ah.....government is absolutely doing nothing for seniors in addiction...absolutely nothing.”

Some of the participants expressed their view on better education on alcohol misuse issues. Dora said if she had access to information and education on alcohol misuse and its consequences, for example as in a television commercial, it would have been very helpful.

It appears from above comments that there is a need for education and that there may be resources available, but they are not specified to older adult population and perhaps this matter needs to be addressed at a policy level.

In summary, Under ‘changes to promote help-seeking,’ three subthemes emerged that describe the changes that some of the older adult participants would like to see that would further help them abstain from drinking; 1) support from the community, 2) improved access to health care providers/age specific screening tool, and a desire to have 3) better resources at the health care level.

Looking towards future, some of the older adult participants expressed their desire to have some immediate changes. Firstly, the importance of connection with the community for support in a variety of ways was emphasised by both the older adult participants as well as the key informants. Secondly, it was strongly expressed that health care providers need to have a better understanding of alcohol misuse in the older adult population. Additionally, it was expressed that the participants should have easier access to health care at the primary health care level where they feel valued and respected. A need for age specific screening instrument for alcohol use at the primary care level was strongly voiced by both the older adult participants and the key informants. Lastly, some of the older adult participants mentioned that more resources should be available to them at the health care level, particularly individual counselling; one of the many resources that was taken away when health authorities merged substance use and mental health as one portfolio some years ago. Most of the substance use counsellors expressed strong opinions that the government needs to review the policies again and provide appropriate resources for substance use issues.

In summarizing the findings on alcohol misuse in community dwelling older adults, it was quite apparent that vulnerability is cumulative over the course of life, and that early life experiences and their adverse effects interact with later events in people's lives that increase the chances of poor adult outcomes (Mechanic & Tanner, 2007). For most of the participants in this study, their earlier years already proved to be challenging with alcohol in the background, impacting them in many different ways. There appeared to be a vulnerability already present that was further increased by the choices they made in later lives such as their marriages, their choice of friends, employment, finance, and so forth. It was also obvious they appeared to be unaware of the economic, social, or political inequities in terms of lack of better educational opportunities, safe places to grow up, exercise, or healthy socialization in their younger years that continued in their later years in terms of lack of employment, social, or healthy opportunities. In a positive light, a number of the participants, particularly those that are currently not using alcohol, showed an awareness of alcohol use issues in hindsight and voiced changes they would like to see to promote their health.

I also noted that most of the participants appeared happy to share their experiences. Often, as the interview progressed, they were able to view their experiences and choices they had made more objectively. Through an active dialogue process, they were often able to articulate what could have been different and what changes they would like to see. A lot of the time, I felt it was a sort of catharsis for them, to talk freely about what they had experienced without the fear of being judged and that it (the interview process) had helped them to do that. I felt I had somehow been beneficial in their struggle to connect with the society because they were sad to see me leave and I sensed they still felt isolated or excluded from others.

4.5 Chapter Summary

In this chapter, I presented findings from the critical ethnographic study on alcohol use among community dwelling adults. I generated three themes. The first theme was the narratives of drinking in the research participants that included six subthemes that described their background, reasons for drinking, drinking patterns, consequences of drinking, additional substance use issues, and what helped them with their substance use issues. Second theme described barriers perceived by the research participants in accessing help that included denial of substance use, feelings of discrimination, beliefs about drinking, and feelings of resentment, pride, or shame that acted as barriers to asking for help. The last theme described the participants' views about changes that would promote help seeking behaviours such as more support from the community, improved access, and age specific screening tools for health care providers, and a wish to have more resources available for older adults with alcohol use issues.

Thus, findings in my study revealed that early childhood adversities such as a background of alcohol in their upbringing, history of childhood sexual abuse, and problematic family relationships not only led to most of the participants experimenting with alcohol early in their lives, but also contributed to continued use of alcohol into their adult lives. It was evident that adversities encountered in early childhood impacted the adult lives of the participants in terms of their educational or employment opportunities, but most importantly, their personal lives. Broken relationships, loneliness, depression, financial stress, and in some cases, children starting to use alcohol were some of the important outcomes noted as a direct consequence of alcohol misuse. Clearly, these findings speak to the issue at a broader societal level and that interventions are required to break the cycle of adversities.

Some of the barriers perceived by the participants such as the feelings of discrimination, shame, or stigmatization speak to a societal issue where ageism seems to be the underlying key factor. An unawareness of alcohol use as an issue, or a denial of the issue again indicates a need for education and creating awareness not only at an individual level, but also at the family, and community level. In terms of seeking help, a change in the attitudes of physicians which in fact, points to a need for education and screening tools that are specific to older adults, a desire to have better age specific programs, and importantly, support from the community points out the importance of creating or changing policies within the health care and social context.

Chapter Five: Summary, Discussion of Findings, Nursing Implications and Conclusions

In this chapter, I present a summary of the research and a discussion of the findings on alcohol use among community dwelling older adults in the context of current literature. The implications for nursing education, practice, and policy based on the discussion of the findings are described, as well as conclusions drawn from the study.

5.1 Thesis Overview

I conducted a critical ethnographic research to gain a better understanding of the older adults' use of alcohol within their social, cultural, and political context. The sample consisted of eleven older adult study participants and seven key informant participants. The eleven community dwelling older adult participants were recruited from an urban center in the Interior of British Columbia who had experience with alcohol whether they were currently sober or not. The key informant participants held positions in the community in a variety of roles and had extensive experience with substance use in older adults.

I collected the data using a semi-structured interview guide. The interviews were between thirty to sixty minutes long, audio-taped, and later transcribed verbatim. I utilized a reflective journal to explain my own views or insights about interviews and how they might have impacted the research process. Trustworthiness and rigor were established by utilizing reflexivity, reciprocity, and relationality.

Carspecken's critical qualitative framework guided the study that allowed for data collection and data analysis simultaneously. Three themes emerged utilizing Carspecken's five stages of analysis; 1) narratives of drinking, 2) barriers to help seeking, and 3) changes to

promote help seeking. Each theme was composed of subthemes that further helped to develop the main themes.

Findings revealed that adversities experienced in early life are closely associated with people continuing to have negative life experiences that often lead to alcohol issues early in life. Besides alcohol, the other substances used were tobacco, amphetamines, cocaine, marijuana, and methamphetamine, indicating increasing diverse health care needs and more resources for older adult population as baby boomers join this cohort. The impact of alcohol use was evident in the participants' personal, social, mental, and financial life, but not so much on their physical health, the reason may again be that most of the participants belonged to the baby boomers cohort. An awareness of alcohol use as an issue, services from a community based mental health and substance use center, and involvement with AA proved to be beneficial. Some of the barriers identified were; denial of an issue, blaming the circumstances, but most notably, discrimination by the primary health care providers. Participants noted that an improved access to primary health care providers where they feel respected and valued, age specific screening instruments, and increased community resources and support will promote toward help seeking.

5.2 Discussion of Findings

In the following section, I present a discussion on the three major themes emerged from my study in the context of the current literature and the two theoretical lenses of post-colonial theory and critical social theory.

5.2.1 Narratives of drinking.

Under this theme, I will discuss the findings with regards to the factors that shaped study participants' early years, reasons for using alcohol in later years, patterns of drinking, additional substance use issues, consequences of drinking, and what has been helpful to them. Nine out of eleven participants in this study belonged to the baby boomers age cohort and all the participants had experimented with alcohol early in their lives.

5.2.1.1 *Factors that shaped early years.*

In my research, seven study participants were raised in an environment of alcohol misuse either by parents or other family members. In more than one instance, alcohol use went as far back as two generations. Health care providers are becoming increasingly aware of the key role that environmental factors play in social, emotional, and mental development of a young child (Loke & Mak, 2013). Children who grow up with parents that misuse alcohol have both experiential and familial factors that increase their risks of alcohol use. Poor family structure, lack of social support, lack of opportunities, or substance use by family members, including parents and siblings create vulnerabilities in a young person and increase the chances of risky behaviours manifolds, which may well continue in their adult lives (Loke & Mak, 2013). The other risk factors mentioned in the literature that increase vulnerabilities in early years are single parent families, lower socioeconomic status, or a lack of a social network (Leanord & Eiden, 2007).

Three of the women participants were sexually abused in their childhood besides being raised with a background of alcohol misuse. Sexual abuse is a well documented risk factor for

alcohol misuse in early years of life. According to Sartor et al. (2013), an estimated 20% of the women in the United States report childhood sexual abuse. Alcohol use in the background, often by parents, is a strong contributor to this type of abuse (Plant, Miller, & Plant, 2004). Childhood sexual abuse occurs frequently in combination with other adverse conditions that may contribute to later psychological problems. Plant et al. (2004) suggested that long-term psychological and behavioural effects of childhood sexual abuse can lead to alcohol use in early years. According to them, distrust of other people, difficulties in forming relationships, low self-esteem, feelings of powerlessness, and stigmatization follow these victims much later in life and are often the reasons these individuals may experience substance use issues even later in life.

Some of the individuals experienced problematic relationships with their parents in their early years; in one instance, even an attempt at suicide in teenage years. Problematic relationships with parents, non-communications, or feelings of being misunderstood and unloved by parents is one of the most significant factor that precipitates self-destructive behaviours in adolescents such as an early use of substances (Dube et al., 2002; Madu & Matla 2003).

In my study, almost all the participants had experimented with alcohol in their teenage years, considering it a 'social thing to do.' There may be a couple of contributory factors. Alcohol use is perceived by adolescents as a coping strategy to deal with difficult, violent, or abusive situations as it creates temporary emotional highs and a sense of well being that temporarily suspends their troubles (Madu & Matla, 2003). Secondly, it has been observed that a friend's substance use significantly predicts an adolescent's risky behaviour. They are susceptible to peer influences and are more likely to engage in risk taking behaviours in groups rather than alone (Lok & Mak, 2013). Adolescents tend to socialize and develop friendships with

peers who share common attitudes, characteristics, and often a similar background. Furthermore, parents of these individuals are less likely to consider substance use as a risky or harmful behaviour, as it is likely they are engaged in the same risky activities. Alcohol tends to be the primary substance of choice among adolescents because of its easy availability.

5.2.1.2 Reasons for using alcohol in early adulthood (early-onset drinkers).

With early-onset drinkers, there is often a family history of alcohol misuse, and a higher incidence of psychological, medical, or legal issues. Menninger (2002) reports that three quarters of the older adult population that use alcohol come under the category of early-onset drinkers. Coulton (2009) reports this group is less compliant with treatment and has a higher rate of relapse. For nine study participants, alcohol continued to be a part of their lives as they progressed from adolescence into adulthood. One of the reasons may be that these individuals socialized with people who came from similar backgrounds and who also used alcohol (Emslie et al., 2012). For most of the study participants, social drinking progressed to problem drinking, which was also the main reason for breaking up of their relationships. Some of the other reasons given for their continual use of alcohol were; destructive relationships, physical or sexual abuse by partners, and depression.

Five of the study participants blamed destructive relationships leading to their social isolation and loneliness as a reason to continue to misuse alcohol. Outcomes of divorce impacted both partners; their circumstances often ended with compromised finances, mental health issues, and most importantly, loneliness occurred. The restructuring of a social network, or the lack of it,

became the reason for a large number of individuals to start drinking or to escalate drinking behaviour (Schaefer, 2011).

The physical or sexual abuse of a partner in an intimate relationship is well documented in the literature (Ostermann, Sloan, & Taylor, 2005). Three women participants experienced violence and abuse in their marriages that contributed to their continuing to misuse alcohol. It has been observed that people often choose partners with similar backgrounds. It is likely these individuals initiated relationships with partners that may have encountered adversities in their childhood, which impacted their ability to form healthy relationships (Ostermann et al., 2005).

Three women participants contributed depression as the cause of their continued use of alcohol. Negative childhood experiences such as physical and sexual abuse, have been linked to depression and anxiety in early adult years (Dube et al., 2002). One woman was sexually abused in her childhood and two others experienced physical and sexual abuse in their marriages.

In discussing the trajectory of drinking for early-onset drinkers, substance use in adolescent years, whether due to a background of alcohol, childhood abuse, to avoid isolation, or peer pressure is a risk factor for its continued use or escalation of it in adult life (Brook et al., 2013). Earlier negative environmental and social factors along with alcohol use certainly play a role in later developmental sequences. Individuals may be less able to respond adaptively to negative life events or stressors and may find it easier to use substances as a way of coping with these problems. They may encounter challenges in completing formal education, initiating stable employment, or developing healthy relationships according to Leanord and Mudar (2000).

Thus, my study revealed that most of the study participants experienced early childhood adversities; a background of alcohol use, history of childhood sexual abuse, and problematic

family relationships. The participants also experimented with alcohol in their youth and continued on with alcohol misuse into their adult lives as they encountered other adversities such as broken relationships leading to loneliness, sexual and physical abuse by partners, and depression.

It is evident that adversities experienced in early years of life are intimately associated with people continuing to have negative life experiences that lead to issues such as alcohol use early in life. There is a need for policies that target the root cause of such behaviours. For example, early socio-economic deprivation makes it less likely that children will have equitable access to good schools or educational stimulation, or have high educational attainment, compete for better jobs, or achieve adequate income and living standards as they age into young adults (Mechanic & Tanner, 2007). Therefore, policies need to address the socio-economic status of this vulnerable population and create long-term sustainable programs. Secondly, there needs to be policies in the context of neighbourhood and community for improved interventions. For example, degraded neighbourhoods can be targeted for improved interventions.

Services should be aimed at addressing the social determinants of health in the population that experiences adversities from childhood into later lives. Programs that would address socio-economic status by providing housing, income support, educational enrichment, and creating healthy families will all work towards breaking the vicious cycle of cumulative adversities from one generation into the next (Mechanic & Tanner, 2007). Programs aimed at improving neighbourhood by providing safety and freedom from victimization, transportation, recreational opportunities to address social isolation, providing education and creating awareness in the

community will aim at laying the foundation for better health, preventing substance use and other risky behaviours and most importantly, improved quality of life.

5.2.1.3 Reasons for using alcohol in later years (late-onset drinkers).

Late-onset drinkers often misuse alcohol as a coping method to endure a variety of life stresses. Some of the risk factors noted in the literature for older adults are; gender, loss of spouse, loss of social support or friends, retirement, or depression (Dar, 2006; Merrick et al., 2008; Sattar, et al., 2003; St. John et al., 2010). Of the two late-onset drinkers in this study, one participant admitted to starting to misuse alcohol after her retirement as she found no purpose to life anymore. The second individual, who started misusing alcohol later in life, experienced a combination of adverse circumstances; loss of multiple family members, stress of a husband being away, and a lack of a social support system.

5.2.1.4 Patterns of drinking.

There is evidence that today's population of older adults tends to be heavier drinkers than previous generations (Mortimer, 2011). In both men and women age forty-five and over, the proportions of those that drink in excess, have been rising steadily. The reasons may be; increasingly relaxed attitude towards alcohol use, greater incomes available, better physical health, and so forth.

The three drinking patterns other than early onset and late-onset drinkers that emerged in my study were; 1) steady drinking, 2) week-end binge drinking, and 3) social drinking. Out of the eleven participants, three drank almost daily and came under the category of steady drinking. Six participants started their drinking as week-end binge drinking. Binge drinking is defined as

any drinking occasion where an individual consumes four to six or more standard drinks (Sattar et al., 2006). The participants started off as being alcohol free throughout the week and binge drank over the week-end as a major part of socializing with friends. This pattern changed for most of them. With time, their pattern changed to steady drinking, drinking almost daily.

Older adults are known to use alcohol for social motives as well (Immonen et al., 2011). In other words, their reasons for drinking are based on personal life experiences, situations, and expectancies. In some instances, from an older adult's perspective, alcohol use is strictly only 'a social thing' (Schofield & Tolson, 2001). Two out of eleven participants looked at their drinking as 'social thing' as they never considered drinking to be an issue. For them, drinking had always only been a 'social thing.'

Some of the participants exhibited risky behaviour while they were drinking. Gmel and Rehm (2003) mention that by causing cognitive, psychological, and emotional changes alcohol reduces self-awareness, or may cause inaccurate assessment of a given situation by a person. One of my study participants exhibited a pattern of risky behaviour only after drinking to excess. She reported she hitch-hiked on the highways, taking rides with complete strangers regardless of their destination. She stated she exhibited this behaviour only when she drank. She admitted that she was fortunate no harm had ever come to her.

Two other participants lived a risky existence during their drinking periods. One of them, an early-onset drinker, admitted that at one point in her life she was extremely vulnerable as she would have 'done anything' for a drink. She exposed herself to a barrage of risks. Besides the risks of acquiring sexually transmitted diseases, she exposed herself to violence, rape, and other brutalities. Sheard (2011) reports that although there have been enough discourses on women and

substance use issues, so far relatively little attention has been focused on personal safety of women while consuming alcohol, especially regarding fears about male aggression or violence towards them. This same participant admitted that she drank during her pregnancy, thus exposing her unborn child to risk as well.

5.2.1.5 *Additional substance use issues.*

Smoking tobacco is one of the most preventable causes of premature death, yet this is the substance most commonly abused by older adults next to alcohol. Tobacco use is a major contributor to morbidity and mortality in older adults (Choi, & DiNitto, 2013; Liu et al, 2013; Wang & Andrate, 2013). While social norms and laws in some countries may have contributed to a reduction in smoking, it still remains a common substance used by older adults in many countries (Choi & DiNitto, 2013). In keeping with the literature, tobacco was found to be the most common additional substance use issue in my study. Seven participants admitted to smoking tobacco at the time of interview. All of them were early-onset drinkers. They had started to smoke in their teens, and never stopped. According to a Canadian study, several factors; income, gender, living status, social participation, and education influence a person's life style choices such as smoking and drinking (Liu et al., 2013). In the older adult population, smoking and alcohol use are used more often as coping strategies to deal with negative stresses encountered, rather than for social reasons alone.

Besides tobacco, four participants at one time used other psycho-active substances such as amphetamine, cocaine, marijuana, and methamphetamine. All of these participants belonged to the baby boomers cohort. One of the growing concerns about baby boomers joining the ranks

of older adults is their early and continuing associated use of substances other than alcohol. According to Johnson and Sung (2009), baby boomers have continued the use of illicit substances along with alcohol use, especially the use of Marijuana. “There is reason to believe that future trends and patterns in illicit drug use will be different as baby boomers, aged 41 to 59 years in 2005, enter older adulthood” (Colliver et al., 2006, p. 257). From the perspective of treatment, there has already been an increase in the number of older adult entering treatment centers for poly substance use (Colliver et al., 2006). This cohort is expected to place a staggering burden on the health care system in a variety of ways with their complex substance use issues (Johnson & Sung, 2009). From the perspective of prevention, so far, most of the resources for substance use have been focused on adolescents and young adults. Motive for continuing to use psycho-active substances along with alcohol use in older adult population may pose different challenges for policy makers of the future.

5.2.1.6 Consequences of drinking.

Findings in this study showed that alcohol misuse by participants impacted their personal life, social life, finances, and their physical and mental health.

Alcohol misuse impacts every aspect of a person’s life. In my study, the most impacted aspect of study participants was their personal life. Alcohol and other substance use issues are an increasing social problem that destroys individuals, families, and communities (Schafer, 2011). In my study, four participants experienced marital discord due to their own alcohol misuse that led to divorce or separation, which had consequence of its own. These individuals experienced loneliness, financial stress, and the stress of having to consider restructuring of their social

network; all of which were further responsible for their increased drinking, a finding which is congruent with other studies (Leonard & Eiden, 2007; Ripley, Cunion, & Noble, 2006; Schafer, 2011).

Alcohol use is closely associated with family structures. That it plays a significant role in marital discord has been recognized a long time ago. Alcohol misuse in a marriage often leads to ineffective communication, verbal or physical aggression, loss of employment, or social isolation. Alcohol use issues colour all behaviour within a family unit. It impacts family roles, communications, social life, and importantly, finances (Schaefer, 2011).

Four other participants, all women, disclosed that they married early in life to men that actively drank and that they moved in the same social drinking circles. They agreed it was not only their drinking, but also their spouses' drinking that broke up the marriages. Interestingly, two women who had been divorced and were abstinent for a period of time, met their second partners in similar settings, and started to drink again. Both relationships turned out to be more violent and more disturbing than the previous ones. It has been observed that people, who drink and believe in the facilitative influence of alcohol on their social relationships, have friends who use alcohol as well. These individuals even seek out and develop social relationships that are congruent with these beliefs (Leonard & Mudar, 2000). Additionally, Leonard and Eiden (2007), report that people who use alcohol actively are more likely to get married to a similar kind of individual, and in fact, these people may subconsciously select spouses whose drinking habits and drinking background are similar to their own. In most instances, socializing in the same drinking circle may begin as the couple enjoying evenings 'out with friends,' which sooner or later exceeds the social aspect and progresses into problematic behaviour (Ostermann et al.,

2005). It is reported that alcohol misuse by couples, over time, tends to escalate into progressive levels of verbal or physical aggression and heightened levels of depression and anxiety.

Depression and anxiety are observed more commonly in women than in men (Ripley et al., 2006).

Besides divorce and living a lonely life, three participants experienced additional loss when their children were removed from their care due to their excessive drinking. Marriage is supposed to provide a background where children are raised and foundations are laid for healthy social, mental and psychological development, but when alcohol becomes the primary cause for a disruption of the family unit, children are often the ones most impacted (Leonard & Eiden, 2007; Ostermann et al., 2005). Constant conflict, stressful, and unfavourable environment influence a child adversely. In extreme cases, where safe parenting becomes questionable, children can be removed by force which is devastating for both the children as well as the parent.

The three study participants, who lost their children in custody battles, described their feelings of guilt, isolation, and shame when their children were removed from them. They also feared the long-term consequences of their actions on their children. Schaefer (2011) points out a likelihood of subsequent substance use by the next generation are common. Early life negative experiences interact with later events in ways that increase the likelihood of poor outcomes even later in life (Mechanic & Tanner, 2007). There is no single path from early life adversities to poor social, cognitive, mental, and emotional health outcomes. Children with parents that misuse alcohol may experience other adversities in their childhood years; parental marital discord, domestic violence, or social isolation (Dube et al., 2002). Impact of drinking on family roles, communications, finances, and social life are some of the other variables that influence a child

adversely. A cycle of these adversities promotes generation after generation of alcohol use issues as children learn to respond to life events and difficulties from their parents' examples, and react in similar ways when faced with similar adversities later in life (Singh-Manoux, 2005). This cycle was evident in the life of three participants as their children began to misuse alcohol as well.

These findings speak clearly to a larger issue that needs to be looked at a higher social level. Interventions are required at multiple levels to break the cycle of adversities. The welfare of adolescents depends on their personal development, resources such as opportunities for education, employment, safe environment, social networks, and community resources. There is increasing evidence that environmental factors, but more importantly, family structure plays a key role in social and behavioural development of adolescents. Family connectedness, warmth, and positive values can act as a protective cover against many of the risky behaviours engaged by adolescents (Lok & Mak, 2013). Therefore, policy developers need to focus on the large-scale risk factors such as socio-economic status of this population, lack of better education and job opportunities, information on substance use and its long-term consequences, lack of social support, and most importantly, community awareness and resources (Mechanic & Tanner, 2007; Shaefer, 2011; Wills, Pierce, & Evans, 1996).

Quite commonly, older adults who misuse alcohol experience social isolation within the community. Most of my study participants had experienced some degree of social isolation at the time they were actively using alcohol. It is important to note that attitudes of the past, that substance use is a moral failing, still, to some degree, contribute to the feelings of shame, guilt, and stigmatization on the part of an individual, family, and society at large (Meninger, 2002;

Morgan et al., 2011; Sattar et al., 2003; Smith, Lee, & Davidson, 2010). The term ‘alcoholism’ entails a process of exclusion and even a social degradation. Stigmatization is experienced by older adults at multiple levels. First, there is the intimate process of censure and social control by family members and friends. Next, there is the society’s moralistic view of an alcohol abuser, and finally, the policy decisions to be ‘tough on substance use,’ carries the potential to marginalize or stigmatize those who do not conform (Smith et al., 2010). Perhaps the most important factor is the self-perceived shame, embarrassment, or guilt that creates social isolation and loneliness in the older adults that use alcohol and prevents them from seeking help. Five individuals voiced feelings of guilt, shame, stigmatization, and social isolation at the time they were using alcohol. Four of them perceived as being judged by their friends that added to their social isolation. These findings concur with the literature (Coulton, 2009; Room, 2005; Sattar et al., 2003; Smith et al., 2010).

Four participants lived alone and still felt isolated. There was one interesting finding; for three participants, all being early-onset drinkers, it was the loneliness experienced after they had stopped drinking, as, prior to their abstinence, their social circle consisted only of the friends that used alcohol. Two of them started to socialize with their support group, but the third one still lived an isolated life. In all, four participants still felt isolated and unsupported in the community.

These findings suggest that it is important not only to implement evidence based health interventions or psycho-social interventions to older adults who misuse alcohol, but to also design policies providing education at large to communities and ongoing support from multiple resources, most importantly from the community, so this population does not continue to feel isolated and marginalized.

Contrary to the literature, there was no evidence of any major illness or the exacerbation of an existing illness as a direct result of alcohol misuse in the study participants. Except for one participant, there was no mention of multiple admissions to the emergency department or acute care wards. This may be due to the fact that most of the study participants belonged to the 'baby boomers' cohort who tend to be in better physical health than their older counterparts, and who continue to drink without any immediate adverse effect (Balsa et al., 2008). This is an important finding as the prevalence of alcohol use in older adults will go substantially up in the next few years as baby boomers keep adding to the increasing proportion of older adults.

The findings of my study correspond with several other studies demonstrating that often older adults who use alcohol, also suffer from associated mood disorders. The most commonly encountered mood disorder in this population is depression (Andrews, Reddy, & Whelan, 2011; Choi & DiNitto, 2013; Cummings et al., 2006; Tait, French, Burns, & Antsey, 2012). A total of five women participants had a diagnosis of depression or depression with anxiety. Within the literature, it has been noted that a substantial number of older adults with a history of alcohol misuse who also suffer from depression, remain undiagnosed (Cummings et al., 2006). And although depression with anxiety is twice as common in older women as men, suicide is more prevalent in men (Choi & DiNitto, 2013). As this is a very treatable illness, implications are many; public education, training, community based integrated services, development of prevention and treatment, and importantly, addressing the disparities in the resources that exists at present for this population.

The impact of alcohol use on the finances of early-onset drinkers in my study was quite evident. Four of the study participants did not complete high school and none of them were able to hold steady employment. Five individuals lived in low income supportive housing. It is noteworthy that not all young people mature out of their heavy alcohol use. Those who continue to drink excessively, often experience negative consequences on various aspects of their lives. Findings in my study concurred with literature that early-onset drinkers often have a strong family history of alcohol misuse, low socio-economic status, limited education opportunities, or limited employment opportunities (Balsa et al., 2008; Coulton, 2009; Gmel & Rehm, 2003; Morgan et al., 2011; Sattar et al., 2003; Schaefer, 2011; Smith et al., 2010). Clearly, my findings imply that rather than focusing on an individual, there is a dire need to address the issue at a broader level. An early healthy environment is extremely important as it influences and shapes the socio-economic trajectories of individuals (Singh- Manoux, 2005). Addressing social determinants of health, programs that provide income support, educational and employment opportunities, creating programs that require mobilization of neighbourhoods, schools, and new social and medical innovations will all contribute substantially to break the cycle of generations of substance use.

Overall, the impact of alcohol use in my study participants was most obvious in their personal lives, social life, finances, and mental health. Impact on physical health did not present as a significant finding, which is somewhat in contrast to other studies. The reason may again be because most of the study participants belonged to the baby boomers cohort.

5.2.2 What has been helpful.

Awareness of drinking as an issue is the first step towards recovering from it. In my study, two participants were able to articulate about their awareness of alcohol use, an issue that had caused their families to disown them. Their main motivation towards trying to stop misusing alcohol has been their reconnection with their families.

For three women participants, awareness that their children had begun to misuse alcohol was a major contributor in their decision to stop drinking. For one woman participant, it was the awareness of being sexually inappropriate every time she misused alcohol. These findings concur with other studies that the awareness of drinking as an issue means different things to different people and so the motivation to stop drinking comes from their own attitudes, experiences, and values (Laudet, Savage, & Mahmood, 2002; Maffina, Deane, Lyons, Crowe, & Kelly, 2013).

In my study, most of the participants accessed a variety of services from the local mental health and substance use center and found them to be extremely useful. Those individuals who were additionally helped with social determinants of health such as food, housing, and transportation felt better supported. This finding has an important implication. Efforts need to focus on increasing the services in the community for older adults who misuse alcohol. Addressing the social determinants of health besides helping this population with their substance use issues, contribute towards longer lasting positive health outcomes (Choi, & DiNitto, 2013). The need for a community based, age specific and multidimensional approach to alcohol use in older adults has been reflected in other studies as well (Barric & Connors, 2002; Culbertson, 2006

b; Dent et al., 2000; Menninger, 2002; Rakshi, Wilson, Burrow, & Holland, 2011; Wang & Andrat, 2013).

Interestingly, my findings revealed that eight participants had accessed AA at some point during their active alcohol use and three individuals found it to be invaluable. In fact, all three individuals gave credit to AA for their successful recovery as well as social support. This finding is supported by Sattar et al. (2003). AA attendance after discharge from an in-patient treatment program can be extremely valuable. One needs to not just attend the meetings, but to engage in ‘working the steps,’ taking service commitment, and having a sponsor or a mentor (Andrews et al., 2011). The importance of AA and its increasing utilization indicates that age does not appear to be a significant barrier in accessing self-help programs such as AA (Barrick & Connors, 2002; Culberson, 2006b; Dent et al., 2000; Meninger, 2002).

Overall, under the subtheme ‘what has been helpful,’ an awareness of alcohol use as an issue, accessing multiple services from a single community based center for mental health and substance use, and for some study participants AA proved to be beneficial.

5.2.3 Barriers to help seeking.

Denial of substance use issue was identified as one of the barriers to seeking help. Five participants in my study denied they had any issues with drinking at the time of their active use of alcohol. This finding concurs with the current literature on barriers to accessing help by the older adults who misuse alcohol. Older adults may not recognize there is an issue as they consider it to be a normal part of socialization, or they may deny due to guilt, shame, and stigma attached to this issue (Immonen et al., 2011). This finding in my study echoes the current

literature where denial is a key component in barriers to accessing help in older adults (Barrick & Connors, 2002; Lay et al., 2008; Loukissa, 2007; Menninger, 2002; Rakshi et al., 2011; Sattar et al., 2003).

Some of the key informants in my study pointed out that the denial of substance use is not only at an individual level, it exists at higher levels as well. Family members, friends, and even society have a tendency to overlook the issue of alcohol as ‘why deny them this last pleasure?’ Several other studies have identified this attitude of the society towards older adults who have alcohol use issues (Culberson, 2006a; Menninger, 2002; O’Connell et al., 2003; Sattar et al., 2003).

5.2.3.1 *Beliefs about drinking.*

Five of the study participants, most of them early-onset drinkers, blamed their circumstances and genetics for their alcohol misuse. This finding concurs with other studies where it has been acknowledged by the researchers that those individuals who grow up in a background of multiple adversities, find it easier to blame their substance use on their lack of opportunities such as education or employment, family structure, parental drinking, and feelings of worthlessness (Schaefer, 2011; Wills et al., 1996). The same participants also mentioned that there could not have been any other outcome due to their genes. Undeniably, genetics play a role in substance use issues (Balsa et al., 2008; Dar, 2006). However, blaming the circumstances solely on genetics by my study participants, speaks to a larger issue where their belief systems appear to be formed by a life-time of experiences as well as a lack of information on substance use at large. Therefore, in order to really make a difference, policies need to carefully examine

the socio-economic challenges of vulnerable populations where alcohol and other substance use issues carry on from one generation to the next (Mechanic & Tanner, 2007; Schaefer, 2011).

Some of the participants expressed feelings of resentment, shame, and pride that acted as barrier for them to ask for help that resonates the similar findings in the existing literature (Sorocco & Ferrell, 2006; Menninger, 2002; Sattar et al., 2003).

5.2.3.2 *Feelings of discrimination.*

Most of the study participants voiced that they experienced a lack of time and interest from their primary care physicians. With the exception of one participant whose physician briefly inquired about his drinking, none of the study participants recalled any conversation with their physician about alcohol use, its ill effects, or recommendations. This is a key finding, and one that has major implications for future trends in the health care system. Ageist view held by health care providers has been mentioned in several studies that may further explain the under-diagnosis and under-treatment of older adults with alcohol use issues. (Aira, Kauhanen, Larivaara, & Rautio, 2003; Andrews et al., 2011; Loukissa, 2007; O'Connell et al., 2003). Factors that may be contributory to a lack of discussion with older adults on alcohol related matters in a primary health care setting may be; a lack of time, inadequate training, and pessimism about the effectiveness of any intervention (Menninger, 2002).

An interesting finding was the high failure rate of treatment centers for my study participants. Four individuals that were advised to enter treatment programs did not find any success. They voiced their frustration about the cost of the programs, and secondly, upon their return, there were no follow-up services or support in the community. All four of them went back

to drinking. These findings point towards a gap in the service. In the current literature, follow up services after discharge from an in-patient treatment center have been recommended (Cummings et al, 2006; Sattar et al., 2003).

It is clear that in order for any in-patient treatment programs for older adults that misuse alcohol to be successful, resources need to be focused on the follow up programs in the community that would ensure that individuals are continued to be supported in the community. Additionally, the health care system needs to be fully prepared for changing characteristics of older adult population as baby boomers enter into this population (Lay et al., 2008).

Findings on barriers to seeking help showed denial of substance use, blaming the circumstances or the genes, feelings of pride, shame, or resentment acted as barriers for the study participants to ask for help. In this study group, in-patient treatment did not help any of the participants that accessed it. Most notably, feelings of discrimination by their primary care giver acted as barriers to seeking any help or treatment by the study participants.

5.2.4 Changes to promote help seeking.

My findings revealed that there needs to be a change in how older adults with alcohol use issues are interviewed and screened at the primary health care level by health care providers, more important, that they feel valued. Secondly, an increase in resources for this population in terms of services as well as community support will go a long way in assisting them.

5.2.4.1 Improved access to health care providers/ age specific tools.

A desire to have an improved access to health care providers where they feel valued and respected was expressed by most of the older adult participants. As well, the need for an age

appropriate screening tool for alcohol use was voiced both by the older adult study participants and the key informants. It is being increasingly recognized that the health care providers need to have expertise in providing treatment, planning prevention, as well as educating the community about substance use (Marcus, 2000). An integrated team of community nurses, health educators, community health workers, counselors, and physicians at the primary care level can improve overall clinical outcomes as well as lead to significant health care cost savings (Padwa et al., 2012).

Nurses form a core component of many health care systems, therefore their role as a part of an integrated team for addressing substance use issues in the community is crucial (Nkowane & Saxena, 2003). At the primary prevention level, nurses have the unique opportunities through interactions with young and older adults, families, and significant others in the community. They also have the opportunities to assess the community's needs, problems, and more importantly, the magnitude of the problem. They provide preventive, curative, or supportive care to individuals, families, or groups that experience substance use issues. They also act as educators to clients as well as other health care personnel.

At a secondary level, community nurses or nurse practitioners with experience in substance use have the enormous potential to support other professionals in collaborative care for the clients who have substance use issues (Ling, 2009). For example, a nurse practitioner or a physician can incorporate screening for substances use as a part of their routine primary care delivery which could significantly improve the detection of alcohol misuse by older adults (Nkowane & Saxena, 2003).

A number of the older adult participants expressed the desire for their physician to take more time and interest in older adults and their issues in the future. Some of the barriers to routine screening and assessment noted for physicians may be ; time and resource restraints, lack of proper training, and lack of established effectiveness of the treatment options (Rush, Urbansoki, & Allen, 2002). It is evident that an integrated team with an expertise in substance use issues is the most effective approach at the primary health care level, as it provides increased access to services, reduced waiting times, improved quality of intervention, and greater provision of information and education (Ling, 2009).

Some of the screening tools appropriate for the older adults mentioned in a large number of studies are; CAGE (Cut down, Annoyed, Guilty, and Eye opener), geriatric version of Michigan Alcohol Screening Test, and The Alcohol Use Disorder Identification Test (AUDIT) (Dar, 2006; Gomez et al., 2006; Memmott, 2003; Menninger, 2002; O'Connell et al., 2004). However, these may not be the ideal screening tools for older adults for several reasons. For example, CAGE or G-MAST may not be able to detect heavy alcohol use by an older adult; secondly, the instruments do not provide any information on the pattern of drinking. Many older adults may misuse alcohol, yet not be considered diagnostic for misuse or dependence, and finally, neither test discriminates between the past and current use of alcohol (Reid, Tinetti, Brown, & Concato, 1998). AUDIT has several items on the inventory that emphasize the quantity and frequency of drinking which may be less relevant in detecting alcohol misuse in older adults (Memmott, 2003). There is a need to have an age specific screening tool that can be used by primary health care providers effectively and in a timely manner.

5.2.4.2 More resources and community support.

Some of the study participants observed that although they are being helped at the local mental health and substance use center, they would like to see more resources available such as counselling on one-on-one basis and better education available to the public on alcohol use and its consequences.

Most of the participants reported they would like to have more community support. There is clear evidence that socially isolated people have a higher rate of morbidity and mortality (Golden et al., 2009). Older adults, as such, are vulnerable to isolation because of their life stressors, limited income, fewer social contacts, fewer friends, physical illnesses, and inability to care for themselves. Additionally, alcohol use is likely to make them even more vulnerable and more socially isolated. The developers of social policies and therapeutic treatment programs need to take into account the socio-cultural factors of this population and create more sustainable programs that would look at the social determinants of health and provide support to older adults in the community who misuse alcohol.

5.3 Nursing Implications

My intent for this study was to gain a better understanding of community dwelling older adults' use of alcohol within their social, cultural, and political context. By utilizing a critical ethnography I have attempted to contribute to the foundational knowledge about the attitudes, beliefs, behaviours, and experiences of older adults who use alcohol. I believe a greater understanding of the social experiences of these individuals is necessary to inform education, practice, and policy. Additionally, the subjective social experiences of this population will offer a

critical outlook for addressing the oppression that they may be experiencing and allow for the involvement of all the stakeholders to bring about a change at multiple levels.

5.3.1 Nursing education.

Nurses are in the front line for detecting alcohol related problems in community dwelling older adults. Barriers can arise by nurses' attitude and limited knowledge about alcohol use in the older adult population. The subject of alcohol use in older adults should be introduced in nursing schools' curriculum. An introduction of the theoretical underpinnings of the historical, political, and societal factors that influence values, belief, or practices of older adults with alcohol use issues will form the foundational concepts of this phenomenon. These concepts will help educate nurses about the attitudes, beliefs, and experiences of older adults that use alcohol, and to view this phenomenon from older adults' perspective in order to provide effective nursing. Equally important, nurses will be encouraged to reflect upon their own beliefs and attitudes and how prior knowledge and experience may influence their understanding of alcohol use issues in relation to individuals and their families. Such education would not only assist an understanding of this medical and psychological condition in a broader sense, but would also be extremely valuable in patient care and attitudes held towards this population (Lovi & Barr, 2009). Thus far, alcohol use in older adults has not been considered a significant health issue.

5.3.2 Nursing practice.

This research topic is relevant to nursing as nurses are the front line health care providers and have numerous opportunities to interact with their clients who may be older adults with a history of alcohol use. This research information will help nurses to have a better understanding

of this population's drinking habits, experiences, beliefs, and attitudes, thus, enhancing the outcome of clinical care of older adults in the community that may use alcohol. As this research was aimed at a transformation process, it will add further insight into the context of nursing such that nurses are able to empower older adults with knowledge and assist them to reflect on their own health damaging situations and to make their own choices about their alcohol use. A successful intervention depends on the readiness of an individual for a change, but also that they are treated in a supportive, respectful, and dignified manner, and where they are assured of confidentiality and discretion.

5.3.3 Nursing policy.

This important issue requires nursing leadership to develop policies around it, develop practice guidelines, and direct practice to be action oriented. Guidelines should be implemented through in-service education programs to be most effective (Tran, Stone, Fernandez, Griffiths, & Johnson, 2009). The purpose of the education programs would be to raise nurses' awareness of this issue, refresh their knowledge of identifying, assessing, and managing older adults who may be using alcohol. Implementing policies on routine screening for substance use on all older adults that are encountered by a community nurse can further minimize any misunderstanding or awkwardness of approaching the subject of alcohol use with an individual, and give the explicit message of providing unbiased, equitable, and high quality of care to all individuals regardless of their personal or medical history (Chu & Galang, 2013).

5.4 Recommendations for Further Research

There have been few qualitative studies on alcohol use in the older adults who dwell in the community, and there is certainly a lack of qualitative studies that will study the phenomenon of alcohol misuse in the older adults from their perspective and try to understand their readiness for change. This knowledge gap may be one of the main reasons for under-detection of this issue. Despite the fact that one in five individuals who experience alcohol use are older adults, there is a lack of well trained health care providers in the growing area of alcohol use in older adults (Morgan et al., 2011). Older adults have diverse alcohol use habits. They report drinking for a variety of reasons. This diversity has increased as baby boomers have now joined the ranks of the older adult population. The findings of this research clearly showed that more research is required to understand this growing problem of alcohol misuse in older adults from their own perspectives, in the hope of building nursing knowledge and providing evidence-based nursing.

5.5 Chapter Summary and Conclusion

In this chapter, I examined the findings on alcohol use among community dwelling older adults in relation to existing literature. I presented nursing implications that emerged from the discussion and made recommendations for nursing education, practice, policy, and future research.

Alcohol use and misuse in older adults is fast becoming a major health problem in Canada. It is also the one that is under-identified, poorly understood, and under-treated. As most of the study participants belonged to the baby boomers cohort and were also early-onset drinkers, the implications addressed the importance of understanding the background of an individual, the

childhood adversities they may have experienced that form their attitudes, beliefs, and behaviours over the course of their lives. This study also pointed out the perceived barriers that may be a projection of older adults' own beliefs, attitudes, and experiences, and need to be understood in that context. In order to truly help this population, nursing practice needs to have an understanding of all the variables that may have been contributory to older adults' use of alcohol in later years of their lives.

This study also revealed that the baby boomer cohort of the older adult population may have poly substance use issues that will increase the complexity of screening, detection, and treatment. Some of the positive attitudes noted in baby boomers were their openness to join self-help groups and any other resources available to them in the community and they were also more forthcoming about their substance use. This information is useful to nursing practice as nurses armed with the knowledge about the complexities of the changing characteristics of the older adult population can work alongside them and be the first ones to have interactions with older adults about their alcohol use.

Another important implication of this study suggests that an emphasis should be placed on improving patient-primary physician interaction. In addition, research is required to look into developing age specific screening instrument and education for health care providers on detecting alcohol use in older adults.

In conclusion, this study was one of the few that explored the attitudes, beliefs, and behaviours of the community dwelling older adults about their alcohol use. This study should encourage future researchers to dwell more deeply into examining the problem of alcohol use

from the older adult population's own perspective for better understanding and effective service delivery.

This study further illustrated the complexities of the baby boomers cohort that have misused alcohol and other illicit substances, and are now becoming an intricate part of the older adult population. Because of social behaviours, life circumstances, and life-style choices, many may find themselves having to utilize health care services and community resources more extensively than previous generations. It is hoped this research will convey the importance of recognizing and facilitating treatment of those struggling with alcohol misuse and act to bring further attention to this concern.

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Appendix A

THE UNIVERSITY OF BRITISH COLUMBIA



Alcohol Use Among Community Dwelling Older Adults

Letter of Initial Contact for Participants

Interior Health Authority
220-1815 Kirschner Road
Kelowna, BC, V1Y 4N7
Phone: [REDACTED]
Fax: [REDACTED]

Research Project: Alcohol Use Among Community Dwelling Older Adults

Principal Investigator: Dr. Jennifer Baumbusch, PhD, RN [REDACTED]

Co-Investigator: Victoria Smye, PhD, RN [REDACTED]

Co-Investigator: Alison Phinney, PhD, RN [REDACTED]

Co-Investigator: Sushma Plested, B.Sc,N [REDACTED]

Dear Participant,

I am a registered nurse and work for Interior Health in Kamloops. I am currently studying to obtain a degree of Master of Science from University of British Columbia. For my research study I have chosen to study the attitudes and beliefs of older adults who drink alcohol. I am interested in looking at this from their point of view; how do they feel, or what are their experiences about drinking?

I invite you to participate in this research study where you can share your attitudes and beliefs about drinking alcohol. Your participation will involve a maximum of two sixty to ninety minutes interview sessions. You will describe your attitudes, beliefs and experiences about drinking alcohol in your own words and at your own pace. I will audiotape the interview and transcribe what was said. These interviews will be kept under lock and key at all times to maintain privacy and confidentiality. Every effort will be made to protect your personal identity.

Your participation is voluntary. All the interviews will be scheduled according to your convenience and at your place of convenience. You may refuse to answer any questions. You may also withdraw your participation at any time in the study. You may also withdraw your information at any time.

There will be no direct benefit to you from participating in this study. However, it is hoped that the outcome of this study will provide us with a better understanding of why people drink at this age and how best we can utilize this knowledge in the future.

Your consideration to participate in this research study is appreciated. If you would like some more information about this project, please contact me at [REDACTED]

Sincerely

Sushma Plested, BscN

Appendix B

THE UNIVERSITY OF BRITISH COLUMBIA



Alcohol Use Among Community Dwelling Older Adults

Letter of Initial Contact for Key Informants

Interior Health Authority
220-1815 Kirschner Road
Kelowna, BC, V1Y 4N7
Phone: [REDACTED]
Fax: [REDACTED]

Research Project: Alcohol Use Among Community Dwelling Older Adults

Principal Investigator: Dr. Jennifer Baumbusch, PhD, RN [REDACTED]

Co-Investigator: Victoria Smye, PhD, RN [REDACTED]

Co-Investigator: Alison Phinney, PhD, RN [REDACTED]

Co-Investigator: Sushma Plested, B.Sc,N [REDACTED]

Dear Participant,

I am a registered nurse and work for Interior Health in Kamloops. I am currently studying to obtain a degree of Master of Science from University of British Columbia. For my research study I have chosen to study the attitudes and beliefs of older adults who drink alcohol. I am interested in looking at this from their point of view; how do they feel, or what are their experiences about drinking?

I invite you to participate in this research study where you can share your experiences and knowledge about older adults and alcohol. Your contribution will help tremendously in understanding this phenomenon and developing the relevant framework. Your participation will involve a maximum of one sixty minutes interview session. I will audiotape the interview and transcribe what was said. These interviews will be kept under lock and key at all times to maintain privacy and confidentiality. Every effort will be made to protect your personal identity.

Your participation is voluntary. The interview will be scheduled according to your convenience and at your place of convenience. You may refuse to answer any questions. You

may also withdraw your participation at any time in the study. You may also withdraw your information at any time.

There will be no direct benefit to you from participating in this study. However, it is hoped that the outcome of this study will provide us with a better understanding of why people drink at this age and how best we can utilize this knowledge in the future.

Your consideration to participate in this research study is appreciated. If you would like some more information about this project, please contact me at [REDACTED]

Sincerely

Sushma Plested, BScN

Appendix C

THE UNIVERSITY OF BRITISH COLUMBIA



Alcohol Use Among Community Dwelling Older Adults

Key Informants Consent Form

The Interior Health Research Ethics Board carried out an ethics review for this research project and made a determination that it met ethical requirements for research involving human subjects.

Research Project: Alcohol Use Among Community Dwelling Older Adults

Principal Investigator: Dr. Jennifer Baumbusch, PhD, RN [REDACTED]

Co-Investigator: Victoria Smye, PhD, RN [REDACTED]

Co-Investigator: Alison Phinney, PhD, RN [REDACTED]

Co-Investigator: Sushma Plested, B.Sc,N [REDACTED]

Study Background

Alcohol use and misuse in older adults is fast becoming a major health problem in Canada. It is also the one that is under-identified, poorly understood, and under-treated. The purpose of this research study is to provide an in-depth knowledge about the attitudes, feelings, and beliefs of older adults who abuse alcohol. The subjective social experiences of these individuals will offer a critical outlook for addressing the oppression that they may be experiencing and allow for the involvement of all the stakeholders to bring about a change at multiple levels.

This study will include two categories of participants. Each category will consist of ten participants. The first group will include population under study, that would be community dwelling older adults (65 years and older), who have used alcohol or currently use alcohol. The second group will include key participants. Key participants are individuals who by virtue of their extensive experience and knowledge about community dwelling older adults with alcohol use or history of use have insight into this issue.

Participation

You are being invited to participate in this research as a key participant as you have extensive experience working with this population. Your insight into the issue of alcohol use in older adults would make a significant contribution to this study. If you agree to participate in this study, a researcher will have a face to face one time interview with you which will last for a maximum of one hour. The interview will be audio-taped and will occur at a time and place that is convenient to you.

Potential Risks

Risks are minimal by your participating in this research. You may experience a loss of privacy by discussing your experiences with a researcher. The conversation will be held in strict confidence.

Potential Benefits

Although there are no immediate benefits, by participating in this study, you will be contributing to a greater understanding of the attitudes and beliefs of older adults who have had experience with alcohol or may be currently using it.

Confidentiality

The identity of all participants will be kept strictly confidential. All audio taped conversations will be transcribed and all identities (such as names and places) will be removed from transcribed data and the notes. Participants will be given pseudonyms. All data will be stored in a locked filing cabinet in a locked office at the UBC School of Nursing. The computerized files will be password protected, encrypted, and kept on a secure server at the UBC School of Nursing. No data will be kept on the web.

Questions or Concerns:

Data from this study may be used for teaching purposes by using it in undergraduate and graduate courses about older adults or addiction. As this is a graduate student research project, a final report will be prepared to be shared with public. You will have an opportunity to request a final report at the time of data collection. If you have any questions or concerns regarding this study or your participation in the study, you may call Sushma Plested at [REDACTED] or Dr. Jennifer Baumbusch at [REDACTED]. If you have any concerns regarding your rights or treatment as research participant, you may contact the office of Research Services, University of British Columbia at 604-822-8581, or Chair of the Interior Health Research Ethics Board at 250-870-4602.

Consent

Your participation in this study is entirely voluntary and you may refuse to participate or withdraw from the study at any time without any consequences. If you wish to withdraw from the study at any point, your data will be removed from the study. This is a critical qualitative study and follows a five stage framework. There will be a preliminary raw data analysis for purpose of identifying themes or patterns; however, a systematic qualitative analysis will begin

only towards the end of the study, thus it is possible to withdraw data at any stage during the study.

By signing below you indicate that:

You agree to participate in this study

Your questions about the study have been answered to your satisfaction

You have received a copy of the consent form.

Signature-----

Date-----

Printed name of the person signing above-----

Appendix D

THE UNIVERSITY OF BRITISH COLUMBIA



Alcohol Use Among Community Dwelling Older Adults

Consent Form for Participants

Interior Health Authority
220-1815 Kirschner Road
Kelowna, BC, V1Y 4N7
Phone: [REDACTED]
Fax: [REDACTED]

The Interior Health Research Ethics Board carried out an ethics review for this research project and made a determination that it met ethical requirements for research involving human subjects.

Research Project: Alcohol Use Among Community Dwelling Older Adults

Principal Investigator: Dr. Jennifer Baumbusch, PhD, RN [REDACTED]

Co-Investigator: Victoria Smye, PhD, RN [REDACTED]

Co-Investigator: Alison Phinney, PhD, RN [REDACTED]

Co-Investigator: Sushma Plested, B.Sc,N [REDACTED]

A research study will be conducted in Kamloops, B.C., on community dwelling older adults (65 years and older) who use or have used alcohol in the past. There will be a total of ten participants for this study. As you are in this age category and have experience with alcohol use, you are being invited to participate in this study where you will be asked to describe your attitudes and beliefs about drinking alcohol.

Purpose:

The purpose of this study is to explore and have an understanding of how older adults use alcohol.

Procedure:

This study will consist of a maximum of two interviews each one lasting from one to one and half hours. Interviews will occur at a time and place that is convenient for you. You will be asked to describe your attitudes and beliefs about drinking alcohol in your own words and at your own pace. All the interviews will be audio-taped. Upon a request from you, the tape

recorder can be turned off or interview erased off at any time. I will transcribe all the taped interviews.

Risks:

There are no anticipated risks to you. However, during the course of interview you may feel uncomfortable talking about your experiences, attitudes or beliefs. Should this happen, you may choose to stop or end the interview. There will also be resources available to you in terms of counsellors in case the interviews upset you in anyway, or if you need to talk further about this topic.

Benefits:

There is no direct benefit to you by participating in this study. However, it is hoped that the outcome of this study will provide us with a better understanding of why people drink at this age and how best we can utilize this knowledge in the future. Also, outcomes of this study may be shared in future with other researchers through publication.

Confidentiality:

Every effort will be made to protect your identity. Research participants will be assigned numbers during the data collection process. Any identifying information will be replaced on transcripts and field notes. Signed consents will be kept in a separate, locked filing cabinet from the data so that they cannot be connected in any way. Only the principal investigator and co-investigators will have access to the data. The data will be stored as computerized files and audio recordings of the interviews. The computerized files will be password protected and encrypted and kept on the secure server at the UBC School of Nursing. Hard copies of transcripts and field notes will be kept in a locked filing cabinet in a locked office at the UBC School of Nursing. No data will be kept on the web. All the data, including audiotapes, and transcripts will be kept secure for five years after the completion of study, at which point all data will be destroyed. Tapes will be demagnetized, hard copies will be shredded, and computer files will be permanently deleted.

No identifying information will be included in any future presentation or publication. Any information provided by you will be kept strictly confidential. Your name and personal information will not be used in any written report of the completed study. Any information that can personally identify you will be kept confidential. The transcripts and notes will be retained for future research purposes.

Participation:

Your participation in the study is entirely voluntary. You may choose to participate or withdraw from the study at any time. You may refuse to answer any questions without affecting your participation in the study. You may withdraw your consent at any time during the study; the data will not be used in the final analysis.

Questions or Concerns:

A summary of the research study results will be provided to those participants who indicate their interest either in person or by mail. Participants will have the opportunity to request a final report at the time of at the time of data collection. As this is a graduate student research project, a final report will be prepared to be shared with public. It you have any questions or concerns regarding this study or your participation in the study, you may call Sushma Plested at [REDACTED] or Dr. Jennifer Baumbusch at [REDACTED]. If you have any concerns regarding your rights or treatment as research subject, you may contact the office of Research Services, University of British Columbia at 604-822-8581, or Chair of the Interior Health Research Ethics Board at 250-870-4602.

Consent:

Your signature below indicates that you have received a copy of this consent form for your own records. Your signature indicates that you consent to participate in this study.

I have read and received a copy of this informed consent form.

Participant's Name (Please Print Clearly)

Signature of Participant

date

Appendix E

Alcohol Use Among Community Dwelling Older Adults

Demographics: Key Informants

Key Informants (7)

No.	Positions	Experience in substance use
2	Community substance use counsellors	>25 years
1	Community Harm Reduction counsellor	>10 years
1	Counsellor- Community treatment Center	>25 years
1	Multi-cultural counsellor	>15 years
1	Family physician	10 years
1	Acute Care Nurse	5 years

Appendix F

Alcohol Use Among Community Dwelling Older Adults

Demographics: Participants

Key participants (11): Four Males &g Seven Females

Age	No.	Education	No.	Occupation	No.	Drinking status	No.
50-60	5	University	3	Working	2	Actively drinking	4
61-70	4	Grade 12	4	retired	5	Not drinking presently	7
71-80	1	<grade 12	4	not – working	4		
81-90	0						
91-100	1						

Appendix G

Alcohol Use Among Community Dwelling Older Adults

Interview Guide for Key Informants

1) In general, what are your experiences with older adults who use alcohol?

2) What do you think are the barriers to older adults seeking help?

3) In your experience, what has been the involvement/impact of health care system with this population?

4) What do you think should be done to support them most effectively?

Appendix H

Alcohol Use Among Community Dwelling Older Adults

Interview Guide for Participants

1) Tell me about your alcohol use over your lifetime.

Prompts:

Can you tell me at what age you started to use alcohol?

Was there any specific reason or trigger that started it?

2) Has alcohol use impacted your health, personal, or social life?

Prompts:

If yes, how? Or please describe?

3) Has a relative or friend, doctor or other health worker ever been concerned about your drinking?

Do you have a story to tell about your experience with alcohol?



If so, would you like to share it?

A research study is starting in the summer of 2012 here in Kamloops to have a better understanding of attitudes and beliefs of people who have had experience with alcohol.

If you are over 65 and would consider sharing your stories, experiences, thoughts and feelings, kindly give a call to Sushma at [REDACTED]. By sharing your unique experience you will be contributing greatly towards a better understanding of this phenomenon.

Please be assured that all communication is strictly confidential, your identity and any personal information is protected at all times.

Appendix J

Alcohol Use Among Community Dwelling Older Adults

Researcher's Field note Guide

Requirements for observation (while researcher is in the field)

- 1) Note the date, time and location of the fieldwork
- 2) A record of specific details and facts (who was there? What was the setting? What did researcher notice around her paying particular attention to nonverbal cues?
- 3) Approximate transcriptions of conversations.

Requirements for Expanded Field notes (After researcher's return from the field)

- 1) Re-read notes shortly after they are taken. Researcher takes time to fill in the details that were not fully written down.
- 1) Reflection – What was researcher's own reaction?
- 2) Aspects/questions that researcher may want to ask in the next interview.

Appendix K

Sushma Plested

Phone: [REDACTED]

Fax: [REDACTED]

Re: A qualitative research on Alcohol use in older adults

Dear Colleague,

As a part of obtaining a degree in masters in nursing, I would like to conduct a qualitative study on 'alcohol use in older adults'. This study has been approved by UBC School of Nursing, and is subject to approval by ethics committee from Interior Health Authority. The purpose of this research study is to have a better understanding in an unbiased manner of attitudes and beliefs of older adults who drink alcohol.

If you currently have any clients who are 65 or above and use alcohol, or have used it in the past, would you ask them to consider sharing their experiences, thoughts, and feelings about drinking for a research study that will start after summer this year here in Kamloops?

If they appear interested, could you kindly hand one of the flyers to them that gives more information as well as my name and contact number? If they are still interested, and contact me, I will then provide further details of the study either in person, or mail out an information letter to them, depending on their choice.

Kindly assure the clients that you are only providing the information about a study; it will have no impact whatsoever on their accessing the services, and that you will have no knowledge whether the client agreed to participate or not. Also, kindly assure the willing participants that all interviews are confidential. The identity and any personal information of the participants will be protected at all times.

I appreciate your co-operation. Please do not hesitate to contact me at [REDACTED]

[REDACTED] for more information.

Principal Investigator: Dr. Jennifer Baumbusch, PhD, RN

Co-investigator: Victoria Syme, PhD, RN

Co-Investigator: Alison Phinney, PhD, RN

Co-Investigator: Sushma Plested, B.ScN

Appendix L

Alcohol Use Among Community Dwelling Older Adults

Demographics: Participants

1) Gender: Male/female

2) What is your age?

3) What is your highest level of education?

4) On an average how much do you spend on alcohol per week?
