

Alcohol Use Among Elderly Primary Care Attendees in North Central Nigeria

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Abstract

Given the growing global population of elderly individuals and the potential increase in alcohol-related issues among this group, it is essential to explore the factors that influence alcohol consumption in older adults.

A descriptive cross-sectional study was carried out in 3 primary health care centres in Ilorin, Northcentral Nigeria, involving consenting patients aged 60 years and above. Each participant completed a proforma designed by the researchers which had sections on socio-demographic variables and alcohol use. The Geriatric Depression Scale (short form) was used thereafter with a cut-off score of ≥ 6 to screen for a presence of depression.

A total of 463 elderly patients participated in the study. Alcohol use was statistically significantly higher among males ($x = 44.483$, $p < 0.001$), those who are married ($x = 7.300$, $p < 0.007$) and elderly Christians ($x = 7.121$, $p < 0.008$). The trend though not statistically significant was that those who lived alone, and those who felt lonely were more likely to use alcohol ($x = 1.579$, $p < 0.209$ and $x = 0.094$, $p < 0.759$ respectively). Probable depression was however not found to be statistically associated with alcohol use ($x = 0.025$, $P < 0.874$).

There should be an increased index of suspicion by the primary care physicians to identify elderly patients who are at risk of engaging in alcohol use. This will assist in instituting early intervention programmes aimed at preventing alcohol related problems.

Keywords: Alcohol use, Elderly, Primary care

Introduction

There is a worldwide consumption of alcoholic beverages, and the elderly are not left out. It is estimated that about 67% of adults aged 50-80 years and about 25% of those over 85 years are involved.¹⁻³

Alcohol is a significant cause of death in all age groups, and this is even more so in the elderly.^{3,4} As an added factor, the majority of the elderly population take various medications, and those who drink alcohol in addition to these medications are more at risk of probable harm, depending on the amount of alcohol ingested.³⁻⁵ Alcohol abuse in the elderly is becoming well documented, and it appears to be one of the rapidly developing health problems in this age group.^{1,6} The elderly use alcohol as a social stimulant and also as self-medication for either physical health problems or psychological states.^{4,7} With the current aging world population, it is expected that the number of elderly people with alcohol-related problems will rise, and this may come to constitute a "silent epidemic".^{6,7}

A significant complication of alcohol use in the elderly is depression. Alcohol use and depression in the elderly are interconnected and complex issues that can have significant implications for overall health and well-being.^{8,9} It has been generally accepted that the prevalence rate of alcohol use disorder is lower in the elderly than in younger adults, though this is under-reported.⁴ Previous lack of attention on alcohol use disorder in the elderly may have been due to ignorance, stigma, and ageism.⁴ In addition, the presentation of alcohol abuse may be similar to those of other physical illnesses like diabetes mellitus and other psychiatric illnesses like depression and dementia that are prevalent in this age group.^{4,10} Additionally, primary clinicians may not be on the lookout for alcohol-related problems in the elderly given that the usual ways of assessing substance-related problems, such as reduced participation in important social activities, time lost from work, and legal problems, may not be relevant in the older adults who may have fewer pursuits outside the home.^{1,4} Also, most screening instruments and diagnostic criteria seem to focus more on the younger age groups than the older adults.¹¹

There is currently a shortage of literature on alcohol use and its related problems among the elderly, particularly in developing countries like Nigeria. We undertook to study the prevalence of alcohol use among the elderly attendees assessing care in three government-owned primary health centres in Northcentral Nigeria and to elucidate the social factors associated with this usage and the relationship with a depressive illness that is related to alcohol use in this age group.

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Method

This study was part of a larger cross-sectional study that was carried out among the elderly primary care attendees in three government owned primary care clinics in Ilorin West Local Government Area Ilorin, Kwara State, Nigeria. These three Primary Health Centres are used by the Department of Behavioural Sciences at the University of Ilorin, Ilorin, for its community outreach programme.

The study was conducted over a period of four months. The patients were first attended to by their primary care physicians, and all those aged 60 years and older, who could talk, were not in severe distress and who gave their consent were approached and recruited into the study. Section A of the proforma designed by the Researchers contained the Sociodemographic details (like age, sex, living arrangement, details of alcohol use etc.) of the participants. Section B of the proforma obtained information on alcohol use and thereafter, the Geriatric Depressive Scale short form (GDS-sf) was completed by each participant.

Statistical analysis was done using Statistical Pack for Social Sciences (SPSS) version 21. Descriptive statistic was done for all the variables and presented as tables showing frequencies and percentages. Chi square analysis was done to examine

association between independent and dependent variables. P value was set at <0.05 for statistical significance.

Ethical considerations

We obtained ethical approval from the Ethical Review Committee of the University of Ilorin Teaching Hospital. The study was also non-invasive, with no financial burdens on the participant. Additionally, permission was obtained from the administration of the three clinics used and informed consent from all the recruited participants; the participants either thumb printed or signed before administering the questionnaires.

Results

A total of 463 elderly patients participated in the study. Table 1 shows the socio-demographic details. The age of the participants in the study ranged between 60 and 90 years with a mean age of 68.2 $\pm$ 6.6 years; 257 of the participants (55.5%) were in the age group 60-69 years. Three Hundred and eighty-six (386) participants (83.4%) were females. Two Hundred and forty (240) participants (51.8%) were separated, divorced or widowed. The participants were mainly of the Yoruba ethnic group (96.1%) and Islamic religion (79.5%) and 6 (13.2%) lived alone while 34 (7.3%) admitted being

Table 1: Socio-demographic variables

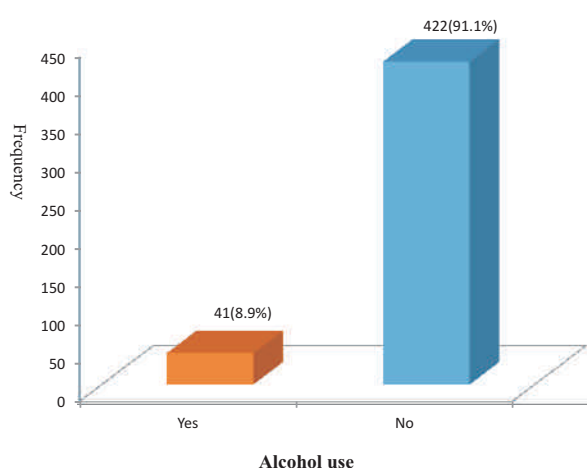
Variable	Frequency (n = 463)	Percentage
Range (years)	60 – 90	
Mean Age $\pm$ SD (years)	68.17 $\pm$ 6.55	
Age group (years)		
60 – 69	257	55.5
= 70	206	44.5
Gender		
Male	77	16.6
Female	386	83.4
Marital status		
Married	223	48.2
Separated/ Divorced/ Widowed	240	51.8
Ethnic group		
Yoruba	445	96.1
Hausa	3	.6
Igbo	3	.6
Others	12	2.6
Religion		
Christian	95	20.5
Islam	368	79.5
Lives alone		
Yes	61	13.2
No	402	86.8
Feel lonely		
Yes	34	7.3
No	429	92.7

Table 2: Relationship between socio-demographic variables and alcohol use

Variable	Alcohol use		Total n	χ^2	p value
	Yes n = 41 (%)	No n = 422 (%)			
Age group (years)					
60 – 69	22 (8.6)	235 (91.4)	257	0.062	0.803
= 70	19 (9.2)	187 (90.8)	206		
Gender					
Male	22 (28.6)	55 (71.4)	77	44.483	<0.001*
Female	19 (4.9)	367 (95.1)	386		
Marital status					
Married	28 (12.6)	195 (87.4)	223	7.300	0.007*
Separated/ Divorced/ Widowed	13 (5.4)	227 (94.6)	240		
Ethnic group					
Yoruba	38 (8.5)	407 (91.5)	445	6.740 ^Y	0.081
Hausa	0 (0.0)	3 (100.0)	3		
Igbo	2 (66.7)	1 (33.3)	3		
Others	1 (8.3)	11 (91.7)	12		
Religion					
Christian	15 (15.8)	80 (84.2)	95	7.121	0.008*
Islam	26 (7.1)	342 (92.9)	368		
Lives alone					
Yes	8 (13.1)	53 (86.9)	61	1.579	0.209
No	33 (8.2)	369 (91.8)	402		
Feel lonely					
Yes	4 (11.8)	30 (88.2)	34	0.094 ^Y	0.759
No	37 (8.6)	392 (91.4)	429		

χ^2 : Chi square; *: p value <0.05; Y: Yates corrected Chi square

Figure 1: Proportion of participants who take alcoholic drinks



lonely.

Forty-one participant (41, representing 8.9%) reported that they take alcohol (Figure 1).

Table 2 shows the relationship between socio-demographic characteristics and alcohol use. The use of alcohol was significantly higher among males ($\chi=44.483$, $p < 0.001$), those who were married ($\chi=7.302$, $p < 0.007$) and Christians ($\chi = 7.121$, $p 0.008$).

Although there was a trend for elderly patients who lived alone [(8), (13.1%)] and those who felt lonely [(4), (11.8%)] to be users of alcohol compared to those who did not use alcohol, this difference was not statistically significant ($p < 0.209$ and $p < 0.759$ respectively). Alcohol use was found in 28.6% of males as compared to 4.9% females, 12.6% of the married respondents and 15.8% of Christians. As shown by Table 3, alcohol use did not predict presence of probable depression in the study population p value 0.874 (OR 1.613, CI 0.351-7.410).

Discussion

Several studies have reported the use of alcoholic beverages by the elderly and an increasing trend in use by the elderly, as well as a possible increase in alcohol-related problems.^{3,4,7} This may now be posing a public health concern. Problems related to alcohol use in the elderly have frequently been under-reported or undetected and thus remain undiagnosed.^{2,4} In addition, the elderly may frequently underestimate the quantity of alcohol taken. The use of alcohol may be "medically hazardous" in the elderly due to age-related changes in metabolism, even when the frequency and amount of consumption do not meet the criteria for a

diagnosis of alcohol abuse or dependence syndrome.^{4,6} This is even more relevant in developing societies like our own, where the quantification of the amount of alcohol ingested may be difficult due to the varied types of brew (both local brews and varying brands of substandard alcoholic beverages) present in the community and often used in local herbs concoctions commonly used.

A high prevalence of use of prescription medications by the elderly further puts them at risk if they consume alcohol along with the medications and other over-the-counter drugs.^{1,3,7}

Alcohol use may also worsen comorbid chronic physical or mental illnesses or lead to new onset of physical or mental illnesses in the elderly.⁷ This may affect hospital utilization, such as increased length of stay, increased hospital visits, and increased health-related costs.^{6,14,16}

The prevalence of alcohol use among the elderly has been previously reported to range from 15% to 50%.⁴ Our study found an overall prevalence rate of alcohol usage of 8.9%. This value is lower than reports from studies from within and outside Nigeria.^{4,17,18,19} Several reasons may be responsible for this lower finding in our study, such as, variability in consumption between countries, ethnicity, religion and socio-cultural groups.^{19,20}

Also, the lower prevalence found may be due to under reporting because of the social expectation in our culture that older adults should not drink alcoholic beverages. Further explanation may be that they were more likely to depend on relatives for access to such beverages because of probable mobility limitation due to the possibility of a higher occurrence of chronic physical illnesses or social isolation in them.²³

Generally, the highest rates are found among the younger ages^{10,21}, although recent studies find an increase in alcohol consumption in the older age groups.²¹ The younger age group having the highest prevalence rate for the use of alcohol may be due to easier access they have to alcohol, being more relatively mobile and, hence, less dependent on others to procure alcohol. They also possibly have a more robust social network. In our study, the highest rate was in those above 70 years. A reason for our finding may be because the older age group may have more major life changes, such as loss of loved ones through death, reduced social milieu, and failing health, which may cause loneliness and the presence of chronic physical illness and mental ill health, which may predispose to alcohol use.

Similar to other studies, this study found significantly more alcohol use among the males as compared with the females.^{4,21,22} This is not surprising in our environment, as it is almost widely accepted that women should not engage in alcohol use. Recent reports however suggest changes in the trend of alcohol

use between the genders, with a trend towards narrowing of the gap between the genders.²²

We found that alcohol use was statistically significant among the married than the separated/divorced/widowed and single elders. However, Alcohol use and marital status are interconnected, with some studies suggesting that marital status influence drinking differently from those who are single or divorced. Marital status influences drinking patterns with factors such as the amount and type of social support provided and the quality of relationships.¹⁴ A married status serves as a buffer for good health and better survival outcomes in late life and has a protective effect by reducing the risk of psychoactive substance abuse, as found in previous studies; the reason for the finding in our study is not known and should be further explored. Some researchers have argued that the assertive mating or marital homophily mechanism may mean that marriage offers partners a shared lifestyle, and as such, the death or loss of a partner may result in reduced use.^{24,25}

The present study found a significant association between alcohol use and religion, similar to other studies.^{9,22} More Christian elders used alcohol than their Muslim counterparts. The participants in this study were primarily Muslim, though (the health centers used for the study were situated within the Muslim-dominated part of the city), and the lower prevalence amongst Muslims may be partly because alcohol use is taboo in Islam.^{20,26}

It has been documented that not being involved in religion increases the risk of the use of alcohol, while participating in religious social activities decreases the risk of depression³² and hence the need for probable self-medication with alcohol.

In this study, the elders who lived alone and those who felt lonely had more alcohol use, though this was not statistically significant. A reason may be the possibility of some degree of social isolation that may engender in them the feeling of anxiety or depression and a need for alcohol.^{27,28}

Ethnicity was not significantly associated with alcohol use in this study, as most respondents were from the Yoruba tribe.

The relationship between alcohol use and depression is complex. Some older adults may turn to alcohol as a way to cope with depressive symptoms, while excessive alcohol consumption can also contribute to or exacerbate depressive feelings. This study did not find an association between alcohol use and probable depression; the majority of the elders may have started the use of alcohol early in life.^{8,9} However, our study found a trend towards more use of alcohol by the probably depressed elders. Studies have suggested that with advancing age, there is a higher risk of depression, which may be a result of loss events (loss of physical health, social status, or loss of loved ones)²⁹

and hence the probable need to self-medicate with alcohol use either for physical, social or emotional reasons.^{9, 30} Future studies using larger samples and a multi-center design would be required to make better inferences and to address alcohol use in elderly.

Healthcare professionals play a crucial role in assessing and addressing the adverse effects of alcohol use, given the probable negative impact on the health of alcohol ingestion in old age. On account of the similarity in symptoms of alcohol use to symptoms of physical illness, it becomes necessary for primary care physicians to have an increased index of suspicion about the use of alcohol in late life and be able to detect and diagnose it. To aid the primary care physician in maximizing time in his busy clinic, the use of simple screening instruments for the detection of alcohol use in the elderly is recommended, especially to detect its association with depression.⁴ The primary care setting can serve as a vital channel for "brief advice" to control alcohol intake and limit the possible negative impact of alcohol on the health of the elderly, as well as link them up with specialty care when needed. Treatment may involve counseling, support groups, medication for depression, and interventions to address alcohol use, if necessary.

Encouraging open communication with healthcare providers and addressing any concerns about alcohol use or mental health can contribute to better overall well-being for elderly individuals. Family and community support are also vital in promoting a healthy and fulfilling lifestyle in later years.

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