

GROUP TREATMENT OF CHEMICALLY DEPENDENT SENIORS

By

Debra Kostyk

A Practicum

Submitted to the Faculty of Graduate Studies
in Partial Fulfilment of the Requirements
for the Degree of

MASTER OF SOCIAL WORK

Faculty of Social Work
University of Manitoba
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ABSTRACT

Chemical dependency among the elderly is a serious problem that affects every aspect of life. Dependency on alcohol and/or mood-altering prescription medications occurs in a significant number of the elderly. However, few seniors are receiving treatment to alleviate their dependency. Such treatment would engage chemically dependent seniors in a recovery process and would reduce social, physical and psychological problems related to chemical dependency.

A group work approach was taken to:

1. guide the chemical dependent elderly to abstain from alcohol,
2. achieve responsible mood-altering medication use, and
3. improve each member's sense of life satisfaction.

Upon evaluation and analysis of this intervention, chemically dependent seniors were able to benefit from their treatment experiences. By working through the stages of recovery, most members were able to make some positive changes with their chemical use and to improve their lifestyles.

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CHAPTER I

INTRODUCTION

Chemical dependency is considered a prevalent and growing problem among the elderly population. A wide variety of negative consequences are experienced by those elderly people who use alcohol and/or mood-altering prescription medication excessively and/or regularly. A widespread and serious problem such as this warrants attention and intervention.

There were a number of reasons why a group was developed for chemically dependent seniors. Firstly, this group addressed the social stigma these seniors faced. Chemically dependent seniors not only experienced ageism but also experienced the shame of being chemically dependent (Kola & Kosberg, 1981; Shanahan, 1984). They were considered to be unproductive, unattractive and worthless in a society that valued productivity and youthfulness. Developing a group for chemically dependent seniors was a way to give a message to this population and society that they were considered valuable individuals.

The second reason for developing the group was because few chemically dependent seniors received treatment. Although seniors were treated in the main chemical dependency program in the city, the numbers treated were very small. This trend seemed to be consistent in the literature as well. King, Altpeter & Spade (1986) reported that only 1.4%

of all clients in a New York chemical dependency treatment service system were over age 65. Blazer & Pennybacker (1984) described a study where 9% of alcoholics treated in a Washington State treatment program were aged 60 or older. This figure was proportionately less than the demographic representation of all the elderly in that community. D'Arcy and Bold (1983) looked at the demographic characteristics of Saskatchewan residents getting alcohol/drug treatment from 1969-1974. They found that the percentage of seniors admitted for treatment in both age groups of 60 to 69 and 70+ was disproportionately lower than other age groups.

Chemical Dependency professionals saw so few seniors in treatment programs that they assumed that this trend reflected a low prevalence of chemical dependency among seniors. Thus chemically dependent seniors became a low priority for the development of special, age-specific outreach assessment and treatment services (King et al., 1986). Chemical dependency professionals were not able to adequately assess for chemical dependency with elderly clients because they were not familiar with the chemical use patterns of this age group (King et al., 1986). Chemical dependency agencies also were known to have believed that chemically dependent elders were poor treatment risks because they were too old to change (Bozzetti & MacMurray, 1977; Kola et al., 1984).

Kola & Kosberg (1981) learned that seniors were more

likely to be turned away for chemical dependency treatment because of policy restrictions to people who were not ambulatory and who had multiple health problems. Lastly, staff in alcoholism treatment services were not knowledgeable about aging and their special needs (Kola & Kosberg, 1981).

Agencies that provided services to the elderly also prevented chemically dependent elders from getting treatment. Many professionals in these agencies were not knowledgeable about chemical dependency. These professionals believed that chemical dependency was not a big problem among the elderly because they saw few chemically dependent elderly in their work (Kola et al., 1984). Kola et al., found that almost half of all geriatric professionals had more negative attitudes about the elderly alcoholic than about the elderly non-alcoholic. Few of these agencies had any established policies outlining how chemically dependent seniors should have been managed.

Chemically dependent seniors frequently used health care services. Many health care staff considered alcohol or drug problems among the elderly as a minor problem compared to the many illnesses that the elderly encounter (Benshoff & Roberto, 1987). Thus, health care staff failed to recognize chemical dependency in elderly patients (Benshoff & Roberto, 1987 Shanahan, 1984). Curtis et al., (1989) found that physicians in a major hospital in Baltimore, Maryland, intervened with 46% of non-elderly alcoholic patients, but

intervened with only 16% of elderly alcoholic patients.

Few seniors received chemical dependency treatment because of the nature of these seniors themselves. Abrahams and Patterson (1979) began to identify characteristics of seniors that led to a low utilization rate of community services, including chemical dependency treatment programs. They found that seniors wanted to be self-reliant. Thus, they avoided using services that may have made them look poor or unable to manage on their own. Mishara (1985) suggested that chemically dependent seniors avoided treatment because they were not aware of the help available to them.

Pruzinsky (1987) speculated that seniors who were unwilling or unable to leave their homes or who were fearful of being admitted to a nursing home, would have hesitated to go to an inpatient treatment centre. Many seniors with fixed incomes believed that they could not have afforded treatment. Another reason seniors were not getting into chemical dependency treatment was that the conventional ways of convincing a chemically dependent person to go into treatment did not apply to seniors. They did not have a boss to threaten job loss. They seldom got into trouble with the law so they were never court mandated to treatment. Chemically dependent elders did not use alcohol or drugs in patterns that were commonly used to identify chemical dependency. For example, smaller amounts of alcohol caused more

physical, psychological problems with the elderly than with young people. Thus the traditional quantity of alcohol use used to identify a problem would have failed to identify the elderly problem drinker (Gordis, 1988).

A third reason a group was developed for chemically dependent elderly was the need for an age-specific treatment group. There had been some sources that did not support age-specific programs for chemically dependent seniors. Janik and Dunham (1983) used a sample drawn from 550 alcoholism treatment programs in the United States. They compared patients 60 years of age or older to patients between the ages of 21 to 59 regarding drinking related characteristics before going into treatment, the kind of treatment received and treatment outcome. Comparisons were based on measures taken at intake and 180 days following the intake interview. They found that the older patients had the same treatment outcome as the younger patients. Because all of the older patients participated in treatment with the younger patients, Janik and Dunham concluded that age-specific programs were not necessary. Mishara (1985) supported this by saying:

To date, we have no hard data which suggests that older alcoholics need special types of treatment programs or respond better to certain approaches than younger clients. Until such data were available, there was no justification to support the segregation of older

alcoholics into specialized programs "for their benefit." (p. 258)

On the other hand, some literature sources strongly advocated for age-specific treatment groups for chemically dependent seniors (Johnson, 1989; Kofoed, Tolson, Atkinson, Toth & Turner 1987). Kofoed et al., (1987) challenged Janik and Dunham's study by comparing one sample of elders that was treated in a age-specific group to another sample of elders that was treated in a mixed-age group. To match both samples according to age, the age-specific group sample had to drop 8 of the oldest group members from the study because the mixed-age group had no one over the age of 66. They found the age-specific group sample had greater treatment compliance and greater rates of treatment completion than the mixed age group. The age-specific group sample showed fewer relapses and had longer periods of time for relapse to occur than the mixed-age group sample. Kofoed et al., (1987) concluded that the oldest alcoholics were only attracted to treatment when age-specific programs were offered. Another reason for supporting age-specific , specialized programs was that many seniors tended to feel outnumbered by younger patients. They had difficulty relating to the issues of younger chemically dependent people (Kofoed, 1984a; Cohen, 1988).

The writer joined those who supported developing age-specific programs for the reasons and findings given above.

Also, because the chemically dependent elderly were a heterogenous group with a wide range of abilities and needs, Kunz, Stanmers, Pashko, & Druley (1985) and Canter and Koretzky (1989) added caution about deciding whether a chemically dependent senior should go into an age-specific group or a mixed-age group. Both sources recommended that psychological and physical health factors be considered rather than age alone when referring a senior to chemical dependency treatment.

The fourth reason why a treatment group was created for chemically dependent seniors was that chemical dependency existed among the elderly in significant numbers. Historically, society has responded to social problems if it affected a large number of people. The writer believed chemical dependency was widespread among the elderly which demanded human service resources. Also, chemically dependent elderly experienced many problems that were caused by the chemical dependency. An intervention was necessary to try to address the problem. If interventions were directed to alleviate the chemical dependency many of the seniors' problems would have also diminished or disappeared. This would have enhanced many seniors' abilities to maintain independent living and improve the quality of their lives.

The last reason why the group was developed was that this population seemed to be treatable. The literature showed that elderly chemically dependent patients responded

as well as younger patients to chemical dependency treatment (Benshoff & Roberto, 1987; Gordis, 1988; Kofoed et al., 1987; Pruzinsky, 1987). Benshoff and Roberto (1987) reported on a pilot program in Florida that did research on late-onset, elderly alcoholics who had completed treatment. At the end of a year long follow-up period, 74% of these elderly alcoholics had maintained their treatment goals. Many had maintained abstinence. Knowing such outcomes could occur elsewhere, it was possible that a program could be developed in Winnipeg to treat this population successfully.

OBJECTIVES OF THE PRACTICUM

A. Objective of the Practicum Intervention:

To develop and facilitate a treatment group for chemical dependent seniors and their significant others.

B. Objectives of Professional Learning.

1. To become comfortable with facilitating groups.
2. To increase group work skills.
3. To be able to identify and to begin to resolve issues common to chemically dependent seniors and their significant others.

An Overview of the Practicum Project

This practicum report was developed to describe thoughts and experiences about a treatment group for

chemically dependent elders which was developed and facilitated. The writer began this report by providing a comprehensive, multi-dimensional literature review about the elderly dependents on alcohol and those dependent on mood-altering prescription medications. A theoretical foundation was created that provided an understanding of the problem and assisted with creating a treatment approach. A description of the actual experience follows. An analysis of observations and an evaluation of the results was done. Lastly, some recommendations were offered for any one or any agency considering the implementations of a treatment group for the chemically dependent elderly.

THE PROBLEM OF CHEMICAL DEPENDENCY AND THE ELDERLY: A LITERATURE REVIEW

This literature review will describe the prevalence, problems and behaviours related to chemical dependency among the elderly. This information will be organized according to the type of chemical used. Prevalence, problems and common behaviours encountered by the elderly who are dependent on alcohol will be discussed. Secondly, these same factors will be explored among the elderly who are dependent on mood-altering prescription drugs. Elderly illegal drug users will not be addressed because the literature suggested that few seniors used illegal drugs (Glantz, 1981). Also, the practicum project had no experience with elderly illegal

drug users, so attention to this population does not fit within this report. The elderly who are dependent on over-the-counter drugs will not be included in this review because no mood-altering over-the-counter drugs were used by clients participating in this project.

CHARACTERISTICS OF THE ELDERLY DEPENDENT ON ALCOHOL

Prevalence

Prevalence rates vary depending on the specific population under study. Alcohol problems occurred between 3-5% of people aged 60 and over in COMMUNITY SURVEYS (Curtis, Geller, Stokes, Levine & Moore 1989). Community based studies yielded a lower rate of alcohol abuse among the elderly than studies done in institutions. For example, in a study done in Winnipeg, Manitoba, (Jacyk, Tabisz, Badger & Fuchs 1991) found that 17% of all people over age 65 presenting in the emergency department of a major hospital were screened as alcoholic. Also, prevalence rates can vary across institutional settings. For example, Atkinson and Kofoed (1982) reported a range of 2-25% of clients in alcohol treatment programs were over the age of 60. Prevalence rates of alcoholism among the elderly ranged from 30% to 44% in medical centres such as nursing homes, veterans hospitals and general hospitals (Curtis, et al., 1989).

The wide variation of prevalence rates may have been

due to a number of reasons. Studies used identifying factors that may have missed the elderly drinker. For example, studies using quantity and frequency measures would not identify the elderly drinker who was only able to drink two ounces of alcohol per day to maintain intoxication (Curtis et al., 1989; Mishara, 1985). The varied prevalence of alcohol abuse among seniors may have been due to how seniors responded to research surveys. Mishara (1985) suggested that seniors may not report the actual use of alcohol. Mayer (1979) believed that seniors tended to de-emphasize negative aspects of life, so they were not likely to report excessive, daily drinking. Atkinson (1988) and Gordis (1988) stated that clinical features common in old age, such as depression or dementia, can mask alcoholism making identification of alcoholism difficult. Symptoms common to alcoholism such as withdrawal or intoxication may not have appeared in the elders (Blazer & Pennybacker, 1984). Many chemically dependent elderly were retired, widowed and live alone which again made identification of alcoholism difficult because they were not under the scrutiny of the public's observation (Blazer & Pennybacker, 1984; Johnson, 1989).

Sociodemographic Characteristics

Most sociodemographic characteristics of seniors dependent on alcohol remained sketchy and inconclusive. However,

with regard to sex differences, study after study found males more likely to be heavy drinkers or alcoholics than females (Busby, Campbell, Borrie, & Spears 1988; Curtis et al, 1989; Smart & Adlaf, 1988). The relationship of marital status to dependency on alcohol remains inconclusive. However, some studies have found elderly alcohol abusers to remarry more often and to be separated or divorced more often than elderly non-abusers (Brown and Chiang, 1984; Schuckit and Miller, 1976).

The ethnic background of seniors dependent on alcohol tended to vary depending on where the sample size was taken. For example, in an inner city hospital in Baltimore, most of the elderly dependent on alcohol were black (Curtis et al., 1989). Whereas, in Ontario and in a suburb in New Jersey, most of the sample was white (Hyman, 1985; Smart & Adlaf, 1988). Level of education was also inconsistent. For example, Hyman (1985) found that elderly chemically dependent men were less educated than younger chemically dependent men, but Smart and Adlaf (1988) found that heavy drinkers were likely to be more highly educated than elderly people who drink less or abstain. Religion was not included in many studies. Meyers (1985) and Smart and Adlaf (1988) found that in their sample of elders who were dependent on alcohol, most were likely to be Roman Catholic. However, these are only two studies and they are not representative of the entire population of the chemically dependent elder-

ly.

Drinking Behaviours with The Elderly Dependent on Alcohol

Schuckit and Pastor (1978) found that almost all elderly alcoholics had begun heavy drinking in their 50's. Schuckit and Miller (1976) learned that many elderly alcoholics began social drinking in their teens and then got into trouble with their drinking after age 40. Hoffman & Harrison (1989) found that of 127 chemically dependent elderly in treatment, none had started drinking before the legal age. Once elderly people had established a drinking pattern in their adult lives, some researchers found that pattern seldom changed after age 60 (Adams et al. 1990; Busby et al. 1988; Glynn et al. 1985; LaGreca et al, 1988). Two sources, however, strongly advocated that drinking patterns did change as people aged. Dunham (1981) was able to identify six drinking patterns that occurred over a lifetime. Four patterns most likely to apply to the elderly who are dependent on alcohol were:

1. The rise and sustained pattern where the heavy drinker continues heavy drinking into old age.
2. The light and late-riser pattern where the drinking is very light through ... life and rises when one reaches old age.
3. The late starter pattern where the person does not drink regularly until later in life [and] rises to

moderate or heavy drinking.

4. The highly variable pattern where the second rise is during later life. (p. 150-151).

Giordano and Beckham (1985) identified four different drinking patterns that occurred among the elderly late onset drinkers:

1. The crisis drinker was someone who binge drank throughout life as a reaction to personal problems and had long periods of abstinence or light drinking in between binges.
2. The progressive drinker drank moderately with no drinking related problems and began heavy drinking in later years.
3. The switched drinker used beverages with low alcohol content throughout adulthood and began using beverages with higher alcohol content as he or she became old.
4. The newcomer never drank until later in life and then started drinking frequently.

With such conflicting findings in the literature, the drinking patterns of elderly who are dependent on alcohol remains inconclusive.

In general, the amount of alcohol consumed has been shown to decrease as people grow old (Adams et al., 1990; Busby et al., 1988; Glynn et al., 1985; Smart & Adlaf, 1988). The elderly were the least likely group to drink

five drinks or more in a single setting as compared with younger age groups (Smart & Adlaf, 1988). Those elders who did have five drinks in a single setting were usually 60 to 65 years old rather than from an old-old age group.

However, Smart and Adlaf (1988) found that the elderly were just as likely to drink daily as the middle-aged group and they were more likely to drink daily than the young adult group. Hoffman and Harrison (1989) found both older men and older women who were in chemical dependency treatment to be daily drinkers. Elderly heavy drinkers (that is, using more than 30 grams per day) seldom stopped drinking as they got older, but a decline in the mean alcohol consumption over time did occur (Adams et al., 1990).

The elderly, dependent on alcohol drink in a variety of places. Giordano & Beckham (1985) said that late onset elderly alcoholics usually drank at home. This was supported by Busby et al., (1988) who found the home as the most common place to drink for 61.5% of elderly female drinkers and 69.2% of elderly male drinkers. Busby et al., also found that 3% of elderly female drinkers drank in clubs and no elderly women drank in hotels. For elderly men, 4.5% usually drank in hotels and 14.9% drank in clubs. On the other hand, Hoffman and Harrison (1989) found that elderly women usually drank alone at home, whereas only a few elderly men drank at home. Elderly drinkers' choice of alcoholic beverage was determined by gender. Busby et al (1988) showed

46.9% of women drank fortified wine, 29.5% drank spirits, 17.4% choose wine and 6.2% preferred beer. For men, spirits was the drink of choice for 44.5%, beer for 34.0% fortified wine for 14.6% and 6.0% preferred wine.

Physical Consequences

Before discussing specific physical problems, it may be helpful to briefly explore the biological effects of alcohol on the elderly. Most experts agreed that the elderly experienced greater sensitivity to the effects alcohol (Gomberg, 1990). Thus, elderly people experienced a greater effect from one ounce of alcohol at the age of 65 than when the same ounce of alcohol was taken at age 35. Gomberg (1990) wrote that one study found elderly people to have higher blood alcohol concentrations than younger people, whereas another study found older rats to produce lower blood alcohol levels than younger rats. Some studies found old people to metabolize alcohol slower than young people and other studies showed no differences in metabolic rates. In a study using rats, there was enhanced elimination of alcohol in older subjects, but another study showed no difference in elimination rates between young and old human subjects. The findings above varied greatly mainly because it was impossible to compare studies that used animal subjects and studies that used human subjects.

There were many physical problems experienced by

seniors who were dependent on alcohol. Elders who were dependent on alcohol tended to develop irreversible organic brain syndrome (Benshoff & Roberto, 1987; Finlayson et al., 1988; Meyer et al., 1984). Brain damage caused by malnutrition during drinking episodes could have been reversible by being treated with good nutrition, vitamin supplements and abstinence from alcohol (Gomberg, 1990; Meyer et al., 1984; Vandeputte, 1989). Organic brain syndrome may not have occurred as a result of alcohol use since causation had not yet been confirmed. Riege, Tomaszewski, Lanto, & Meter, (1984) found that age seemed to affect memory more than alcoholism did. Mellstrom, Rundgren & Svanborg, (1981) found that senior drinkers had lower psychometric test scores than senior non-drinkers. Cermak (1985) found that chronic alcoholics had trouble with memory. When comparing global intelligence tests, the elderly dependent on alcohol did not differ from their matched control group. More of a difference occurred when comparing specific cognitive functions Gomberg (1990). Gomberg reported that seniors who drank regularly were likely to have impaired abstract thinking and difficulty with learning, short term memory, and visual-spatial relationships.

Finlayson et al (1988) and Mellstrom et al., (1981) both found a high mortality rate among elderly alcoholics. Physical problems common to elderly alcoholics were peripheral neuropathy, gastrointestinal disturbances,

hepatic changes, chronic obstructive pulmonary disease and electrolyte imbalances (Benshoff & Roberto, 1987; Cohen, 1988; Finlayson et al, 1988). Simon, Elpstein & Reynolds (1968) found that elderly alcoholics presented with poor personal hygiene. Another indirect danger that alcohol dependency posed to the physical health of seniors was that even a small amount of alcohol may have masked physical symptoms from serious medical conditions, for example, cancer, or heart conditions (Schuckit and Pastor, 1978).

Psychological Characteristics

Psychological characteristics of elderly alcoholics has been considered in the literature. However, some findings were contradictory of one another. Elderly alcoholics tended to show less anti-social behaviour, less psychopathology, and less adjustment difficulties than young alcoholics (Faulstich, Carey, Bellatte, & Delatti, 1985; Schuckit & Pastor, 1978; Schmitt, 1976). However, some research suggested that the elderly who drank for many years and experienced more alcohol related problems seemed to have more psychopathology than the elderly with fewer years of drinking and fewer alcohol related problems (Atkinson, Turner, Kofoed & Tolson, 1985). Comparing MMPI scores for young and old alcoholics, Faulstich et al., (1985) found old alcoholics had lower levels of paranoia and higher levels of responsibility than young alcoholics.

Among the elderly dependent on alcohol, depression was a psychological state that had not been adequately addressed in the literature. In their study of 216 seniors who had received chemical dependency treatment, Finlayson et al. (1988) found that only 8% had a major depression. Pruzinsky (1987) reported that elderly alcoholics were more likely to attempt suicide than elderly non-alcoholics. Comparing depression scores between elderly alcoholics and elderly non-alcoholics, Funkhouser (1977-78) showed depression to be higher with the non-alcoholics than with the alcoholics. Funkhouser also found elderly alcoholics were more anxious and hostile than elderly non-alcoholics. Conflicting findings occur again with Finlayson et al. (1988), who reported that less than one percent of his sample were diagnosed with an anxiety disorder.

Regardless of conflicting findings about depression, Perez (1989) insisted that professionals should have been willing to make dual diagnoses of depression and alcoholism among the elderly. The elderly may have denied the depression by frequently expressing physical complaints. The common signs of depression could have been caused by the chemically dependent elderly patient's reaction to physical illness or they could have been caused by medications given to treat an illness. Perez stated that the depression may have lifted once a chemically dependent senior was abstinent from alcohol for three to four weeks. If depression still

existed at that time, treatment with antidepressants may have been considered.

Social Consequences

There was some attention focused on social problems among the elderly who were dependent on alcohol, yet the information available remained sparse and inconclusive. Atkinson & Kofoed (1982) cited that older drinkers tended to be over-represented with arrests for public drunkenness and for driving while intoxicated. Eighteen percent of 216 elderly alcoholics who had received treatment, reported that legal problems were the main motivating factors for entering treatment (Finlayson et al., 1988). Schuckit & Miller (1976) found that elderly alcoholics were more likely to have been in jail than elderly non-alcoholics.

Pruzinsky (1987) suggested that, with regard to elder abuse, seniors who were dependent on alcohol tended to leave themselves vulnerable to financial, physical, and/or psychological abuse. This population was thought to have had employment problems as well. Finlayson et al., (1988) found that 17% of their sample had reported that work related problems led them to treatment. Rathbone-McCuan and Triegaardt (1979) described this problem as follows: the work role for the older alcoholic can be cut short through premature forced retirement ... the policies of some companies are to force the older worker to take optional

retirement.... It may cut him off from health benefits which could cover the cost of ... comprehensive treatment.
(p. 9)

There was widespread agreement in the literature that many elders who were dependent on alcohol tended to be socially isolated from others (Cohen, 1988; Benschhoff & Roberto, 1987; Pruzinsky, 1987). Brown & Chiang (1983-84) reported that elderly substance abusers were more likely to be separated or divorced than elderly non-abusers. Those elderly substance abusers in treatment were more likely to live with someone than elderly substance abusers who were not in treatment. The elderly substance abusers were more likely than elderly non-abusers to have moved in the past two years. The elderly substance abusers were less likely to have a significant other living nearby. They were also more likely to have a disrupted social network than non-abusers.

Early Onset and Late Onset Alcoholism

There had been much controversy in the literature about the existence of two types of chemically dependent seniors. These two types were called early onset and late onset. Atkinson et al., (1985) defined early onset as "typical, lifelong alcoholics grown old." Late onset was defined by Giordano and Beckham (1985) as "the onset of problem drinking occurring later in life." Atkinson et al., (1985)

added to this definition by saying that the late onset alcoholism was created by "adversity in later life."

There were two problems in defining what was early onset and what was late onset. The first problem was the age criterion that identified early and late onset varied from study to study. One study used a criterion for early onset as drinking problems occurring before age 40 and late onset as drinking problems occurring after age 40 (Atkinson et al., 1985). However, according to this criterion, a person aged 65 who had been drinking for 25 years would have been considered a late onset problem drinker (Gomberg, 1990). Also, using an age such as 40 to determine late onset may have implied that the elderly were a homogeneous group; but, a great number of differences exist among the cohorts between 40 and 80 years of age (Giordano & Beckham, 1985).

The second problem with the definition of early and late onset was that only alcohol use was involved. This left out the elderly who had used mood-altering prescription drugs exclusively or had switched to alcohol.

The adversity Atkinson et al., (1985) were referring to was late life stressors including bereavement, retirement, poor health and loneliness. Finlayson et al., (1988) supported the link between late onset alcoholism and late life stressors. The group of late onset alcoholics were more likely to identify late life events as causing problem

drinking than the group of early onset alcoholics. However, many sources stated that there was no empirical proof that such causation actually existed (Atkinson, 1988; Giordano & Beckham, 1985; Gomberg, 1990; LaGreca et al, 1988; Nowak, 1985). The main points that created a strong argument against making a link between late onset alcoholism and late life stressors were the following:

1. Old men who were divorced or separated had greater rates of alcohol abuse than old widowers. So, marital problems had a stronger relationship to alcohol abuse than death of a spouse (Gomberg, 1990).
2. Old men who were employed were more likely to be heavy drinkers than elderly who were not working. Retirement may have led to a decrease rather than an increase in drinking (Barnes, 1982).
3. Using life stress to explain late onset was too simplistic. It left out other possible factors such as family history, biological reactions to alcohol, and changes in drinking habits (Gomberg, 1990).
4. Atkinson (1988) wondered if elderly people gave late life stressors a rationalization for chemical dependency. Thus these stressors may not have had an actual direct effect on drinking.
5. The late onset alcoholism concept seemed to assume

that alcohol was being used as a coping mechanism for stress in old age although this coping mechanism had not ever occurred in earlier years. Giordano & Beckham (1985) strongly doubted that personal styles of coping could have changed so dramatically because of aging alone.

More research is needed to prove that two types of chemically dependent elders exists. The questions of what causes late onset alcoholism and at what age does late onset actually occur requires more study and clarification.

Summary

To summarize what can be interpreted from the literature about the elderly who were dependent on alcohol, it can be seen that serious consequences were related to regular excessive drinking or binge drinking not only by young to middle-aged people, but also by seniors. Seniors were just as physically, socially, and psychologically vulnerable to becoming dependent on alcohol as younger people. A person who is 45 years old and a person who is 80 years old may develop stomach ulcers due to excessive regular drinking. Young and old persons dependent on alcohol may seek out others who also drink. A 78 year old woman and a 30 year old woman may develop a dependency on alcohol because they both drank to subdue depressed feelings resulting from memories about being sexually abused. Much

has been learned about this specific population in a wide variety of studies. However, research needs to explore this problem at greater depth, and to replicate studies so that findings could begin to be generalized and compared to each other.

CHARACTERISTICS OF THE ELDERLY DEPENDENT ON MOOD-ALTERING PRESCRIPTION DRUGS

Prevalence

The elderly in the United States were found to have used 25% of all drugs that are prescribed (Carty & Everitt, 1989). The five major classes of drugs most often prescribed to seniors were cardiovascular drugs, central nervous systems drugs, diuretics, sedatives and analgesics (German & Burton, 1989; Gomberg, 1990; Lamy, 1985; & Nolan & O'Malley, 1987). Researchers found high levels of mood-altering prescription drug use among seniors (Glantz, 1985; Guttman, 1978; Smart & Adlaf, 1988). A study specific to mood-altering prescription drug use among elders in Manitoba was conducted by Mitenko, Sitar, & Aoki (1983). During 1975 and 1978 they found that two thirds of people over 65 who were Pharmacare claimants had been prescribed mood-altering drugs. Most of these drugs included benzodiazepines, sedative-hypnotic barbiturates, antidepressants and antipsychotics. Codeine and other opiates were also widely used.

Surprisingly, barbiturates continued to be prescribed although they were recognized as obsolete and potentially dangerous to seniors. Many of the seniors in this sample were getting multiple and concurrent mood-altering prescription drugs. Jacyk, et al., (1991) found that 16.8% of all people over age 65 presenting in the Emergency unit of a 750 bed hospital in Manitoba were identified as being possibly drug dependent.

There were some methodological problems influencing research results about drug dependency among seniors. Glantz (1985) identified these problems, starting with difficulties related to research of the elderly. It was often difficult to get a random sample that was large enough and geographically widespread enough to be generalizable. Poor health and social isolation made accessing this subgroup troublesome. Administering forms posed definite obstacles for seniors with hearing, visual or motor impairments.

The second set of problems with research were related to the drug dependency research. Only one study - by Jacyk et al., (1991) - directly addressed drug dependency. All others focused on quantity, duration and frequency of use without assessing specifically for dependency (Johnson, 1989; Nolan & O'Malley, 1988; Smart & Adlaf, 1988). Many operational definitions of drug usage and drug classifications differed among the studies. Most studies used

different research tools. Measurement tools were used that lacked the ability to determine the more subtle and different behaviour patterns of drug dependency in the elderly. Few studies were done in the general community, most were done in clinical settings. Doing studies in clinical settings did not access those elderly who tended to self-medicate themselves and avoided clinical settings. Lastly, elderly people who were drug dependent may not have been aware of the dependency; thus, they would have been unable to admit to the excessive drug use.

Sociodemographic Characteristics

The sociodemographic characteristics of seniors dependent on mood-altering prescription drugs began with considering gender differences. Women were more likely to be using mood-altering prescription drugs and to be using more of these drugs than men (Nolan & O'Malley, 1988; Smart & Adlaf, 1988; Stephens et al., 1981; Whittington et al., 1981). However, this finding was inconclusive because Gomberg (1990) stated that elderly men were more likely to use mood-altering prescription drugs than women. Also, German and Burton (1989) reported that men and women showed no differences with drug usage. Swanson (1973) found mood-altering prescription drug abusers to have high levels of academic and occupational achievement. German & Burton (1989) reported that higher drug use was related to

increased age, low income, low education level, unemployment, being white and widowed. Yet, Smart and Adlaf (1988) found that no sociodemographic variables were related to mood-altering prescription drug use except age.

Behaviour Patterns of Use of Mood-altering Prescription

Drugs

In studies of abuse of mood-altering prescription medications, it appeared that there was a wide duration of drug use spanning 2 to 40 years, with a mean duration of 16 years (Finlayson, 1984). Many began their drug dependency before they were considered elderly (Swanson et al., 1973; Finlayson, 1984). Glantz (1985) described how some of the elderly took alcohol at the same time as mood-altering prescription drugs over the years. Others alternated their use of alcohol or drugs, thus creating a single pattern of drug dependence by only changing the chemical of choice. Finlayson (1984) suggested that the continued use of analgesics despite the lack of pain relief was a sign of chemical dependency.

Of 100 elderly women, 45% took a benzodiazepine every night (Johnson, 1989). In ten percent of all benzodiazepine users, more than one kind of benzodiazepine was used every day (Nolan & O'Malley, 1987). Among elderly respondents in a study by Smart and Adlaf (1988) approximately seven percent used sleeping pills and tranquilizers daily.

Some seniors who were dependent on mood-altering prescription drugs hoarded medications. They kept old prescriptions, sought out extra mood-altering prescription drugs from friends and family, and obtained refills of their prescriptions over and over (Glantz, 1981). Also, a widely recognized pattern of drug dependency was to use multiple physicians and multiple pharmacies (Finlayson, 1984; Glantz, 1981; Raffoul, 1986). Drug dependent elderly took twice as much or more of the prescribed dose of one or more drugs (Ellor & Kurz, 1982; Raffoul et al., 1981).

There were many reasons for seniors to become dependent on mood-altering prescription drugs. Glantz (1981) mentioned that seniors legitimately believed that they were "just following doctors orders." Some used the drugs for self-medication (Raffoul, 1986). Ellor and Kurz (1982) stated the attitude of "if one is good, two is better" indicated intentional abuse. Baker (1985) stated that drug dependent elders believed that attending to the demands of daily living depended upon the use of mood-altering prescription drugs. Chronic pain and insomnia were frequent reasons given for the use of analgesics or benzodiazepines (Finlayson, 1984). Another reason given for the elderly becoming dependent on these drugs was to act as a coping mechanism with multiple losses related to aging (McKie, 1983; Raffoul, 1986; Ranalli, 1988).

However, some of the responsibility for the behaviour

of seniors dependent on mood-altering prescription drugs not only rested with the patient, but also with the physician and pharmacist. The physician may have lacked knowledge about mood-altering prescription drugs and about the normal aging process (Bozzetti & MacMurray, 1977; Glantz, 1981; Levenson, 1981). The physician could have made errors in judgment by quickly prescribing mood-altering prescription drugs before making an accurate diagnosis (Ranalli, 1988). They may have prescribed these drugs to help the elderly deal with normal aging issues or to just keep the patient quiet (Glantz, 1981). These prescribing habits were due to

"the attitude that, since old age is "irreversible" patients with late-life psychiatric disorders must be beyond recovery ... psychopharmacologic palliation and control of symptoms may constitute the mainstays of treatment with little effort to achieve remission and optimal rehabilitation. (Levenson, 1981, p. 194)

Mandolini (1981) added that the physician felt the "need with every office visit to offer a technical solution to his/her clients ... Drugs, particularly psychoactives, solve both the physicians need for providing a solution and the client's expectation that s/he will receive one" (p. 136).

Physicians and pharmacists were known to provide little, if any, direction about the type of medication prescribed, the specific scheduling for taking the drugs,

the addictive potential of the drugs, and about side effects (Lundin, 1978).

To summarize, the prevalence studies have made it clear that the elderly use a disproportionate amount of mood-altering prescription medications compared to younger populations. However, more of these studies needed to identify drug dependency. This would have provided a clearer sense of the size of this specific problem. Very little could have been concluded from the sociodemographic characteristics which made it difficult to target those elderly who were likely to have a drug dependency. This problem was a socially acceptable condition that seemed to be present at every level of the medical system from drug companies, to physicians, to pharmacists and to the patients.

Pharmacological Effects of Mood-Altering Prescription Drug Use in the Elderly

To fully understand the physical and psychological problems that these drugs caused, it was helpful to learn how the elderly physically responded once the drugs were taken. One pharmacological factor was pharmacokinetics. This was defined as "the movement of a drug toward and away from receptor sites, specifically the absorption, distribution, metabolism and elimination of the drug" (Levenson, 1981, p. 195). Organic changes in the body as it ages

have been related to drug overdose and increased sensitivity to mood-altering prescription drugs. The elderly have decreased muscle mass and decreased total body water, but increased total body fat (Baker, 1985, Carty & Everitt, 1989; Cherry & Morton, 1989; German & Burton, 1989). As a person ages, the blood flow in the liver and the liver size decreased (Baker, 1985; Berlinger & Spector, 1984; Carty & Everitt, 1989; Cherry & Morton, 1989; German & Burton, 1988).

The second pharmacological effect was pharmacodynamics. This was defined as "the effects of a drug on the target tissue and other receptor sites and the desired and undesired therapeutic responses" (Levenson, 1981, p. 195). Elderly people have greater responses to analgesics and benzodiazepines than younger people (Baker, 1985; Carty & Everitt, 1989; German & Burton, 1988). For example, the elderly were sedated with lower levels of diazepam in the blood than younger people (Baker, 1985; & Berlinger & Spector, 1984; German & Burton, 1988).

Physical, Psychological & Social Characteristics and Consequences

Physical problems caused by mood-altering prescription drug dependency among seniors has been described in the literature. Ray, Griffin, Schaffner, Baugh, & Melton, (1987) found a consistent relationship between the current

use of long acting hypnotic-anxiolytics and the risk of hip fracture. He also showed a relationship between flurazepam, diazepam and chlordiazepoxide and an increased risk of developing confusion, drowsiness and ataxia. These physical symptoms most likely led to an increased risk of falling. Although mood-altering prescription drugs were often given to treat insomnia, prolonged, regular use of these drugs led to a longer length of time to fall asleep, more nighttime awakenings, earlier morning arousals, poorer quality of sleep, and less total sleep time (Baker, 1985; Carty & Everitt, 1989; Johnson, 1989; Ranalli, 1988). Johnson (1989) also found that women who took benzodiazepines daily for longer than fourteen days reported increased difficulty with concentration, increased drowsiness and more trouble doing daily tasks. Mood-altering prescription drugs caused confusion or exacerbated dementia (Baker, 1985; Berlinger & Spector, 1984; Cherry & Morton, 1989; Ranalli, 1988). Movement disorders and hypothermia were associated with prolonged, regular use of these medications (Berlinger & Spector, 1984; Ranalli, 1988).

There was nothing described in the literature about social consequences experienced by elderly who were dependent on mood-altering prescription drugs.

There appeared to be psychological characteristics related to mood-altering prescription drug dependency among the elderly. Glantz (1981) identified psychological factors

that predisposed the elderly to drug dependency. Some of these factors included dependence, depression, alienation, apathy, anxiety, a positive attitude of drug use among peers, and a social environment that favoured drug use. Glantz also proposed that drug dependency among the elderly was related to lowered self-esteem and low self-assessment of personal capabilities. These elderly people tended to have difficulty coping with problems. Psychological defences such as denial and projection prevented the senior drug abuser from becoming aware of a drug dependence.

Finlayson (1984) also cautioned that "one should not assume ... that addiction in older persons typically begins as result of failure to cope later in life" (p. 63). He found that patterns of drug abuse and dependence by the elderly seemed to start long before troubles related to aging occurred. The psychological consequences to drug dependency among the elderly also involved the creation or exacerbation of anxiety, or depression (Baker 1985; Cherry & Morton, 1989; Berlinger & Spector, 1984). Also, mood-altering prescription drugs flatten the expression of personality in a patient. (Ranalli, 1988, p. 3)

In summary, long-term, regular use of mood-altering prescription drugs created serious, negative consequences that jeopardized the health and well-being of many seniors. The faith and trust of the elderly to utilize personal resources to cope with loss, insomnia, anxiety or pain has

been lost. Instead, they were given a "quick fix" that resulted in worsening their original problems. More needs to be learned about the elderly who are dependent on mood-altering prescription medications.

THE EFFECTS OF CHEMICAL DEPENDENCY AMONG SENIORS ON FAMILY MEMBERS.

Not only did chemically dependent seniors experience difficulties with physical, psychological and social aspects of life, they also affected the lives of those who cared about them, such as family and friends. The literature that addressed drug and alcohol abuse among the elderly only "hinted" at this idea. Only a few researchers even gave mention to families (Gaitz & Baer, 1971; Rathbone-McCuan & Triegaardt, 1979). Rathbone-McCuan & Triegaardt (1979) offered a descriptive report on older families and issues of chemical dependency. There was little elaboration on the effects a senior's chemical dependency had on the family, except that families may have attributed some of the problems a chemically dependent senior experienced to the aging process. Rathbone-McCuan and Triegaardt (1979) reported that the destructive impact of alcoholism was felt across the generations no matter what generation of family member was alcohol dependent.

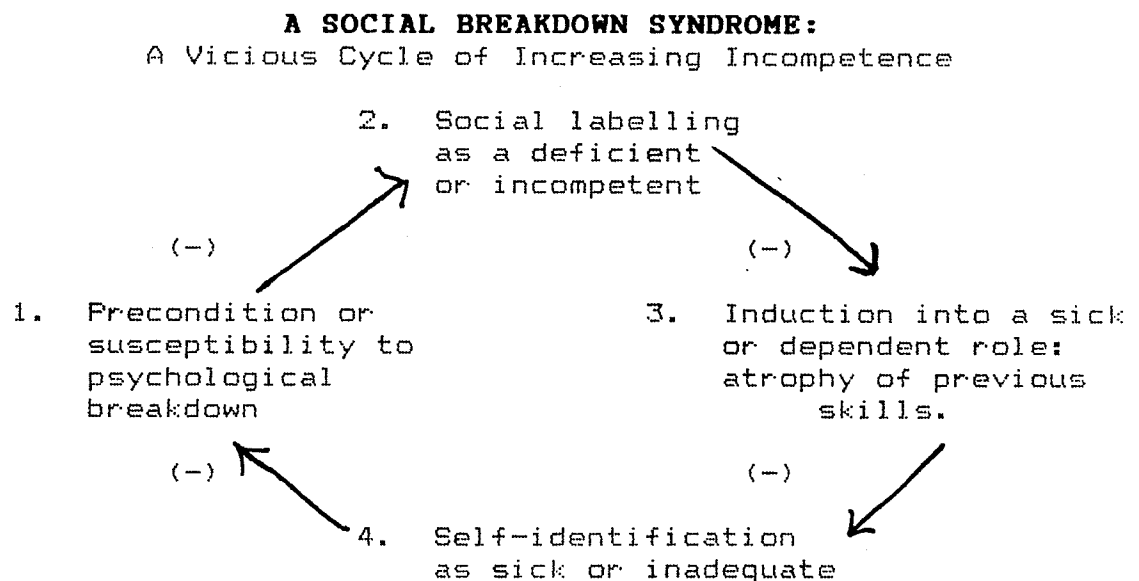
CHAPTER II

THEORETICAL FRAMEWORK

Concept of Aging

As a foundation for developing the practicum project, the Social Reconstruction Model (Bengtson, 1973) offered the most appropriate theoretical perspective on aging. Combining labelling theory with systems theory, it was applied to the difficulties of adjusting to the aging process. Society's attitudes about aging and social policies related to aging were interwoven into this theory. The impact of these attitudes and policies on the elderly were also illustrated by Bengtson. This model began with a description of the Social Breakdown Syndrome. Refer to Figure 1 shown below.

Figure 1



(Bengtson, 1973, p. 47)

Many elderly people were vulnerable to psychological breakdown because they lacked norms about aging to use as a guide as they grew old. Many of the elderly were also predisposed to psychological breakdown because of the loss of roles associated with becoming old, such as no longer being employed or being a spouse. Without these norms or roles to help determine what identity and behaviour was appropriate for old age, elderly people then looked to external sources to identify or label who they were. Bengtson wrote that many of these external sources portrayed the elderly as unproductive and worthless members of society. The elderly person who accepted this negative labelling would have let go of any previous skills and abilities and also, slowly adopted a negative self-identity as worthless and inadequate. This poor self-identity served as a predisposition to further psychological breakdown reinforcing the vicious cycle.

The Social Reconstruction Model showed the interaction between the elderly person and society adding interventions that could have been done to prevent social breakdown. This model had five goals that may have prevented social breakdown:

1. decreasing vulnerability and increasing self-confidence,
2. reducing dependency and promoting self-reliance,

3. self-labelling as able,
4. increasing and maintaining coping skills, and
5. establishing internalization of self-identity as effective and valuable.

Each of these goals led to accomplishing the next goal, creating a cycle of increasing competence among the elderly.

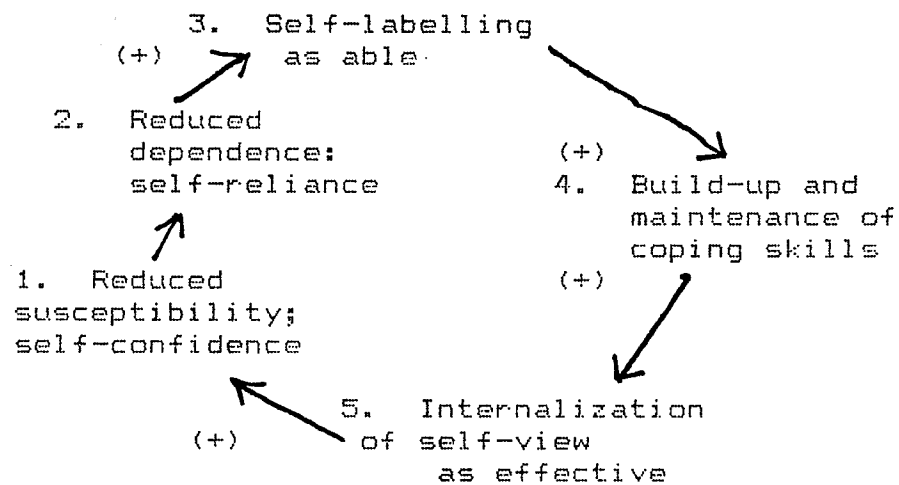
The Social Reconstruction Model incorporated interventions into the cycle that may have achieved any of the goals. These were shown outside the cycle to illustrate that the interventions came from the external environment such as government policies or professionals in service agencies. These interventions could be applied at any point in the cycle.

One drawback to this model was that it seemed to be directed to the elderly as a homogenous group assuming that all elderly people possessed a predisposition for psychological decline. However, a large percentage of the elderly are managing well and are very active. It may have been more appropriate to apply this model to segments of the elderly population that have specific types of social breakdown such as poor health or mental illness. Another drawback was the assumption that the social breakdown was related to the stresses of aging which began in old age. A vulnerability to social breakdown may not have had anything

Figure 2

**THE SOCIAL RECONSTRUCTION SYNDROME:
A Benign Cycle Of Increasing Competence
Through Social System Inputs**

INPUT B: Improved maintenance conditions (housing, health, nutrition, transportation)



INPUT A: Liberation from the functionalistic ethic;

INPUT C: Encourage internal locus of control; build adaptive problem solving.

(Bengtson, 1973, p.48)

to do with chronological age. Rather, lifelong personal coping skills and attitudes about aging may have been just as likely to serve as predisposing factors to social breakdown among the elderly.

Despite the drawbacks, the reason this model of aging was chosen for the practicum was because it addressed the problems faced by the chemically dependent elderly. This segment of the elderly population was known to breakdown

socially and psychologically. Chemically dependent elders needed interventions from the external environment such as treatment for chemical dependency, medical care, good transportation, and home making services. These interventions seemed to apply to the goals outlined by Bengtson in the Reconstruction Model.

This practicum project was considered as an input into the Reconstruction Model in Figure 2 and designed to decrease vulnerability, and dependency among the chemically dependent elderly. The practicum project could have been applied as an input anywhere on the cycle because it had the potential to alleviate any factor related to the social breakdown cycle. The practicum project may have also been able to help the chemically dependent elderly increase self-reliance, establish self-labelling as able, increase and maintain coping skills and create an internalized self-identity as effective and valuable. These goals in the Social Reconstruction Model provided ideas for therapeutic approaches during the treatment group that were well received by the members. For example, to establish an internalized self-identity as able, the topic of self-esteem was incorporated into the treatment group. The main exercise in that sessions was for members to focus on the positive qualities they liked about themselves and other members.

CONCEPT OF CHEMICAL DEPENDENCY

For the purpose of the practicum, the concept of chemical dependency was chosen as part of the theoretical framework. It was chosen over such concepts like substance abuse, addiction or alcoholism for a couple of reasons. It included users of any mood-altering chemical including alcohol and mood-altering prescription drugs. It included individuals who used more than one type of mood-altering chemical over time. The term chemical dependency seemed to be connected to few negative mental images and reasonably free from moralistic judgement. Concepts like abuse or addiction seemed to conjure up thoughts of heroine addicts or skid row alcoholics. Seniors, who already possessed strong judgements about this problem, were likely to have great difficulty accepting themselves as alcoholic or as a drug addict. They may have had less resistance to accepting the idea of being chemically dependent.

The disease model of chemical dependency was chosen as part of the theoretical framework. It was defined by the Alcoholism Foundation of Manitoba (1984):

Chemical dependency is an illness where dependency upon mood-altering substances had attained such a degree as to disrupt academic or work performance, interfere with family and interpersonal relationships, disrupt smooth social and economic functioning, and impair the state of physical and/or mental health. (Chemical Dependency

Intervention Course Resource Book p. 26)

Chemical dependency was considered a primary disease which must be dealt with first before any other problems were addressed. It was progressive, meaning symptoms worsened over time if chemical use continued. Chemical dependency was predictable, with an identifiable course of progression common to most people who have the disease. It was permanent, so once someone was chemically dependent he or she would have remained chemically dependent. It was treatable, but if it progressed without treatment, it may have been fatal. (Alcoholism Foundation, 1984)

The disease model of chemical dependency was integrated into the practicum project for a few reasons. Firstly, most treatment programs in the community used the disease model. If the practicum project served clients who had gone to other chemical dependency programs in the past, the transition from one resource to another may have been easier because the philosophies about chemical dependency were consistent. Secondly, this perspective had been adopted by many experts on chemical dependency such as Vernon Johnson (1980) and Gorski and Miller (1982). Lastly, personal comfort with using the disease model of chemical dependency was considered since this perspective had been used in past clinical work with chemically dependent clients.

To further describe the concept of chemical dependency, the Elders Health Program defined the term "chemicals" to

include all legal mood-altering substances including alcohol, prescription medications and over-the-counter drugs. Mood-altering substances suppressed central nervous system activity. Prescription medication that acted in this way included barbiturates, benzodiazepines, and narcotic and opiate analgesics. Over-the-counter drugs that were mood-altering included antihistamines, some cough syrups, analgesics and sleeping medications. Taking more than one kind of mood-altering substance can have a magnified depressant effect (Jacyk et al., 1991).

The term "dependency" was defined as chronic habitual use of substances beyond their efficient, beneficial effect or in spite of significant negative consequences or side effects. All of the prescription and over-the-counter medications were only to be used for a short period of time, but no longer than about three months. If they were used for a longer period of time. Use of these drugs prevented the consideration or searching out of therapeutic alternatives that could be just as effective or less prone to negative consequences.

WORKING CONCEPTS OF RECOVERY

Once a chemically dependent senior decided to seek treatment, recovery from chemical dependency had begun. Gorski and Miller (1983) defined recovery as a process which unfolded and changed as time passed. It required daily,

never ending activity. This activity could have included attending A.A. meetings, maintaining sobriety-based values of honesty and helpfulness, and meditation. Once the activity of maintaining recovery stopped, then relapse occurred. Relapse was defined as a progressive psychological/physical/behavioral deterioration that ultimately leads to chemical use again (Gorski & Miller, 1983).

Recovery was developmental, meaning that a chemically dependent person moved through various stages of growth and maturation. Each stage was built upon the successful completion of a previous stage. If a person resumed chemical use and later returned to treatment, the person usually started the recovery process from the beginning (Gorski & Miller, 1983).

There were six stages in the Developmental Model of Recovery created by Gorski and Miller (1983). A detailed, complete reference of the developmental model of recovery is given in the table below.

Table 1

The Developmental Model of Recovery (DMR)		
THE PRE-TREATMENT PERIOD	THE STABILIZATION PERIOD	THE EARLY RECOVERY PERIOD
1.1 Learn by the Law of Consequence that alcohol and drug use was not safe	2.1 Screening and Differential Diagnosis	3.1 Self-Assessment with knowledge help.
1.2 Experience a motivational crisis	2.1 Compliance with a stabilization program for alcoholism	3.2 Establishment of an externally regulated recovery program.
1.3 Recognize the pattern of crisis	2.3 Discontinuation of alcohol and drug use.	3.3 Acceptance of alcoholism as a primary disease that requires treatment.
1.4 Recognize the need to find the underlying cause of the crisis	2.4 Withdrawal management.	3.4 Patient and family education.
1.5 Recognize the need for outside help	2.5 Stabilization of life crisis	3.5 Management of the Post Acute Withdrawal and other sobriety-based symptoms of alcoholism.
1.6. Acceptance of help.	2.6 The preliminary assessment	3.6 Development of personal strengths and communication skills.
	2.7. The preliminary diagnostic presentation	3.7 Management of complicating factors.
	2.8 Initial motivational counselling.	

The Developmental Model of Recovery (DMR)		
THE MIDDLE RECOVERY PERIOD	THE LATE RECOVERY PERIOD	THE MAINTENANCE PERIOD
4.1 Resolving demoralization crisis	5.1 Personal history examination	6.1 Maintain a recovery program
4.2 The stabilization of long term alcohol and drug related life problems	5.2 Establishment of a low stress life style.	6.2 Be alert for relapse warning signs
4.3 The acceptance of alcoholism and the loss of the old lifestyle.	5.3 Psychotherapy to create a low stress integrated personality style (if necessary).	6.3 Problem solving and daily coping skills.
4.4 Review and self-application of information about alcoholism and recovery.	5.4 Life planning and learning to live again.	6.4 Continued life planning.
4.5 Values clarification of the separation of alcohol centered and sobriety centered valued.		6.5 Live productively.
4.6 Establishing a self-regulated structured recovery program		6.6 Sobriety check-ups. Periodic formal inventories of progress.
4.7 Habituation of sobriety centered lifestyle.		
(Gorski & Miller, p. 48-54)		

This model had some drawbacks. It was based on chemically dependent people who got help from professional treatment centres. For example, references to a

agencies. The recovery process seemed closely linked to these kinds of events. It was unknown if recovery maintained the same process if people recover on their own. This model may not have applied to those who recover in self-help groups like A.A. A second drawback appeared to be the model's narrow reference to alcohol users exclusively. The model was not generalizable to mood-altering prescription drug users.

Thirdly, no evidence had been given to support the assumption about starting the recovery process over again if a relapse occurred. Anything learned from previous recovery attempts may have assisted with moving through recovery in the future. Maybe some tasks or some stages did not need to be dealt with over and over again. For example, a person had a brief relapse of drinking a couple of drinks and then stopped drinking and returned to A.A. again. This person may not have needed to be admitted to a stabilization program. It may not even have been necessary to move through the stabilization stage especially if a strong commitment to recover already existed.

In spite of these drawbacks, the model did provide a framework for recovery that could be applied to chemically dependent seniors and the practicum project. It provided some guidelines about what elements could be integrated into a treatment program. This insured that the recovery process was strengthened and encouraged in treatment. For

example, learning about chemical dependency and applying it to personal experience as a part of middle recovery suggested that education should be offered in treatment.

To summarize, chemical dependency is a complex issue that does not offer a concise, absolute conceptual framework. Any social worker dealing with chemical dependency is likely to be faced with choosing a concept that seems to fit with a personal working style and value system. The model of recovery was helpful to identify the challenges chemically dependent seniors need to address. However, this recovery model would be even more helpful for the purpose of this practicum if it had been adapted to the specific and unique recovery stages that seniors experience.

CHAPTER III

THEORETICAL FRAMEWORK OF GROUP WORK

This chapter is designed to establish the theoretical foundation for the intervention approach used in this practicum. The literature offered many perspectives and concepts describing group work and the activities that occurred in a group setting. The concepts chosen in this chapter assisted with describing the approach taken in this practicum.

Rationale for Group work

Why was group work chosen as a method of intervention with chemically dependent seniors? With the help of Corey & Corey (1977) and Toseland & Rivas (1984), the advantages of group work were outlined below:

1. Group members can explore their style of relating to others and can use the group to learn better social skills.
2. The group setting can offer support for new behaviours and encourages experimentation.
3. A group is often a reincarnation of the everyday world where members recreate problems that exist for them. Members can get helpful feedback about how the part they play in creating their problems.
4. Groups help members know that they are not alone with their problems.

5. Groups give members the chance to help others.
6. Group members can learn through the experience of others.
7. It can be beneficial for those who were socially isolated.

Group work had some limitations (Corey & Corey, 1977). Knowing these pitfalls helped the leader to identify the problems as they arose in group. As problems occurred, the leader could deal with them. The disadvantages to group work are:

1. Groups are not "cure-alls."
2. There is pressure for group members to conform to group norms and expectations. This can be troublesome for members who compromise themselves by conforming to group norms that go against their beliefs and values.
3. Some people get hooked on groups, making the group experience an end in itself.
4. Not all people are suited to groups.
5. Some people make the group a place to "dump" their miseries without intending to make any change.
6. Sometimes people who self-disclose can be faced with a barrage of harmful, unsupported responses.
7. Groups can focus on the members who are talkative or assertive, neglecting those who are quiet or

less assertive.

The advantages of using a group approach for chemically dependent seniors outweighed the potential disadvantages. Group work offered the best way to address the problems chemically dependent seniors experience such as social withdrawal and the lack of non-clinical coping mechanisms, and low self-esteem. Group work has been used successfully with chemically dependent seniors. This point will be discussed later in this report.

Definition of Group Work and Type of Group Chosen for the Practicum

The concept of group work has a variety of definitions throughout the group work literature. For the purposes of this practicum, group work is defined as a "goal directed activity with small groups of people aimed at meeting socioemotional needs and accomplishing tasks. This activity was directed to individual members of a group and to the group as a whole within a system of service delivery" (Toseland & Rivas, 1984, p. 12)

The kind of group that was most useful for chemically dependent seniors was a treatment group defined by Toseland & Rivas (1984). Treatment groups had members with common needs or common problems. Roles developed as members interacted with each other. Verbal and nonverbal communication was open with members talking to each other.

Procedures for an actual meeting in a treatment group was flexible, depending on the needs of the group members. Members were encouraged to self-disclose about concerns and problems which were confidential.

The treatment group for chemically dependent elders seemed to work best with two components: an education component and a remedial component. The main purpose of the educational component was to help group members learn about themselves or society. Increasing members' knowledge or skills was usually done by formal presentations by guest speakers or group leaders. Group discussions often followed the presentations. If the group was small, member-to-member interaction and a minimal to moderate degree of self-disclosure was achieved. Group leaders often utilized the experience and knowledge of more advanced members, so new members learned from the more advanced ones.

The remedial component had the primary purpose of changing group members' behaviours and helping them cope with problems, or rehabilitating them after a social or health trauma. The group leader was often seen as an expert or authority figure. Group members had individual goals. The focus was often upon the individual in the group. Group member interaction was encouraged, accompanied by a high level of self-disclosure.

Group Development

The group as a whole went through definable and predictable stages of development called group development (Toseland & Rivas, 1984). These stages changed throughout the life of the group. Toseland & Rivas offered a simple, yet complete model for stages of group development. They included the planning phase, beginning, middle and end phases.

The planning phase involved any planning and preparation a group leader needed to do before the group met for the first time. The first and most important task was to decide on the group's purpose. The next task was to assess potential sponsorship and membership (Shulman, 1984; & Wickham & Cowan, 1986). The planning phase also involved recruiting members, assessing their suitability for the group, and preparing them for their first group session.

The beginning phase of group work set the tone for the rest of the time the group got together. The group leader's main task was to begin developing communication and interaction patterns, and task accomplishment patterns (Toseland & Revis, 1984). The middle phase of group development focused on goal achievement of the group as a whole and of its members (Toseland & Revis, 1984).

The last phase of group development was the ending phase (Toseland & Revis, 1984). This was an important part of group development because it determined the success of

the whole group experience. During the ending phase, some feelings and issues that often arose included pain of separation, guilt about leaving the group, unfinished business about past group issues, and feelings of anger (Shulman, 1984). Wickham and Cowan (1986) identified behaviours that group members demonstrated in response to an upcoming termination. Some members might flee emotionally or physically from the group before it ends. Some members may deny that the ending was happening or may show regressive behaviour to keep the group going. Some may ask to keep the group alive.

Group Structure

Group structure involved many aspects that had to be taken into consideration when a group was created. The first aspect was determining how much homogeneity or heterogeneity would exist in the group. Group members should share some similar personal characteristics. These similarities would make it easier for group members to feel like they belonged in the group and could identify with each other (Corey & Corey, 1977; Toseland & Rivas, 1984). Member heterogeneity existed through members' diversity of coping skills, life experiences, knowledge and expertise (Toseland & Revis, 1984).

With regard to the size of the group, Wickham and Cowan (1986) suggested that the smaller the number in a group the

greater level of intimacy and member interaction can be achieved. They also suggested that the best working size for a treatment group was from five to nine. Another aspect of group structure was the timing of the group. Timing referred to how often a group met. It also referred to the length of each session and to the number of sessions the group would have before it ended. Another aspect to consider was deciding upon the location of where the group was to be held.

A major aspect of group structure involved deciding whether to develop an open or closed group. An open group was a group with group members who were constantly joining or leaving. A closed group had the same members throughout the life of the group (Shulman, 1984). There were advantages to an open group. Adding new members added new ideas and more resources to the group; old members helped new members (Shulman, 1984). The new members quickly achieved the same level of openness as old members (Shulman, 1984; Toseland & Revis, 1984).

The main disadvantage to open groups was that cohesion was more difficult to achieve because trust between members was never stable. Group dynamics remained unstable. Old members' ability to work on problems was disrupted as new members joined the group. Each group meeting required more work from the group leader. Constant attention was given to new members beginning and to old members leaving. Member-

to-member communication patterns changed as group members came and went. Group rules were easily forgotten. Each group member's position and role in the group changed from session to session (Corey & Corey, 1977; Shulman, 1984; Toseland & Rivas, 1984). Despite the disadvantages related to an open group, it was decided that an open group is the best option to use with chemically dependent elderly. This will be discussed in more detail later.

Co-Leadership

Co-leadership in group work was a controversial theme in the literature. There was little empirical evidence to support co-leadership or to advocate against it. Co-leadership was also known as multiple therapy, co-therapy, dual leadership and many other terms (Rosenbaum, 1983). For the purposes of the practicum, co-leadership was the chosen term. The concept of co-leadership was used by Toseland & Rivas (1984) which meant two people led a group together. This clearly and simply described the leadership unit in the treatment group for the chemically dependent elderly. Toseland & Rivas (1984) listed the advantages to co-leadership as follows:

1. Provides a leader with a source of support.
2. Provides a leader with a source of feedback, and an opportunity for professional development.
3. Increases a leader's objectivity by providing

alternative frames of references.

4. Is an excellent way of training an inexperienced leader.
5. Provides group members with models for appropriate communication, interaction, and resolution of disputes.
6. Provides a leader with assistance during therapeutic interventions.
7. Aids in setting limits and in structuring the group experience (pp. 107-108).

Co-leadership also had some disadvantages as indicated

below:

1. Having two group leaders can be expensive.
2. More coordination and communication between both leaders is necessary to plan for group sessions thus requiring more time and effort to run the group.
3. Two group leaders who do not work well together are not good role models for group members.
4. Having an experienced and an inexperienced group leader work together can create tension and conflict between the leaders.
5. An inexperienced and an experienced co-leader would not share equal responsibility and equal participation because it is common for the inexperienced group leader to assume a passive, obser-

vatory role (Toseland & Rivas, 1984).

To maximize the advantages of co-leadership and minimize its disadvantages some guidelines were suggested. Meeting regularly right after a group session was recommended as a time to discuss how the group was doing, how well the co-leaders were working together and what the plan was for the next group. (Toseland & Rivas, 1984). It was important for co-leaders to learn each others leadership style and to be comfortable with it. Rather than pushing for similarity, maintaining co-leaders different therapeutic styles kept a variety of techniques available for facilitating group member's work on individual goals. If conflict did arise between co-leaders, resolving it in group may have been therapeutic as long as the impact on group members was helpful rather than harmful. If conflict cannot be resolved, it was better to have the group led by one person than by two leaders who were not getting along (Toseland & Rivas, 1984). Rosenbaum (1983) suggested that conflict be addressed outside of group. If conflict cannot be resolved, genuine respect and collaboration was to be maintained in the group session.

Use of Peer Counsellors in Group Work

The use of a peer counsellor as a leader in group had little attention in the literature. A peer counsellor was defined as someone who had a common characteristic with the

clients and used natural skills to conduct therapy (Lieberman & Bliwise, 1985). The peer counsellor leader in this practicum possessed these same qualities. More details are given in Chapter IV.

The benefits of having a peer counsellor as a group leader began with a peer counsellor being able to have more understanding about clients' problems and being less threatening to clients (Lieberman & Bliwise, 1985). Using peer counsellors as group leaders proved cost effective when they were involved on a volunteer basis. Lieberman & Bliwise suggested that peer counsellor group co-leaders work most effectively when they can use natural skills such as friendship and support, advice and practical problems solving.

Drawbacks existed when peer counsellors and professionals worked together as co-leaders or even worked separately within the same agency. Lieberman & Bliwise found that because peer counsellors were closely affiliated with social workers, the group members lost some of the ability to closely identify with the peer counsellor. The reason this happened was because the peer counsellor seemed to have taken on some of the power and authority of the social workers. Working with the social workers, the peer counsellors may have learned some professional skills. The peer counsellor may have then taken on responsibilities and roles within the group that he or she remained unqualified

to do (Clark, 1987; Lieberman & Bliwise, 1985). Conflict arose between peer counsellors and professionals because of their differing perspectives and approaches to clients' problems (Clark, 1987).

Group Work with Chemically Dependent Elderly

Qualities that Impede or Enhance Group Treatment

The literature mentioned some personality characteristics and behaviours that were observed in chemical dependency treatment programs (Kofoed, 1984; Linn, 1978; Schmitt, 1976). Knowing this information allowed for anticipation of these characteristics in this practicum project. Some characteristics of chemically dependent elders did pose difficulties in treatment as described by Kofoed (1984). These included intense guilt-feelings, strong denial and a resistance to change. However, these difficulties were outweighed by positive characteristics. It was documented that chemically dependent seniors did have characteristics that enhanced treatment. The chemically dependent elderly were reported to be more socially and psychologically stable and less prone to crisis and regression than were younger chemically dependent people (Kofoed, 1984; Linn, 1978; Schmitt, 1976). They also brought with them a wealth of life experiences (Kofoed, 1984). Linn (1978) discovered that seniors developed greater socioemotional bonding with staff, and had less authority conflict with them. Chemical-

ly dependent elders were known to complete treatment more often than young chemically dependent people (Carstensen, Rychtarik & Prue, 1985).

Descriptions of Age-Specific Treatment Groups for the Chemically Dependent Elderly

A few age-specific groups had been developed for chemically dependent seniors. A brief description for each group follows. Kofoed (1984) discussed the "Class of '45" as a specialized, elderly-oriented outpatient program. It was open to any veteran who served military duty from 1945 to earlier years. The group met once per week for 1½ hours, during the day. The group was an open group with no termination date for group members. Recreational activities had been offered to group members. Two alcoholism counselors led the group. Staff did outreach visiting to those members who were unstable or were relapsing. The group pace was much slower than younger-aged groups. Many members maintained sobriety. Frequently, delayed responses from previous discussions and topics arose. Self-disclosure was slow and cautious. Reminiscence occurred with great frequency. Compliance in treatment was high with few drop outs or relapses. There was an 81% rate of attendance with an average length of stay of 10 months.

Zimberg (1985) reported on group work with chemically dependent seniors in an outpatient psychogeriatric program. He recommended that group treatment was more likely to be

successful if social and psychological stresses related to aging was emphasized while the chemical dependency was deemphasized. Denial was common with this population, but confrontation techniques had not been found helpful. Seniors who were not willing to join a treatment group were seen individually to find interests and personal strengths that eventually were used to lead them into group. Group therapy included up to 15 to 20 members. The group met at least once per week for one and a half to two hours. A problem solving approach was used. Group sessions began with informal socializing and eating, followed by a problem solving period, and ended with more informal socializing. Recreational activities were encouraged. Group leaders included a psychiatrist, a nurse and one or two para-professionals.

Dunlop, Skorney & Hamilton (1982) held their group meetings twice per week during the day for 1½ hours. One session per week offered a half hour of educational presentations including topics about the twelve steps of A.A., assertiveness training, sexuality, nutrition, family dynamics, grief, and relaxation techniques. The group was divided into small counselling groups which lasted about 45 minutes. Each session ended by socializing with each other. They attempted to meet any physical impairments by selecting a meeting room that was accessible to wheelchairs, canes and walkers. Speaking slowly and distinctly accommodated

hearing difficulties. Large print handouts were distributed among members. Professional jargon was avoided to insure that misinterpretation did not take place. Self-disclosure was slow and reluctant. Group members enjoyed being with peers. Reminiscing and the expressing of feelings were the two main therapeutic activities done in the group.

A fourth group was described by Felker (1988). A geriatric nurse and a geriatric social worker began the Elderly Recovery Group in 1977. It was located in a craft room in a senior's apartment complex. It was an open group where members could stay as long as they wanted. The group size was kept to eight members per session. Member attendance usually included two thirds of all members. Absences were due to poor health, medical or social services appointments or transportation problems. Members were expected to call one of the leaders if they could not come to a meeting. The group met from 9:00 to 10:30 in the morning with the first 30 minutes spent socializing. The "Thought and Meditation for the Day" book was read and followed by a discussion about the reading or an unrelated personal problem. Confidentiality was maintained. Disruptive group members were taken out of group by one of the leaders. If a member came intoxicated but was not disruptive, that person could stay but not participate in discussion. Sometimes individual members were given homework assignments. Attendance to Alcoholics Anonymous was encouraged. The treatment

outcome was that out of 15 active members, 12 had abstained from alcohol. Group members provided positive feedback about the group. Felker (1988) quoted one elderly lady as saying "When I tell something, I know you've all been there" (p. 113).

Another referred to the group as his true family, stating that they had been there for him in a way that his relatives had not. "I need a lot of love, I get a lot of love here," (p. 113)

The last group to be described was developed by Dupree, Broskowski & Shonfeld, (1984). It was called the Gerontology Alcohol Project located in Florida. The group was held during the day and each session lasted 45 minutes. It was run by para-professionals who were trained in using the therapeutic techniques. A behavioral, self-management approach was used in the group. There were four sets of groups, called modules. Each client proceeded from the first module to the second module which led to the third and fourth modules.

Dupree et al. found that the members learned the educational material. Alcohol consumption was reduced. The members increased their number of friends as well as the number of contacts to relatives. Unfortunately, one half of their clients dropped out after admission to the group. Reasons for the high drop out rate was not speculated upon.

Most of the treatment mentioned in the literature focused on serving seniors who used alcohol only. This left out the large numbers of seniors dependent on mood-altering prescription drugs. However, there were a few sources that had drawn attention to treatment for seniors who were dependent upon mood-altering prescription drugs. Finlayson (1984) and Atkinson and Kofoed (1982) discussed the need to hospitalize these seniors in order to manage withdrawal symptoms, denial and somatization. Both of these sources advocated post-hospital follow-up similar to treatment for alcoholism. Finlayson (1984) also believed that Alcoholics Anonymous could be helpful for seniors dependent on mood-altering prescription drugs. Gaitano & Epstein (1979) suggested group health education for seniors. This served to "create positive health behaviours," which emphasized the appropriate use of drugs when necessary, rather than discourage or encourage drug use.

To summarize, it seemed that chemically dependent seniors benefited from treatment groups. They possessed positive characteristics that enhanced their success in age-specific groups. Despite the varied methods of group work and therapeutic philosophies used, the needs of the elderly and knowledge of chemical dependency recovery seemed well understood by those who developed these groups.

CHAPTER IV

THE PRACTICUM PROJECT

Sponsoring Agency

The sponsoring agency for the practicum was the Elders Health Program. This was a demonstration project that was funded by Health and Welfare Canada from September, 1987 to March, 1991. It was affiliated with the Departments of Social Work and Geriatric Medicine at St. Boniface General Hospital. The two aims of the Elders health Program were:

1. to determine the prevalence of elders presenting at St. Boniface General Hospital Emergency whose health was negatively affected by chemical dependency, and
2. to develop intervention and treatment strategies designed for chemically dependent seniors.

This was the first project in Winnipeg that was targeted to serve the chemically dependent elderly. To get a visual idea of the Elders Health Program operation, see Figures 3 and 4. The aims of the Elders Health Program were carried out in three phases: Identification, Intervention and Treatment. These phases were described in the next few pages.

Phase One - Identification.

The main task of this phase was to determine the

prevalence of chemical dependency among elders visiting the Emergency Room at St. Boniface General Hospital. A random selection of all patients over the age of 65 visiting the Emergency Room were asked to complete a questionnaire. If they agreed, a consent form was signed. These patients were interviewed at home, in Emergency, or on an inpatient ward at the Hospital.

This questionnaire was made up of various measurement tools that identified chemical dependency. One of these tools was a drug screen that focused on mood-altering prescription medication use. This drug screen was a new instrument developed specifically for the Elders Health Program. Reliability and validity has not yet been determined. Another measurement tool was the CAGE, a standardized, four-item screening tool for alcoholism. This was followed by the Brief Michigan Alcoholism Screening Test, a standardized 10-item test for alcoholism. The last part of the questionnaire was a Social Network Screen that asked five questions to identify people most involved with the patient.

Once the questionnaire was completed, the interviewer scored each measurement tool, except for the Social Network Screen. The clinical impression, social impression and the cumulative score from the measurement tools were each scored separately on a range from 0 to 3. A "0" meant there was absolutely no suspicion of chemical dependency, a "1" meant

there was a slight suspicion of chemical dependency, a "2" meant there was a moderate suspicion and a "3" meant there was a very strong suspicion that chemical dependency problems existed. All three scores were totalled. If there was a total score of "2" or more, the selected patient's questionnaire was brought to the weekly team meeting.

The interviewer's social impression was influenced by any information other than the questionnaire information that aroused concern about the senior possibly being chemically dependent. The clinical impression was determined by the Medical Co-investigator of the Elders Health Program. He decided whether or not the admission complaint on the patient's Emergency report was related to physical or psychological problems common to chemical dependency.

At the team meeting, staff decided if there was enough specific concern about each patient's prescription drug use and/or alcohol use to suspect chemical dependency. If chemical dependency was suspected, the next step was to decide whether or not the senior would benefit from an intervention. If so, then the senior was randomly assigned to either be referred to the Alcoholism Foundation of Manitoba for a chemical dependency assessment or to have an intervention done by the Elders Health Program.

Phase 2 - Intervention

Once the identification phase was well under way, the

Elders Health Program began the intervention phase which involved the development of an intervention process adapted for use with the elderly and their social networks. The Elders Health Program utilized the definition for intervention by Meagher (1987) who stated:

Intervention describes the systematic approach used to break through the shield that a chemically dependent person builds ... it was necessary to break through defenses to show the dependent person that treatment was needed. An equally important goal of intervention was to motivate the person to act at once. (p. 27)

The work of an intervention focused on collaborating with a chemically dependent senior's social network to effect change within the social network and with the senior. If the social network was unwilling or unable to participate in an intervention, then the Elders Health Program worked alone to break down the denial of the chemically dependent senior. To be considered successful, the Elders Health Program advocated that intervention did not have to lead to treatment. By doing an intervention, a seed had been planted within the social network and/or with the chemically dependent senior that a concern existed about the chemical use and that change was possible.

Phase 3 - Treatment

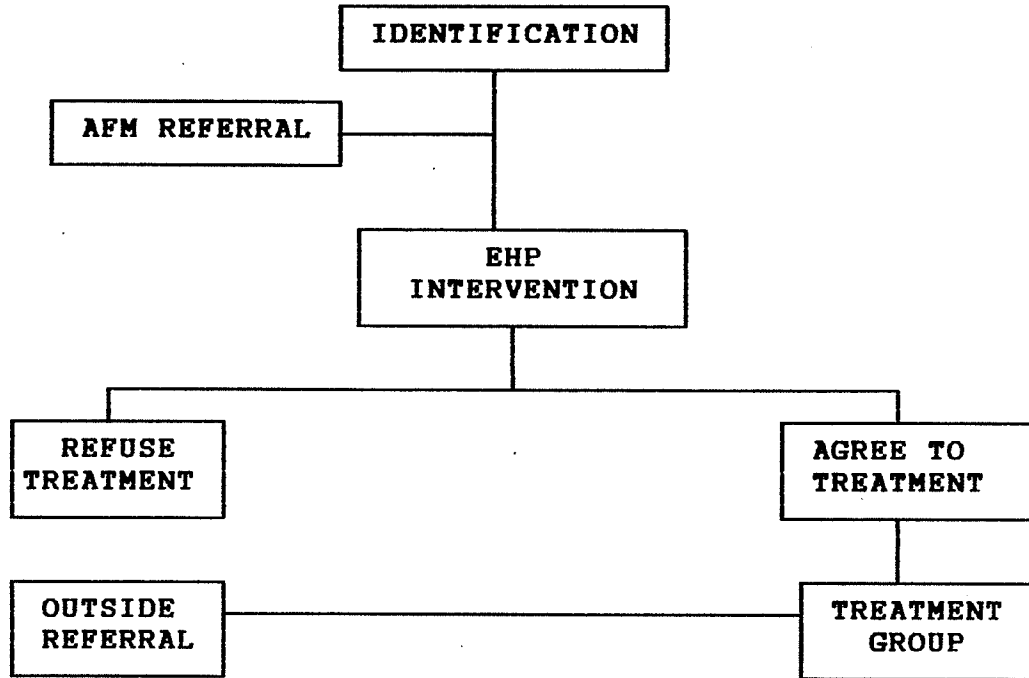
Once the identification and intervention phases were working smoothly, the treatment phase began. This involved designing and implementing a treatment program. When the treatment group was developed, the first 12 weeks of the treatment group served as an experimental pretest group. Any changes that needed to be made to the treatment program depended on the successes and failures of the pretest group. The practicum group began February 27, 1989 and was completed June 4, 1989. After that, no changes of the structure and content of the treatment group were allowed. The Elders Health Program treatment group ended on July 20, 1990. Six treatment cycles were completed, with the practicum project occurring as the second treatment cycle. The definition of a treatment cycle is discussed later in this report.

Figure 3 illustrates how the Elders Health Program moved through all three phases.

Figure 3

MODEL OF ELDERS HEALTH PROGRAM

IDENTIFICATION/INTERVENTION/TREATMENT PROCESS



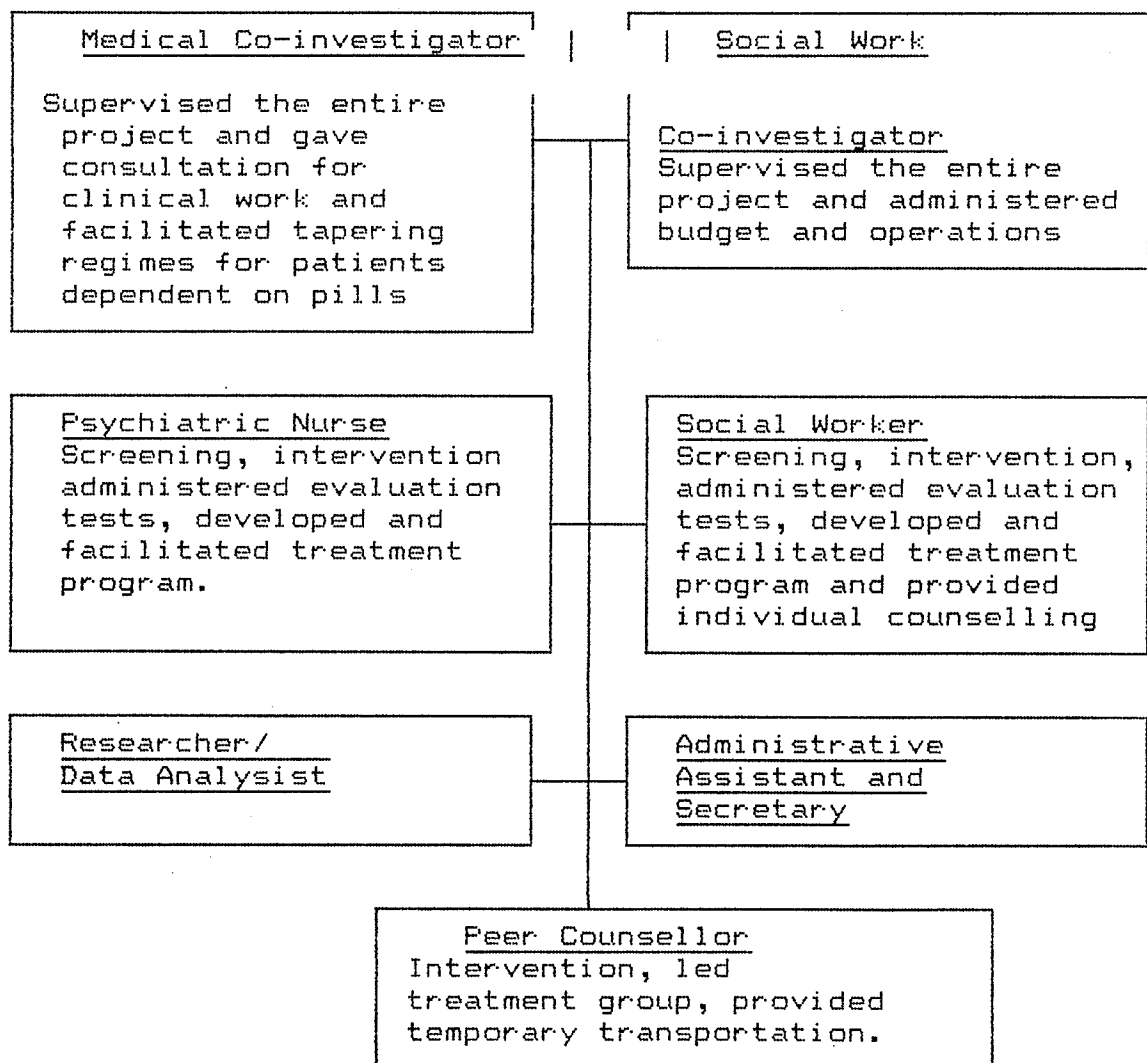
Sponsoring Agency Staff

The Elders Health Program consisted of a small staff as shown in the figure below.

Figure 4

Organization Chart

ELDERS HEALTH PROGRAM STAFF



DESCRIPTION OF TREATMENT GROUP

Group Purpose

The purpose of the treatment group was to provide a supportive group atmosphere that would create an opportunity for chemically dependent seniors and their significant others to:

1. begin to explore issues related to chemical dependency, and
2. improve the quality of their lives.

There were three group goals for the treatment group. The first goal was to establish responsible use of mood-altering prescription medications. A number of objectives were set to insure that the goal was accomplished. Medication use needed to be monitored. Tapering off mood-altering prescription drugs through the project physician or family physician required coordination from the social worker. Information about responsible medication management, and the effects of chemical dependency was offered during group meetings. The advantages of responsible medication use was explored and reinforced. Exploring ways of meeting individual needs without the regular use of a chemical was encouraged. Group support and the peer counsellor encouraged responsible use of medications. Psychological defense mechanisms that maintained chemical dependency, such as denial were challenged.

The second goal was to establish abstinence from al-

cohol. Objectives that helped to achieve this goal began with following the program's policy of attending group meetings sober. Exploring the advantages of abstaining from alcohol and the ways of meeting individual needs without the regular use of alcohol was to be carried out in group sessions. Group support and the peer counsellor encouraged abstinence from alcohol and challenged psychological defense mechanisms that maintain alcohol use, such as denial.

The third and last goal was to increase each group member's sense of life satisfaction. There were many objectives created to achieve this goal. Group support was used to give members positive feedback and encouragement. Topics were structured to address factors that may decreased life satisfaction, such as, guilt and shame, loss, poor self-esteem, and lack of meaningful relationships. Topics that addressed factors that increased life satisfaction, such as stress management, identifying and meeting needs, and creative retirement were also incorporated into the group sessions. Recreational activities during Wednesday meetings were encouraged. Each member's sense of isolation was to be lessened by attending meetings. Each group member was guided to identify aspects of their lives that created dissatisfaction or satisfaction. Identifying aspects of life that a person had no control over and aspects of life that a person did have control over was encouraged. Members were guided to take action on the things that they could

control.

Recruitment of Group Members

The group received clients from the identification and intervention process of the Elders Health Program. The group also got clients from outside referrals. Outside referrals were considered to be any referral that did not originate from the identification or intervention efforts of the Elders Health Program. Outside referrals came from concerned family members, The Alcoholism Foundation of Manitoba, family physicians, social workers in Winnipeg hospitals, and from self-referrals.

Eligibility for Admission into the Group

Clients allowed into the treatment group had to be 60 years of age or older and identified as being chemically dependent. Clients were identified as chemically dependent by using the Elders Health Program screening tools and/or gathering information about chemical use, negative consequences related to the chemical use, and assessing for characteristics commonly seen in the chemically dependent elderly. Individuals had to agree to come to group. Some members came into group with strong resistance and denial. They may or may not have had the internal desire to decrease or abstain from their chemical use at the onset of attending treatment. These individuals attended because of strong

familial or professional pressure to attend. It was hoped that as a resistant member continued coming to group, the internal desire to abstain or to decrease use and to recover would take over. The resistant member would have then made a commitment to the group and would have been willing to attempt change. The chemically dependent senior was allowed to bring a significant other who was directly affected by the chemical dependency. This was because the significant other had already been affected by the chemical dependency and may benefit from group. Also, the significant other provided external support for the senior's ongoing participation in treatment.

Elders eligible for group had minimal cognitive impairment, minimum to moderate physical limitations and had to be able to speak English. If someone had a speech impairment due to stroke, the person was expected to be able to follow group conversation. If there was any doubt about a senior's ability to manage well in a group, the senior was given a chance anyway and closely monitored for any negative effects to the member or to the group. If a member did not relate well in group, the senior was then taken out of the group and offered individual counselling.

Before the chemically dependent senior joined the group, or soon after starting the group, an intake interview with the senior was conducted. These interviews were usually done in a senior's home at the request of senior.

Sometimes a senior refused to participate in an intake interview, however, the senior was still welcomed to the group. Each senior's work on recovery seemed too important to allow the refusal of an intake interview to get in the way.

At the intake interview, individual goals were established. These were to be as easily achieved, as specific and as concrete as possible. Abstaining from alcohol or getting off mood-altering medications was always added as an individual goal. This was to reinforce the purpose of the senior's involvement with the group. Expectations of group members and of the group leaders were discussed. The first group session to be attended was also negotiated with the rule of thumb of "the sooner the better," to ensure the senior got involved while motivation was high. The writer negotiated with the potential member about the length and frequency of attendance.

Each member came to the treatment group for different lengths of time. Some negotiated to leave their attendance open-ended. Some agreed to come for 12 weeks, attending most of the sessions that were offered. Others requested to extend their stay after completing the length of time originally negotiated.

Some seniors experienced problems attending group sessions regularly. Such problems included poor health, difficulty with transportation, poor mobility, difficulty

getting out of work, and the many social supports involved with the senior. These obstacles to regular attendance were carefully considered. Although the social supports were previously identified as obstacles to group attendance, they were also recognized as important aspects of the seniors' lives. All of these problems were considered when negotiating frequency of attendance each week. For example, Esther, who was hard of hearing with severe arthritis in her hips and knees, was unable to arrange her own transportation. She was unable to walk the distance from her apartment to the lobby alone. She could only come twice a week because she relied on her daughters for transportation and for walking assistance.

Frequency of attendance also depended on where a senior was in the recovery process. Seniors in the earlier stages of recovery were encouraged to come to group more often than seniors who were in later stages of recovery. Seniors in early recovery seemed to need much external support to engage in change. For example, Stan was in the early recovery stage, so he was strongly encouraged to come to group three times per week, whereas Clara was in late stage of recovery so she came on a drop in basis.

The length of attendance was determined by the severity of chemical dependency. For example, a senior with many problems and strong denial may have required a longer length of time in group to deal with these issues than those

seniors with few problems and minimal denial. Length of attendance also depended on how quickly a senior regained physical and/or psychological functioning.

Completion of treatment for a group member was decided by the group member and the group leader. The criteria that helped determine when a group member was ready to terminate group included:

1. Achieving the group's treatment goals and the individuals' treatment goals.
2. Being able to offer support to others.
3. Being able to confront others appropriately.

Prior to a member leaving the group, information was shared about the departure with the Elders Health Program staff. Family and involved community professionals were also informed about the termination. The terminating member and the student explored options about what to do after completion of treatment. Some group members also chose to leave the Elder's Health Program entirely. If they chose the second option, attendance at another support program such as Alcoholics Anonymous or a Senior Centre was encouraged. A referral to these resources was made for the group member if necessary.

Group Structure

Location of Treatment Group

The treatment group was held at 403-400 Tache at the

Elders Health Program. It was well suited for seniors. The building where the group was held was wheelchair accessible. It was easy to locate because it was across the street from St. Boniface General Hospital. The building was located on a major bus route and parking was readily available. An elevator opened right in front of the program's door. The group room was comfortable with two big stuffed chairs, hard chairs, and a couch for those with poor sitting tolerance. Wheelchair accessible washrooms were nearby. It was a quiet room which helped hearing impaired seniors to follow conversation. Two restaurants were in the lobby of 400 Tache where many group members met before and after the sessions.

Time and Frequency of Meetings

Meetings were held three times per week on Monday, Wednesday and Friday from 10:00 a.m. to 12:00 noon. Having meetings three times per week maintained the intensity required for active participation in chemical dependency recovery. It also accommodated the needs of the seniors. It allowed time between sessions to go to medical appointments, family outings and leisure activities. For the frail elderly, it allowed for a rest between sessions which increased the likelihood for them to attend regularly. Group sessions were held during the day because most elderly were reluctant to venture out after dark. The time also

insured easier accessibility to public transportation for the handicapped.

Size

The group consisted of a maximum of six members per group session. Keeping the number of members low insured that group members had an adequate amount of time to talk in group. This size of group was small enough to create comfort for self-disclosure. Individual needs such as visual or hearing impairment were easily accommodated. New members or shy members did not get lost or forgotten in a group of this size. Having six members generated a wide variety of experiences and ideas to help with problem solving.

Open Group

This was an open group because once a potential member agreed to go to treatment he or she needed to begin as soon as possible while motivation or external support was strong. In spite of the drawbacks of an open group, some activities were found useful in promoting cohesion and a feeling of security for group members. At the beginning of each session, the student summarized what had gone on in the previous one or two sessions. Members that came only once a week or had missed a few sessions found this helpful to establish a common ground with regular members. Another useful activity was to identify life experiences, feelings or chemicals of choice that group members had in common.

Group members were then able to emotionally connect with others who seemed to be able to understand their situations.

Another activity to promote cohesion involved "ice-breaker" exercises when new members were introduced in group sessions. The first ice-breaker involved asking group members a general question and giving each member an opportunity to answer. A group member who did not wish to say anything could pass. Such questions included: "What did everyone do on the weekend?" or "How is everyone feeling right now?" The members responded well to these ice-breakers. Many gave input, often telling about a specific incident or problem. The second ice-breaker began bringing out a brightly painted rock and giving it to a member. The member who had the rock was to ask a question to any person in the group. This question had to be worded in such a way as to allow other members to get to know the member better. If the question was too personal, the person being asked could request a different question. Once the question was asked, the person who must answer was given the rock. Only the person with the rock was able to talk. Once a question was answered, then someone else was asked a question and the rock was passed on again. This activity was met with some ambivalence from group members because it was a new experience. However, once they began, they enjoyed it. One caution about this activity was the potential for two mem-

bers to pass the rock back and forth between them, ignoring the others. This did occur in group, requiring me to ask that the rock be passed to someone else.

Another way to promote cohesion and stability in an open group was to establish routine ways of introducing new members and of terminating with old members. The student introduced a new group member to the group and explained the group purpose, goals and norms. Each group member was asked to state his or her name, substance of choice and individual goals. Anyone who did not wish to share information about themselves could pass. The new member was asked to share this information last. Leaving the new members last took into consideration the new member's feelings of anxiety or discomfort. They got to know the group members and became familiar with the group setting before risking a self-disclosure.

Endings happened at a different time for each group member. When possible, the group leader or the leaving group member let the group know about an ending one week in advance. At a member's last meeting, feelings about ending were explored. Memories about experiences in group and the leaving member's progress were discussed. Good byes were shared. A symbolic gift was given to leaving group members to commemorate their experiences, their growth in recovery and to remind them of the group. This was done for two group members, who both received a small ceramic set of

praying hands. Sometimes members left without notice because of relapse, hospitalization or choosing to continue chemical use. These endings were also discussed in group because members were sensitive to the loss of any one leaving without saying good bye.

Co-leadership

The co-leaders for the group were the student and a peer counsellor. The combination of a social worker and a peer counsellor as group leaders was a unique approach to co-leadership. The peer counsellor was called a co-leader because he acted as a co-leader in many ways as described in the literature review. The peer counsellor was 64 years old, and a recovered alcoholic for 5 years through the help of A.A. He was a widower for 7 years and had one daughter and two granddaughters. He was a World War II veteran and was a retired air traffic controller. Because the peer counsellor lacked group work skills and was a volunteer with the Elders Health Program, this placed the writer in the role of supervisor over the peer counsellor.

One reason the peer counsellor was chosen as a co-leader was to serve as a role model for the group members. For example, one member asked the peer counsellor how he maintained abstinence. Another member asked the peer counsellor how long he would be an alcoholic? Members learned from the peer counsellor that it was worth it to try to

recover. He offered hope and optimism. He also built a bridge between me and the group members. He helped them to accept the involvement of a much younger, non-chemically dependent group leader. The peer counsellor also helped to instill within the group members the sense of being understood and being unconditionally accepted.

The peer counsellor's duties in group were to co-lead the group, assist with transportation on a temporary basis, and to be available to members on weekends, evenings and holidays. The students' duties included co-leading the group and obtaining and preparing materials for group sessions. The student also managed tapering regimes and maintained contact with other involved professionals and arranged for resources as needed.

As co-leaders, it was necessary to establish a working relationship to run the group as smoothly as possible. Outside of group, it was helpful to explain to each other what our backgrounds were regarding chemical dependency, treatment experiences and aging. The reasons behind our approaches in group were discussed. This established understanding and respect for each other. We met before group to exchange greetings, talk about our day, and to plan the group session. We met after group to discuss how the session went, each members' progress, and our observations about what went on in group.

While we were leading group, we slowly developed a

complementary style of working together. The peer counsellor seemed to be able to confront group members and received little resistance or defensiveness from members. This may have been due to the members relating to the peer counsellor as a peer, rather than as an authority figure. The peer counsellor used self-disclosure, empathy, active listening and advice giving as primary counselling skills in group. The writer was able to work for more details and feeling content from members. Also, the writer used a wider variety of counselling skills as well as therapeutic activities to effect change.

Because of his A.A. background, the peer counsellor introduced philosophy and principles of Alcoholics Anonymous if it applied to the topic and if the group seemed willing to hear references to A.A. This gave the members some exposure to A.A. and clarified any misconceptions. Both co-leaders emphasized that this treatment group was not an A.A. group. Attendance to A.A. was encouraged, but not expected.

There were some drawbacks to the peer counsellor acting as co-leader. Because he was not trained in group work skills, the peer counsellor sometimes led the group off topic or encouraged a member to monopolize group discussion. If he had difficulty empathizing when a group member (usually women pill users) was speaking, he displayed obvious nonverbal cues of disinterest such as moving his chair out of the group circle or looking at his watch. The peer

counsellor had difficulty with silence and strong emotional feelings. In response he would sometimes cut these therapeutic moments short. Although such difficulties occurred by having a co-leader with no professional training, it was recognized that a trained professional also could have behaved in the same manner.

Group Content

The group sessions had two components. The first approach was educational. Every Monday and Friday session followed this format. A brief overview of a topic was provided at the beginning of a session. The overview would last from 15 to 30 minutes. The length of overview depended on the topic and the needs of the group. Once the overview was finished, a strong emphasis was placed on group member participation. Group members were constantly asked to apply the information to their own knowledge and life experiences.

A variety of instructional tools were used to enhance the educational content. Some people such as hearing impaired members seemed to learn more efficiently with a visual aid. A flip chart was used to show an outline of a session's content and to illustrate group members' ideas or experiences. A flip chart also helped keep the group focused on the topic. A guest speaker was used occasionally to present a topic the group leader was not experienced.

For example, a geriatric pharmacist was an essential part of discussing medication management.

Many reading materials were sent home with group members to read at their leisure. Reading at home allowed the senior to continue his or her learning outside of group sessions. They received these articles with good humour, often joking about getting a folder to hold all of them. Only one or two members refused to take articles home. Discussion about the articles was frequently encouraged at the beginning of group sessions. Articles were given at the same time a similar topic was being explored.

Films and audiotapes were used to enhance a topic being presented, but were shown or played only with the approval of group members. However, some consideration had to be taken into account when using films or audiotapes. Films and audiotapes were obtained from the Alcoholism Foundation of Manitoba and shown. In order to assist hearing impaired members, films were seen only on video cassette recorder to avoid the clatter of a film projector. Also, those tapes with fast speaking lecturers often lost these seniors. In addition, there was great difficulty finding video cassette films that specifically addressed chemically dependent seniors. Although the films related to chemical dependency, they often used a lot of trendy jargon and focused on younger people. Thus, group members had difficulty relating to them.

The second component of group sessions involved a remedial approach. The main emphasis was behaviour change involving actions, thoughts and feelings. The remedial approach was used primarily in Wednesday sessions which were called Open Forums. Open Forum focused on individual group members' problems or issues. An advantage of Open Forum sessions was that they allowed for discussions arising from delayed responses about previous sessions. For example, in one session the topic of loss was discussed. Three or four weeks later Esther told the story of her husband's death. It seemed that she had never shared this story since her husband's death. She required a length of time to decide on the right time to tell the group. An Open Forum session gave her the opportunity to do this when she was ready.

These sessions established a main theme decided on by the entire group. Group members learned that Wednesday sessions were their time. This was not to imply that the student had no role, rather, the writer served to keep the group focused on the chosen theme and assisted with any issues by using various therapeutic techniques.

To help members achieve behavioural change, the co-leaders used a variety of therapeutic techniques. These techniques were used by the writer or the peer counsellor. Although the peer counsellor had no training with some of these techniques, he used them in accordance with his natural helping skills. These therapeutic techniques

included role play, problem-solving and reframing. Reminiscence was used to assist with grieving and developing meaning for life. Confrontation, interpretation and reflection of feelings were used frequently. Relaxation exercises were practised for one week as a way to combat stress and to control anger.

The Treatment Cycle

The treatment cycle was defined as the period of time necessary to complete all the chosen topics that seemed appropriate for a senior's chemical dependency recovery. The topics covered a twelve week period. Sometimes a topic was discussed for an extended period of time if the group found it extremely helpful for recovery. This resulted in the treatment cycle lasting longer than twelve weeks. The treatment cycle proved to be flexible in order to meet the group's needs. When all the topics were completed, the cycle would repeat itself with the topics being covered in the same order. The content of the twelve week treatment cycle is available for reference in Appendix 12.

Topics in the treatment cycle were organized to accommodate group development. The planning phase of group development occurred before the group began. The beginning phase of group development was carried out during the first four weeks of the treatment cycle. The main goal of this part of the treatment cycle was to build an information base

that the group members could draw from during later weeks.

The objectives for the beginning phase were:

1. to educate members about the nature of chemical dependency;
2. to correct members' misconceptions about chemical dependency;
3. to integrate group members' personal experiences with the information about chemical dependency;
4. to teach group members that it was safe to self-disclose; and
5. to assist members with identifying and reducing defense mechanisms.

Some examples of topics covered in this phase included:

1. chemical dependency and families;
2. chemicals and sleep; and
3. psychological adjustment to chemical dependency.

The middle phase of the treatment cycle occurred from the fifth week through the ninth week. The goal of this phase focused on goal achievement of individual group members and of the group as a whole. This phase offered an opportunity for group members to focus on interpersonal and intrapersonal issues. Chemically dependent elders used the chance to problem solve about repairing relationships, including identifying personal obstacles and resources that could affect these relationships. The objectives in this phase were:

1. to begin identifying feelings;
2. to help clients express feelings appropriately;
3. to address relationship problems; and
4. to enhance clients' socialization and communication skills.

Examples of group session topics included:

1. spirituality;
2. identifying losses; and
3. guilt and shame.

The end phase of the treatment cycle happened from the tenth week through the twelfth week. The goal of this phase was to prepare group members to eventually leave the group. Group members were encouraged to make whatever lifestyle changes were necessary to maintain ongoing chemical dependency recovery.

The objectives of the ending phase were:

1. to show group members various lifestyle opportunities;
2. to alert group members to lifestyle activities that could interfere with recovery; and
3. to develop individual plans with group members that would enhance quality of life.

Examples of the topics these sessions covered were:

1. relapse prevention;
2. stress management; and
3. identifying and meeting needs.

CHAPTER IV

EVALUATION METHOD

The evaluation method used two approaches. The first approach was process-oriented, meaning it focused on how the group was conducted and how it functioned over time. Using an outcome orientation as the second approach, the evaluation also focused on goals achieved by group members and by the group as a whole (Bloom & Fischer, 1982). Two aspects of the practicum were evaluated, both of which were the practicum objectives.

Evaluation of Practicum Objective Number One

The first practicum objective of developing and facilitating a treatment group for the chemically dependent elderly was evaluated in two parts: 1) Effectiveness of the group as a whole; and 2) Effectiveness of the groups' ability to help group members change.

To evaluate the effectiveness of the group as a whole, the value of the group experience to its members was evaluated. This was accomplished by using a self-report measure called a Post Session Report which had been developed especially for the treatment group by the Elders Health Project data analyst and myself. It was not a standardized test. The writer administered this tool after each session. Although it would have been more confidential for members to fill it out on their own, the members refused to

do this. A copy of the Post Session Report is included in Appendix 6. A group leaders summary report was used to follow each individual members' progress and the group process. The writer developed it and completed it after every session

Another way to measure the effectiveness of the group as a whole was to determine if the group goals were achieved. To evaluate the goal of responsible use of mood-altering prescription drugs, the Manitoba Drug Dependency Screen (See Appendix 3) was used. A brief description of the M.D.D.S. was given in the Project Description Chapter. Instructions about how to complete and score the M.D.D.S. is given in Appendix 3. A copy of the summary report can be seen in Appendix 5. The writer administered pre- and post group and six month follow-up tests. To measure the goal of abstaining from alcohol, the group members who used alcohol were asked at the post and six month follow-up trial periods if they had drank any alcohol.

To control for the effect of the alcohol users tendency to deny or minimize alcohol use, a retrospective self-report scale was given to significant others of members who used alcohol. This tool was designed and administered by me. It was to be given by the social worker at the six month trial period, asking about members' alcohol use before and after involvement with the group. Before significant others were contacted, the members were asked for permission to contact

the significant others. This approach maintained trust between the writer and the members.

The last treatment goal to be evaluated was the life satisfaction of group members. Two measurement tools were used. The first tool used to measure life satisfaction was the Delighted-Terrible Scale or in shortened form, the D-T Scale. It was developed by Frank M. Andrews and Stephen B. Withey in 1976. See the Appendix 4 for a copy of the scale. Andrews and Withey reported that, compared to other life satisfaction scales, the D-T Scale had a high level of validity and a moderate level of reliability. This tool was short and quick to use and the items seemed applicable to the elderly population. This tool was given to group members at the pre, post and six month trial periods by me.

The second measurement tool was the Brief UCLA Loneliness Scale which was initially developed by Kissel, Peplau and Ferguson (1978). It was revised by Perlman (1978) into a shortened version with new, positively worded items as seen in Appendix 10. For the reasons given below, the Brief UCLA Loneliness Scale was chosen to help measure life satisfaction among the chemically dependent elderly in the treatment group. Firstly, Perlman (1978) reported that this scale was used in many other research studies. Secondly, Russell, Peplau and Cutrona (1980) found that the brief UCLA Loneliness Scale has a high level of internal consistency and indicated concurrent and discriminant

validity. Lastly, in his study, Perlman (1978) found that loneliness was related to life satisfaction and believed that loneliness was a significant aspect of the well-being of seniors.

This scale included nine items, all scored 1 to 4 as never, rarely, sometimes and often. Three items were reversed before scoring, for example, 1 = 4, 2 = 3, etc. Perlman (1978) developed cut off scores as follows: 20 and below = no evidence of loneliness; 20-26 = possible loneliness; and 27 and above = definite loneliness. Scores that decreased over time suggested a decrease in loneliness and scores that increased over time suggested an increase in loneliness. Scores ranged from 9 to 36, with 9 be the lowest and 36 being the highest.

The third part of evaluating the development and facilitation of the treatment group was measured according to each member's achievement of his or her own personal goals. Each member's goals and outcome of their goals are included in the client profiles in Appendix 14. The criteria for setting individual goals are explained in the practicum project section of the report. At the post-group evaluation, the writer checked with each member about whether or not individual goals were achieved. At the six month follow-up, each member was asked if the same goals had been maintained. Clinical observations and assessment of each member's progress in group was also helpful in deter-

mining this third part of the evaluation. This type of evaluation enriched the evaluation data on intervention outcomes.

Evaluation of Practicum Objective Number Two

The second practicum objective that was evaluated involved my own professional learning. The focus of evaluation was directed at increasing my group work skills. It was assumed that if the group work skills improved, so would the comfort level of facilitating groups. Also, if the group work skills improved, the ability to help group members identify and resolve their issues would have been enhanced. Three different methods of evaluating the group facilitation skills were getting supervision, videotaping the sessions, and using a group leadership scale.

I met with my Faculty of Social Work advisor approximately every two weeks throughout the twelve week project. We discussed my progress with group work skill development and the progress of the group members. Having an objective knowledgeable colleague available to provide supervision was instrumental in encouraging professional growth.

Most of the sessions were videotaped. Videotaping was chosen to provide the actual group experience for the social work advisor to observe and assess. The videotape also allowed for making verbal and nonverbal observations when

reviewing group sessions. Prior to taping each session, the group members were asked for permission. They were informed that the taping served the purpose of evaluating my masters degree practicum project. Also, they were told that only the practicum advisor and myself saw the tapes. No members refused to be taped. Two Alcoholics Anonymous members arranged for their faces to be hidden from view to maintain anonymity. Each tape of a session was seen within one week after that session occurred.

The last method of evaluating group leadership skills was the use of the Group Leadership Scale developed by Corey & Corey (1977). An example of this scale is in Appendix 7 for further reference. Although the skills listed in the scale seemed to pertain to general counselling skills rather than specific group work skills, it did provide a more objective way to evaluate my own performance. It had not been tested for reliability or validity and thus, was not standardized. It did seem to work well as a repetitive measure that was sensitive to change over time. It was also quick and easy to use.

CHAPTER V

Analysis of the Progress of Group Members and of the Group as a Whole

This part of the practicum report presents the results of the evaluation procedures. As the recommended process of evaluating group, Toseland and Rivas (1984) divided the analysis into two parts: 1) the progress of individuals in the group; and 2) analysis of the group as a whole. Chapter V will focus on the analysis of the members progress in group.

Case Illustrations

Three vignettes were chosen at random from the client profiles to highlight the group experiences of the members. This showed some idea of the issues that were dealt with in group. Lastly, these case histories provided some insight into the type of clients that were in the group. The three cases that were chosen seemed to represent many of the life histories, behaviour patterns and current problems that the other members possessed.

Clara

Clara was referred to the group by Dr. W. Jacyk, Co-investigator of the Elders Health Program.

Clara was 71 years old. She lived alone, and had been

widowed for seven or eight years. She was retired having worked as a clerk and bookkeeper with her husband's business. She had three children, one son lived in Winnipeg and the other two lived in other provinces.

Clara was an attractive woman, well dressed with make-up and perfectly matched accessories. She was an extremely private woman, saying very little. When she spoke she was succinct with little expression of feeling.

Chemical Dependency Information

Clara's substance of choice was alcohol. She actively drank while her husband was alive. She had never been interested in attending A.A., instead she attended the aftercare group from St. Boniface Hospital Chemical Dependency Unit. She had difficulty getting to the aftercare group because it was held in the evening. Her vision was quite poor when driving at night. Also, she had difficulty relating in a group of primarily young members. She wanted to remain in the aftercare group, yet she also wanted a group experience with people her own age. Since she had engaged in recovery, she continued to dislike the term alcoholic because the negative image and guilt associated with the term made it hard for her to apply it to herself.

Progress in Group

Clara's individual goal for attending the treatment group was to maintain sobriety. She was averse to any administering of evaluation tools. Because she was going to

continue attendance at the aftercare group one time per week, she wished to attend the Elders Health Program group on a drop-in basis. Clara attended the treatment group on seven occasions throughout the 12-week period. Her verbal feedback after each session was favourable.

Clara was consistently quiet during each session, reporting that this was her usual behaviour in group. By listening, she learned much more than by talking. Clara helped other members by offering an empathic statement or by giving some advice. She maintained interest in the group meetings. Clara was clearly a peripheral group member which was acknowledged within the group. Her erratic attendance may have contributed to her quietness in group. However, she did achieve the group goal of maintaining abstinence.

In summary, because she was so quiet in group and she refused to participate in completing the evaluation tools, it was difficult to assess her progress with chemical dependency recovery. However, her goal achievement and positive feedback about her group experience indicated that the group was of some benefit to her.

Margaret

Margaret was referred to the treatment group by her three daughters and the writer. Margaret was 71 years old. She was married and lived in an apartment. She had four

children, all daughters. The eldest lived in a nearby town while the middle daughter and the youngest daughter lived in Winnipeg. Margaret had several previous foster children who kept contact with her. Margaret had six years of education. Her previous occupations included Child Welfare case aid worker and running a group home. She was a devout catholic.

Margaret had a few chronic illnesses such as chronic heart failure, asthma, arthritis and diverticulitis. Her heart condition demanded that she slow down when she did daily chores. However, she walked independently and continued most of her daily tasks.

Margaret was born and raised on a farm in rural Manitoba. Both her parents were of French descent. She was a middle child of many children. Margaret married her first husband when she was about 17 years old. This man was a piano player who spend most of his time on the road entertaining and binge drinking. He was the father of their four daughters. The eldest daughter died in childhood from a rare disease. Margaret divorced her first husband and he died two years later.

Her second husband was a veteran of the Second World War, hard working and honest, but he could also be short tempered and mean. Financially he provided well for the family. He died as a result of Alzheimers disease.

She married her third husband, Fred who was her husband at the time she was in group. After this marriage she had a

number of hospitalizations for her heart condition. She then focused on her illnesses and herself. Her daughters observed that Margaret would focus on her illnesses to get attention. Understandably, the daughters were never sure which of Margaret's illnesses and symptoms were real and which were not. Because of this behaviour many family members withdrew, which in turn led Margaret to focus even more on her illnesses.

Chemical Dependency Information

Margaret had been using diazepam for 20-30 years. She learned that mood-altering prescription drugs made her feel better. Thus her drug seeking behaviour worsened.

She went to three different doctors to get analgesics or benzodiazepines. If one physician refused to refill her prescriptions, she went to another doctor. Her family physician saw no problem with her medication use, yet felt helpless and fed up with treating Margaret's many minor complaints. At the time of completing the identification questionnaire, she was taking Nitrazepam, Halcion, Xanax, and Tylenol #3.

Margaret had drunk alcohol excessively for five years. Her husband used to buy brandy on a weekly basis. Two years ago she was hospitalized for a gastrointestinal problem. After she was discharged, she never had another drop of alcohol.

Margaret's emotional state and behaviour indicated that

her life was negatively affected by her chemical use. She became increasingly depressed and anxious. On two occasions she had thoughts of suicide. She had difficulty concentrating and was very forgetful. She had developed a sleep disturbance with both sleep initiation and maintaining sleep. She had no appetite. She could no longer deal with every day responsibilities.

Prior to the interview, Margaret had little denial about her chemical dependency and she easily accepted it. As she continued attending group, her denial grew. She insisted on maintaining control over her pills and refused to taper off under our supervision. She minimized the problems caused by her pill use. She made strong attempts to stop discussions about her chemical dependency.

Progress in Group

Margaret had agreed to attend the treatment group twice a week. She used Handi-Transit to get to the sessions. Her individual goals included:

1. talking about her addiction to pills,
2. lifting her depressed feelings,
3. developing companionship with group members,
4. improving her companionship with her husband via improved communication, getting Fred to the group, increased touching and warmth, doing more activities together, and
5. giving to others.

Margaret increased her leisure activities such as becoming involved in bible study group, going for walks, cleaning, cooking and knitting. She reported that all five of her individual goals were achieved and maintained at the post group and six month follow-up interviews. She was more able to talk about her chemical dependency. She no longer felt depressed. She felt emotionally close to the group members. She felt good about helping fellow group members. She enjoyed her relationship with Fred a little more.

Attendance was fairly regular and consistent. It was sporadic on two occasions, when Fred was hospitalized and when she was hospitalized for pneumonia. Margaret came to 17 sessions throughout the treatment cycle. She terminated before this cycle finished because she wanted to go on a trip to Alberta with her husband.

Margaret had made some progress in personal growth. She was much more content with her sleeping habits. She became more aware of her feelings. For example, Margaret had denied feeling anger when she participated in the first treatment cycle. During the practicum project, she was able to identify her feelings of anger and began to express it.

Margaret was beginning to communicate more effectively. She was starting to speak up for herself, stating what she did or did not want. She was learning to be more specific when making an observation and to check out any assumptions. Some problems remained unresolved. She continued to carry

many resentments from the past. To protect herself from being hurt and from emotional pain, she had become aggressive. She still used her illnesses and her symptoms to gain attention.

She was reluctant to accept help, often refusing to accept suggestions. She responded in silent anger when confronted about some discrepancy. She had honestly said she found it very hard to accept help from others because she had always helped other people.

In terms of Margaret's part in the group process, Margaret assumed the role of informal group leader quickly. This was achieved because of her gregarious and talkative nature. She had been in group longer than of any other member. Margaret monopolized group discussion quite often, yet other group members seldom challenged her status. Her monopolizing behaviour allowed other group members to avoid dealing with their own chemical dependency issues. However, the group recognized her as the monopolizer and informal group leader. Margaret's ability to self-disclose encouraged other group members to share in group. She was also an integral part of the group. She supported and confronted new members appropriately despite her own inadequacies.

She did achieve her group goals to a small extent. She was completely off benzodiazepines and analgesics by the six month follow-up. Her sense of life satisfaction improved as

was seen by her more active day-to-day living and by life satisfaction scores. Her scores increased in eight categories in the Scale. They included health, family relations, friendships, housing, religion, self-esteem, transportation and life as a whole. She indicated no change, but was satisfied with the dimensions of finances, living partner and recreation activity. Her total score consistently improved over time from 51 to 57 to 66. Margaret's UCLA Loneliness scores moved from 10 to 16 to 20. This score increased over time, yet all three scores still indicated no evidence of loneliness. If there would have been a year follow-up test, she may have continued with this trend and may have scored as lonely.

Overall, Margaret made small gains as a result of her participation in the group. The group did give Margaret an opportunity to recover from her chemical dependency. It enabled her to stabilize her daily life, her family relationships and her physical condition.

Ronald

Ronald was referred to the group by a St. Boniface Hospital social worker and the Elders Health Program peer counsellor.

Ronald was 66 years old. He had a heart attack a number of years ago, prostate cancer three years ago, and

Parkinson's Disease. He walked independently and had no functional limitations. Ronald was intelligent and bright, relying on logic as a coping mechanism. Ronald tended to be very defensive and to react quickly in an aggressive manner, funneling all his emotions into anger. He had difficulty identifying feelings that were not anger and struggled with expressing affection.

Ronald was a high school graduate, he fought in the Army during World War II, and for many years, was a postman in Winnipeg. He participated in few activities or charitable organizations. He did not belong to a church and had no spiritual beliefs. His days off work were spent relaxing, watching TV, and going to parties or to the Legion. Ronald took an early retirement and he and his wife moved to an apartment downtown. The couple took daily walks together. Aside from these activities, Ronald did little else. The family would invite him on outings, but he often refused.

He had been married for over 40 years. His relationship with his wife had been warm and very close. They had three children, two daughters and one son, all of whom lived in Winnipeg. Through his wife's connection to them, he felt close to them.

Chemical Dependency Information

While fighting in World War II, Ronald started his drinking. He was a heavy drinker all of his life.

Drinking progressed from weekend parties to daily drinking after work and on weekends. He experienced no repercussions of his drinking while working because many of his fellow postmen were drinkers as well. He heard few protests from family or friends. His wife often went with him to parties and drove them both home.

After retirement, drinking became his sole activity. The time he used to spend at work was spent drinking at home and at the Legion. When he was at the Legion, he would sit with the heaviest drinkers. He began falling down when intoxicated. He fell on Portage Avenue while making his way home from the Legion. The police picked him up and took him home. Ronald recalled extreme shame about the incident. He was falling at home, hitting his head on the edge of the coffee table. He fell in the bathtub and was lifted out by his wife who hurt her back in the process. Ronald felt very guilty about this. Once his walking became precarious, his wife bought him alcohol to drink at home. His appetite was very small due to drinking. He finally went to hospital when he could no longer walk one more step. Ronald had minimal denial, admitting he had an alcohol problem and wanted to abstain. Two obstacles to recovery were his hesitancy to make lifestyle changes and his aggression.

Progress in Group

Ronald's individual goals were to abstain from alcohol and to be able to walk from home to the sessions. He agreed to come to group twice a week on Mondays and Fridays. He came to sessions and had regular attendance. He took the city bus or walked to the sessions.

Ronald had learned to accept his chemical dependency, however he did not make any lifestyle changes to support his recovery. He only stopped drinking and stopped going to the Legion. He started to deal with his short temper by identifying the cognitive thoughts that escalate his anger and the physical sensations of his anger. He learned to use deep breathing and removing himself from the situation as ways to control his temper.

Ronald was an active group member. He self-disclosed readily and encouraged other members to do the same. He was very supportive of other members and was also able to gently confront them. He did achieve the group goal of abstaining from alcohol at the post group and six month follow-up interviews. He refused to do the evaluation tests, so the goal of improved life satisfaction was not measured.

In summary, Ronald did receive some benefit from attending the group. He moved from early through middle recovery. He achieved all of his individual goals and one of the group goals. Unfortunately, he did not move further towards making lifestyle changes to maintain his recovery.

Common Characteristics Among Group Members

All of the group members had a number of characteristics in common with each other. Some of these commonalities were openly acknowledged by the members, while others were observed by the leaders. Each member described in the vignettes will be analyzed by identifying characteristics each client had in common with other members. This analysis will help to describe other group members and to identify individual issues and themes addressed by the group.

Six characteristics were shared by all of the group members.

1. All members had their chemical dependency problem identified and experienced some form of intervention. Identification and intervention occurred in a different way and at different times, but both activities led each member to treatment.
2. They all had a chemical dependency problem for five years or longer. This indicated that all had a relatively long history of chemical dependency.
3. The twelve group members had one or more health problems.
4. All members came from stable family lifestyles and middle to upper class backgrounds.
5. They all shared conservative, traditional beliefs and value systems. For example, all members firmly believed in the work ethic and polite,

social etiquette.

6. All were caucasian.

From the first vignette, Clara had a few characteristics that she shared with others. She represented four of the female members by her experience with widowhood. All of these women had been widowed for at least six years. She had received chemical dependency treatment before which Dennis, Inez and George had done as well. She had come to the group to add an age-specific treatment program to supplement her recovery activities as did Dennis.

As the second vignette, Margaret was very representative of other group members. Her most pervasive characteristic was her somatic behaviour which was common with Ruby. Both clients made constant physical complaints and used these physical complaints for getting nurturing and validation. Both had heavy investments into the medical system. Margaret had a sleep disturbance which was shared by five others. However, each person experienced different symptoms and coping behaviours. Five group members had been seen by a psychiatrist at least once as did Margaret. She had reported feeling depressed to the point of wishing to die, but so had Inez, Stan, Fred, George, Helen and Ruby. Double doctoring was a way for her to obtain medications, which was also done by Ruby. She had unresolved grief about her oldest daughter and Stan was unable to grieve in anticipation of his wives' death. Fred remained bitter about

his first wife who had been dead for about 10 years. Still missing her husband who died about sixteen years ago, Esther had not resolved her guilt about not forcing him to see a doctor sooner. Ronald still resented his younger brother who died during World War II and hated his deceased mother. Being a victim of wife battering and a wife of an alcoholic, Isabel had not resolved her life as a widow.

Margaret found that re-establishing trust between her and her family members was a long, painful process. This trust had been broken because of the inconsistent, hurtful behaviour resulting from the chemical dependency. Clara, Isabel, Stan, Ruby and Esther also discussed trust issues in group. Unable to meet her socioemotional needs in a direct assertive way, Margaret often felt frustrated and taken for granted. Her past role as caregiver led to this behaviour and emotional state. Isabel, George, Helen and Ruby all described the same experience. Refusing to believe that chemical dependency was a disease, Margaret shared this conviction with Fred, Helen and Esther. No matter what approach was taken or what information was given, all of these clients could not be shaken from their opinions. Although she acknowledged that she was dependent on mood-altering prescription medications, she was unable to further extend that to having the potential of becoming dependent on alcohol.

Helen and Esther had the same difficulty understanding

the concept of chemical dependency. These clients, as well as Fred and Ruby, held much contempt and moralistic judgement on the alcoholics. For example, Fred said in group that alcoholics should be lectured and punished as a form of treatment, not forgiven.

As the third vignette illustrated, Ronald shared other common characteristics with the rest of the group members. Ronald was clearly not a joiner; that is, he developed a few solitary activities and participated in few clubs or organizations. This was pervasive in group among seven other members. Ronald and three others expressed intense feelings of guilt and shame about being chemically dependent and about past wrongs done to family and friends. He described a very troublesome, dysfunctional family of origin. Isabel, Stan, Fred and George all came from dysfunctional families. Three of these members, Isabel, Stan and George all described alcoholism present in their families when they were young. Ronald described himself as a distant family member meaning that he seldom attended family outings, seldom exchanged affection with family and seldom engaged in intimate conversations with family. Five other members reported the same behaviour. Interestingly, the level of satisfaction with family relationships seemed to be split in two subgroups. The two female members disliked this arrangement in their families, but both refused to directly ask for changed behaviour like a hug or a weekly visit because

of not wanting to overburden their children. Ronald and the other three were all men who highly preferred their positions in the family. All of them were extremely uneasy with emotional and social closeness with their families, so they avoided situations that required intimacy. However, two of the men made one attempt at behavioral change in this area. Fred phoned his brother for the first time in years and George asked for a hug from his six year old grandson for the first time ever.

Although Ronald had been chemically dependent for some time, he had never been in treatment before. Six other members had never been in treatment before either. Isabel had been in AlAnon and Alcoholics Anonymous to deal with her husband's dependency, but had never gone for her pill use.

Difficulty identifying and expressing feelings was a main characteristic in the group. Six others including Ronald had to meet this challenge. Ronald and nine other members were considered active in group. That is, they all talked without being directly asked for input and were considered a part of the group. They were all missed when they were absent from a session or terminated from group.

In summary, the members of this group had a high degree of homogeneity. However, even with the presence of homogeneity, members showed differences even in the way they manifested these similarities. For example, although half of the twelve group members had a sleep disturbance, all of

them dealt with their problem differently. All of them had a different kind of sleep disturbance. This served as an important consideration regarding the chemically dependent elders. One could not have assumed that, just because a client was elderly and chemically dependent, every one had the same needs, problems, coping mechanisms, perspectives and values. By virtue of members having old age and chemical dependency in common, the treatment group was able to be cohesive and to clearly proclaim a group identity. The individual difficulties allowed for a rich, creative and varied pool of ideas essential for problem solving and learning new behaviours in group.

General Group Member Demographic Characteristics

From information obtained in the intake interview and the group sessions, some member characteristics were evident. Describing these characteristics helped to develop a sense of the group as a whole and a sense of who the members were.

The range of ages of the group members was 61 - 84 years, with a mean age of 68.7 years. Individual ages are indicated in Table 3. With regard to gender, there were seven females and five males. Gender seemed to be related to the choice of chemical used in a lifetime. Table 2 illustrates that elderly women were more likely than elderly men to use mood-altering prescription medications or both

mood-altering prescription medication and alcohol. As Table 3 indicates, elderly men in the group were more likely to be married than the elderly women. On the other hand, elderly women were more likely to be widowed than the elderly men. The levels of income ranged from \$750 - \$999 per month to \$3000 or more to per month. The range of educational levels was from 4 to 18 years with a mean of 9.3 years.

Table 2

USE OF CHEMICAL BY GENDER			
	Substance		
	Alcohol	Medications	Both
Men (n = 5)	4	1	0
Women (n = 7)	1	4	2

Table 3

SELECTED DEMOGRAPHIC DATA NUMBER ONE					
Client	Age	Sex	Marital Status	Income	Education
Margaret	71	F	Married	\$1250-1499	6 yrs
Fred	78	M	Married	\$1000-1249	9 yrs
Helen	80	F	Widowed	\$750-999	8 yrs
Esther	84	F	Widowed	\$750-999	6 yrs
Stan	74	M	Married	\$2000-2249	6 yrs
George	69	M	Married	\$2050-2999	18 yrs
Ronald	66	M	Married	\$3000 +	11 yrs
Isabel	72	F	Widowed	\$750-999	4 yrs
Clara	71	F	Widowed	Refused	Unk
Dennis	61	M	Married	Refused	13 yrs
Ruby	72	F	Single	Refused	11 yrs

Group members often gave historical and current information about psychiatric help they had received prior to involvement with the treatment group. Of all the group members, six had seen a psychiatrist at least once in their lifetime or were in the process of seeing one. It seemed that male group members and female members were equally as likely to have had psychiatric help. Group members who exclusively used mood-altering medications were more likely to see a psychiatrist as compared to alcohol users or members who used both chemicals as shown in the Table 4 below.

Table 4

SELECTED DEMOGRAPHIC DATA				
CLIENT	EMPLOYED	OCCUPATION	TREATMENT SESSIONS	PSYCHIATRIC HISTORY
Margaret	No	Case Aid for CAS Group Home	38	Yes
Fred	No	Sheet Metal	29	Yes
Helen	No	Housewife	29	Yes
Esther	No	Nurse	29	No
Stan	No	Canada Packer	18	Yes
George	No	Teacher	31	Yes
Ronald	No	Postman	27	No
Isabel	No	Housewife	7	No
Ruby	No	LPN	10	Yes
Clara	No	Bookkeeper	9	No
Inez	Yes	Day Care Manger	2	No
Dennis	Yes	Management	14	No

Group members also tended to discuss past experiences with other forms of chemical dependency treatment programs. These included Alcoholics Anonymous, a medical detoxification unit, or an inpatient treatment program. Elderly female members were less likely than elderly male members to have had previous chemical dependency treatment. Also, one third (4) of the members had some experience with A.A. Members who exclusively used mood-altering medications were less likely to have had a previous experience with chemical dependency treatment than alcohol users or those who used both chemicals.

Group member attendance range from attending 2 to 38 sessions. The reason the largest number of sessions exceeded the total number of sessions included in this practicum was because Margaret had attended the 12 week treatment cycle prior to the onset of the practicum. The mean number of sessions attended by group members was 20.2 sessions. The Table 5 below provided visual analysis of group member attendance. Table 5 shows that eight group members or the majority of participants completed the Treatment program. The group seemed effective with keeping group members engaged throughout the treatment experience. A low drop-out rate can help to interpret this group as an effective treatment approach recovery.

Table 5

GROUP MEMBER ATTENDANCE OUTCOME (n = 12)	
Number	Attendance Outcome
8	Completed treatment per contract agreement
1	Completed treatment but very irregular attendance
2	Dropped out for unknown reasons
1	Dropped out due to relapse

CHAPTER VI

The Group as a Whole

This section discusses the stages and processes used in group development; further, it examines group dynamics as the group developed. The outcomes derived from the post session report and from evaluation of group goals will follow these observations.

Observations of Group Development

The question that was to be answered here was: How did group formation occur in this group for chemically dependent seniors? The summary report in Appendix 5 was the tool most helpful with identifying the various group development stages and tasks. Each developmental stage will be explored in terms of how it was carried out in the group. The planning stage was not covered because it occurred prior to the group's existence.

The Beginning Stage

The beginning stage lasted from the beginning of the practicum to about four weeks later. Activities that seemed distinct in this stage involved group discussions easily moving off topic, member-to-member interaction occurring in dyads, one member monopolizing group discussion, or the eldest, most ill and disabled members being ignored. Self-disclosure was at a minimum while trust was being es-

established. Members seldom offered help to each other. Group communications were directed to the leaders first. These members' behaviours required the leaders to work hard at facilitating member-to-member interaction, developing trust and cohesion and maintaining discussion to the topic at hand.

The beginning stage seemed to emerge again the last three weeks of the group. Reasons for this were: 1) the group was an open group which usually required that the beginning stage was a prominent, if not the only stage, an open group achieved; and 2) four key group members left and three new ones began at this time.

The Middle Stage

The middle stage covered the rest of the twelve week cycle. It started from the third week of the cycle and lasted to the tenth week. This group responded to the demand for work in this stage. Many members actively struggled with achieving individual and group goals. It was consistently documented that self-disclosure, group cohesion, mutual aid, member-to-member communication and a strong sense of group identity occurred at high levels. The student tried to facilitate change by using problem solving techniques, structured exercises and some role play.

The Ending Stage

Since this group was an open group, endings were dealt

with frequently throughout the group. Endings occurred at the end of each session and at the planned or unplanned termination of members. There was one session that focused primarily on an ending which occurred at the ninth week of the treatment cycle.

Treatment Group Dynamics

The areas of group dynamics explored were: communication and interaction patterns, group attraction, social controls, group culture and mutual aid. Member-to-member communication was difficult to achieve and maintain. The usual pattern involved members speaking to the group leaders first then back to the members again. This pattern occurred more frequently under certain conditions:

1. one or more members were hearing impaired; very old or very disabled;
2. group cohesion was low;
3. the group topic had lengthy and detailed discussion from group leaders; and
4. there was group resistance to dealing with a topic, such as identifying loss.

Member-to-member communication was at its highest when:

1. cohesion was high;
2. the group was in the middle phase of group development;
3. all the members knew each other well; and
4. active problem-solving was happening to assist a

member.

When blocks to direct member-to-member discussion were at work, I constantly encouraged the members to talk to one another. Often, the members tried to do this. Monopolizing did occur frequently, usually by Margaret or Fred. The members tolerated this well because it let them off the hook from taking responsibility for group discussion. A few times pairing occurred in the group because sharing commonalities linked these members together. These dyads usually survived only for one or two sessions because the membership in the group always changed. The dyads did not seem to interfere with the development of cohesion and group identity. Instead, they seemed to help create positive group dynamics.

Group Attraction

Group attraction was the most influential dynamic that created and maintained the group as a positive experience. Two thirds of all the group sessions were documented as cohesive.

A session was considered cohesive according to criteria such as 1) a sense of caring was expressed among members, 2) members listened to and helped each other, and 3) members enjoyed each other's company. This dynamic grew in frequency as time went on, from five sessions as cohesive in the first month, to seven cohesive sessions in the second month

and nine cohesive sessions in the last month. Group attraction occurred just as often during scheduled topic sessions as it did during open forums. Surprisingly, group attraction did not seem to be affected by which group members attended the session. Group attraction was also evident by members returning to group repeatedly.

Group attraction seemed to thrive in this group because of the two main commonalities of chemical dependency and old age. The homogeneity of members strengthened the commitment and attraction members had for the group. Active group leadership helped to create positive and beneficial group experiences for the members, thus drawing members back to the group. The Leaders worked to meet members' emotional and physical needs by linking members together and encouraging the group in addressing the problems of individual members. Conflict among members was resolved as quickly as possible. Mutual aid was strongly encouraged. High levels of self-disclosure led to strong care and concern among members which facilitated group cohesion.

Group attraction was diminished when very difficult issues such as identifying losses, the psychological aspects of chemical dependency and chemical dependency and the family were scheduled. These topics were emotionally painful and demanded personal reflection and intense self-disclosure. This made members feel very vulnerable. They feared losing of control of their emotions and self-

disclosing too much which would have made them feel embarrassed. Thus, group members said very little in these sessions or one member monopolized the discussion because of emotional discomfort. Leaders tended to take more control of these sessions by talking more or scheduling more audiovisual materials. Such group dynamics and activities led to more isolation among members and less satisfaction with the group experience.

Norms

The norms established by the writer and the peer counsellor were: 1) one person talks at a time, 2) do not repeat names of group members outside of group, 3) we know more together than each of us knows alone, and 4) each of us is responsible for getting our needs met. Two norms that should have been added were: 1) all members will be given a chance to talk; and 2) when giving advice, speak from your own experience. The first norm that should have been added could have decreased monopolizing. The second norm may have insured that personal judgements were not passed on to other members.

Some norms were not openly acknowledged. Rather, some rules of group conduct occurred in a subtle, covert way. Members seldom confronted each other. When monopolizing occurred, no one ever interrupted or complained. Another norm at work was that no one came to group intoxicated or

with alcohol on his or her breath. Conflict between members was never addressed in group, rather it was discussed when one member was absent in group or when group was not in session.

Roles

Margaret acted as informal group leader, but in her absence, Fred took on this role. When Margaret and Fred terminated from the group, George assumed the role of informal group leader. He was the peace keeper in the group, insuring that everyone was satisfied with the group experience. Esther also took on this role, but also mediated in any subtle conflict or disagreements between members. Stan and Helen took on the role of lost members. That is, they saw themselves as listeners and were initially ignored or avoided by other members. Stan also took on the role of a clown because he often used humour to relieve the group from emotional pain. Isabel was a group follower.

Ruby seemed to be a group scapegoat, seen as helpless and pathetic by other members. Fred insisted that Ruby was afraid to die without actually checking this out with her. Fred seemed to project his own fear or his interpretation of his wife's behaviour onto Ruby. She passively accepted Fred's interpretation. Ronald assumed the role of advocate where he insured that the members, including himself, stayed on topic, got active assistance with problem solving and

were not pushed to do or say more than they wanted to. Dennis , Inez and Clara came into group as experts with their own recoveries often using past experience to assist others who were just starting their recoveries.

Group Culture

Most of the members came into group with the social value of withholding the expression of feelings, avoiding direct, personal interaction with others, and avoiding discussion of sensitive issues. However, after a few weeks of coming to group, members were able to identify and express feelings such as anger, guilt, self-pity, remorse, loneliness and fear. Many of the members took the risk of self-disclosing to other members about intimate details about their lives. They were able to explore sensitive issues like sexuality, chemical dependency, anticipation of their own death, loss, and past and present relationships. These self-disclosures were often met with empathy, compassion and encouragement. Many members were able to move beyond the social values to create a group culture that nurtured intimacy among members and personal self-disclosure.

Mutual Aid

Aside from group attraction and cohesion, mutual aid was the next most powerful dynamic that kept the group

together and made it a beneficial experience. Only two members felt as though they did not belong in the group due to their strong denial about their chemical dependencies. All the rest felt that "all-in-the-same-boat" feeling.

There were many instances in group where members reached out to help each other. Members usually listened intently to each other's stories and problems. Seldom was anyone judged for his or her problems or faults. Advice was given occasionally, but sparingly. When Stan was telling about his frustration with the vague information his doctor was giving about his wife's cancer, the group strongly suggested that he seek out a second opinion. When Helen threatened to leave group, all the members urged her to stay, which she did. Members actively engaged in problem solving in group.

Members gave each other compliments and praise for accomplishments and improvements in recovery. They helped each other by telling of their similar experiences with the chemical dependency and relationships. This validated and normalized the feelings and experiences of the group members, which, in turn, helped the members to decrease feelings of shame and to accept themselves as chemically dependent.

Evaluation Results: The Group as a Whole

To determine the effectiveness of the group, this

section will analyze the results of the measurements that were taken. This will be done by looking at the group members' verbal feedback about their satisfaction with the group experience and by evaluating the successfulness of achieving the group goals.

The Post Session Report Results

Group member's perceptions of the group were obtained by using a Post Session Report. Table 6 shows that the members overwhelmingly found the group useful. Members may not have given negative answers because of fear of offending the writer and the peer counsellor. The missing data was largely due to members' early departures from group. Members usually left early to catch public transportation for home. The comments given to the open-ended questions are listed in Appendix 13.

Table 6

DISTRIBUTION OF POST SESSION REPORT RESPONSES	
RESPONSE	NUMBER
1. Not Useful at All	2
2. Very Little is Useful	1
3. Not Sure	17
4. Somewhat Useful	47
5. Very Useful	58
Total Responses	125
Missing Data	12

To summarize the responses given in the Post Session Report as seen in Appendix 13, group members gave more positive answers than negative answers regarding the group experience. These positive comments validated the members' satisfaction with the group. They seemed to benefit from the strong sense of group attraction and mutual aid that was at work. The negative comments seemed to refer mostly to the perceived limitations or shortcomings of the group members themselves.

The comments given were used to improve the effectiveness of the group experience. Comments about not liking an audio tape or film helped to determine that some educational aids may not have been appropriate for this particular group. For example, a movie about young children living in alcoholic homes did not apply to the members' life experiences. Thus, few members found the film relevant to their interests or needs. That film was no longer used in the group. Positive comments about an audiotape about guilt led to the leaders using that tape in every treatment cycle. Five of the comments seemed to reflect the students lack of direction rather than the overall group experience. Those comments were helpful working toward more control of the group sessions and encouraging more member-to-member communication. Negative comments aimed at themselves guided the student to work harder at meeting individual needs and reinforcing positive personal qualities. The positive

comments encouraged the student to continue building structure into the sessions and emphasizing that members can help each other.

Group Goals: Achieved or Not Achieved

The Goal of Abstinence

Achieving and maintaining abstinence from alcohol was the goal for seven of the group members. Of these seven, four members achieved and maintained abstinence at the post and six month evaluation testing periods. One member maintained abstinence at the post group testing period, but had drunk alcohol for a short period of time (less than a week before the six month follow-up). However, he stopped drinking by reading articles about relapse obtained from the treatment group. One member dropped out of the treatment group, thus was unavailable for evaluation. The seventh member relapsed by the post group testing period and died two months later.

The Retrospective Self-Report completed by the members' significant others gave little information because members were reluctant to give permission to interview family members. Only Ronald gave permission to interview his wife. She reported that she was satisfied with the change she saw in Ronald and attributed that improvement to his attendance in the treatment group.

It was impossible to determine whether the group was

the only factor that helped the members to abstain. So many other factors may have been involved - family support, poor health, close family physician supervision, home care help. Interestingly, most of those who abstained were able to maintain abstinence for at least six months. However, two members did, relapse despite all the efforts made in the treatment group to prevent it. Why these relapses were not prevented by the treatment group experience is unknown. It is known, however, that relapse is a common occurrence among chemically dependent people including seniors.

Because the numbers were small and the follow-up was fairly short-term, these results are not statistically significant and are not generalizable to other chemically dependent elders. Despite these limitations, it did appear that the goal of abstaining from alcohol was achieved because more members were able to abstain (5) than those who were unable to abstain (2).

The Goal of Responsible Mood-Altering Prescription Drug Use

There were seven members who used mood-altering prescription drugs. Two members had come into group already tapered off their mood-altering drugs. Another member had used a barbiturate, for 16 years, but was no longer taking it when she started group. Instead, she was occasionally using an opiate, called 222's for pain relief. This was considered responsible use. The other four members were

actively using mood-altering prescription drugs when they started group. Table Seven showed this in the pretest column of the M.D.D.S. scores.

Because of the missing data, it was very difficult to interpret these findings in terms of group outcome. Reasons for the poor follow through with all three evaluation trials are explored in the section below. Three members achieved or maintained responsible use, while two members made no change. The group goal of achieving responsible use of mood-altering prescription drugs seemed to be inconclusive.

Table 7

USE OF MOOD-ALTERING PRESCRIPTION DRUGS			
Group Members	M.D.D.S. Scores		
	Pre	Post	6 Month
Margaret	2	2	4
Fred	2	2	2
Isabel	6	6	6
Helen	2	6	Refused
Ruby	2	Dropped Out	Dropped Out
Esther	4	Refused	Refused
Inez	Refused	Refused	Refused

(Scores: 2 = Dependency is Possible; 4 = Irregular Use; 6 = Not Applicable)

The Goal of Improved Life Satisfaction

The last group goal was to improve group members' perceptions of life satisfaction. This goal was difficult

to evaluate on a group level because only four out of twelve members completed all three testing periods. One member completed two trial periods. Four completed only the first test and three refused to do any at all. One reason for only one third of the members completing all three trials was the length of time required to complete each trial. The evaluation tools were included in a larger number of tools administered by the Elders Health Program. Each evaluation trial took two to four hours to complete. This seemed too long and exhausting for the members to finish because some members stated that they felt tired when the evaluation was over. An intelligence scale used as part of the evaluation which appeared to intimidate some members. One person seemed nervous taking it because he called it an IQ test. Other members commented about how the intelligence scale was like child's play.

Table 8 shows the results from the administration of the Delighted - Terrible Life Satisfaction Scale. Because only one third of the group members are included in the analysis, it is highly unlikely that the results would represent the group as a whole. Also, these results may not have been exclusively due to the treatment group. Many other factors which were not controlled when analyzing the data could have influenced life satisfaction. However, an attempt was made to analyze the available data.

A number of items of the Delighted-Terrible Scale

showed little change throughout the three testing trials. These included Health, Family, Friends, Religion, Transportation and the Cumulative Score. No change was considered to have occurred if the mean score did not increase or decrease to a higher or lower number in a single direction or trend. One reason the item Health did not show change may have been because poor health was a common part of aging that could not be significantly improved or eradicated with the application of treatment. The items Family and Friends did not show change possibly because the members were satisfied with their relationships to begin with, thus they had little room for improvement with this aspect in

Table 8

DELIGHTED-TERRIBLE SCALE			
(Mean Scores)			
	Trial 1	Trial 2	Trial 3
Health	4.556	3.600	4.33
Finances	4.778	4.600	3.667
Family	5.333	5.000	5.667
Job	N/A	N/A	N/A
Friends	5.111	5.400	5.333
Housing	4.889	4.600	5.333
Partner	6.000	5.333	5.500
Leisure	4.667	4.800	5.333
Religion	5.125	5.400	5.500
Self-Esteem	4.222	5.000	5.333
Transportation	4.667	4.40	4.000
Life	4.778	5.000	5.000
Cumulative Score	4.880	4.780	4.942

their lives. Also, change with the quality of their relationships may have taken longer than the six month follow-up to occur.

No change occurred with Religion scores because the members seemed to interpret this as church affiliation. Church affiliation may not change as people grow old. Transportation did not show change possibly because little change occurred in the type of transportation members used while they went to the group. The Cumulative Score failed to show change possibly because half of the items did not show change, thus influencing the cumulative mean.

Only one item, Finances, showed a downward trend in mean scores. As the members recovered from chemical dependency, they may have spent less on chemicals and would then have had more money available to spend on other things. However, they may have shown more interest in leisure activities and ventured out of their homes more often. The members may have taken a renewed interest in their own financial management once they felt better. These behaviours may have created a dissatisfaction with finances because increased activity led to increased spending which led to difficulty in making ends meet.

Satisfaction with the partner may have decreased over time for two reasons. Two of the four members who completed all three trials were married to each other which involved half of the sample. Thus, low marital satisfaction of this

one couple may have strongly influenced this trend. The second reason involved the common occurrence of mutual dissatisfaction arising once a spouse began to recover from chemical dependency. As a result of treatment, the chemically dependent members identified hurtful behaviours they inflicted on their spouses and began to try to make amends for these past regrets. However, most of the spouses did not get help to deal with the intense feelings of resentment, guilt and confusion that resulted from living with the unpredictable, self-centred behaviour of the chemically dependent partners. When the members attempted to improve their relationships with their spouses, they were met with mistrust, scepticism and hostility.

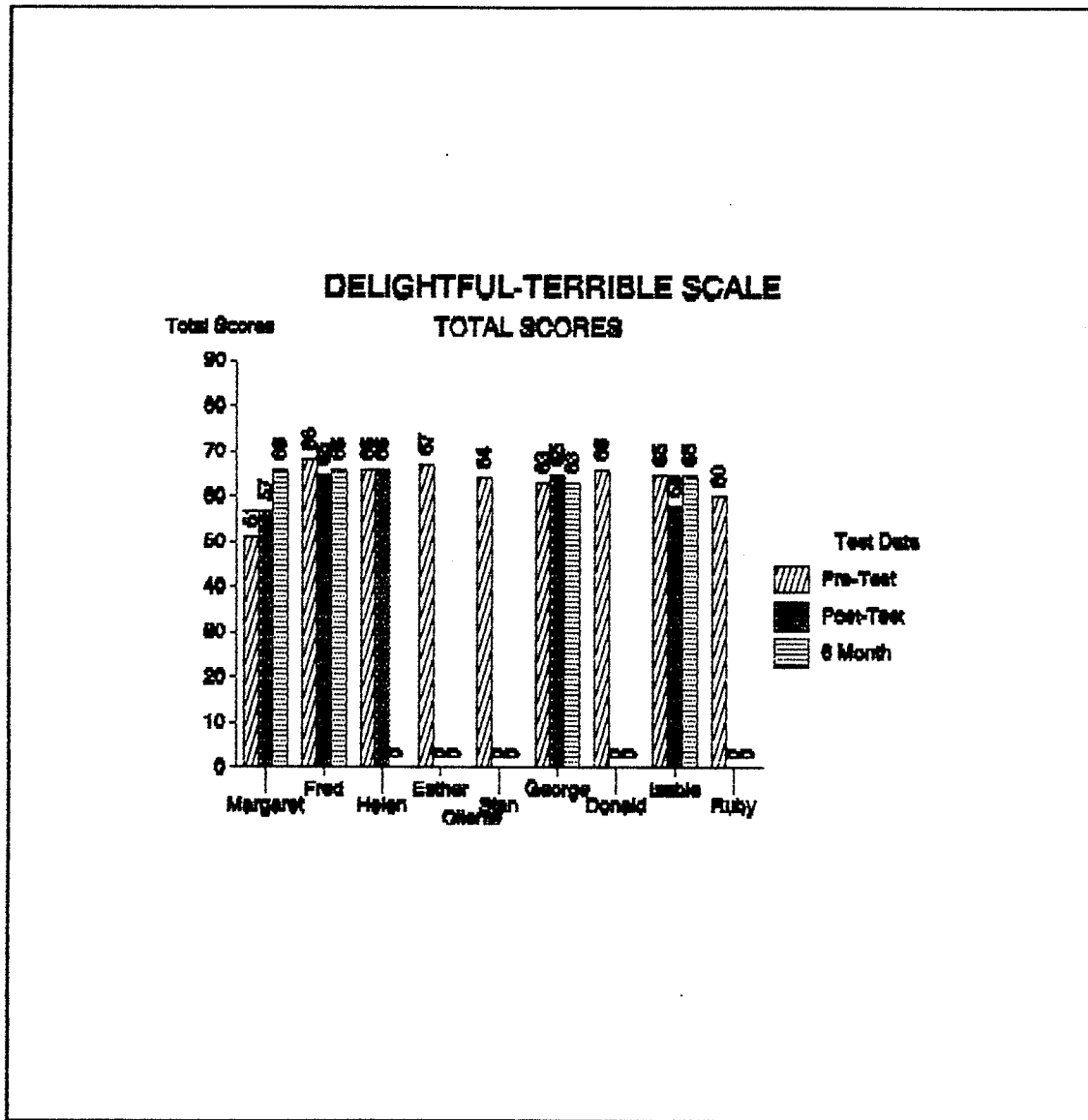
Four items showed improvement: Housing, Leisure, Self-Esteem and Life as a Whole. Housing showed improvement possibly due to members becoming more able to carry out household activities as they grew physically stronger and psychologically brighter once they had discontinued the chemical use. Members could be more content and proud of themselves as they regained activities they used to do. Leisure positively changed because members increased their interest in hobbies and social activities as they spent less time and effort engaged in taking a chemical. Self-Esteem improved over time possibly due to members feeling successful with abstaining from chemicals and rebuilding their lives. Life as a Whole may have showed some positive change

because as they felt more optimistic and confident, recovery would have positively affected the members' perception of the quality of their lives.

Looking at individual total scores in the Figure 5, it was interesting to note that those who reported improved or stable perceptions of life satisfaction had abstained from alcohol or achieved responsible use of mood-altering prescription medications. Those who reported worsened perceptions of life satisfaction had experienced poor health, relapse or unchanged chemical use.

Figure 5

Delighted-Terrible Scale Scores



To summarize, it was unknown whether the treatment group accomplished its goal of improving members perceptions of life satisfaction because of the limitations of the data.

Table 9

THE BRIEF UCLA LONELINESS SCALE (Mean Scores)		
Trial 1	Trial 2	Trial 3
20.22	18.20	19.25

Based on the raw data from the Loneliness Scale from Appendix 10, mean scores in Table 9 were determined to develop a sense of change within the group as a whole. This group showed little change in its perceived levels of loneliness over time. The group also seemed to maintain the degree of loneliness that indicated no evidence of loneliness.

The reasons for this occurring may have been due to the treatment group failing to impact on the general perceptions of loneliness. Although participation in a group could have lessened the loneliness of members while they were in group, the positive effect of the group may not have been sustained throughout the members' life experiences outside of the group. This group did not seem to be very lonely to begin with, so change in this area may not have occurred or may not have been necessary.

Implications of Findings

This section made a comparison between what was indicated in the literature about chemically dependent seniors and what was actually observed in the practicum experience. Similarities between the characteristics of chemically dependent seniors described in the literature and the characteristics of the clients seen in the treatment group will be explored first. To follow, similarities between the group process and outcomes from groups of chemically dependent seniors highlighted in the literature and the practicum experience will be discussed. Differences between the characteristics of chemically dependent seniors described in the literature and the characteristics of the members of the treatment group will be reported. Lastly, differences in the group process and results between those outlined in the literature and those observed in the practicum will be presented.

Similarities Regarding Client Population Characteristics

Alcohol Users

As described in the literature, none of the group members who used alcohol started drinking until the legal age. Dunham (1981) and Giordano and Beckham (1985) each described a number of different drinking patterns that chemically dependent seniors may have experienced. The group members all had different drinking patterns that could not be easily categorized in only one or two different types

of patterns. However, the literature did say that drinking patterns seldom changed after people became 60 years old (Adams et al., 1980; Busby et al., 1988; LaGreca et al., 1988). This was also found among most of the alcohol users in the group. Hoffman & Harrison, (1989) and Smart & Adlaf, (1988) and the writer observed that the alcohol users in the treatment group tended to be daily drinkers.

Most of the members of the group drank at home, however, those who drank outside of the home were men which was also supported by the literature (Busby et al., 1988; Giordano & Beckham, 1985; Hoffman & Harrison, 1989). The women drinkers in the group preferred drinking wine or spirits whereas men drinkers preferred beer or spirits which was also supported by Busby et al., (1988).

The literature review in this report described a multitude of physical problems that were experienced by the elderly who were dependent on alcohol. Most of the alcohol users in the treatment group had more than one physical limitation. No one in the treatment group presented with antisocial, psychopathological behaviours or symptoms. This was also supported in the literature. Few chemically dependent seniors who use alcohol have these psychological problems (Faulstich et al., 1985; Schuckit et al., 1978). Faulstich et al., (1985) reported that the chemically dependent elders who used alcohol had high levels of responsibility. This characteristic was observed with the members

of the treatment group, in spite of the interference alcohol had in their lives. All of the alcohol users in the group maintained employment and remained loyal to their families. The family was affected by the chemically dependent elderly as briefly mentioned in this literature review. Observations of the members of the treatment group supported this occurrence. For example, most of them described how their chemical dependency disrupted the level of trust with their families.

Mood-Altering Prescription Medication Users

The literature review reported that women were more likely to use medications than men, which was also observed in the treatment group. Members of the treatment group who used mood-altering prescription medications experienced confusion and drowsiness, which was also mentioned in the literature as physical consequences from regular use of these drugs (Baker, 1985; Berlinger & Spector, 1984; Cherry & Morton, 1989; Ranalli, 1988). All group members took these drugs because of insomnia which literature sources found was a main reason the chemically dependent elderly started using them (Johnson, 1989; Ranalli, 1988). J.E. Johnson (1989) found that many seniors experienced sleep disturbances due to long term regular use of mood-altering prescription medications which was also experienced by group members.

All group members using mood-altering prescription medications lived amidst a positive attitude of drug use among peers and within the social environment. Glantz (1981) reported that this condition predisposed seniors to become chemically dependent. Most group members were chemically dependent before late life issues, such as death of a spouse or loss of physical health arose. This was also supported by Finlayson (1984) who asserted that chemical dependency in seniors had no relationship to the inability to cope with late life issues. As cited in the literature review, long-term use of mood-altering prescription medications may have created or exacerbated depression. Most group members described feeling depressed. Glantz (1985) described how the elderly used alcohol and mood-altering prescription medications alternately, thus creating a single, continuous pattern of chemical dependency over the years. Those in the group who used both kinds of chemicals used them in that manner.

Chemically dependent seniors taking one or more mood-altering prescription medications daily was consistent in the literature (Johnson, 1989). Glantz (1981) stated that the elderly hoarded medications and kept old prescriptions, as was done by some of the group members. However, all members dependent on these medications continued to get refill after refill from a physician, which was also mentioned by Glantz (1981). All of the members who used mood-

altering prescription medications took them after the therapeutic benefit was achieved. Raffoul et al., (1981) and Ellor and Kurz (1982) described this same phenomena.

All group members dependent on these medications held two beliefs: 1) that they were just following doctor's orders; and 2) that they depended on mood-altering prescription medications to carry out day-to-day activities.

Glantz (1981) and Baker (1985) believed that these same thoughts were used by the chemically dependent seniors to justify the continuing use of mood-altering prescription medications. The literature review briefly discussed how the family may be affected by a senior's chemical dependency. Although no reference was made about seniors dependent on medications, most group members who used medications described how family members were negatively affected by their chemical dependency. Family members seemed to lose trust in the senior's ability to maintain responsible use of mood-altering prescription drugs, and consequently tired of the seniors many somatic complaints.

Similarities Regarding Group Process and Results.

Kofoed (1984a) found that the chemically dependent elderly often felt intense feelings of guilt and shame. In the treatment group, issues of dealing with these same feelings came up repeatedly. Kofoed also observed that this population had strong resistance to change in his treatment

groups, which was also observed in this treatment group. When seniors resistance was strong, it led the chemically dependent senior to do one of three things: 1) leave the group; 2) avoid participating in group or emotionally joining with other members; or 3) melt down the resistance and try to change.

In the treatment group, the members life experiences helped to develop group cohesion because of their shared life histories. Their varied life experiences enhanced group problem solving because of the variety of skills, perspectives and knowledge all the members brought into the group.

Kofoed (1984a) recognized the advantage a chemically dependent senior's long life experiences added to the group experience. Linn (1978) found that the chemically dependent elderly in treatment programs developed strong emotional bonds with group leaders, which was also experienced in this treatment group. The peer counsellor and the student felt strong emotional bonding with all the members regardless of the length of stay or the resistance of the members. Kofoed (1984a) described how chemically dependent elders often presented with delayed responses originating from previous group sessions. This was observed occasionally in the treatment group. For example, Esther disclosed about her husband's death a few weeks after the topic about loss was held.

In the treatment group, self-disclosures were made slowly which was also observed by Kofoed (1984a). Reminiscence happened frequently in the treatment group and in the group described by Kofoed. Zimberg (1985) mentioned that denial was common among chemically dependent seniors, which also occurred in the treatment group. From the chemically dependent elderly in their treatment groups, Dunlop et al., (1982) and Felker (1988) obtained verbal feedback about the satisfaction members felt by being with peers. This treatment group received many positive responses from the post session report.

Differences Between the Literature and Group Member Characteristics.

Alcohol Users

The literature stated that elderly men were more likely to be heavy drinkers or alcoholics than elderly women (Busby et al., 1988; Smart & Adlaf, 1988). However, in this treatment group it seemed that women were just as likely to use alcohol as men. This may have been because the elderly women drinkers were more willing to be in treatment than elderly male drinkers or because of sheer coincidence. This practicum's sample size was too small to speculate any further about the reason for the different findings. Gornberg (1990) mentioned that seniors who drank regularly were

likely to have impaired abstract thinking; however, the members in the group who drank may have had difficulty with this ability not because of chronic alcohol use but because of low education levels. Atkinson and Kofoed (1982) and Finlayson et al., (1988) identified a high incidence of legal problems experienced by elderly drinkers. This was not consistent with the findings of the treatment group as few members of the group who used alcohol had legal problems in the present or in the past.

Fruzinsky (1987) discussed how elders dependent on alcohol were vulnerable to abuse; however, none of the members of the group were currently experiencing abuse. Employment problems experienced by elderly drinkers were described by Finlayson et al., (1988) and Rathbone-McDuan and Triegaardt (1979). Few members of the group had employment problems. Most group members remained a part of their social networks. Yet the literature strongly asserted that the elderly who were dependent on alcohol were socially isolated. One reason for these differences may have been that our chemically dependent elders came from a population sample that was socially and economically stable. Studies and clinical reports may have drawn their samples of alcoholic elderly from city areas that tend to be disengaged from family and friends. Also, some services may have wrongly assumed that if a senior was chemically dependent then that person must have also been totally alone.

Mood-altering Prescription Medication Users.

Glantz (1981) said that the elderly who were dependent on these drugs tended to share medications with others. Few of the group members shared their medications with others, because they knew that sharing medications may have been harmful to others. Few group members who used mood-altering prescription medications sought out multiple doctors and pharmacies to get their pills which contradicted Glantz's (1981) observations. The group members may not have had to do this because they easily got refills from the same physician and pharmacy.

Raffoul et al., (1981) and Ellor and Kurz (1982) found that drug dependent elderly took twice as much medication per day as prescribed; however, this behaviour occurred infrequently among group numbers. Ellor & Kurz (1982) also stated that drug dependent elders used the rationale of - "if one is good, two is better" to justify their drug use. However, this attitude was not heard from treatment group members. In the literature review, one of the reasons given for becoming dependent on mood-altering prescription medications was to help cope with the losses related to aging. Few members gave age-related losses as a reason for using their medications. This may have been because they were less aware of the psychological reasons for ongoing use and because physical reasons were more easily identifiable.

Linn (1978) noted that few authority conflicts occurred

with the chemically dependent elderly in treatment. However, authority conflict did occur in the treatment group especially between informal group leaders and the co-leaders. Zimberg (1985) stressed that confrontation was not necessary in groups for chemically dependent seniors; however, confrontation was used successfully in this treatment group.

In summary, there were more similarities than differences between observations made in the practicum and research from the literature. When drawing parallels between the practicum observations and the literature, there was always one or two exceptions to the rule that did not fit with what was found in the literature and what was found in the practicum experience. Although many similarities existed, it appeared that the chemically dependent elderly were a heterogenous group.

CHAPTER VII

The Role of the Group Worker in the Treatment of Chemically Dependent Elderly

To effectively lead a treatment group for the chemically dependent elderly, it was necessary to develop expertise in group work skills and in dealing with chemical dependency and aging issues. To improve group work skills and to develop a personal therapeutic style that would have guided seniors to change, some evaluative activities were found to be extremely helpful. This section will explore what I learned from the experience of leading a group for chemically dependent seniors. Also, the measurement results of my professional goals will be discussed.

From watching the videotapes of the group sessions and from supervision by my advisor, it was possible to follow progress made with my group leadership abilities throughout the twelve weeks of the practicum. Using the videotapes was a very helpful tool for evaluating group dynamics and the use of leadership skills. The Corey and Corey Group Leadership Skills Rating Scale helped me to focus on specific group work skills and on my overall approach. Having the advisor view the tapes added some objectivity to evaluating my performance. The advisor's supervision helped to address any personal obstacles to effective leadership and to identify work that needed to be done with group members.

By the end of the practicum, I had made many improvements with group leadership skills. The professional objective of improving group leadership skills seemed to be accomplished. My strengths in leadership had been identified and developed. I was very attentive to each member's needs, such as speaking loudly and summarizing for Stan and getting Esther a pillow to sit on. I was better able to identify group dynamics and to actively create group cohesion and mutual aid. I did this by increased scanning of the group, linking group members together, and referring to the group as a whole. I had become more systematic with bringing new members into group and helping group members terminate. I had increased clarification, interpretation and confrontation skills. I was able to create a demand for work with group members and the group as a whole by asking for more details during self-disclosure and by encouraging change.

From the practicum experience, I became more aware of the group work skills that are essential for leading a group of chemically dependent elders. Commenting on my personal feelings and making observations about group process and members' behaviours helped to improve group cohesion and to deal with group resistance directly and quickly. Dynamic therapeutic approaches such as cognitive restructuring, role plays, and relaxation techniques helped group members work on the individual and group goals .

Providing structure to group sessions by stating the purpose for a topic early in the session or summarizing at the beginning and the end of sessions, helped to develop a sense of stability and security within the group. I learned that leading a treatment group such as this demanded active and intensive guidance from a group leader. Assuming an directive role was necessary to insure that the demand for work was accomplished among group members.

A second objective, becoming more comfortable with leading groups, had also been accomplished. By the end of the practicum, I felt less nervous and less fearful about leading a treatment group. I felt more confident about relying on my own observations and inner feelings to give me direction about how to proceed in group.

The last objective of my professional learning, which was to work with group members to identify and resolve chemical dependency issues, seemed to be accomplished by the end of the practicum. I was more able to identify problems related to chemical dependency and to guide group members to deal with their problems. Improvement of group leadership skills also improved my ability to help members work on their issues.

Results of the Group Leadership Skills Rating Scale

The results from using the Corey & Corey Group Leadership Skills Rating Scale supported the observations I had

made about my growth in leadership. The scores obtained throughout the implementation of the group were tested for autocorrelation. Autocorrelation meant that the data were so closely related to each other, that activities in the beginning of the group predicted what I did in the later part of the group. To some extent, professional growth with group work skills depended on how I started and what skill level I started with. However, testing for autocorrelation would statistically prove that I did not develop the scores to insure that improvement did occur. The data turned out to be free from autocorrelation.

The proportion/frequency approach was used to determine if my group work skills had reached a desired level (Bloom & Fischer, 1982). I had determined that there was significant improvement of using group work skills at the .05 level. Table 1 showed the improvement of the cumulative group skills as the group moved over time. For Tables 2-16, I had created a consistent mid-zone for all of them. This allowed me to visually analyze each table and make comparisons between them. At the same time, the creation of the mid-zone helped to indicate very poor, average, to very good levels of each specific group work skill. Refer to Tables 1 - 16 in the Appendix 9.

Each specific skill showed improvement except for Table 16, Termination. Termination was highly variable without any trend in any significant direction. One reason for this

may have been due to termination of each session being very difficult to do routinely when group members left quickly to catch their public transportation. Another reason may have been that termination was not a skill that occurred on a continuum. Possibly, it was a dichotomous skill that you either did or did not do it when a session was over or when a member left the group.

Tables 2, 3, 10, 14, 15, of Appendix 9, of active listening, reflecting, supporting, facilitating and empathizing showed more stability than the other tables. This stability may have been due to these skills being more familiar and comfortable for me to use. Tables 4, 5, 6, 7, 8, 9, 11, 12, 13, and 16 of Appendix 9, evaluating, clarifying, summarizing, interpreting, questioning, linking, confronting, blocking, diagnosing, evaluating, and terminating showed low stability. These skills were rarely used in my past clinical work, thus requiring me to develop these skills. However, when leading this group, these skills improved by the end of the practicum and became a routine part of my group work skills.

Working in a co-leadership unit with someone who did not have a professional background, was much older, was male, and was a member of a self-help group allowed me to learn a few things. Meeting regularly to discuss the sessions was crucial to the co-leadership relationship. We not only kept up-to-date about the group and its members, but we

also nurtured our understanding of each other in areas such as personal values, theoretical perspectives and therapeutic approaches. This reduced conflict between us and cultivated mutual respect. I needed to become accepting and respectful of the peer counsellor's self-help principles and approaches as well as to explain the reasons behind my activities in group.

To summarize, there were some mixed results in terms of positive and negative outcomes from the analysis. However, the positive findings and experiences in the group sessions outweighed the negative results. This group for chemically dependent seniors seemed effective and successful in bringing about change in the members. It provided a useful resource to the community as a program of this kind had never existed before.

CHAPTER VIII

Recommendations

Five recommendations come from the experience with this practicum project. These recommendations may assist those professionals who are considering implementation of a treatment group for the chemically dependent elderly.

Firstly, because this group was done in a community based organization, it could be replicated in any other community based program. This group may be done where a number of chemically dependent seniors gather together naturally or are brought together by professionals or an agency. The community setting may be a service agency with the target population being the elderly such as geriatric day hospitals, geriatric day centres, or wellness centres for seniors. Existing chemical dependency treatment programs may be able to implement a group for the chemically dependent elderly. This kind of group could have easily been added to an outpatient chemical dependency program designed to accommodate this population's many physical challenges and multiple chronic illnesses.

This group may also be implemented in institutional settings such as general hospitals, psychogeriatric units, or even personal care homes. For these groups to be done in an institutional setting, it would be important to insure that full support is given by administration and all staff. Because of the stigma associated with chemically dependent

seniors and strong scepticism about their ability to change, it may be easy to sabotage the existence of the group resulting in deepening feelings of shame and hopelessness among the group members. Institutional settings may need to make adjustments to the group structure or content to accommodate more severe or unstable physical/psychological conditions, especially cognitive impairment. Specific recommendations about the kind of adaptations necessary will vary from agency to agency which is beyond the scope of this practicum.

The second recommendation involves the importance of gaining support from the three levels of the system to ensure the success of the treatment group. The first level is the sanction, funding and administration from the government. Without this support, a treatment group for chemically dependent seniors would not have the resources of space, staffing and credibility to the public which are all necessary for the group's existence. The second level of the system includes the involvement of multidisciplinary professionals and social agencies. The treatment group can not provide all the services these resources provide. To meet the many and varied needs of the chemically dependent elderly, strong reliance upon home care agencies, visiting nurses, family physicians, and housing officials is necessary to provide the care for day-to-day living and well-being. With these resources in place, the chemically depen-

dent elderly can then focus on their work toward recovery. The third system level is the family and friends of chemically dependent elders. This support seems to be crucial for the members to continue in group and their recovery. With the desire to maintain these relationships, members are motivated to strive for abstinence thus strengthening their commitment to the group. The external support of family and friends insures the ongoing existence of the group by encouraging and expecting the members to go to group. To help the families and friends cope with the chemical dependency and recovery of a loved one, a family support group may further enhance the recovery of the chemically dependent senior. This support group may help families heal past resentments, reestablish trust and decrease enabling behaviours that unintentionally reinforce chemical use.

The third recommendation is that social workers share this expertise with professionals from any background and offer support and collaboration while they develop and implement treatment programs. Leaders must possess and integrate experience and knowledge in the fields of aging, chemical dependency and group work. A group of this kind seems to demand integration of these three fields for increased effectiveness to act as group leader. A dynamic, firm, yet warm leadership approach may also be helpful for facilitating the treatment group. Striving for high levels

of self-disclosure and of the demand for work among members seem to require the leader to continually encourage members to risk new behaviours.

A fourth recommendation is to encourage professionals to recruit peer counsellors as co-leaders for facilitating treatment groups for the chemically dependent elderly. This unique co-leadership experience is a positive and satisfying experience for both leaders, for the members and for the group as a whole. The peer counsellor can add a different perspective to the group sessions and enhance the members' sense of hope and optimism. Contacting any established chemical dependency treatment agency or Alcoholics Anonymous may lead to accessing a peer leader.

The last recommendation is to consider separating the members into two groups - one for the pill users and another one for the alcohol users. Having both types of users in one group led to the creation of natural subgroups of pill users and alcohol users because of the strong commonalities they found with each other. A lack of understanding about each preference of chemical existed between those two subgroups. Some issues seemed more appropriate for one subgroup or another. For example, relapse prevention seemed more relevant to alcohol users whereas dealing with anger and blame toward the prescribing physician seemed more relevant to the pill users. Separating these members into their natural subgroupings may have improved the level of

cohesion, mutual aid and group identity in each group. Commonalities, sense of belonging and universality may have been more clearly felt among the members. Separating the group into two subgroups can be done as long as there are enough clients to make up two groups consistently over time.

Conclusions

It seemed that this practicum project was able to bridge a gap that existed in this community. It was the first age-specific treatment group for the chemically dependent elderly. Involved professionals, family members and group members gave verbal feedback about how fortunate they felt that this resource finally came into being. Finally, there was a place for chemically dependent seniors to get help.

This practicum may have shown this community that a treatment group for the chemically dependent elderly was moderately effective. It was able to achieve a therapeutic group process. Some members were able to change in ways that were fulfilling for them. Most individual and group goals were achieved.

Professional learning was significant. Experience in this practicum enhanced my growth in group work skills. Comfort with leading a treatment group was achieved which allowed for increased feelings of confidence and trying new therapeutic approaches. Participating in a co-leadership unit added a challenging, rich dimension to the group experience. Through the peer counsellor, I was able to learn about the self-help group, Alcoholics Anonymous. Also the co-leadership unit built a strong bridge between the leaders and the members and possibly between professionals and self-help group members. This linkage of co-leaders and the

improvement made with group work skills proved to benefit the chemical dependent elderly. They received guidance and support necessary to help them move through recovery stages and to improve the quality of their lives regardless of age.

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DELIGHTED-TERRIBLE SCALE RAW DATA

Client	#	1	2	3	4	5	6	7	8	9	10	11	12	TOTAL*
Margaret	1	2	5	4	8	5	2	5	4	5	4	3	4	51
	2	2	5	6	8	6	4	5	4	7	5	5	4	57
	3	5	5	6	8	6	4	5	4	7	6	4	6	66
Fred	1	5	5	5	8	6	5	6	5	6	6	6	5	68
	2	5	6	5	8	7	4	5	4	5	5	6	5	65
	3	5	5	5	8	4	6	5	5	5	5	6	5	64
Kather Refused	1	5	5	5	8	5	5	8	5	5	5	5	5	66
	2	5	5	5	8	5	5	8	5	5	5	5	5	66
	3													
Esther Refused	1	5	5	6	8	5	5	8	5	5	4	5	6	67
	2													
Stan Refused	1	4	6	6	8	6	5	6	4	6	3	6	4	64
	2													
Andy	1	4	4	5	8	6	5	6	5	6	3	6	4	64
	2	5	5	5	8	4	6	6	6	5	5	5	5	65
	3	4	5	5	8	5	6	6	6	4	5	4	5	63
Ronald Refused	1	5	5	6	8	5	6	7	5	8	1	5	5	66
Isabel	1	6	3	5	8	5	5	8	5	5	5	5	5	65
	2	1	2	7	8	6	4	8	5	5	5	1	6	58
	3	4	1	6	8	5	6	8	6	8	5	4	4	65
Rosalie Dropped Out	1	5	5	6	8	4	5	8	3	4	5	2	5	60
Clara - Refused Inez - Dropped Out Dennis - Refused														

LEGEND: * 1 = Health; 2 = Finances; 3 = Family Relations; 4 = Paid Employment; 5 = Friendships; 6 = Housing; 7 = Living Partner; 8 = Recreation Activity; 9 = Religion; 10 = Self-Esteem; 11 = Transportation; 12 = Life as a Whole.

= Trial 1, 2 & 3

M.D.D.S SCORES RAW DATA			
Client	Pretest	Posttest	6-Month
Margaret	2	2	4
Helen	2	6	
Esther	4		
George	6	6	6
Ronald	6		
Isabel	6	6	6
Dennis			
Inez			
Clara			
Ruby	2		
Stan	6	6	
Fred	2	2	2

INTRODUCTION

The Manitoba Drug Dependency Screen (MDDS) is designed to identify patients at risk of physiologic dependence to benzodiazepines, barbiturates, or opiates or miscellaneous sedative/hypnotic agents. The screen is not intended to be diagnostic for chemical dependency. Patients with "POSSIBLE" dependency, as determined by this instrument, require further assessment of their condition or drug therapy.

One component of the questionnaire involves the calculation of a Cumulative Benzodiazepine Exposure (CBE) or Cumulative Opiate Exposure (COE) to determine the probability of physiologic dependence. The MDDS also investigates behaviors suggestive of chemical dependency. A perception that medicines are not working as well as they used to, a desire to do without the medicine, and receiving medicines from more than one physician or pharmacy are noted.

This manual provides instructions on how to complete the questionnaire and calculate the CBE or COE. A picture chart of certain brand name drugs available in Canada and lists of drugs according to their trade and generic names is also appended to assist in using this instrument.

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INSTRUCTION FOR USE

The Manitoba Drug Dependency Screen consists of a one page questionnaire (Appendix 1) and a chart section (Appendix 2). The number of pages included in the chart section will depend on the number of drugs the patient reports taking.

STEP 1 Asks the patient questions 1 through 8 on the questionnaire. Record each medication reported by the patient on the chart and circle whether the medication is a benzodiazepine (Bz), barbiturate (Bd), opiate (O), miscellaneous sedative/hypnotic (M), or none of these drug categories (N). A comprehensive list of the trade and generic names of Bz, Bb, O and M currently available in Canada are listed under Appendix 3. Analgesic compounds containing aspirin or acetaminophen and miscellaneous CNS agents currently available in Canada are included under Appendix 4.¹

STEP 2 For all medications recorded on the chart, obtain the information requested on the left hand side and record this information down the column in the appropriate box.

If a patient reports use of either Bz, Bb, or M,

¹. NOTE: Drugs listed under Appendices 3 and 4 may not include all trade names.

it is important to determine the drug name and dose being taken. Pictures of a majority of brand name O, Bz, Bb, and M available in Canada are illustrated in Appendix 5. Use these picture charts to assist a patient in identifying the correct name and/or dose of the drug prescribed to them.

STEP 3

Score each drug at the bottom of the appropriate column using the algorithm outlined in Appendix 6.

- * Drugs which are not Bz, Bb, O, and M are scored 6 (Not Applicable).
- * A drug score of 5 (Do Not Know) is used when a patient reports taking a "nerve pill" etc. However he/she is unable to provide the NAME of the medication.
- * If a patient reports taking a Bz, Bb, O, or M however he/she reports using these agents less frequently than on a REGULAR DAILY BASIS, the score for that drug is 4 (Irregular Use).
- * For patients who report taking a Bz, Bb, or M drug on a REGULAR DAILY BASIS, calculate the Cumulative Benzodiazepine Exposure (CBE) using the equation outlined in Appendix 6.
- * For Bz, Bb, or M other than diazepam refer to Appendix 3 to determine the Diazepam E-

equivalence Factor necessary for the CBE equation.

- * If a patient reports taking more than one Bz, Bb, or M, the final CBE is the sum of individually calculated CBEs²
- * As illustrated in the algorithm outlined in Appendix 6, if the CBE is less than 1,000 mg the score is 1 (Unlikely). If the CBE is greater than or equal to 1,000 mg the score is 2 (Possible).
- * Similarly, for patients taking O on a REGULAR DAILY BASIS, calculate the Cumulative Opiate Exposure (COE) using the equation outlined in Appendix 6.
- * For O other than morphine refer to Appendix 3 to determine the Morphine Equivalence Factor necessary for the COE equation.
- * If a patient reports taking more than one O, the final COE is the sum of the individually calculated COEs.
- * As illustrated in the algorithm outlined in Appendix 6, if the COE is less than 500 mg the score is 1 (Unlikely). If the COE is greater than or equal to 500 mg the score is 2 (Possible).

². CBEs and COEs are NOT additive.

- * If the patient knows the name of the drug but he/she is unable to recall the dose, use the lowest dose available for that drug in the CBE or COE calculation. This information will usually be available from the picture chart in Appendix 5.
- * A drug score of 7 is used when the patient has no ideas what he/when is taking.

MANITOBA DRUG DEPENDENCY SCREEN (MDDS)

1. What medications are you currently taking?
(Ask information on chart.)

2. Are you taking any **other** medication to help you sleep?
NO YES (Ask information on chart.)

3. Are you taking any **other** medication to help you with your nerves?
NO YES (Ask information on chart.)

4. Are you taking any **other** medication for pain?
NO YES (Ask information on chart.)

5. Do you find any of your medications **no longer** work as well as they used to?
No Yes
(I f Y e s) W h i c h o n e s ?

- Ask information on chart for any drug not listed previously.)

6. Are you taking any medications you would like to do without?
NO Yes
(If Yes) Which ones?

- _____ (Ask information on chart for any drug not listed previously.)

7. Do you receive prescriptions from more than one doctor?
NO Yes

8. Do you get all your medications from the same pharmacy?
NO Yes

Drug _____ Drug _____ Drug _____

CIRCLE ONE	O Bz Bb M N	O Bz Bb M N	O Bz Bb M N
Why are you taking it?			
How often do you take it?			
How much do you take at one time? (Include dose if available)			
How long have you been taking it?			
Was it prescribed by a doctor?			
How often do the directions say to take it?			
How much do the directions say to take at one time?			
Could you do without this medication?			
(If NO) Why?			
SCORE			

A LIST OF BENZODIAZEPINES AVAILABLE IN CANADA

DIAZEPAM EQUIVALENCE FACTORS

DRUG (GENERIC)	TRADE NAMES	DIAZEPAM EQUIVALENCE FACTOR
ALPRAZOLAM	XANAX	
BROMAZEPAM	LECTOPAM	1.7
CHLORDIAZEPOXIDE	LIBRIUM, SOLIUM, MEDILIUM, NOVOPOXIDE, APO-CHLORDIAZEPOXIDE (IN APO-CHLORAX, CORIUM, LIBRAX, MENRIUM)	0.2
CLONAZEPAM	RIVOTRIL	2.5
CLOFAZEPATE	TRANXENE, NOVOCLOPATE	1.3
DIAZEPAM	VALIUM, E-FAM, MEVAL, NOVODIAPM, VIVOL, APO-DIAZEPA, DIAZEMULS	1.0
FLURAZEPAM	DALMANE, SOMNOL, NOVOFLLUPAM, SOM-FAM, FMS-FLURAZEPAM, APO-FLURAZEPAM	0.3
LORAZEPAM	ATIVAN, APO-LORAZEPAM, NOVOLORAZEPAM, FMS-LORAZEPAM	5
NITRAZEPAM	MOGADon	2
OXAZEPAM	SERAX, OX-FAM, ZAFEX, NOVOXAFAM APO-OXAZEPAM, FMS-OXAZEPAM	0.2
TEMAZEPAM	RESTORIL	0.7
TRIAZOLAM	HALCION	10

A LIST OF BARBITURATES AVAILABLE IN CANADA (1989)

DIAZEPAM EQUIVALENCE FACTORS

DRUG (GENERIC NAME)	TRADE NAMES	DIAZEPAM EQUIVALENCE FACTOR
AMOBARBITAL	AMYTAL, SOCIUM AMYTAL, ISOBEC, NOVAMOBARB (IN TUINAL)	0.1
BUTABARBITAL	BUTISOL SODIUM, DAY-BARB, NEO-BARB (IN ANCATROPINE, NEO-HS)	0.1
BUTALBITAL	IN FLEXONAL, FIORINAL, TECNAL	0.1
PENTOBARBITAL	NEMBUTAL, PENTOGEN, NOVO-PENTOBARB, NOVA-RECTAL (SUPPOSITORY) (IN CARBITAL)	0.1
PHENOBARBITAL	LIMINAL, GARDENAL (IN FLEXONAL, DONNATAL, BELLADENAL, DICOLPHEN, NEURO-SFASEX, ROBINUL-FH, BELLERGAL, PERITRATE, w/PHENOBARB S.A., TEDRAL	0.3
SECOBARBITAL	SECONAL, SODIUM, NOVOSECOBARB (IN TUINAL)	0.1

A LIST OF MISCELLANEOUS SEDATIVE/HYPNOTICS AVAILABLE IN CANADA (1989)

DIAZEPAM EQUIVALENCE FACTORS

DRUG (GENERIC NAME)	TRADE NAMES	DIAZEPAM EQUIVALENCE FACTORS
MEPROBAMATE	EQUANIL, MEDITRAN, NOVO-MEPRO (IN NEO-HS)	0.03
METHAQUALONE	TUALONE-300 (IN MANDRAX)	0.03

A LIST OF NARCOTIC ANALGESICS AVAILABLE IN CANADA (1989)

MORPHINE EQUIVALENCE FACTORS

DRUG (GENERIC NAME)	TRADE NAMES	MORPHINE EQUIVALENCE FACTORS
CODEINE	FAVERAL, NUMEROUS COMPOUNDS	0.3
HYDROMORPHONE	DILAUDID, DILAUDID-HP	8
HYDROCODONE	ROBIDONEK HYCODAN, NUMEROUS COMPOUNDS	
LEVORFHANDOL	LEVO-DROMORAN	15
MEPERIDINE/ PETHIDINE	DEMEROL	0.2
MORPHINE	M.O.S. SYRUP, MS CONTIN, MORPHITEC ROXANOL, STATEX, EPIMORPH	1.0
OXYCODONE	SUFELDOL, NUMEROUS COMPOUNDS	2
OXYMORPHONE	NUMORPHAN (SUPPOSITORY)	15
PENTAZOCINE	TALWIN, NUMEROUS COMPOUNDS	0.3
PROPXYPHENE	DARVON-N, 642, NOVOPROPOXYN, NUMEROUS COMPOUNDS	0.1

ANALGESIC COMPOUNDS CONTAINING ASPIRIN
(IN mg)

	ASPIRIN	CODEINE	CAFFEINE	OTHER
222	375	8	15	
222 FORTE	500	8	15	
282	375	15	15	
282 MEP	350	15	15	MEPROBAMATE (200 mg)
292	375	30	15	
293 (S-R)	375	60	15	
692	375		30	PROPOXYPHENE HYDROCHLORIDE (65 mg)
ANCASAL 8	375	8	15	
ANCASAL 15	375	15	15	
ANCASAL 30	325	30	15	
C2 WITH CODEINE	325	8	15	
CORYPHEN-CODEINE	325	30		
CORYPHEN-CODEINE	650	30		
DARVON-N (WITH ASA)	325			PROPOXYPHENE (NAPSYLATE) (100)
DARVON-N COMPOUND	375		30	"
ENDODAN	325			OXYCODONE (5)
FIORINAL	330		40	BUTALBITAL (50)
FIORINAL C1/4	330	15	40	" "
FIORINAL C1/2	330	30	40	" "
OXYCODAN	325			OXYCODONE (5)
PERCODAN	325			" "
PERCODAN-DEMI	325			" (2.5)
PHENAFHEN #2	325	16.2		PHENOBARBITAL (16.2)
PHENAFHEN #3	325	32.4		" "
PHENAFHEN #4	325	64.8		" "
ROBAXISAL C1/8	325	8		METHOCARBAMOL (400)
ROBAXISAL C1/4	325	16.2		" "
ROBAXISAL C1/2	325	32.4		" "
TALWIN CPD 50	390		32	PENTAZOCINE (HYDROCHLORIDE) (50)
TECNAL	330		40	OXYCODONE (5)
TECNAL C1/4	330	15	40	BUTALBITAL (50)
TECNAL C1/2	330	30	40	" "

ANALGESIC COMPOUNDS CONTAINING ACETAMINOPHEN
(IN mg)

	ACETAMINOPHEN	CODEINE	CAFFEINE	OTHER
ATASOL 8	325	8	15	
ATASOL 15	325	15	15	
ATASOL 30	325	30	15	
EMFRACET 30	300	30		
EMFRACET 60	300	60		
EMTEC-30	300	30		
ENDOCET	325			OXYCODONE (5)
EXDOL 8	300	8	15	
EXDOL 15	300	15	15	
EXDOL 30	300	30	15	
LENOLTEC #1	300	8	15	
LENOLTEC #2	300	15	15	
LENOLTEC #3	300	30	15	
LENOLTEC #4	300	60		
MERSYNDOL w/CODEINE	325	8		DOXYLAMINE SUCCINATE (5)
OXYDOCET	325			OXYCODONE (5)
PARAFON FORTE CB	300	8		CHLORZOXAZONE (250)
PERCOCET	325			OXYCODONE (5)
PERCOCET-DEMI	325			OXYCODONE (2-5)
ROUNDX 15	325	15		
ROUNDX 30	325	30		
ROUNDX 60	325	60		
SINUTAB w/CODEINE	325	8		PSEUDOEPHEDRINE (30)
				CHLORPHENIRAMINE (2)
TYLENOL #1	300	8	15	
TYLENOL #1 FORTE	500	8	15	
TYLENOL #2	300	15	15	
TYLENOL #3*	300	30	15	
TYLENOL #4	300	60		
TYLEMOL #4 ELIXIR (/5 ml)	160	8		
VEGANIN	500	8	15	

MISCELLANEOUS CNS AGENTS
(IN mg)

TRADE NAME OF COMPOUND	DRUG CONSTITUENTS (QUANTITY)
ANCATROPINE INFANT DROPS (/0.3ml)	BUTABARBITAL (8)
BENYLIN WITH CODEINE	CODEINE (3.3)
CHERACOL (/5ml)	CODEINE (10)
COACTIFED EXPECTORANT (/5ml)	CODEINE (10)
COACTIFED TABLET	CODEINE (20)
COPHYLAC EXP (5ml)	NORMETHADONE (50)
COPHYLAC (/5ml)	NORMETHADONE (50)
CORISTEX DH (5/ml)	HYDROCODONE (5)
CORISTINE DY (/5ml)	HYDROCODONE (1.7)
DIMETANE EXP-DC (5/ml)	HYDROCODONE (1.8)
DIMETAPP WITH CODEINE	CODEINE (8)
HYCOMINE (/5ml)	HYDROCODONE (5)
HYCOMINE-S (/5ml)	HYDROCODONE (2.5)
HYCODAN	HYDROCODONE (5)
HYCODAN (/5ml)	HYDROCODONE (5)
MERCODOL (/5ml)	HYDROCODONE (1.65)
NOVAHISTEX DH (/5ml)	HYDROCODONE (5)
NOVAHISTEX C (/5ml)	CODEINE (15)
NOVAHISTINE DH (/5ml)	HYDROCODONE (1.7)
OMNI-TUSS (/5ml)	CODEINE (10)
PENTUSS (/5ml)	CODEINE (10)
ROBITUSSIN A-C	CODEINE (10)
ROBITUSSIN w/CODEINE	CODEINE 3.3)
SOLLUCODON (/5ml)	HYDROCODONE (2)
SOLLUCODAN-H (/5ml)	HYDROCODONE (2)
TRIAMINIC EXPECTORANT DH (/5ml)	HYDROCODONE (1.67)
TUSSAMINIC DH FORTE	HYDROCODONE (5)
TUSSAMINIC C FORTE	CODEINE (15)
TUSSIONEX	HYDROCODONE (5)
COACTIFED SYRUP (/5ml)	CODEINE (10)
DIMETAPE EXP-C (5ml)	CODEINE (10)

**EQUATIONS TO CALCULATE
THE CUMULATIVE BENZODIAZEPINE EXPOSURE (CBE)³
and
THE CUMULATIVE OPIATE EXPOSURE (COE)**

CBE (a) = DRUG DOSE (mg) x DIAZEPAM EQUIVALENCE (b) x DURATION (c)

PHYSIOLOGIC DEPENDENCE IS:

1. **UNLIKELY** IF CBE IS: LESS THAN 1,000 mg
2. **POSSIBLE** IF CBE IS: GREATER THAN OR EQUAL TO 1,1000 mg

(a) CBE is the cumulative Benzodiazepine Exposure in mg
 (b) if drug is not diazepam refer to Appendix ;3 for DIAZEPAM E-
 QUIVALENCE
 (c) DURATION is the number of DAYS of REGULAR daily use

COE (a) = DRUG DOSE (mg) x MORPHINE EQUIVALENCE (b) x DURATION (c)

PHYSIOLOGIC DEPENDENCE IS:

1. **UNLIKELY** IF COE IS: LESS THAN 500 mg
2. **POSSIBLE** IF COE IS: GREATER THAN OR EQUAL TO 500 mg

(a) COE is the Cumulative Opiate Exposure in mg
 (b) if drug is not morphine refer to Appendix 3 for MORPHINE E-
 QUIVALENCE
 (c) DURATION is the number of DAYS of REGULAR daily use

DRUG SCORES

1. UNLIKELY
2. POSSIBLE
4. IRREGULAR USE
5. DO NOT KNOW
6. NOT APPLICABLE
7. MISSING INFORMATION

³. Adapted from: Harrison, M.; Busto, U.; Naranjo, C.A.; Kaplan, H.L.; Sellers, E.M. Diazepam tapering in detoxification for high-dose benzodiazepine abuse. Clin Pharmacol Ther 1984; (36(4):527-553)

DELIGHTED-TERRIBLE SCALE

We would like you to consider your life as it is right now. Please pick the number that describes you own life as it is now.

1 = Terrible 2 = Very Dissatisfying 3 = Dissatisfying 4 = Mixed
5 = Satisfying 6 = Very Satisfying 7 = Delightful 8 = Not Applicable

INSTRUCTIONS: Put the appropriate number from the chart on the blank space before each item.

- _____ Health (The present state of your general, overall health).
- _____ Finances (Your income and assets).
- _____ Family Relations. (Kind of contact and frequency of contact you have with your family members, including personal contact, phone calls, and letters).
- _____ Paid Employment (Any work for wages, salary, or fees) (If you are not currently receiving wages, put an 8 on the blank).
- _____ Friendships (Kind of contact and frequency of contact you have with your friends, including personal contact, phone calls, and letters).
- _____ Housing (The present type, atmosphere and state of your home).
- _____ Living Partner (Includes spouse, common-law partner). (If you are not living with a spouse or common-law partner, put an 8 on the blank).
- _____ Recreation Activity (Personal recreation activities you engage in for pure pleasure when you are not doing normal daily living chores or some type of work: Include relaxing, reading, TV, regular get togethers, church activities, arts and crafts, exercises, trips, etc.).
- _____ Religion (Your spiritual fulfilment) (If you are not religious, put an 8 on the blank).
- _____ Self-Esteem (How you feel about yourself; your sense of self-respect).
- _____ Transportation (Public and private transportation, including convenience and expense).
- _____ Using the same scale, how do you feel about your life as a whole right now?

SUMMARY REPORT

DATE:

TOPIC OF SESSION:

PRESENT:

GROUP PROCESS:

INDIVIDUAL PROCESS:

SUMMARY:

PLAN FOR NEXT MEETING:

POST SESSION REPORT

PLEASE INDICATE HOW USEFUL THIS SESSIONS WAS FOR YOU.

1	2	3	4	5
Not Useful at all.	Very Little is Useful	Not Sure	Somewhat Useful	Very Useful

WHAT DID YOU LIKE BEST ABOUT THIS SESSION?

WHAT DID YOU LIKE LEAST ABOUT THIS SESSION?

OTHER COMMENTS:

GROUP LEADERSHIP SKILLS RATING SCALE

Rate each item on a scale of 1 to 7.

1 = I am very poor at this.

7.= I am very good at this.

- ___ 1. **Active Listening:** I am able to hear and understand both direct and subtle messages.
- ___ 2. **Reflecting:** I can mirror what another says, without being mechanical.
- ___ 3. **Clarifying:** I can focus on underlying issues and assist others to get a clearer picture of some of their conflicting feelings.
- ___ 4. **Summarizing:** When I function as a group leader, I'm able to identify key elements of a session and to present them as a summary of the proceedings.
- ___ 5. **Interpreting:** I can present a hunch to someone concerning the reasons for his or her behavior without dogmatically telling what the behavior means.
- ___ 6. **Questioning:** I avoid bombarding people with questions about their behavior.
- ___ 7. **Linking:** I find ways of relating what one person is doing or saying to the concerns of other members.
- ___ 8. **Confronting:** When I confront another, the confrontation usually has the effect of getting that person to look at his or her behavior in a nondefensive manner.
- ___ 9. **Supporting:** I'm usually able to tell when supporting another will be productive and when it will be counterproductive.
- ___ 10. **Blocking:** I'm able to intervene successfully, without seeming to be attacking, to stop counterproductive behaviors (such as intellectualizing) in a group.
- ___ 11. **Diagnosing:** I can generally get a sense of what specific problems people have, without feeling the need to label people.
- ___ 12. **Evaluating:** I appraise outcomes when I'm in a group, and I make some comments concerning the ongoing process of any

group I'm in.

- ___ 13. **Facilitating:** In a group, I'm able to help others openly express themselves and work through barriers to communication.
- ___ 14. **Empathizing:** I can intuitively sense the subjective world of others in a group, and I have the capacity to understand much of what others are experiencing.
- ___ 15. **Terminating:** At the end of group sessions, I'm able to create a climate that will foster a willingness in others to continue working after the session.

(Corey & Corey, 1977)

RETROSPECTIVE SELF-REPORT ABOUT ALCOHOL USE

Before my spouse/parent/friend began attending the Elders Health Program:

I observed his/her alcohol use as:

1	2	3	4	5	6	7
Not troublesome at all			Moderately troublesome			Very troublesome

After attending 12 weeks at the Elders Health Program, I have observed my spouse/parent/friend's current alcohol use as:

1	2	3	4	5	6	7
Not troublesome at all			Moderately troublesome			Very troublesome

USE OF GROUP SKILLS

Table 1

USE OF GROUP SKILLS

Corey & Corey Total Scores

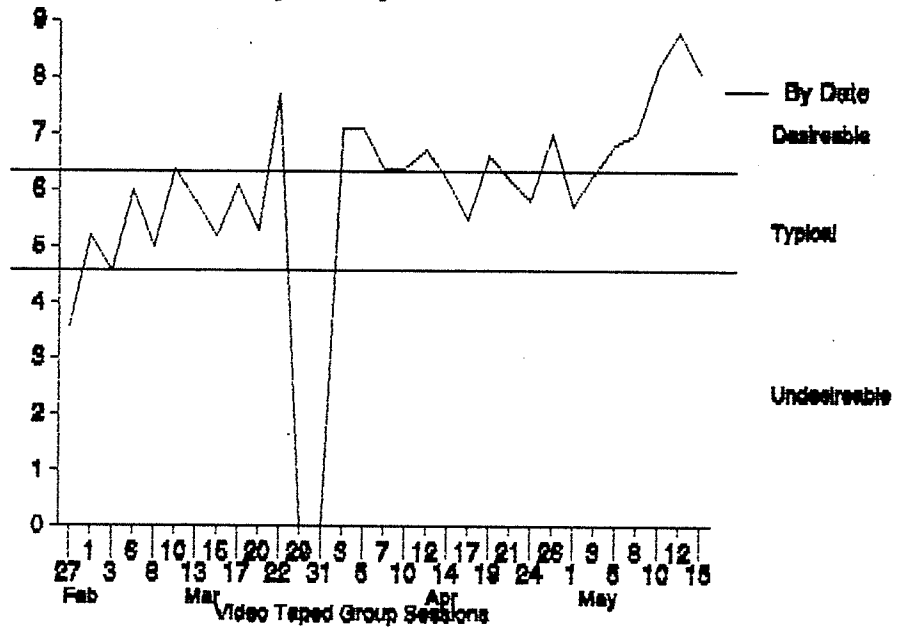


Table 2

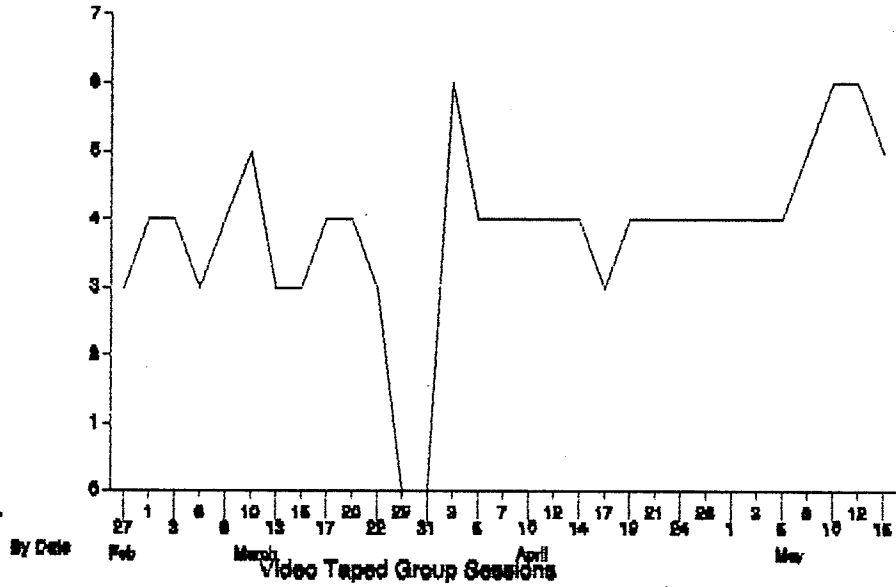
ACTIVE LISTENING

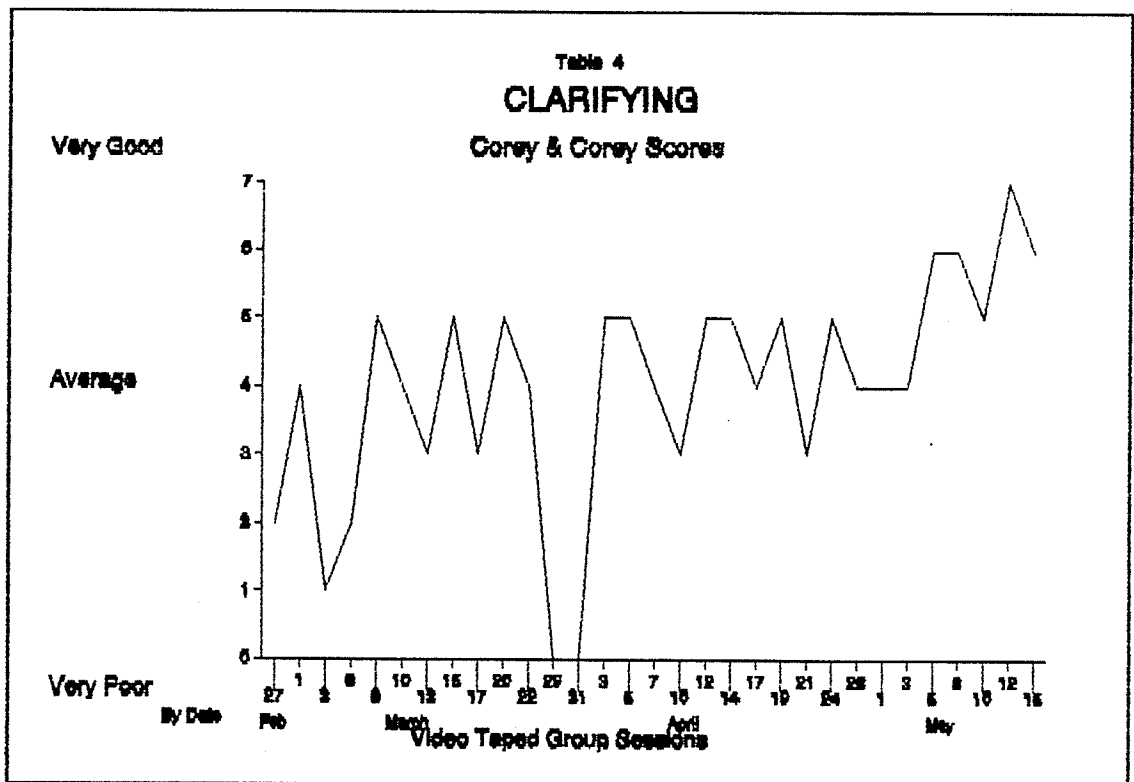
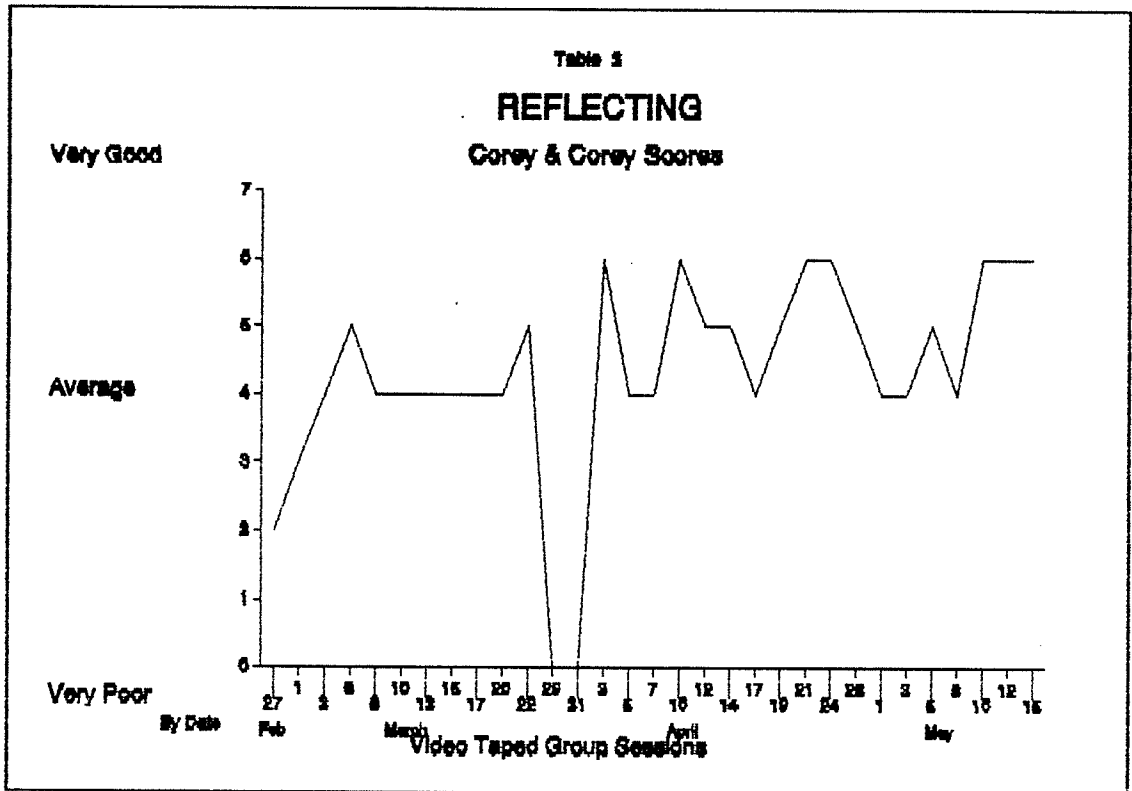
Corey & Corey Scores

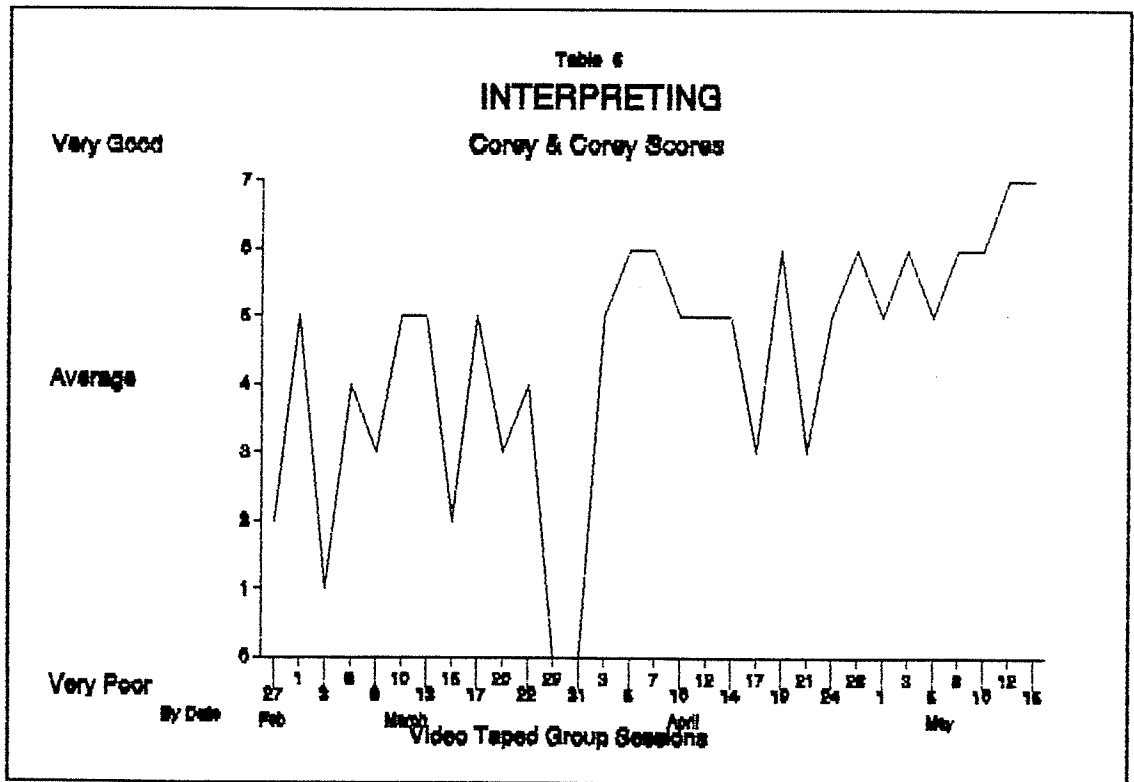
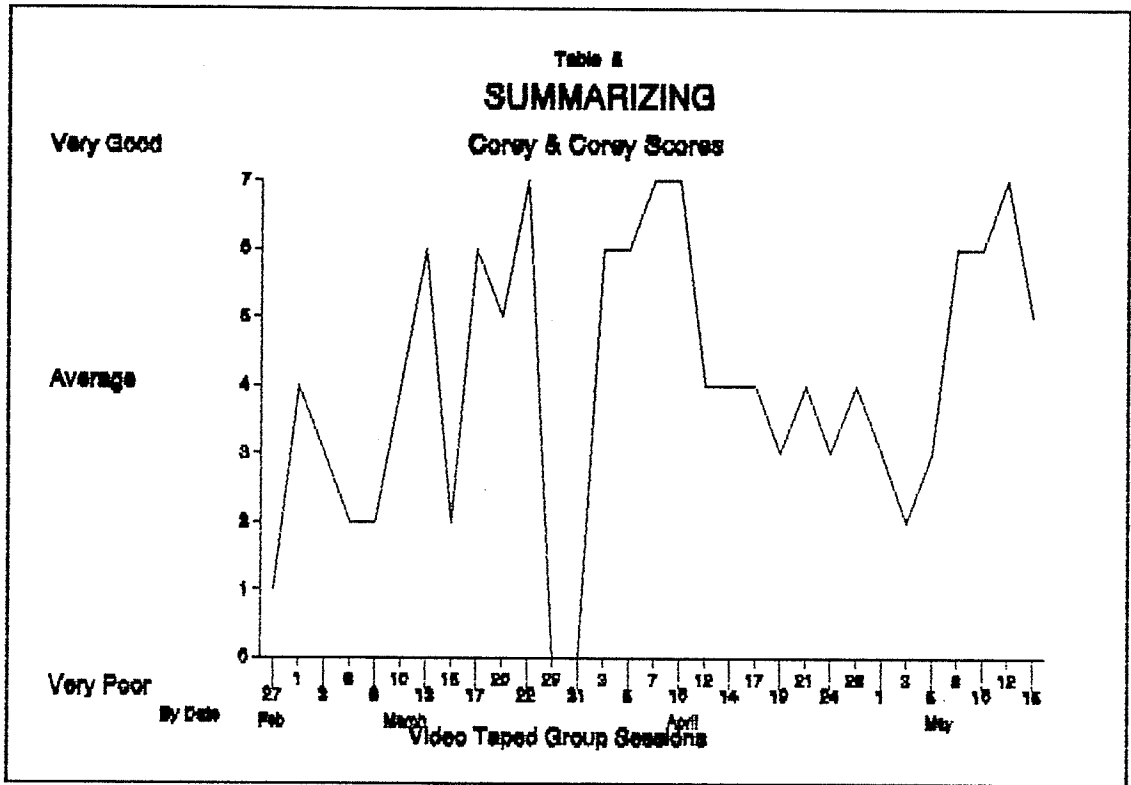
Very Good

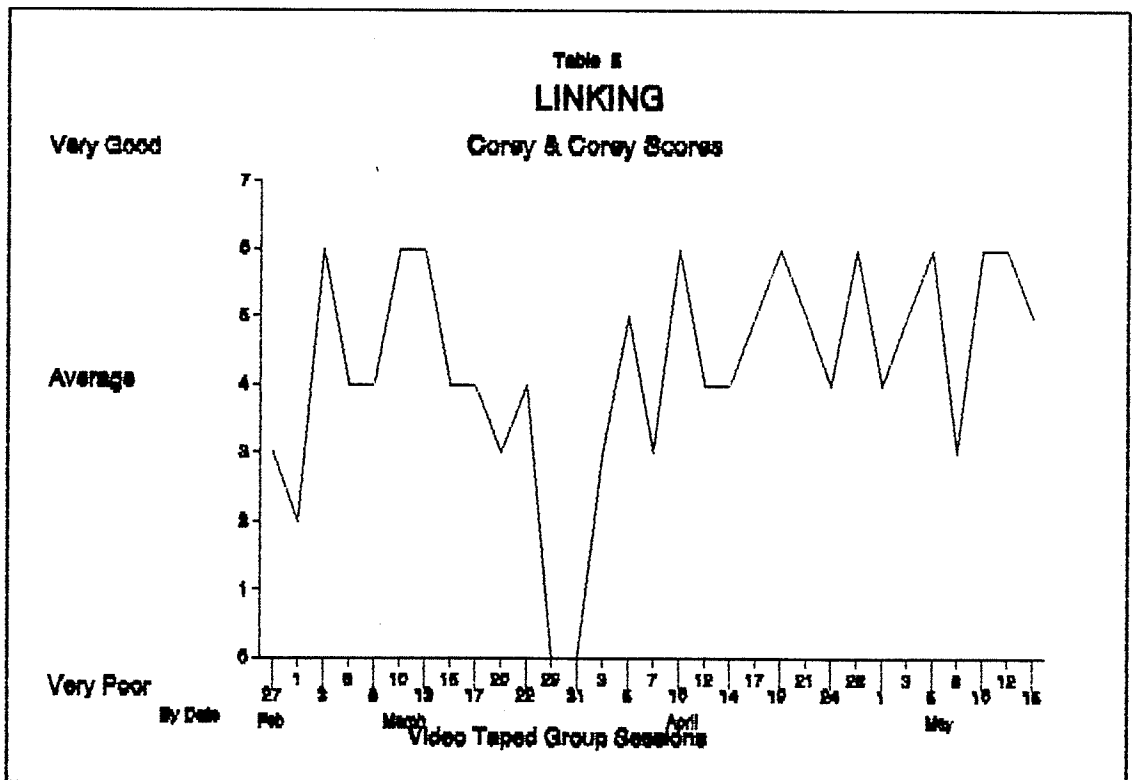
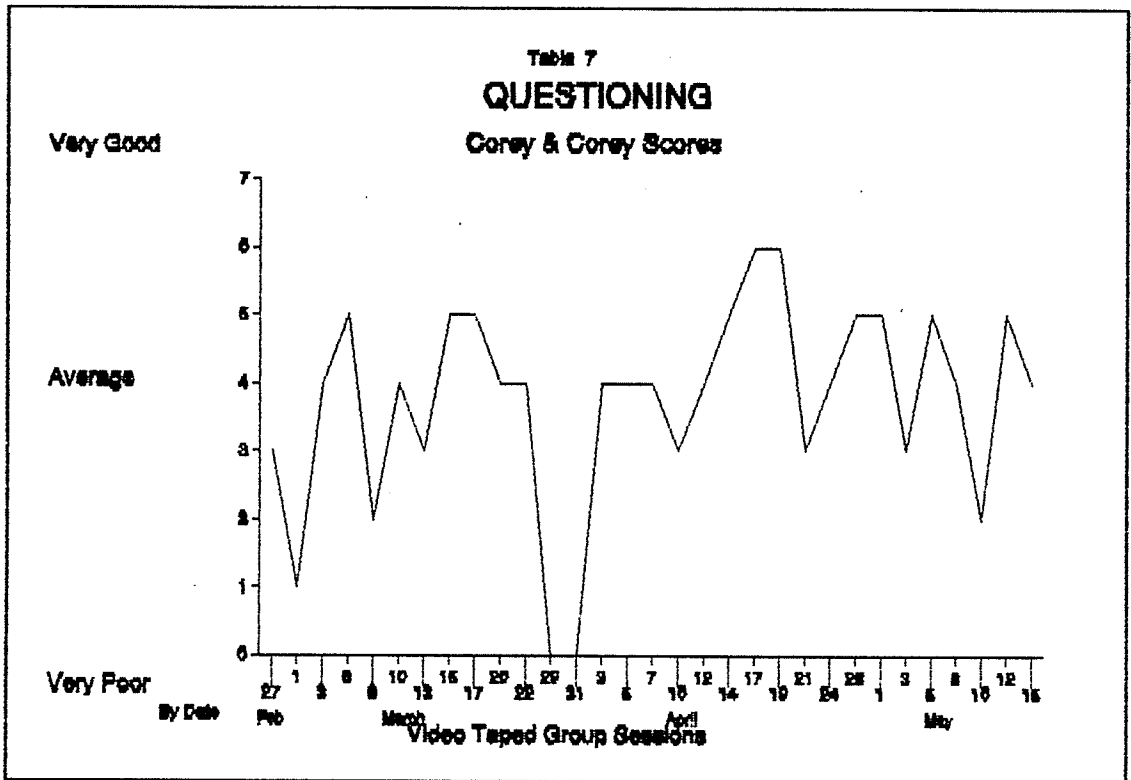
Average

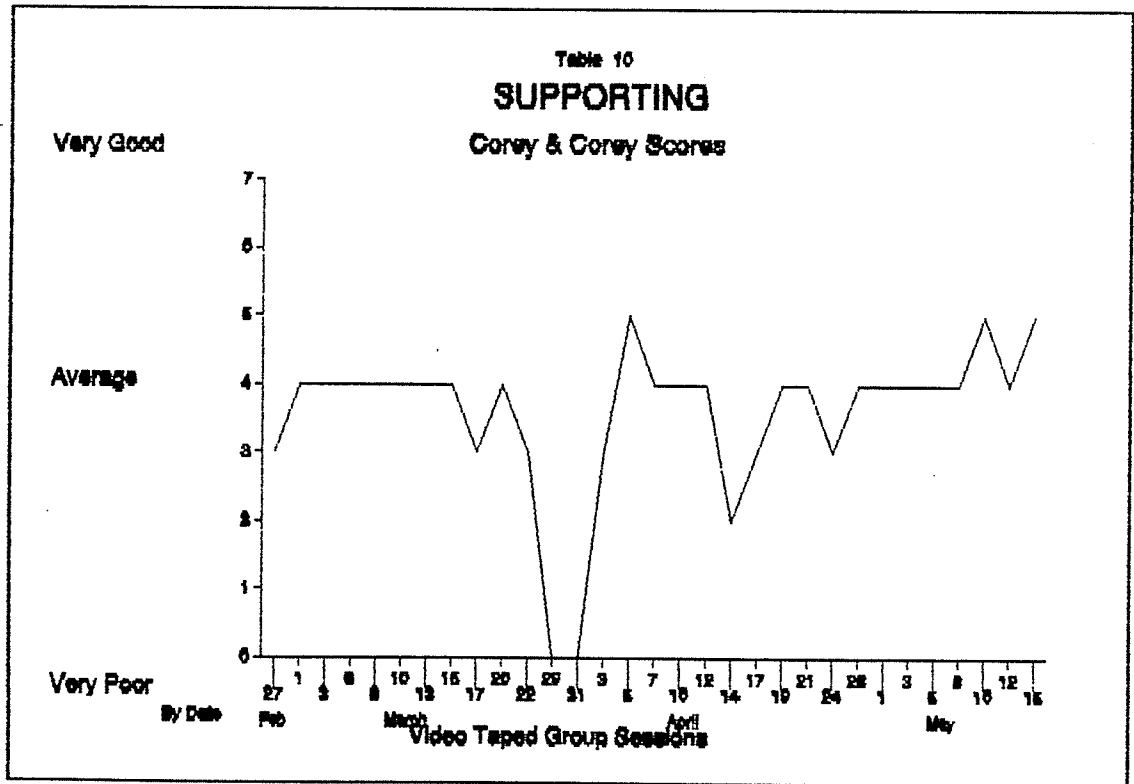
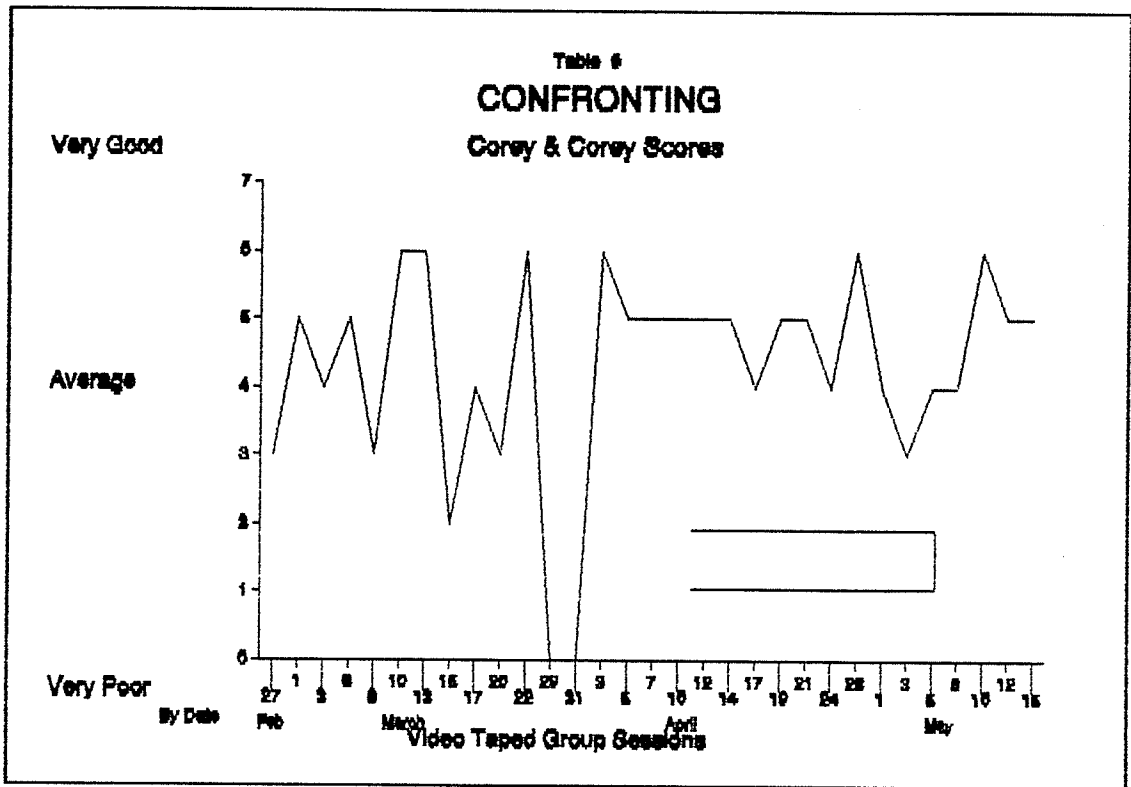
Very Poor

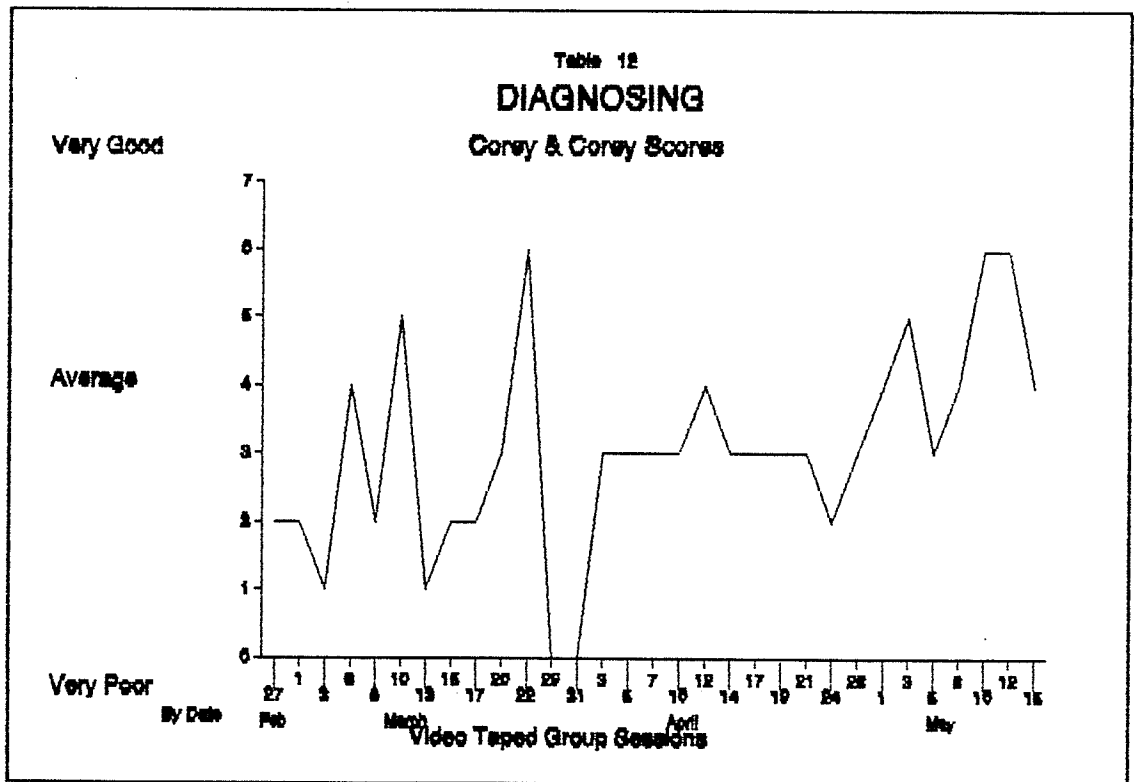
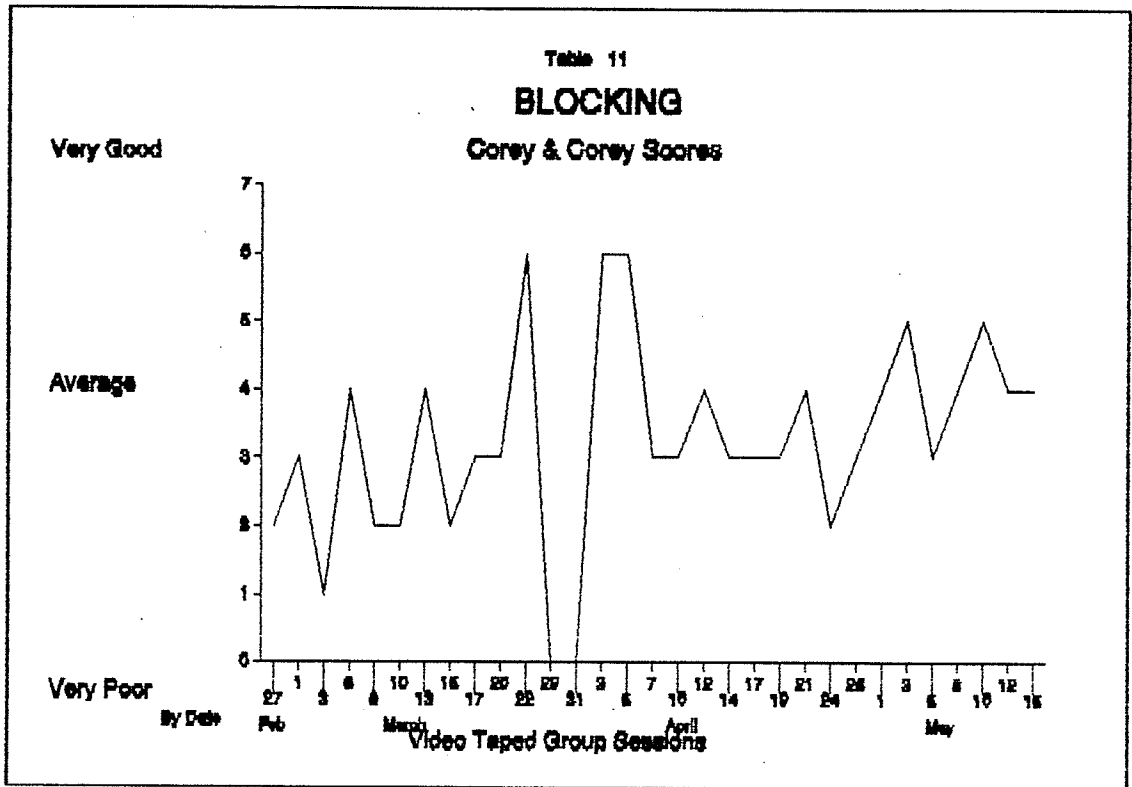


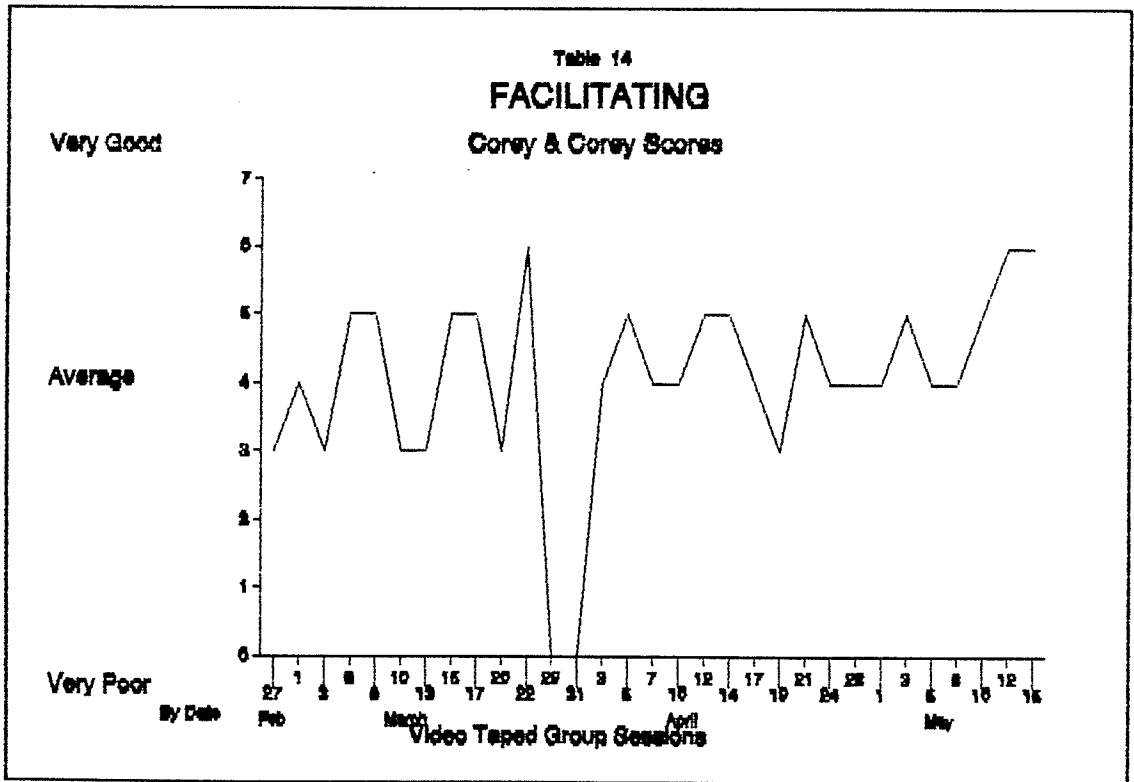
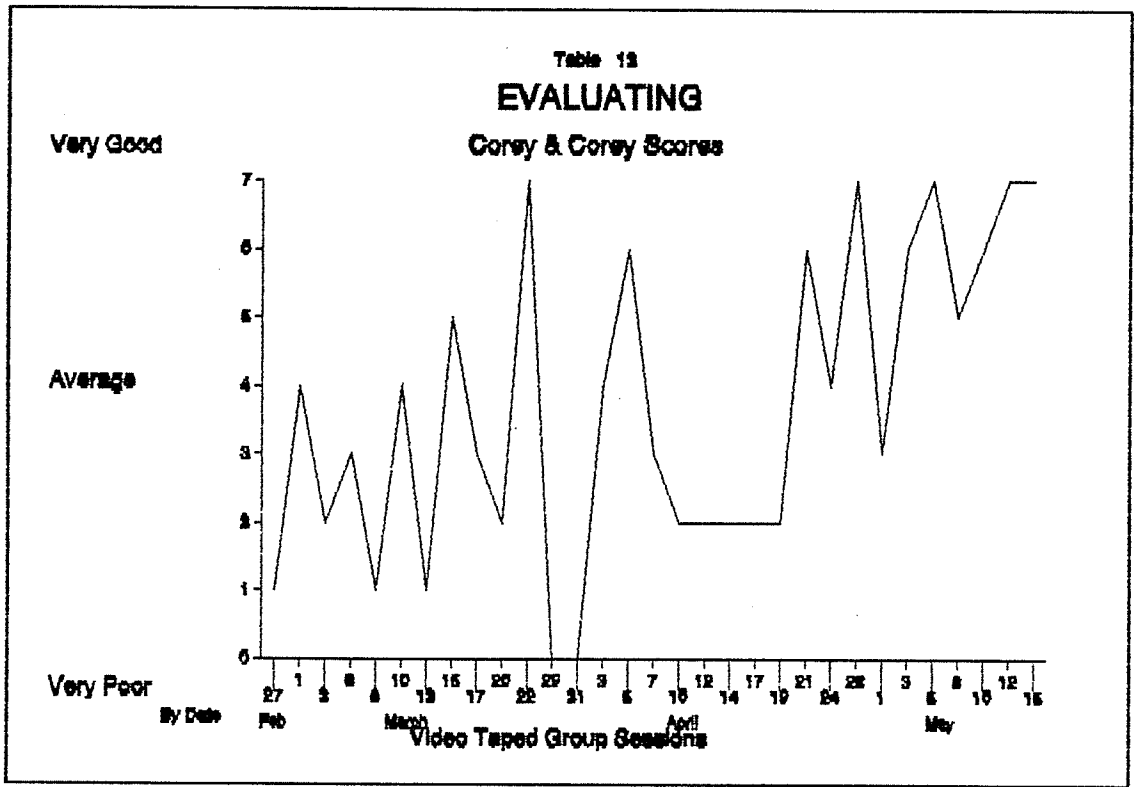


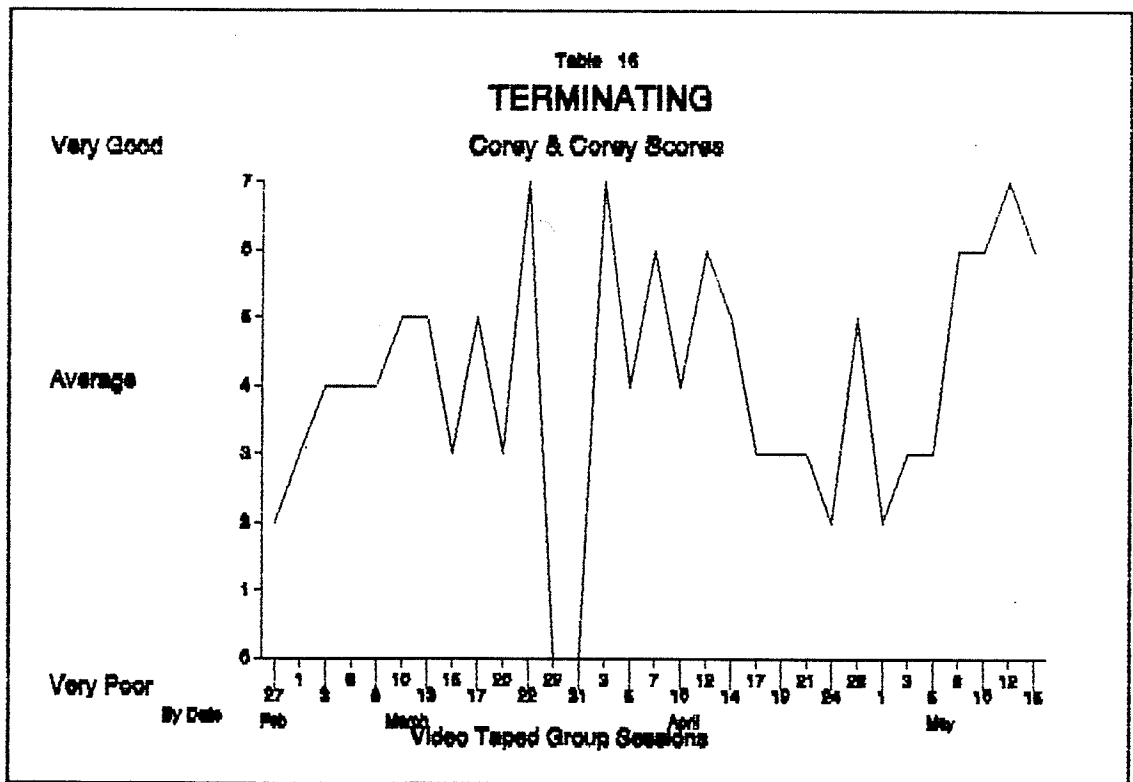
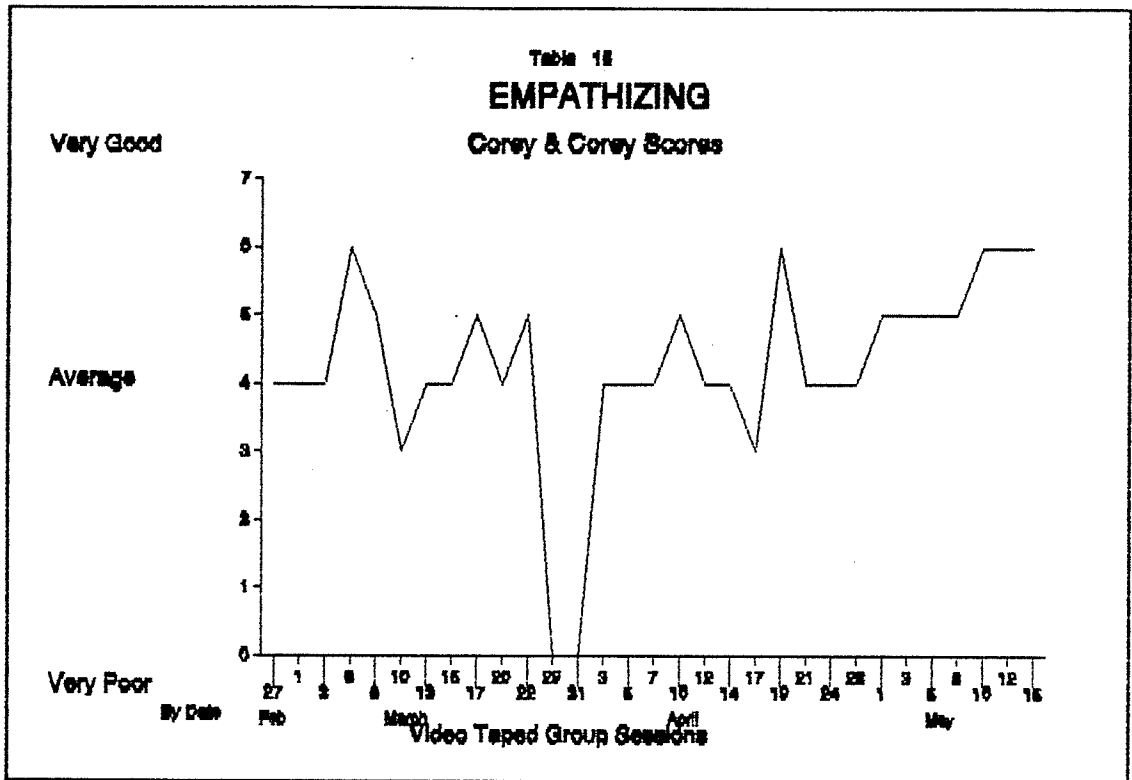












THE BRIEF UCLA LONELINESS SCALE

Instructions: I will read some statements that express the way that most people feel sometimes. Choose the number, for each statement, that expresses how often you feel the statement describes your feelings. (NOTE: Patient receives a chart with the following scores on it)
1 = NEVER 2 = RARELY 3 = SOMETIMES 4 = OFTEN

- 18) I lack companionship _____
- 19) There is no one I can turn to _____
- 20) I am an outgoing person _____
- 21) There are people I feel close to _____
- 22) I feel left out _____
- 23) I feel isolated from others _____
- 24) I can find companionship when I want it _____
- 25) I am unhappy being so withdrawn _____
- 26) People around me, but not with me _____

(Items 20, 21, & 24 are reverse scored)

THE BRIEF UCLA LONELINESS SCALE RAW DATA			
CLIENT	TRIALS		
	1	2	3
Margaret	10	16	20
Fred	17	22	18
Helen	25	18	Refused
Esther	23	Refused	
Stan	31	Dropped Out	
George	13	15	15
Ronald	15	Refused	
Isabel	17	20	24
Ruby	31	Dropped Out	
Clara	Refused		
Inez	Dropped Out		
Dennis	Refused		

TWELVE-WEEK TREATMENT CYCLE - CONTENT

The content of the 12-week treatment cycle was as follows:

WEEK 1**Monday - Introduction to Chemical Dependency****Purpose:**

It is important to understand what was meant by the term chemical dependency. An accurate understanding could help the chemically dependent person to accept that he or she is chemically dependent.

Goals:

1. To explore misconceptions about chemical dependency.
2. To replace misconceptions with an accurate definition of chemical dependency.

Wednesday - Open Forum**Friday - Basic Principles of Medication Management****Purpose:**

Many of the elderly use a number of medications. Misuse of medications by the elderly is prevalent. It is important to help the chemically dependent elderly to take their medications correctly.

Goals:

1. To give information about medications and their appropriate use and storage.
2. To reinforce good medication management.
3. To offer suggestions to change poor medication management.

WEEK 2**Monday - Chemicals & Sleep****Purpose:**

Many seniors experience changes in the quality of their sleep. Many seniors resort to sleeping pills as the only alternative to cope with these changes. A number of seniors then develop a chemical dependency to long term, habitual use of this substance.

Goals:

1. To explore the normal changes of sleep patterns because of aging.
2. To explore causes of difficulties with sleep.
3. To provide ideas of improving the quality and quantity of sleep without the use of a chemical.

Wednesday - Open Forum**Friday - Physical Adjustment to Chemicals****Purpose:**

It is important to explore the physical adaptations to the use of alcohol or mood altering drugs. This could help the chemically dependent senior begin to make connections of past and current physical symptoms and behaviours that are caused by chemical dependency. This assists with breaking down denial and helping the recovery process along.

Goals:

1. To discuss the physical effects of chemical use.

2. To identify physical symptoms and illnesses caused by chemical dependency.
3. To explain the increased sensitivity a senior had when using chemicals.

WEEK 3

Monday - Social Indicators of Chemical Dependency

Purpose:

It is important to explore the social aspects of chemical dependency to develop a greater understanding of the disease. This will begin to break down denial and to enhance one's acceptance of being chemically dependent.

Goals:

1. To explore the social/behavioral aspects of chemical dependency.
2. To assist group members to apply personal experiences to the material.

Wednesday - Open Forum

Friday - Psychological Adjustment to Chemical Dependency

Purpose:

The chemically dependent seniors are to explore the psychological learning involved with chemical dependency. They also need to identify the defense mechanisms that maintain chemical dependency. This is to enhance awareness about chemical dependency and to

alert the group members to their own thoughts and feelings that led to chemical use.

Goals:

1. To show V. Johnson's Cycle of Chemical Dependency.
2. To assist group members to apply personal experiences to the material.

WEEK 4

Monday - Chemical Dependency and Families

Purpose:

Chemically dependent seniors do not live in a void as they recover. The impact of their chemical dependency on family/friends often remains once the drinking/pill use stops. It is important for them to learn how families were affected, to recognize and understand the responses they may receive once they begin to recover. This topic may also shed some light on their own experience as a child of an alcoholic.

Goals:

1. To increase understanding of how chemical dependency affects the family.
2. To explore feelings about having a part in creating this impact.
3. To share experiences about family/friends current responses to recovery.
4. To identify childhood experiences that may relate to growing up in an alcoholic family.

5. To explore this experience in detail.
6. To suggest family consider seeking their own help.

Wednesday - Open Forum

Friday - Relationships

Purpose:

Chemical dependency can destroy relationships with others. It isolates the chemically dependent senior from others, leading to self-centredness and self-pity. Recovery requires restoring relationships as a part of establishing a healthy lifestyle.

Goals:

1. To explore how chemical dependency had affected the quality of their relationships.
2. To explore what qualities make a good relationship and what qualities damage a relationship.
3. To explore feelings associated with the quality of personal relationships.
4. To describe what relationships were like in the past and what they are like now.
5. To explore what group members can do today to improve the quality of their relationships.

WEEK 5

Monday - Storytelling

Purpose:

Every recovery program includes the telling of the personal story about chemical dependency. This helps the chemically dependent senior become less ashamed of the disease, to enhance acceptance of being chemically dependent and to reduce denial about the problem.

Goal:

1. To encourage every group member to tell his or her story about their experience with chemical dependency.

Wednesday - Open Forum

Friday - Guilt and Shame

Purpose:

Feelings of guilt and shame are common feelings shared by everyone. For the recovering chemically dependent senior, these feelings are pervasive. Sometimes guilt is a reasonable and necessary response. When feelings of guilt are irrational and destructive, it often leads to feelings of shame. This is often destructive to a person's recovery and leads to relapse. By discussing this topic and expressing feelings and thoughts, these obstacles to recovery can be minimized.

Goals:

1. To identify what guilt and shame are and how these two feelings were expressed.
2. To separate what are rational, necessary feelings of guilt

and what is unrealistic, harmful guilt.

3. To explore ways to resolve these feelings.

WEEK 6

Monday - Guilt and Shame.

(Same purpose and goals as Friday, Week 5)

Wednesday - Open Forum

Friday - Spirituality

Purpose:

Spirituality is an integral part of chemical dependency recovery.

It allows the growth of inner contentment and the development of sobriety-based values. This could have prevented the chemically dependent senior from returning to the chemical use.

Goals:

1. To describe how spirituality promotes recovery.
2. To explore what spirituality is.
3. To determine how it can be used to aid ongoing recovery.

WEEK 7

Monday - Identify Losses

Purpose:

Aging is synonymous with loss. As we age, we accumulate losses.

Chemical dependency seems to cloud the experience of the loss. To effectively grieve losses, a grieving process has to be allowed to

happen naturally with no help from chemicals.

Goals:

1. To give an overview about grief and its process.
2. To encourage each group member to share losses, big or small, in detail.
3. To encourage members to express feelings about losses.

Wednesday - Open Forum

Friday - Grieving Losses

Purposes:

Once the losses have been identified, grieving is encouraged.

Goals:

1. To encourage group members to express feelings about the losses.
2. To develop ideas to help group members begin to resolve their grief.

WEEK 8

Monday - Anger

Purpose:

Anger seems to be a widely misunderstood feeling. Chemically dependent seniors are known to have trouble expressing and dealing with anger in a healthy way. If chemically dependent seniors continue to have this difficulty when engaged in recovery, there is a risk for resuming chemical use.

Goals:

1. To identify physical/cognitive/emotional experiences of anger.
2. To develop appropriate ways of handling anger.

Wednesday - Open Forum**Friday - Self-Esteem****Purpose:**

Chemical dependency and low self-esteem are strongly connected. Building a sense of self-esteem seems to be a buffer against stress and adversity, which, in turn, prevents relapse from occurring.

Goals:

1. To define what self-esteem is.
2. To assess each group member's level of self-esteem.
3. To begin building self-esteem.

WEEK 9**Monday - Asserting Yourself****Purpose:**

Many chemically dependent people tend to present with communication problems. Other chemically dependent seniors seem to have trouble relating to others in an open and honest way. Recovery requires the ongoing attempt to be open, honest and responsive to others.

Goals:

1. To define assertiveness.
2. To explore beliefs, expectations, values and behaviours that prevent assertive behaviour.
3. To explore ways of becoming assertive.

Wednesday - Open ForumFriday - Identifying and Meeting Needs**Purpose:**

Chemically dependent seniors learn to expect the chemical to meet all their needs, especially emotional and spiritual needs. Recovering from chemical dependency often include learning to meet ones' needs without the help of a chemical.

Goals:

1. To identify various needs people have that must be met in order to survive and to be content.
2. To identify needs that are being adequately met.
3. To identify needs that remain unmet.
4. To explore ways to satisfy unmet needs.

WEEK 10Monday - Stress Management**Purpose:**

Chemically dependent seniors often respond to stressors by using a chemical. Once the chemical is no longer used, management of

stressors is an important aspect of recovery.

Goals:

1. To provide a brief overview about stress.
2. To explore areas in the group members lives that create distress.

Wednesday - Open Forum

Friday - Stress Management

Purpose:

Same as Monday

Goals:

1. To explore personal methods of managing stress.
2. To determine helpfulness or harmfulness of each method.
3. To generate more ideas that help to manage stress.

WEEK 11

Monday - Relapse Prevention

Purpose:

Chemically dependent seniors benefit from relapse prevention planning because it serves as a preventative measure against resuming chemical use.

Goals:

1. To discuss relapse and preventive measures.
2. To discuss group member's personal experience with relapse.

3. To develop a prevention plan for each group member.

Wednesday - Open Forum

Friday - Creative Retirement

Purpose:

Many chemically dependent seniors lose the enjoyment of retirement years because of a preoccupation with a chemical. It is important to develop leisure activities to replace the time and energy previously taken by chemical use.

Goals:

1. To explore dreams and realities about retirement.
2. To explore ways to add further enjoyment to free time.

WEEK 12

Monday - Community Resources for Seniors

Purpose:

To keep the chemically dependency a secret, chemically dependent seniors may avoid services that assist them with daily living problems. They may require help from aging and chemical dependency resources that are beyond the scope of this group. Increasing awareness of what is available enables them to enhance social interactions and functional abilities.

Goals:

1. To explore various community resources that may be helpful to chemically dependent seniors.

2. To encourage group members to access resources that are appropriate for them.

Wednesday - Open Forum

Friday - Tools for Ongoing Recovery

Purpose:

It is important to learn what has been helpful to other people recovering from chemical dependency. It is then possible to use their experiences to assist with ongoing recovery. It may be helpful to trace where one is in the recovery process in order to see one's progress and to prepare for the tasks ahead.

Goals:

1. To identify the process of recovery.
2. To discuss where each group member is in that process.
3. To identify important activities that aid recovery.
4. To help group members choose which activities best fit for them.

GROUP MEMBERS COMMENTS**Comments About What Members Liked Least**

1. Being hard of hearing (was expressed 12 times over the twelve week cycle).
2. Did not like it (From Medication Management).
3. I was disappointed that Dr. Jacyk was not there (in group).
4. I would like to hear more from Esther (two different sessions).
5. I did not like coming (to group) in the middle of a conversation.
6. It was embarrassing to have shaky hands.
7. Fred talked in circles (stated in Fred's absence).
8. I do not like myself.
9. The tape (tape from the session on Guilt and Shame - The Answer to Guilt was Forgiveness by Phil Hanson).
10. I feel bad about others not achieving their goal.
11. I did not like the film (Three members agreed on this about a film on chemical dependency and families).
12. I can not find anything in common (with other group members).
13. I am embarrassed about talking most of the time.
14. The session was too short (from Assert Yourself session).
15. I did not like getting off topic.
16. I would like more structure with these sessions.
17. We spent too much time on one topic.

Comments About What Members Liked The Best

1. I can talk about it (from medication management session).
2. I like the sharing (six other similar comments were given).

3. I like the smokeless atmosphere.
4. It was helpful to have others here in the group. I like talking to others.
5. I can talk freely (There were six other similar comments given).
6. I like the openness of the group.
7. I like the socializing.
8. I liked the (audio) tape (about Guilt & Shame).
9. I like getting new ideas. I like the stimulating conversation.
10. I like hearing from Clara and Margaret (two people said this at one session).
11. I enjoyed hearing Fred's story (three members gave this comment at one session).
12. It was good to talk about the group.
13. I liked talking about my relationship with my wife.
14. I liked hearing my husband open up.
15. I like talking about sleeping (at sleep and substances session).
16. I like talking in a more specific way.
17. I like the closeness of the group. I like the atmosphere (here).
I feel welcome.
18. There were upstanding people in this group.
19. I like the honesty (here).
20. I like the resourcefulness.
21. I like how the good byes were handled.
22. I feel accepted by others.
23. I liked hearing others (two other comments like this were given as feedback).

24. It was good to find someone else in the same situation.
25. I like the handouts.
26. I am learning a lot I did not know (before).
27. I like having a subject.

CLIENT PROFILES

Dennis

Dennis was referred to the treatment group from Dr. W. Jacyk, one of the co-investigators of the Elders Health Program. Dennis was 63 years old and in good health except for stiff knees from an old football injury. He was a tall, immaculate, husky gentleman who came to group each day dressed in a suit. Dennis was married and had one daughter who was approximately 32 years old and worked in Toronto. He was an independent businessman and served on a number of boards of directors, for example, the Lions Club.

Dennis was very controlled and had a good sense of humour. He was quick to give advice. He struggled with low self-esteem and searched for a sense of identity. He tried to deal with feelings of anger, guilt and shame. However, he had much difficulty in expressing feelings since he tended to intellectualize about any personal issues.

Chemical Dependency Information

Dennis had a long drinking history beginning with attending business lunches and numerous social occasions. He sought out drinking occasions, avoiding events where drinking did not occur. He progressed to drinking alone.

Dennis had a number of drinking and driving offenses, the latest being the worst he had ever committed. While intoxicated, he hit a pregnant woman who luckily was unharmed. Dennis was afraid and ashamed, so he hid for three days and considered suicide. He decided to get help

and began attending A.A. He also attended an inpatient treatment program at the Hazelden Foundation in Minnesota.

Progress in Group

Dennis's attendance was erratic since he came only seven times throughout the 12-week period. His verbal feedback about the group experience was favourable each time he attended.

Dennis was slow to shed his tendency to be aloof, to intellectualize and to speak in generalizations. He had much difficulty dealing with topics of loss and shame. He also showed discomfort when other group members disclosed issues of loss and emotional pain. However, level of self-disclosure seemed to increase throughout his attendance, for example, discussing how painful it is for him to express anger. His interaction with group members increased as well. He was very willing to assist other group members by making tea, helping someone get up from a chair and offering information about various resources. Because of his previous treatment experience, he served as a role model for fellow group members.

Dennis had refused to develop any individual goals and to take any of the tests. However, he still wanted to attend the treatment group, so this opportunity was not denied to him.

Isabel

Isabel was referred to the treatment group by a social worker from St. Boniface Hospital. She was 72 years old and a widow for 12 years. She lived alone in a seniors' apartment block. She recalled how hard life was being married to an alcoholic. To help her cope, she had gone to AlAnon meetings and to A.A. meetings with her husband. Her only son also became an alcoholic and was violent with his wife.

Isabel called a family priest to go into her son's home to calm the situation down when he was violent. This priest helped Alice's son to stop drinking and start going to A.A. The son has been sober for 13 years and Isabel still fears he will relapse and resume drinking.

Isabel received \$12,000 from her husband's estate which was quickly spent. She accumulated debts and took out bank loans to pay them.

Isabel presented as extremely sincere and very nice. She is intelligent and has some degree of insight. She was very willing to share on a personal level. However, by relying on the advice and demands from others to determine her own actions, she avoided taking responsibility over her life and blamed others for her unhappiness.

Isabel is content with most aspects of her life. She has friends in her apartment block and enjoys the activities held in the block like bingo and card games. Her sister is a great support to her. Yet she felt lonely because her son and his family seldom visit her.

Chemical Dependency Information

Isabel's substance of choice was benzodiazepines. Her worries

about financial debts, inability to think clearly and sleep difficulties caused her to request help. She was prescribed a sleeping pill approximately five years ago and she took them regularly. Four and one-half years later, her thinking process was still affected, her movements slowed down and her daily activities came to a halt. Her sister and son expressed concern about the effects of the sleeping pills. Her son phoned the pharmacist and demanded that the prescription for sleeping pills be stopped. Isabel was admitted to hospital because of her inability to function at home. She admitted to becoming addicted to the sleeping pills. By the time she attended the first treatment group meeting, Isabel was completely off the sleeping pills.

Individual Progress in Group

Isabel's goals were to become less shy with others and to learn more about herself. At the post and six-month evaluation interviews, Isabel believed both goals were met.

Isabel's attendance was erratic because of poor health and other family commitments. When in group, she was supportive of others by offering understanding and compassion. She was readily accepted by other group members and said she felt she was a part of the group. Her role in group was as a follower, willing to go along with other group members decisions. Her verbal feedback was always positive. She achieved the group goals of responsible drug use and seemed to achieve improved life satisfaction.

At the post group interview, Isabel's Delighted-Terrible Life Satisfaction results showed a decrease in the total scores at the post

group interview. This was largely due to a severe heart attack and hospitalization that happened two months before the test. She scored mixed satisfaction or higher on all items except the with health and finances. As her health improved, she wanted to do more activities, but found a fixed income restrictive. Isabel showed improvement in the areas of family relationships, housing and recreation. She maintained the same level of satisfaction with religion and self-esteem. There was a slight decrease in satisfaction with friendships, transportation and life as a whole. This decrease may have accounted for Isabel's consistent increase of loneliness scores over time. If she got less satisfaction in friendships and transportation, this may have led to an increase in her sense of isolation and loneliness.

Inez

Inez was 67 years old and had one daughter who lived out of the province. She worked at two day care centers, together creating a full time job. She lives alone in an apartment block and drives when there is light traffic. Inez has bouts of bronchitis, catches colds easily and takes asthma medication regularly.

Inez presented as an attractive woman who often came to group in blue jeans. She is a compassionate, soft spoken person who is intelligent and bright but presents as lonely and depressed.

Chemical Dependency Information

Inez's substances of choice is benzodiazepines and alcohol. She began using Valium when she was 40 years old which was discontinued and

replaced with Librium. After a car accident when she was sedated, she stopped taking pills and used only rye whisky. She limited her drinking to Sundays because they were her loneliness and hardest days to get through. She often drank a 26 ounce bottle a week. As her drinking episodes increased in frequency, she recalled that her drinking no longer made her feel better. Instead, she felt weak, apathetic, more lonely and more depressed.

Progress in Group

Inez's individual goal for attending the group was to maintain sobriety. She wanted to attend group whenever her work schedule allowed so she was unable to give a commitment to a definite day or frequency of attendance. Inez came to group twice in March and dropped out after that because of poor health. I was unable to do any testing for that same reason.

Inez was an active group member who was quickly accepted into the group. She quickly identified herself as a part of the group. She shared feelings, thoughts and personal events readily. Inez was willing to meet the demand for work by specific self-disclosure, keeping on topic and relating the topic to her own experiences. She easily addressed her conversation directly to group members. Inez sensitively gave advice and enthusiastically participated in problem solving with other group members. At the end of both sessions, she gave favourable feedback.

Because Inez only came to two group sessions, it was difficult to assess the effectiveness of the treatment group. It is unknown if

attending the group had any affect on her perception of life satisfaction. Inez was sober on both occasions, so she did achieve her goal and the group goal of maintain abstinence at those times.

Stan

Stan was referred to the group by the intervention team - daughter Louise, myself, and Geriatric Medicine staff at St. Boniface Hospital (a Social Worker, a Primary Care Nurse, the attending Physician, and a Pastoral Care Worker).

Stan was 74 years old, married and lived with his wife and grandson in a house. He has three daughters with two living in Winnipeg and one in Vancouver. He is proud to be a World War II veteran and to have survived as a prisoner of war in a German camp. He lost most of his hearing during the war and has Parkinson's Disease and a heart condition.

Stan presented as good-natured, cheerful, and intelligent. He was extremely sensitive to others' responses to him. He used withdrawal and escape as a way of coping with any conflict. He had low self-esteem, strong values in traditional sex roles and extreme feelings of guilt and shame. Stan often minimized intense feelings and situations by giggling and making jokes.

Stan's family has suffered from the effects of his chemical dependency. Thirty-five years ago, he had been violent with his wife. Stan's wife was referred to AlAnon but she never attended. The youngest daughter is very distant and cold toward Stan. His daughter, Louise, attempted to control what happened in the family, assuming the role of

gatekeeper. She determined who was in contact with the family and who the family accessed. She also served as a mediator in the family by passing along messages between family members.

Chemical Dependency Information

Stan has been chemically dependent for years. His substance of choice was alcohol and he drank beer daily. When he needed to increase his alcohol intake he supplemented it with distilled liquor. He usually drank at the nearby hotel pub or rode his bike to the liquor commission to take the alcohol home. He spent most of his money on alcohol. He had previous hospital admissions due to his alcoholism. Stan was forced to stop drinking because he was getting ill when he drank. When he would try to stop drinking, he experienced tremors, hallucinations, and paranoia. He was remorseful about the trouble his wife went through because of his drinking. However, he minimized the extent of that trouble, blamed others for his drinking and had a moderate level of denial. Stan had never been in treatment before and had never stopped drinking for any longer than two days.

Progress in Group

Stan agreed to attend the treatment group on Monday and Friday for an indefinite length of time. He struggled with embarrassment and shame about his deafness, so he did not enjoy the group. To ease his discomfort about his hearing, the group reassured him at each group session that his hearing was not a hardship to them and that his attendance and his input was held in high regard. The group often encouraged Stan to try to get a hearing aid.

He attended 18 sessions throughout the 12-week period. His attendance was erratic in March, more regular in April and erratic again in May. One reason for his erratic attendance was that he felt fearful and guilty about leaving his terminally ill wife at home alone. To ease his worry about his wife, the group offered ideas such as getting a homemaker to be with her in his absence, phoning her midway through the group session or learning that he has no control over what happened to her. Stan did not follow through on any of the above suggestions.

His individual goal was to feel less lonely. However, Stan felt more alone by the end of the 12 weeks than when he began group.

Stan's denial remained strong throughout his time in group. He joked about drinking almost defiantly. He continued to blame others for his problems. Stan was fearful of expressing feelings because he believed he would lose control. Feelings of self-pity, guilt, resentment and shame grew more intense and pervasive. He grew more self-centered.

By the middle of the twelve week period, Stan began going to the Pembina Hotel for 7-up and continued this with increasing frequency. He did not feel as though he belonged anywhere. His drinking friends did not want him to sit with them if he was not drinking. He felt awkward trying to talk to his family when he was sober. Despite confrontive efforts to show Stan the risk of this behaviour leading to drinking, he was convinced that he still had control over alcohol. Stan refused all offers of increased support. He eventually started to drink again.

The main reasons for Stan's relapse began with his inability to see himself as an alcoholic. The process of entering treatment due to

external motivating factors and then slowly developing personal internal motivational factors did not happen for Stan. Another factor for Stan's relapse was the poor timing of his recovery. It occurred at the same time his wife was diagnosed with cancer which depleted the supports for Stan. The natural thing for Stan to do in response to this situation was to drink.

Stan had become a part of the group. Often, he was directly address by group members. His difficulty with hearing separated Stan from the group, yet the group did not find his poor hearing an impossible obstacle to tackle. He was often very quiet.

Stan seemed to share most in a small group of three or four. In these small groups, Stan would talk directly to other members. He seemed to bond with Esther, another group member that used alcohol and was deaf. His sense of humour was admired by many group members. He seldom participated in problems solving or advice giving and was very slow with self-disclosure. He waited until he had been coming to group for about eight weeks before he shared his story about his wife's illness. There were two occasions later on in Stan's attendance to group that focused on Stan's problem coping with his illness. The group was very helpful and caring with Stan. Considering group process, Stan took a long time to check out the trustworthiness of the group.

No conclusions can be made about Stan's achievement of group goals. None of the measurement tools given in the pre-group test were used to come to any conclusions because he refused to participate in the posttest and had died by the six month follow-up. He achieved abstinence for only a short time. Stan's perception of life satisfac-

tion seemed to worsen. Although he refused to participate in post group evaluations, By the end of the 12 weeks, it was clinically obvious that he was terribly miserable.

Fred

Fred was 78 years old, married for eight years to his second wife. They had lived on a farm, but when his wife became ill with congestive heart failure, they moved to an apartment in Winnipeg about two years ago. Fred was a diabetic with a slight respiratory condition. He only drove the car in his neighbourhood.

Fred was cheerful, pleasant, intelligent and articulate. He was easy going but not lazy. He was able to express feelings with some guidance and encouragement and was very opinionated and at times, judgemental. He had difficulty empathizing with others and tended to be self-centered.

Fred had six children in his first marriage. He described this marriage as turbulent and unhappy. Fred was 50 years old when his first wife died of cancer. He had many regrets and unresolved issues with her. Fred remains alienated from his children and they seldom visit or phone him nor does he visit or phone them.

Fred was somewhat happy with his current marriage. His current wife serves as a companion for him. He said he found her to be sexually aggressive and he was disturbed about her high expectations of their relationship. He said she expects them to do everything together, to talk to each other a lot and to interpret situations in the same way. His lack of interest in meeting her expectations often caused conflict between them. In spite of this conflict, he described his life as the

best it has ever been.

Chemical Dependency Information

Fred's chemical dependency started about fourteen years ago with daily use of diazepam. He was unable to sleep without it suggesting a psychological dependency as a possible sleep disorder. It may also have contributed to his inability or to initiate activity, and to sleeping most of the day. By using diazepam exclusively to solve his sleeping problem, it inhibited his ability to seek out alternative methods may have offered fewer side effects. Any efforts to address the negative consequences from his diazepam use was met with moderate denial. When confronted with the negative consequences of his long term use of diazepam, he decided to continue taking it. Fred believed that the negative consequences did not interfere with his life seriously enough to consider making a change.

Progress in Group

Fred agreed to attend the treatment group with his wife two or three times per week. He came by Handi-Transit, a low cost, handicapped transportation service. Fred attended 17 sessions in the 12-week period. He came to six sessions in the first month, nine in the second and two sessions in the third month. Fred did miss some sessions due to illness, a hospitalization and during his wife's hospitalization. All-in-all, his attendance was fairly consistent.

Fred was slow to self-disclose and to meet the demand for work, however, the longer he came to group the more he self-disclosed about

painful, personal issues. His habit of speaking in generalities, getting off topic and gossiping about other members remained a struggle to control. His self-disclosure increased to the point that he monopolized the sessions especially when he came to group alone. The group became dependent on Fred to do most of the talking because it took them off the hook to generate conversation.

Fred found his self-disclosure a cathartic experience. When encouraged to take this catharsis a step further by actively doing something to change his life or resolve an issue, he hesitated. One positive outcome came about when he phoned his brother for the first time in years. He initially joined the group because of his wife, but by the time he ended group, he was coming because he wanted to.

Fred became an active, integral member of the group. He helped establish a group culture that encouraged the expression of feelings and disclosure of very personal issues.

Fred's individual goals were to learn about diazepam and to decrease his feeling of nervousness. He heard about the nature of diazepam, its linkage to specific negative consequences and the alternatives that would have helped him sleep. This information was met with a more firmly entrenched denial. Fred thought that his level of nervousness remained the same over time. He did learn how he created it, thus he assumed control over some of his symptoms. Therefore, he partially achieved his goals.

Fred did not achieve any of the group goals. He did not achieve responsible use of diazepam and he continued to take it daily in spite of the negative consequences. He did not improve his perception of life

satisfaction, however, he seemed content with his life as indicated with the measurement tools. The Delighted-Terrible Scale only showed three scores of mixed perceptions about life satisfaction while all other scores indicated satisfied or higher. There was no change in the items of health, family relations, transportation and life as a whole. The items of finances, friendships, housing and recreation failed to show any consistent trends. Fred showed a downward trend in religion and self-esteem. This may have occurred because of his choice not to take any action to improve the quality of his life.

The Brief UCLA Loneliness Scale showed that Fred had no evidence of being lonely throughout all three trials.

George.

George was referred to the treatment group by a hospital nurse and a social worker. He had an enlarged liver from excessive drinking and a stroke which required three months of rehabilitation. He had partial paralysis of the left arm and walked independently with a cane. He was a diabetic which was controlled by diet, and used a hearing aid to correct a life-long hearing loss.

George was 69 years old, married, has three children and lives in Winnipeg. His sons live out of town and his daughter lives in Winnipeg. Each year they took in two foreign college students as boarders. He has no religious affiliations or spiritual practices. George no longer drives and relies on his wife or Handi-Transit for transportation. He spends most of his leisure time alone and restricts his interests to sports and reading.

George's wife was very resentful, sceptical and distant when she was asked to take part in the intervention by hospital staff. I assumed she had been negatively affected by George's chemical dependency.

Chemical Dependency Information

George had his first drink of alcohol in his early twenties. He discovered he enjoyed the taste and the way alcohol made him feel. He started going to beer parlours more often, and hiding his alcohol in the basement and in his library. He suspected people believed him to be "a drunk" and he felt angry about casual comments about his drinking from loved ones.

The School Board recommended he seek treatment for alcoholism or he would be fired. He received outpatient treatment from the Alcoholism Foundation of Manitoba for two or three months. At the same time he attended A.A. He dropped out of both to resume drinking. In addition, he saw a psychiatrist following a suicide attempt 15-20 years ago.

George quit swimming and jogging because his drinking interfered with his performance. Coaching allowed him to continue drinking and still keep involved in his favourite sports. When George retired, his drinking increased in quantity and frequency. He spends more time alone and developed a close, personal relationship with alcohol, calling it "John Barley Corn," and "a good friend." He feared his alcohol use contributed to his stroke so he decided to do something about his drinking.

George entered group with minimal denial. His most biggest obstacle to recovery was his need to be different or special from other

alcoholics. His rambling, intellectual communication style and the deep loss of his relationship with alcohol were also a hinderance to his ability to recover.

Progress in Group

George agreed to attend group twice a week on Wednesday and Friday. He arranged to come by Handi-Transit.

George chose four individual goals:

1. he wanted to get his ideas across to other people clearly;
2. he wanted to keep his health as it was at the beginning of his attendance at group;
3. freedom from any controlling substance; and
4. achieve inner peace.

George's third goal was not achieved. He had a slip before the six month follow-up. By reviewing information about relapse, he was able to quit again. His fourth goal was not achieved because he remained anxious, guilty and ashamed about his chemical dependency.

George began to identify feelings, but had difficulty expressing them openly. He accepted his chemical dependency and learned to value his recovery. He also increased his awareness about his anxiety. He learned to use thought-stopping techniques and deep breathing exercises.

George was an integral part of the group and was accepted by other group members. He helped other members by offering his empathic listening and comforting words. He also allowed others to give him support and suggestions.

George improved his perception of life as a whole by the post

group test, but it worsened with his six month follow-up. This was possibly due to his relapse. His satisfaction with religion, friendships and transportation steadily worsened. His satisfaction with finances, housing, recreation activity and self-esteem all improved. This occurred possibly because of his increasing pride in himself as he maintained and regained abstinence and an improved home life. He became more intimate with family. As he recovers, he may have wanted to improve his lifestyle outside of his immediate family and home life, but found poor transportation and the lack of friends as obstacles. The UCLA Loneliness Scale showed that loneliness was not a problem as indicated in the scores of 13, 15 and 15.

Helen

Helen was overweight and had poor personal hygiene. She often came to the group after she had slipped on only a dress and a pair of shoes. She has a past history of high blood pressure, osteoporosis, osteoarthritis and a slight stroke. Her walking was limited to only short distances and requires a walking aid. Helen has difficulty initiating sleep and once asleep she was no longer able to achieve a deep sleep.

Helen seemed to have slow thought processes, poor short-term memory and poor long-term memory. She had some difficulty understanding abstract concepts but understood concrete, simple ideas well. Her affect was flat, and she responded slowly to others. Helen possessed a sense of humour although it was rarely seen in treatment. She possessed rigid values about right and wrong and seemed fairly stoic, reluctant to

expose her weaknesses to others and to accept help.

Helen was of German descent and a member of the Mennonite church. Her activity in the Mennonite church declined over the past ten years because her physical condition made it more difficult to get to church and to sit through the services. Although she did have a strong Christian faith, she lacked an inner peace or contentment. Her husband was a Mennonite and they had three children - two daughters and a son. She has a daughter in Winnipeg, one in Vancouver and her son is in rural Manitoba. Her first husband had a stroke leaving him speechless and with right sided paralysis. He required a lot of personal care and emotional support. Helen cared for him for six years. When he died, she quickly moved out of the family home and into a mobile trailer near her son.

Helen was married a second time to a man who lived in Saskatchewan. They moved to Saskatchewan to be near his children. He turned out to be verbally abusive and violent. Helen believed he married her only for sex. She felt trapped, lonely and ashamed. When he fell ill, she cared for him until his death. With her regained freedom, her children helped her return to Winnipeg in an elderly person's apartment complex.

Helen has a few friends in the block. She often met them in the lobby or had lunch with them. However, she was not a big joiner in group activities. She did enjoy making her own cakes and cookies and serving her visitors in regal fashion.

Chemical Dependency Information

Helen had trouble sleeping about six years ago. She was given Halcion, a benzodiazepine. She took Halcion more frequently as each day went by. Her drug seeking behaviour increased to getting prescriptions more often and knocking on residents doors asking for sleeping pills. She was mixing Halcion with alcohol, or over-the-counter drugs such as Gravol and Aspirin.

Helen's denial was strong and she refused to acknowledge the drug-related difficulties she was experiencing. She minimized the poor physical shape she was in. She blamed the physicians for her substance use.

Progress in Group

Helen agreed to attend the Elders Health Program treatment group three times per week for twelve weeks. She achieved that agreement, missing only a few sessions due to illness or transportation mix-ups.

Helen's individual goals she wished to achieve included:

1. being able to sleep without pills;
2. being more independent with self-care;
3. decrease her wish to die;
4. decrease her sense of isolation; and
5. to become more active.

Helen achieved the last goal. She started group walking with a walker, shuffling and stumbling along. By the end of her time in group, she was briskly walking without an aid. Six months later, she was taking long walks to the nearby shopping mall. She also achieved her second goal. She started group with a dishevelled appearance and body odour and

ended group wearing her best dresses and combing her hair. She used to leave leftover food rotting for days in the kitchen and by her six month follow-up visit, she was serving tea with her favourite china to visitors. When Helen started group, she needed help with cooking, cleaning and bathing. By her six month follow-up she had no help with bathing and was able to choose whether or not she wanted to cook or do her own cleaning.

Considering the achievement of her individual goals, her ability to sleep without her pills improved somewhat. By the twelve week posttest, she reported to be trying other means to help her fall asleep. By her six month follow-up, she had used alcohol to help her sleep and started to ask for sleeping pills again. However, these behaviours had subsided a couple months later and she was trying to sleep without a substance again. Regarding her wish to die, she felt more content, secure and happier with herself by her six month follow-up. Helen was feeling less isolated, so she thought she had achieved the fourth individual goal.

Helen's progress in group was very slow and somewhat limited but she made some surprising gains. At the beginning of her group experience, she worked hard at not becoming a part of the group. She did not speak at all, had no eye contact with others, denied knowing why she was in group and insisted she had nothing in common with group members. In turn, the group members tended to ignore her which only further alienated Helen. The peer counsellor and I asked her open questions, invited her to engage in dialogue and encouraged group members to speak directly to her. Slowly, members drew Helen into the group. When Helen

firmly expressed her decision to leave group prematurely, group members rallied together to encourage her to stay, which led her to stay. Katherine did take some risks by self-disclosing very personal details about her life. When she was challenged to make any active changes in their life, she often rejected help from others. Helen seldom offered help to others.

Helen achieved group goals in a limited way. She did achieve responsible use of mood-altering prescription medications, but she resumed drug seeking behaviour and developed few natural alternatives as a substitute for inducing sleep. Although alcohol use was not a concern at the beginning of group, it became a concern midway through because she started using brandy to help her sleep and following treatment she was buying alcohol every few days. At her six month follow-up, she was no longer using alcohol. The goal of abstaining from alcohol was eventually achieved, in spite of a relapse. The last group goal of improving her sense of life satisfaction may have been achieved. Her testing with the Delighted-Terrible Scale remained stable as being satisfied with her sense of life satisfaction. This applied to all of the items on the Delighted-Terrible Scale. She did show some improvement with her UCLA Loneliness Scale scores, moving from being possibly lonely to not showing any evidence of loneliness.

Ruby

Ruby was referred to the Elders Health Program treatment group by a priest. She had been fairly ill over the past five years. She suffered from chronic bronchitis, which left her short of breath

occasionally. Her recent complaint was abdominal pain although it did not occur consistently. She talked of physical symptoms constantly, although when she was asked to specify these complaints, she was unable to give details. Ruby used her poor health to gain attention and nurturing. She was always searching for an answer for her malaise, yet when she got an answer, she sought out another opinion. Ruby looked for new medications she had never tried before, or asked for different dosages because a medication did not work as she thought it should. She reported that she was able to walk only short distances, yet when she was in physiotherapy she walked so well the treatment was discontinued. Other physical complaints included loss of appetite, loss of weight, poor sleep, weakness, and fatigue. Ruby frequently went to Emergency, but usually was sent home and directed to see her own doctor.

Ruby was curious, intelligent, very warm and caring. She seemed to have difficulty trusting others especially people with authority. She had been a nun for many years. Ruby hardly participated in any activities in the Convent and she had alienated her friends because of her inconsistent behaviour and constant somatic complaints.

Chemical Dependency Information

Ruby had been taking mood-altering medications since her health problems started five years ago. Collateral sources reported that she used them longer than that. She used narcotic analgesics and benzodiazepines and continued using them throughout her stay in group. Ruby used these pills regularly by seeing different doctors and presenting problems with sleeping and chronic pain. If she needed more

sleeping medications to induce sleep, she would increase the dosage or mix the medication with an analgesic to make the sleeping pill work better. She used rationalizations to justify her chemical use. Ruby believed her pill use was okay because the doctor prescribed them and her chronic pain and poor health warranted using the medications. If she did not stay on the same chemical for too long, she believed that she avoided becoming addicted. With a nursing background, she thought her knowledge was enough to keep control over her pill use.

Progress in Group

Ruby had agreed to come to the treatment group three times per week. She was unsure how long she would come. She came to 10 sessions in total. Her reasons for not attending included being ill, feeling as though she did not belong because she did not think she was chemically dependent. Ruby disclosed that she felt upset between sessions which caused her much discomfort.

Ruby's main goal for attending group was to discover whether or not she was chemically dependent. She perceived she achieved her individual goal by deciding in the end that she was not chemically dependent. Unfortunately, she was clearly chemically dependent. The group was not effective with helping Ruby make an accurate discovery.

The lack of medical involvement in the group disturbed Ruby because she felt her general malaise demanded constant monitoring. She found it difficult to understand how people got better in group. Being faced with learning about herself and the possibility that she was chemically dependent created fear and apprehension which may have led to

resistance to change.

Ruby was quickly embraced as a group member because of her articulateness, warmth and the ability to engage with all of the members. She often did not accept the help that others offered her. She immediately identified with Margaret and they developed a strong subgroup that held a lot of power. Both Ruby and Margaret seemed to mirror each other because of their many commonalities. Although Ruby participated easily in group, she always seemed to keep one step away from making a commitment to becoming a part of the group. She helped to create cohesion due to her politeness, compassion for others and willingness to self-disclose to some extent. Without formally terminating, Ruby left the group and the members felt abandoned.

Ruby did not achieve responsible mood-altering drug use. She continued to use mood-altering medications daily and to seek out these medications aggressively. Ruby did not achieve an improved sense of life satisfaction. She remained focused on her physical symptoms and remained inactive and isolated. Because she left the group before completing twelve weeks, Ruby did not complete any posttest and six month follow-up testing.

It appears that an outpatient treatment program did not provide adequate support for Ruby. She requires an inpatient program to provide her with the constant emotional support, distance from her source of pills, and a very intense therapeutic approach.

Esther

A social worker from Victoria Hospital referred the family to the

Elders Health Program for assistance with an intervention with Esther. After a meeting with her two daughters and the psychiatric nurse, Esther agreed to attend the group.

Esther was born in Holland, married in her mid-teens and had ten children. She and her husband managed a grocery store. When Esther was about forty years old, the family moved to Canada which made Esther feel homesick for her family and friends that were left behind. About 16 years ago, her husband became increasingly ill but he refused to go to the doctor for many months. Finally he agreed to go. He was told that he had cancer that was so extensive throughout his body that nothing could be done. He only lived one month after the diagnosis. Esther remembered being furious with him for being so stubborn. After his death, she moved to a senior's apartment block. Four daughters and one son visit her regularly, help with household tasks, and take turns having her over for Sunday dinner. Esther has few friends to socialize with so she relies heavily on her family for social contact. Her activities include crocheting, playing Hi-Q, watching some TV shows, reading and watering her plants. She also writes letters to her family and friends in Holland.

Esther has a background in the Protestant faith, but did not attend church. She remained faithful in the Christian beliefs and seemed to increasingly develop inner contentment and peace. Dutch was her preferred language but she was also fluent in English.

Esther has severe, chronic arthritic pain especially in her knees and hips. She had fallen and fractured her pelvis. Both factors required her to use a cane and one person assist or to use a walker

independently. Chronic pain also inhibited her ability to sleep at night. She fell asleep easily, but pain always woke her up within a few hours. Analgesics gave her minimal relief. She found it difficult to cook, dress, clean and do errands. She received a private cleaning lady once per week, a visiting nurse once per week and meals on wheels five times per week. Esther has hypertension, wears hearing aides in both ears and reads lips. Hearing continued to be very difficult, embarrassing and frustrating.

Esther was bright, good humoured, honest and open, preferring to be direct with others. She allowed her feelings to show and was not afraid to express them. Her warmth, caring and willingness to help others was a strong characteristic. She did experience mood swings throughout treatment. Esther did not feel depressed but she was prepared to die because her life has been complete. She tries to keep some independence while allowing others to help her with things that were difficult to do. She coped by taking a "stiff upper lip" approach, believing she did what she could and the rest had to take care of itself.

Chemical Dependency Information

Esther was a moderate drinker throughout her adult years. About twenty years ago, her doctor prescribed Tuinol, a barbiturate, to help her sleep. She took this daily and developed a tolerance to the drug. She increased the dosage, taking two or three pills per day instead of one. Esther took Tuinol for sixteen years, prescribed by the same physician. Finally, the doctor decided she had taken it too long and

discontinued her prescription.

While Esther took the Tuinol, she also drank alcohol. When her husband came home for supper, he invited her to have an after dinner drink with him and she obliged. As soon as she was no longer on Tuinol, she began having brandy or whisky in her tea during the day. This pattern continued with no repercussions until her husband died. She increased her alcohol intake to two or three 40-ounce bottles per week. She tried to control her alcohol use by only drinking on weekends. Esther tried stopping many times, but returned to drinking after three to eight weeks of being sober. She had her alcohol delivered by taxi.

Problems with drinking occurred during the past two years. Esther took a bottle to bed with her at night. When she got up to go to the bathroom, she often fell and called her children to help her get up. She felt ashamed and remorseful about being discovered drunk. A fractured pelvis was the result of alcohol use. She lost interest in most of her activities and no longer left her apartment.

Upon entering treatment, Esther showed little denial, and felt intense guilt, shame and loss. Fear of being institutionalized and of disappointing her children were strong motivating factors for Esther to maintain sobriety.

Progress in Group

Esther agreed to attend the treatment group twice per week on Wednesday and Friday. This arrangement allowed her children to drive her to each session. She did meet the agreement, coming to 21 sessions in all. Her individual goals for treatment were to maintain abstinence

from alcohol and to attend a complete treatment cycle. The treatment group seemed to be effective with helping Esther achieve her individual goals. She achieved and maintained abstinence from alcohol and she did complete the treatment cycle.

Esther made very good individual progress while she was in group. She became more interested in her personal appearance, dressing up in her best dresses and jewelry for each session. Her physical condition did not improve. Esther was jealous of Helen because Helen showed marked physical improvement of time while Esther made no physical improvements. Her social activities increased in a limited way. She occasionally went to play bingo in her block. Esther enjoyed her visits to the Elders Health Program. She returned to her crocheting, reading, TV interests and she went to more family outings. At the end of her first treatment cycle, Esther left on a month long trip to Holland with her daughter. She attributed her ability to resume these activities to attendance at the Elders Health Program.

Esther became an integral part of the group and was well loved by all group members. Her participation in discussion helped to develop group attraction because she brought a sense of humour and warmth to the group. She became a respected group member, and was an informal group leader when Margaret was not present. Esther consistently found all the group sessions satisfactory. Her hearing impairment did slow the pace of group discussion, but it also enhanced member-to-member interaction because she needed to hear direct messages loud and clear.

Esther helped to develop mutual aid within the group by her warmth and responsiveness to other group members. As the oldest member in the

group, her advice and guidance was readily accepted and considered by others.

Esther's termination from the group was strongly felt by remaining group members. They felt hope for their own recovery, but they also felt a deep sense of loss.

Esther accomplished the group goals. She achieved abstinence from alcohol. She improved the quality of her life with increased outings, more involvement with her children and going on a trip to Holland. Unfortunately, Esther remained in chronic pain and physically challenged and lonely at times. The negative effects of aging may not have yielded to change, but the negative effects due to chemical dependency were dramatically reduced. Because the pre-test of the evaluation tools took four hours, she refused to take the posttest and six month evaluations. Thus, there was no way to support the clinical observations with test scores.

LETTERS OF PERMISSION

Letters of permission were received from:

Frank M. Andrews (Delighted-Terrible Scale)

Mark Badger (M.D.D.S.)

Terence T. Gorski (Developmental Model of Recovery)

Carlene Haga (Group Leadership Rating Scale)

Daniel Perlman (UCLA Loneliness Scale)