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The experience of depression and alcohol abuse among older women : four case studies

Gretchen Goebel Skoglund
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The Experience of Depression and Alcohol Abuse
Among Older Women:
Four Case Studies

A Thesis
Presented to
The Faculty of the Department of Occupational Therapy
San Jose State University

In Partial Fulfillment
of the Requirements for the Degree
Master of Science

By
Gretchen Goebel Skoglund
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ABSTRACT

THE EXPERIENCE OF DEPRESSION AND ALCOHOL ABUSE AMONG OLDER WOMEN: FOUR CASE STUDIES

by Gretchen Goebel Skoglund

A sample of four women over the age of sixty-five who have combined depressive symptoms and prior alcohol abuse were interviewed. The subjects shared information regarding their life experiences and functional abilities as they relate to the combination of age, depression, and alcohol abuse and the Occupational Performance frame of reference.

The qualitative data were subjected to content analysis of the experiences described by the subjects and common themes were determined among the subjects' accounts. The themes that emerged were: alcoholism and depression as a response to stress, interpersonal relationships that supported the abuse of alcohol, imbalance in the occupational performance area of leisure, loss of social contacts, and the benefit of a specialized support group.

Implications for occupational therapy intervention with this population, especially the need for maintenance of leisure activity are discussed, and for further research are suggested.

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CHAPTER 1

INTRODUCTION

Purpose

The purpose of this study was to 1) explore the experiences of four older women who have engaged in excessive consumption of alcohol and who also have documented symptoms of depression and 2) discover and examine common themes among their accounts, particularly regarding aspects of occupational performance such as self-maintenance, work, and play/leisure.

Statement of the Problem

Though the incidence of alcohol abuse by older persons is on the rise, it is largely overlooked as a condition worthy of study. Yet, as the older population continues to grow, this phenomenon may become more obvious and problematic for all of society (Schonfeld & Dupree, 1990). In addition, "most elderly who have been admitted to . . . treatment programs drank at home, alone, and in response to depressive states" (Schonfeld & Dupree, 1990, p. 6).

When the additional factor of gender, particularly that of women, is combined with the above alcoholic and depressed population, one is hard-pressed to find literature that addresses the special characteristics of this diagnostic picture. It has been noted in recent literature that:

to date most research, policy, and treatment initiatives in respect of substance misuse has focused on men and thus the special features of women substance misusers have received scant attention. However, the extent of problem drug and alcohol use among women is considerable and is believed to be on the increase (Oppenheimer, 1991, p. 36).

As the "baby-boom" generation rapidly approaches late adulthood, society could see a similarly rapid increase in the incidence of alcohol abuse among elders. Older women in particular are prone to this behavior because women on the average enjoy a longer life span than their male counterparts and therefore endure more loss and grieving that so often lead to depression (Warheit, 1979). In the older woman, the abuse of alcohol in combination with depression is a complicated yet common clinical picture and most assuredly indicates impaired functioning in the areas of occupational performance. The lack of research in this area limits understanding and therefore inhibits effective treatment of this combination of disorders. More research is needed if occupational therapy is to provide successful intervention for this population.

Research Questions

The study proposed to answer the following questions:

1. What are the experiences of a sample of older women with prior alcohol abuse and documented depressive symptoms?
2. How do the subjects explain the relationship between their abuse of alcohol and their depressive symptoms?
3. What are the subjects' perceptions of the daily effect of alcohol abuse and depression on their occupational performance in the areas of self-maintenance, work, and leisure?
4. Are there common themes among the experiences related by a sample of older women with prior alcohol abuse and depressive symptoms, particularly in regard to occupational performance?
5. What information garnered in this study could be of use to occupational therapists in their intervention efforts with this population?

Definitions

For the purpose of this study, the following definitions will be employed:

1. Activities of daily living--The basic everyday activities of a human being for self-care and self-maintenance including grooming, oral hygiene, bathing, toilet hygiene, dressing, feeding and eating, medication routine, socialization, functional communication, functional mobility, and sexual expression (American Occupational Therapy Association, 1988).
2. Alcohol abuse--Any of three characteristic patterns of destructive alcohol-drinking which result in functional impairment in the individual: daily intake of large amounts of alcohol, regular binges of alcohol, or long periods of abstinence interspersed with heavy alcohol binges (Bonder, 1991).
3. Alcohol misuse--Any use of alcohol which harms or threatens to harm the physical or mental health or social well-being of an individual, or of other individuals, or of society at large (Oppenheimer, 1991).
4. Alcohol use--Drinking or consumption of an alcoholic substance or beverage, regardless of the purpose or intention of the drinker.
5. Alcohol-related activities--Include traveling to and from a bar or store to obtain alcohol, buying alcohol, hiding alcohol, preparing alcoholic beverages as well as actual alcohol consumption (Scaffa, 1991).
6. Comorbidity--The presence of any distinct additional clinical entity that has existed or that may occur during the clinical course of a patient who has the index disease under study (Davidson & Ritson, 1993). In this study, comorbidity is the co-existence of alcoholism and depression or depressive symptoms.

7. Depressive symptoms--Symptoms such as depressed mood, diminished interest in activities, insomnia, loss of energy, or difficulty in concentrating that may indicate a diagnosis of Axis I Major Depression, yet for various reasons is not clinically diagnosed (American Psychiatric Association, 1994).
8. Dual diagnosis--The existence of two separate diagnoses in one person, such as a substance abuse disorder and a psychological disorder, which when combined may result in amplification of the effects of each individual disorder (Davidson & Ritson, 1993).
9. Leisure--Includes those activities which are freely chosen and are engaged in for pleasure. Leisure excludes all activities which are considered self-maintenance, work, or alcohol-related activities as described in the definitions of those terms. Leisure activities range from quiet reading or watching television to active participation in sports or hobbies (Scaffa, 1991).
10. Major depression--A psychiatric diagnosis characterized by mood disorder or loss of interest/enjoyment in activities for at least two weeks. Five of nine criteria must be present, at least one being depressed mood or loss of interest/pleasure: depressed mood, markedly diminished interest or pleasure in almost all activities, significant weight or appetite changes, disturbance in the sleep cycle, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness, altered cognition or concentration, and recurrent thoughts of death (APA, 1994).
11. Occupational performance--Broadly, the variety of skills and types of behavior executed in the course of daily life, including the performance

areas of work, leisure, and self-maintenance. Performance components are sensory, motor, cognition, psychological, and social (Christiansen, 1991).

12. Self-maintenance--Activities that one performs on a daily basis for personal care, such as meal preparation, eating, cleaning-up, housekeeping, grooming, hygiene, and dressing (Scaffa, 1991).
13. Work--Competitive employment, generally for the purpose of earning one's livelihood, education for the purpose of obtaining a marketable skill or child care responsibilities, if this is subject's primary occupational role (Scaffa, 1991).

Assumptions

The literature suggests that older women who abuse alcohol experience impaired functioning in areas of occupational performance. Depression or depressive symptoms in an individual also negatively affect performance of daily activities. The combination of these two criteria, specifically selected for study in this subject population, constitutes a complicated yet common diagnostic picture of dysfunction in the older individual. In addition, the older individual invariably experiences simultaneous decline and/or changes in functional ability due to factors associated with aging, such as decreasing physical strength, the possibility of declining health, retirement and reduction in income, losses of family and friends, and feelings regarding one's own death (Llorens, 1991). For the purpose of this study, it is assumed that the subjects have had, and may still be experiencing, dysfunction in areas of occupational performance related to their prior alcohol abuse and depressive states. It is further assumed that the abuse of alcohol and the symptoms of depression are related in this population. Lastly, it is assumed that the

accounts related by the 4 subjects are descriptive of their own life experiences, and although they may hold similarities to each other, they may not reflect the views of others who also have suffered from alcohol abuse and depression.

Limitations

The major limitation of this study lies in the small sample size used in data collection. However, as thesis research using qualitative case studies, a smaller sample size is justified. This particular sample also presents a major limitation in its homogeneity--all are white, of middle-class economic and social standing, educated (for this age group), and members of the same recovery group; the experiences of other socioeconomically and ethnically diverse subjects are not explored in this study. Another limitation is that the honesty of the subjects' responses cannot be verified and fabrications may be reported to disguise the truth. Denial is also a common characteristic in this population (Benshoff & Roberto, 1987) which may contribute to questionable subject responses. It is hoped, however, that the use of a subject population that has admitted its problems with alcohol abuse and is actively engaging in a recovery program will serve to increase the accuracy of the data collected. Lastly, as with any qualitative study, subject areas of discomfort or embarrassment such as those related to aging, alcohol use, depression, and other life circumstances may be avoided by the subjects, thereby limiting a more thorough understanding of these subjects' experiences.

Significance of the Study

The incidence of alcohol abuse by older persons is on the rise, though largely overlooked as a condition worthy of study. However, as the large "baby-boom" generation approaches late adulthood, society will likely see a

rapid increase in the incidence of alcohol misuse among its elders, therefore creating an even more compelling reason to study this population. It appears that older women, due to their longer average life expectancy relative to that of men, are at risk in even greater numbers. In addition, because of their longevity, older women are more susceptible to bouts of depression because they are likely to experience more loss, grieving, and health problems in their later years (Warheit, 1979). The combination of alcohol abuse and depression in older women is a complicated yet common clinical picture that occupational therapists are likely to encounter in their practice. Their clients are likely to exhibit occupational performance dysfunction in the areas of self-maintenance, work, and leisure, yet the lack of research in this area inhibits understanding and therefore effective treatment of the problems caused by this combination of disorders. More research is needed if occupational therapy is to be successful in its efforts with this population. It is hoped that this study will lead to greater understanding of this population and its needs while also increasing the occupational therapist's knowledge, understanding, and abilities relating to intervention with this population.

CHAPTER 2

LITERATURE REVIEW

A review of occupational therapy, gerontology, and psychology literature indicated that there is a paucity of recorded research regarding the experiences of older female drinkers with depressive states. Studies that examine the combinations of alcohol abuse and depression in younger adults, alcohol abuse in the elderly, depressive states in the elderly, depressive states and health status, mental illness in older women, and alcohol abuse in older women are more prevalent in the various literature bases than the particular combination of criteria presented in this study. "Very few studies have analyzed the influence of age and cognition among later life alcoholics and accounted for the effects of depression" (Hyer, Carson, Nixon, Tamkin, & Saucer, 1987, p. 1237). As a result of the limited research addressing this particular problem, there are few references to be included for discussion and analysis. However, as evidenced by the following literature review, this dilemma in itself is well-documented as an area of research in much demand. This literature review is divided into seven sections covering the following topics: alcoholism and depression in the human being, special characteristics of comorbidity in women, comorbidity among older adults, depression and alcohol abuse in the older woman, limitations in functional performance, theoretical framework, and case study methodology.

Alcoholism and Depression in the Human Being

Alcohol abuse and depression, alone and in combination, work to produce specific changes and dysfunctions in the life, health, and functioning of the human being. Use of alcohol can elicit temporarily improved mood by

bringing on positive feelings of happiness and freedom, while lessening inhibitions, stress, tension, and depression (Dufour, Archer, & Gordis, 1992). However, at higher doses and with prolonged abuse, especially in older adults in which it takes less alcohol to produce harmful results, the physical and functional effects are many and varied. The body becomes less equipped to repair damage, is at increased risk for major illness, performs at a poorer functional level, suffers the inability to perform many activities of daily living, and becomes increasingly susceptible to debilitating diseases such as myopathy, cerebrovascular disease, gastritis, cardiomyopathy, and sleep disorders, just to name a few (Liberto, Oslin, & Ruskin, 1992). Depression, on the other hand, besides encouraging an overall lowered mood, can act to bring on somatic symptoms including altered patterns of sleep, appetite and libido; negative self-evaluation including lowered self-esteem, self-blame, suicidal ideation, guilt, pessimism, despair, and an overall gloomy outlook (Warheit, 1979); and memory and concentration problems (Molinari, 1990).

Alcohol abuse and depression have also been shown to covary to a high degree in individuals with one or the other primary diagnosis (Hyer et al., 1987). Cook, Winokur, Garvey, and Beach (1991) cite statistics of depression rates varying from 3% to 98% among alcoholics. While there is no argument that alcohol and depression are indeed related, their precise causal relationship is very much questioned and disputed (Dunne, Galatopoulos, & Schipperheijn, 1993). There seem to be three schools of thought on the matter--that alcoholism precedes depression, that depression induces alcoholism, and that the two are comorbidly related disorders in which neither is the cause of the other.

Schonfeld and Dupree (1990) stated that "loneliness and depression preceded the first drink" (p. 6) in most elderly alcoholics, thus putting forth the hypothesis that it is more likely than not that depression is a precipitating factor to alcoholism. Dunne et al. (1993) added support to this notion by stating that "alcohol-dependent women are more likely to have a primary depressive illness prior to their first drink" (p. 95) and engage in alcohol use as a result of their feelings of inadequacy and low self-esteem. It is not uncommon for depressed individuals to engage in a quick "pick-me-up" beverage to bolster their mood and energy (Davidson & Ritson, 1993). Zimberg (1974) suggested that "alcoholism is not just a disease, but it is often a cry for help, a signal that an individual is unable to cope with the loneliness, depression, hopelessness, and other stresses" (p. 222). She suggested here that alcohol abuse is a tool that may be used by depressed people to call attention to their need for intervention.

In their review of the relationship between alcohol and depression, Davidson and Ritson (1993) proposed a reverse causal relationship stating that alcohol's effects "on the psychosocial functioning of an individual may lead to feelings of guilt and hopelessness which, when combined with the physical effects of large doses of alcohol, may increase the likelihood of a depressive illness developing" (p. 153). They further stated that in their research, affective disorder was the most common secondary diagnosis in alcoholics. In fact, alcohol research has shown a greater psychiatric comorbidity in alcoholic populations than in the general population (Liberto et al., 1992). In addition, many researchers warn of the common mistake many doctors make in diagnosing depression in alcoholics, when often the so-called depressive symptoms are simply a "transient state of alcohol withdrawal" (Blow,

Loveland-Cook, Booth, Falcon, & Friedman, 1992, p. 994; Keeler, Taylor, & Miller, 1979).

Regardless of whether alcoholism breeds depression or vice-versa, it appears evident that the two are interrelated. Solomon, Manepalli, Ireland, and Mahon (1993) go as far as to state that "addictions are not secondary to other medical or psychiatric disorders. They coexist with these disorders as co-primary disorders" (p. 60). One explanation for the seemingly high rate of comorbidity of these disorders may be Berkson's bias--patients with multiple disorders are more likely to seek treatment, so that higher comorbidity rates are seen in treatment settings than really exist in the larger community (Blow et al., 1992). However, the need for further research and understanding of this problem is uncompromised.

Special Characteristics of Comorbidity in Women

Oppenheimer (1991) stated that:

there has been a limited interest in women who misuse alcohol and other drugs. To date most research, policy, and treatment initiatives in respect of substance misuse has focused on men and thus the special features of women substance misusers have received scant attention. However, the extent of problem drug and alcohol use among women is considerable and is believed to be on the increase. (p. 36)

Research on women and women who have been diagnosed with alcoholism is slowly but steadily showing itself to be an area for future study, yet still lacks the degree of attention of which it is worthy. Women's drinking patterns, incidence, and treatment issues differ in many ways from those of men, thus making the issues of female alcoholics unique and deserving of special attention. In addition, alcohol-dependent women are more likely to also have a

primary depressive disorder, to drink in response to lowered mood states, and are at an increased risk of physical and psychiatric morbidity from alcohol consumption since they develop problems in a shorter period of time than do men (Dunne et al., 1993). A separate study (Davidson & Ritson, 1993) reinforced the assertion that females with alcoholism were more likely than males with alcoholism to have an additional psychiatric diagnosis, mostly depression and phobias. The women in all three of these studies were discovered to be suffering from disturbances in married life, high levels of stress, financial difficulties, feelings of low self-worth, suicidal tendencies, isolation, and lack of resources more than were men (Davidson & Ritson, 1992; Dunne et al., 1993; Schuckit et al., 1979). It has also been suggested that "male partners may seriously exaggerate women's emotional problems through violence and manipulation, and may thereby reduce their coping capacity to such a degree that alcohol becomes a coping mechanism" (Dunne et al., 1993, pp. 99-100). It is also worth mentioning that because men have received more attention in terms of alcoholism and psychiatric dysfunction, most treatment services have been designed to meet their needs, leaving women and their special needs for treatment and intervention relatively ignored and unexplored (Dunne et al., 1993).

Comorbidity Among Older Adults

Accurate rates of alcohol abuse and/or depression among older individuals are not known precisely because, as one author suggests, "the diagnostic criteria have been established through observations of younger populations where significant social and job impairment is more likely to signal alcoholism" (Schuckit, 1990, p. 84). It is known, however, that alcoholism in combination with depressive states is more pervasive among older adults than

is actually acknowledged by the medical community (Benshoff & Roberto, 1987). Although alcoholism and psychiatric dysfunction of the older adult are generally situational, brought on or further exacerbated by failing physical and mental health and by emotional and environmental changes (Brody, 1982), the special characteristics of older adults with comorbid alcoholism and depression are not to be so easily dismissed. For depression, "the most common precipitating events are losses that the elderly must confront: death of a spouse, close relatives, or friends; retirement; illness; parenting role; prestige; and independence" (Molinari, 1990, p. 24). Likewise, alcohol abuse is similarly promoted by retirement, with its boredom, change of role status, and loss of income; deaths of close friends, relatives, and the knowledge that more (including ones own) will occur; poor health status; and loneliness (Brody, 1982). One statistic cited that at least 27% of the elderly living in the community suffer from depressive symptoms. If this and the fact that alcohol has longer lasting effects on the physical and mental status of the elderly (Molinari, 1990) are accurate and combined in the older individual, there is potential for development of a vicious cycle of depression leading to alcohol abuse resulting in more depression. In addition, since heavy drinking can compromise ones nutritional status (Liberto et al., 1992), it combined with the natural changes with age in brain functioning and the effects of psychiatric dysfunction can result in severe cognitive deficits. Should these deficits be misdiagnosed, severe consequences may result for the older individual, such as inappropriate treatment or wrongful institutionalization (Brody, 1982). Although many have asserted that older individuals with a dual diagnosis are easier to treat and respond better to intervention than the general population (Brody, 1982; Davidson & Ritson, 1993; Liberto et al., 1992), the existence of

these disorders in the older adult is often overlooked by physicians and caregivers as symptoms associated with older age (Schuckit, 1990) or labeled simply "negative affect" (Dupree & Schonfeld, 1989, p. 65).

Depression and Alcohol Abuse in the Older Woman

Roughan (1993) indicated that "women over the age of sixty-five are the fastest growing segment of the American population. The longer life expectancy of women has already become a major social issue because of its impact on the individual, family members, and the health care system" (p. 174). Like the younger population of women who are susceptible to alcoholism and depression, the older woman, too, has unique characteristics which make her vulnerable to the hazards of comorbidity. Once the emerging problem of alcohol abuse in women had been established, researchers began including studies for older women alcoholics in their research endeavors (Dunne et al., 1993). Higher occurrence rates were discovered with this population because women on the average out-live men and therefore their higher numbers translate to increased presentations of drinking behaviors (Willenbring & Spring, 1990). Depression is also a common occurrence in the life of the older woman. Warheit (1979) asserted that persons who experience a high degree of loss also have a significantly higher degree of depression, while Luke, Norton, and Denbigh (1982), stated that the strongest predictor of low psychologic well-being is low social interaction and isolation. As it is, women as a whole out-live men, and therefore their significant others. This high degree of loss combined with the resulting lowered social interaction and increased isolation so commonly seen in the older woman typically places the older woman in a position for increased risk of depression.

Numerous clinicians and researchers have pointed out that depression and abuse of alcohol are commonly seen co-existing disorders in older women (Oppenheimer, 1991; Solomon et al., 1993; Speer & Bates, 1992). However, Speer and Bates (1992) indicated that despite the prevalence and almost customary occurrence of this clinical picture, research on dual diagnosis among this population has been neglected, perhaps due to the invisibility of the problem to outsiders. There are many obvious factors which promote depression and alcohol abuse among older women, including retirement, deaths of close relatives and friends, anticipation of one's own death, failing health, and particularly loneliness (Brody, 1982). However, symptoms of alcohol abuse among older women with depression are frequently overlooked by physicians and caregivers as merely symptoms of aging or additional traits of the diagnosed depression (Benshoff & Roberto, 1987; Nahmias & Froelich, 1993; Roughan, 1993). References dating back to 1968 show evidence of the research void surrounding the particular combination of alcoholism, depression, aging, and women (Simon, Epstein, & Reynolds, 1968). Furthermore, Solomon et al. (1993) cited 25 years later that still not enough attention is being paid to this problem. The obvious needs for research, standard diagnostic criteria, and increased resources are of utmost urgency for this population. In addition, an overall better understanding of the comorbidity of mental and substance disorders among older adults, particularly women as they continue to live longer and compose the majority of the older population, is necessary in order for these needs to be addressed (Speer et al., 1992).

Limitations in Functional Performance

Occupational therapy, gerontology, and psychology literature as a whole agree that age, depression, and alcohol abuse alone and in combination work to decrease one's performance in activities of daily living. Age by itself is very often a cause of functional impairment, as older adults typically show age-related decline with functional tasks (Dickerson & Fisher, 1993) due to health problems, mobility limitations, and cognitive deficits. Brody (1982) stated additionally that at least 40% of people 65 or older have a serious health problem that causes limitations in conducting normal daily activities.

Alcohol also causes dysfunction in performance of daily activities. Bonder (1991) stated that the abuse of alcohol presents a barrier to the successful performance of daily life activities in any population; its effects include drowsiness, reductions in perceptual and motor function, and central nervous system damage/changes, all of which lead to impaired vocational and social performance, impaired leisure and social activities, and impaired work behavior (also Roth, Roehrs, & Moskowitz, 1992; Schuckit, 1990). Dufour et al. (1992) supported these findings by acknowledging that in some types of task performance, alcohol induces impairment, which worsens with age. Alcohol may worsen insomnia, breathing difficulties, and pain; inhibit optimal cognitive functioning; exacerbate dementias of other etiology; and impair driving and other complex activities.

Depression also manifests itself in impaired activity engagement due to withdrawal, loss of pleasure, and decreased motivation (Bonder, 1991). In addition, Musetti et al. (1989) found that depressed older subjects tended to have slower movements and slower gait when studied amongst a population of 400 individuals with a primary diagnosis of major depression.

Comorbid alcoholism and depressive diagnoses have been found to result in significant dysfunction. In a study of over 22,000 alcoholic outpatients, Blow et al. (1992) found that more than 50% of the alcoholics with a comorbid psychiatric disorder were rated as severely impaired in their everyday adaptive functioning. When age was factored into this equation, these researchers found that the highest rate of dysfunction for any comorbid diagnosis was in patients between the ages of 60 and 69. Thus, it is clear that the older depressed alcoholic is at significant risk for severe dysfunction in activities of daily living. With the aid of a wider knowledge base regarding older depressed alcoholics, occupational therapy can be an important link between this population and optimal functioning (Trace & Howell, 1991).

Theoretical Framework

It is not only important to increase understanding of the older adult woman with a comorbid diagnosis for purposes of more accurate and recognizable diagnostic criteria, the reduction of wrongly institutionalized elders with misdiagnosed senile dementia, and the prevention of harm and avoidable accidents (Brody, 1982). It is also equally important to discover the problems that these people have in their everyday activities and to find ways to intervene and promote a better quality of life where possible. The combination of these three factors, alcohol abuse, depressive states, and old age, present a complicated diagnosis for any clinician to address effectively. Yet, despite its complexity, occupational therapists need to increase their knowledge about this population and find effective methods to address and intervene in the dysfunction apparent in this growing population.

The occupational performance frame of reference, therefore, presents itself as an ideal framework for this study. Occupational performance is

referred to in the literature as "the day-to-day engagement in occupations that organize our lives and meet our needs to maintain ourselves, to be productive, and to derive enjoyment and satisfaction within our environments" (Christiansen, 1991, p. 27). The three categories of self-maintenance, work, and play/leisure are most often used to classify the diverse scope of this theoretical framework for practical purposes of application and research (Christiansen, 1991). The ensuing disruption in these separate areas of functioning in the life of the older woman with a dual diagnosis can lead to overall occupational performance impairment and elicit questions regarding well-being, quality of life, and intervention strategies.

Evaluation and remediation of imbalances in a person's life and daily activities are integral components of an occupational therapist's training. However, with this population, it is only by thorough examination and interview that a person's need for support services can be identified (Skruppy, 1993). By asking detailed questions regarding both past and current functional abilities and activity-involvement, one can gain insight into the experiences, problems, and needs of this particular population. Additionally, the special characteristics of older women with a comorbid diagnosis can be discovered, thereby providing a reference point for the creation of tailored treatment and intervention strategies that will be more effective with this population. Therefore, the occupational performance frame of reference, with its focus on self-maintenance, work, and play/leisure, will serve as the filter through which this study will be conducted and analyzed.

Case Study Methodology

By definition, a case study is "a detailed, in-depth description of a single unit, subject, or event" (DePoy & Gitlin, 1994, p. 154). Its design may be limited

to one or involve many individual cases. Over the past two decades, the case study design for research has become a well-respected mode of inquiry into a subject area which is atypical or difficult to study in a group design. It is also often the most practical way to research a phenomenon and it allows for generalization to theory even when not generalizable to the larger population.

Case studies are quite useful for the health care provider to develop understanding of a particular phenomenon, evaluate the effectiveness of treatment strategies for a specific group, and provide support for one's practice methods and personal theories (DePoy & Gitlin, 1994). The use of a multiple case study approach, as in this study, allows for the researcher to gain insight into how several individuals experience similar disease processes or disabilities while also examining the complexity of human experiences. By interviewing 4 subjects who have been similarly diagnosed with alcoholism and depressive symptoms, varying viewpoints and differing experiences relative to the same topic can be explored and compared to enhance the understanding of this phenomenon and lend support and suggestions for intervention strategies.

Summary

In summary, this literature review has described studies that investigated the various combinations of relationships of alcoholism and depression in the human being, special characteristics of comorbidity in women, comorbidity among older adults, depression and alcohol abuse in the older woman, and limitations in functional performance associated with this population of women with depression and alcoholism. For areas in which actual research and results were not available, documentation of the need for further research

was noted. The theoretical framework of Occupational Performance and its areas of self-maintenance, work, and play/leisure that are used in this study were discussed. Case study methodology as a form of data collection was also briefly discussed.

CHAPTER 3

DESIGN AND METHODOLOGY

Purpose

The purpose of this study was to 1) explore the experiences of four older women who have engaged in excessive consumption of alcohol and who also have documented symptoms of depression and 2) discover and examine common themes among the subjects' accounts, especially regarding aspects of occupational performance such as self-maintenance, work, and play/leisure. The research was conducted using qualitative case-study methodology and focused on the experiences of 4 subjects.

Research Questions

The study proposed to answer the following questions:

1. What are the experiences of a sample of older women with prior alcohol abuse and documented depressive symptoms?
2. How do the subjects explain the relationship between their abuse of alcohol and their depressive symptoms?
3. What are the subjects' perceptions of the daily effect of alcohol abuse and depression on their occupational performance in areas such as self-maintenance, work, and leisure?
4. Are there common themes among the experiences related by a sample of older women with prior alcohol abuse and depressive symptoms, particularly in regard to occupational performance?
5. What information garnered in this study could be of use to occupational therapists in their intervention efforts with this population?

Subjects

The research sample was one of convenience attained voluntarily through the Chemical Dependency Recovery Group of the Senior Day Treatment Center (Senior Focus) at a Bay Area hospital. The primary criteria for subject selection comprised the following conditions: all were women 65 years of age or older with clinical documentation of alcohol abuse, currently members of the chemical dependency group, and in active pursuit of recovery from their addiction. A secondary criterion for the subject selection was documented depressive symptoms, not necessarily an Axis I Major Depression diagnosis (American Psychological Association, 1994). Satisfaction of the above criteria was confirmed by the group's leader (a social worker) and was further corroborated by the patient's statements and interview findings.

All subjects were members of a group that met at a regularly scheduled time in an easily accessible location. They also were women already actively discussing and analyzing their abusive and depressed behavior, thus facilitating the attainment of more credible data. The subjects received no benefits from participating in the study other than knowing that their shared experiences might assist health care providers to better understand the interactions of prior alcohol abuse and depressive symptoms in the older woman.

The Instrument

The instrument (Appendix A) was developed by the researcher exclusively for use with the sample in this study. The guideline was developed from a combination of the researcher's prior experience with the population to be studied, a review of relevant literature (Cummings, Strull, Nevitt, & Hulley, 1988; DePoy & Gitlin, 1994; Kibele & Llorens, 1989; Krefting, 1990) and

comparison with other similar interview instruments. The interview guideline was divided into seven general sections including early life and family experiences, perceptions of occupational performance before the occurrence of alcoholism and depressive symptoms, perceptions of occupational performance during the occurrence of alcoholism, perceptions of occupational performance during the recovery process and in current functioning, experiences with depression, the role of occupational therapy in recovery, and general observations about the subject's experiences with alcoholism and depression. The general topic headings and specific questions within each were developed according to their relevance to alcohol abuse, depression, and Occupational Performance. The questions were also designed to elicit and guide the recollections and speculations of the subjects to be interviewed. Revision suggestions and approval for use of the interview guideline were received from the Chemical Dependency Group leader (a social worker), several professors of the occupational therapy curriculum, the thesis advisor, and peers who were also engaged in the development of similar instruments.

Procedures

The data were collected by one-time interviews using a pre-approved interview guideline prepared by the researcher to guide the interview (Appendix A). Permission to collect data at the Senior Focus Center was given by the director of occupational therapy services at the facility (Appendix B) and subjects were asked to sign a consent form (Appendix C) prior to the interviews, permitting the research to be undertaken and for the data to be used in the written report. The four interviews lasted an average of 52 minutes, with the longest one lasting 1 hour and 10 minutes and the shortest,

35 minutes. Confidentiality was maintained by using neither the subjects' names nor any other identifying information in the data analysis or study results. The subjects were referred to by number only so as to ensure confidentiality while eliminating confusion.

The four women were asked pre-formulated and approved questions (see Appendix A) relating to their experiences, and given the option of answering additional questions as deemed appropriate by the researcher, always with the option of halting or discontinuing the interview process. The interviews took place at the Senior Day Treatment Center in a setting that was comfortable for the clients. Because of the age, diagnoses, and concurrent health conditions of the subjects, the interviews were limited to approximately 45 minutes to 1 hour or until a sense of closure was perceived by the interviewer. The need for a second interview was assessed by the interviewer at the end of the allotted time period and was not found to be necessary in any of the cases. The interviews were taped, then transcribed into written form. All of the data were kept in a locked desk drawer in the researcher's possession and then destroyed following the conclusion of the study and written report.

Data Analysis Procedure

The data analysis consisted of listening to and transcribing the taped interviews into written form. By careful attention to and exploration of these transcribed interviews, common themes among these subjects' accounts were identified and are further discussed in Chapter 5. Direct quotations and thoughts from the subjects regarding the research and interviews are included to illustrate the themes and ideas that emerged from this research.

CHAPTER 4

DATA AND RESULTS

The data were collected through one-time interviews at the Senior Focus Center at a Bay Area hospital. All of the interviews were conducted on the same day as a way to increase consistency among the interviews, ensuring that the interviewer conducted the research similarly with each subject without a significant lapse of time between interviews. The data are presented first through chronological reviews of the subjects' experiences as reported in the interviews, then organized according to the format of the interview guideline (see Appendix A), and finally to answer the research questions posed for this study.

The Participants

The four participants who were interviewed for this study were all members of the Chemical Dependency Recovery Group at the Senior Focus Center at a Bay Area hospital and had documented depressive symptoms. All were women between the ages of 65 and 70 years of age. The age of onset of drinking problems ranged from about age 20 (college years) to age 60 (after retirement). Symptoms of depression were noticed by the subjects as early as the teenage years to as late as age 60. Three of the subjects are currently married and one is divorced. All of the subjects were able to share their experiences with alcohol and depression, though some shared more than others.

Subject One

Subject One is 67 years old, has been married for 46 years and has seven children. She started abusing alcohol at the age of 29 and although she was

diagnosed with severe depression only 6 months ago, she feels that she "probably was depressed all these years but nobody put a label on it." She stated that she thinks she experienced alcoholism and depression most of her life because "I had a lot of problems and I still have a lot of problems and I had problems all through the years."

Subject One remembers her childhood as a lonely, dark time. She reported having few friends because her father was in the armed forces and the family was transferred too often to make many lasting friendships. She was sexually and physically abused as a child and "not liked" by her father when she was a teenager. This participant recalled being a good student in high school and really enjoying the sciences--anything that challenged her intellectually. She was admitted to a 4-year college and received her degree in the behavioral sciences. She became a member of a very exclusive junior league toward the end of the war and went to tea dances and parties with Naval officers. This began her exposure to alcohol--"Pink Ladies," "Singapore Slings" and other exotic drinks. The abuse from her father, however, continued throughout this time and, unable to tolerate it any longer, she moved to San Francisco and "never went back for the rest of my life--and I'm their only child and they didn't seem to care."

She married soon after moving and remembers being depressed because she was "living in abject poverty, for one, and, two, I was always pregnant--I even lost two in miscarriages." She stated that she loved her little children and enjoyed being with them, but found herself in a similar situation as when she lived with her father--a man who yelled at her all the time and always told her what to do. She stated that she and her husband took raising the children as a great responsibility, but "when they got to be teenagers the whole lid blew

off of everything and that's when I started drinking." The atmosphere of the 1960's also presented a challenge to her in raising her teenage children. She remembered them as wild and that she couldn't control them. She said that making the decision to send them away to a foster home in the country and a convent to be raised was a very difficult decision, but she believed that they might then graduate from high school and benefit from being in a structured environment.

Subject One reported that the problems that she was experiencing with her family definitely led to her abuse of alcohol. She recalled complaining to her father when she was 29 about "all the problems in my life and he set the bottle down on the table in front of me and said, 'have a drink of this--it'll make you feel better.'" For the next 20 years, as a result of her father's advice, her turbulent marriage, her children's continuing battles with the law, and her own depressive state, this subject found comfort in alcohol. "There was nothing I could do except for reach for a bottle of cheap wine . . . I mean, who wouldn't drink?"

Subject One gave birth to her last child at age 37, 8 years after her other six. She began working as a junior clerk at a junior college at age 41, working her way up to management and pursuing a second degree in the process. She stated that while she did not drink while at work, the cocktail hour occurred daily at 4:30 PM and she would come home to her bar in the kitchen and start her evening drinking. She reported that "somehow I'd manage to cook dinner and have it on the table when my husband came home" and denied having had any problems with performing her daily activities at that time. When her daughter was 10 years old and became active in volleyball, Subject One began "really having a feeling that I couldn't control it [the alcohol]." She was able

to recognize her problem as a result of not being able to go to her daughter's volleyball practices because at that time of the evening she was "four sheets to the wind." She stated that it was a feeling of guilt that led her to go to Alcoholics Anonymous (AA). She began going to AA meetings every night without missing a night for 9 straight months.

Subject One stated that after the period of regular attendance at AA meetings, she was able to stay sober for more than a year-and-a-half. Subsequently, she frequently fell back to drinking for a week at a time and then stopping for long periods. She reported that her drinking was usually triggered by going to a party or being in a social situation where alcohol was available in great supply. She started conducting research for her master's thesis during the evenings after work; this occupied her time and kept her away from alcohol to a large degree. This subject stated that she was and still is able to control her drinking since having gone to AA. However, to this day, she still has periods of "on and off" drinking. She stated that she would be out of control for a few days and then would say, "no, I don't want to have to go through that again. You don't want to have to stop again. If you start, you have to stop." She retired 2 years ago from her position at the city college after 25 years of service. At about the same time, the subject's 94 year-old mother moved into her home. Subject One reported having to make a "big adjustment" to these changes in her life. She also stated that she missed talking about "meaty subjects" with her colleagues at the college and did not enjoy using her retirement time to take care of her mother.

In December of 1992, just before New Year's Eve, Subject One remembered drinking alone one evening, thinking about all of her problems and of her son who had just been rushed to the hospital after an almost fatal heroin

overdose. The thoughts "kept getting worse in my head and I just like a zombie went upstairs and wrote my husband a note to tell my kids and my mother I love them." She swallowed a bottle of pills, but her husband discovered her and called an ambulance before the combination of alcohol and pills had taken full effect. During her stay in the hospital following this incident, Subject One repeatedly told social workers and hospital personnel that she could not believe she had done such a thing. The incident made her realize that "I'm not really cured of alcohol if I can drink that much that I don't really know what I'm doing, which I didn't." She also received a diagnosis of Major Depression at that time.

Part of Subject One's recovery program was to begin attending the Senior Focus Center and become a member of the Chemical Dependency Group. Although she still does not define herself or her behavior as alcoholic and admits to drinking occasionally, she does recognize that she has a problem with alcohol. Subject One stated that her depression has interfered with her daily activity. For six months she was unable to engage in any household chores, social activities, or schoolwork for her thesis. She said that during this period she did not receive any support from her husband. When he would demonstrate his disapproval of her, she would run to the bedroom and "go into this black hole for about 36 hours." She says that her new medication is giving her some energy and interest in activities again, but she fears "over-doing it" in case she starts something and then is unable to continue due to her depression.

Currently, Subject One attends Senior Focus three times a week and is looking forward to restarting her volunteer job with Friends of the Library and perhaps taking a few classes.

Subject Two

Subject Two is 66 years of age and divorced. She stated that she began abusing alcohol at age 32 and only since her recent surgeries has experienced severe depression. Subject Two reported a normal childhood and teenage years. Her troubles with alcohol began during her marriage. She stated that her husband was "very protective and very possessive" and she experienced quite a bit of domestic violence in her years with him. He was a very successful liquor salesman. His business required a great deal of entertaining and drinking and she participated by inviting many people to their home for cocktails and dinner. Subject Two stated that her husband had a hard time with alcohol and "couldn't handle any of his addictions." She did not recognize anything in herself at that time as being characteristic of an alcoholic.

After Subject Two and her husband had three children, he switched jobs and traveled extensively. He became "very much of a womanizer then" as she stated. The emotional tension between Subject Two and her husband grew until the pressure was too much for him. He quit his job and tried to "find himself" in another line of work. He left Subject Two with three children and no income or support. She went to work as a cocktail waitress while her spouse attempted other small jobs--all of which failed. Subject Two remembered sitting at that time at the bar in their home and "I made myself a martini and I had that martini and it just like relieved me of all these fears and awful feelings, insecurities--monetarily as well as emotionally." She began "indulging" herself regularly and enjoyed the feelings that came with intoxication. She eventually suffered a nervous breakdown, after which she decided to leave her husband and find a new life for herself and her children.

Subject Two stated that for several years afterward, her husband made efforts to rectify their relationship, "stalking me and terrorizing me and begging me," trying to get her and the children back. She was both emotionally compromised and heavily into alcohol as a result of the terror she experienced during this time. Knowing that their marriage was over, Subject Two filed for divorce, though he was never fully out of her life after that time. She subsequently went to a trade school to become a clerical receptionist and support herself and her children.

Subject Two asserted that she was a functional drinker all through her working years, never experienced hangovers and never lost a job over alcohol. She was compulsive in caring for her children, her home was spotless, and there was always food on the table. Subject Two admitted that she was very "self-destructive" in her drinking patterns, but holds to the belief that the alcohol enabled her to survive through those years. She remembered going to bed drunk every night and having large and lavish parties in which alcohol was always involved. As her children grew older, she realized her dependence on alcohol and began to "get the shakes in the mornings;" she went to a doctor who failed to recognize any symptoms of alcohol abuse and instead prescribed tranquilizers to be taken daily. Subject Two stated that she "had a real habit going" after that. She admitted that during the 1970s she tried to overdose on pills three times because of depression, alcohol abuse and fears of her husband hurting the children. Today, she explains those incidents as "trying to tell somebody that I can't deal with this anymore."

Though she still is not able to discuss the details of her son's death, this tragedy that happened several years ago had a profound effect on Subject Two. At the time, all of her children were grown and she was alone, so she moved

nearer to her two remaining children for added support. She was working, but realized that she could not handle the alcohol any longer, was beginning to get sick and felt very depressed. She entered an alcohol rehabilitation program and has achieved sobriety, but the depression has remained. Subject Two attends Alcoholics Anonymous occasionally and finds strength in some of their teachings and from contact with the members. Subject Two reported feeling fairly comfortable with her alcoholism at this point, but wants to concentrate on her "mental [state]--where am I going, like I'm spinning my wheels now, I need to find a place in my life." She also has found help through coming to the Senior Focus chemical dependency group. Subject Two stated that she does not have any specific hobbies or activities that occupy her time currently. She has indicated a future goal of finding a job that does not just keep her busy. She stated, "I want to do something that I can maybe get a tad little bit of pleasure out of."

Subject Three

Subject Three is 70 years old and married. She stated that there was "nothing spectacular" about her childhood or young adult life. She raised four daughters and for several years took care of her mother and mother-in-law, both of whom had been widowed. She stated that she was very content when the children were growing up, though she did not have any interests or activities outside of her everyday responsibilities and chores--"you just didn't do those things very often. I was very busy." She reported making dresses and coats, reupholstering furniture, washing and cleaning, doing laundry, and cooking for her mother and mother-in-law. She acknowledged that her husband was inclined to be depressed and grumpy most of the time, though it was not unbearable until in the later years.

Subject Three worked for 7 years at a private golf club as a bookkeeper during and after the time when her daughters were in college. She was forced to resign when her vision grew too poor to work. During her working years, she developed the habit of having a few drinks before dinner to perk up her spirits. This habit continued and grew into a nightly drinking pattern, until at age 60 she realized that she was "definitely drinking too much." Looking back, the subject speculated that she probably drank as much as she had because she was overtired. She was constantly asked to babysit with her daughters' children on short notice or stay with them when their husbands were away on business trips. Subject Three had an exhausting tendency to care for and "worry so much about everybody else."

Subject Three's daughters suspected that she was being verbally abused by her husband during this time as well. Although they attempted to intervene and confront her husband regarding the alleged behavior, Subject Three did not report that any significant changes in his behavior occurred afterward. From this period of her life onward, Subject Three drank heavily for 8 years before she was able to stop drinking for approximately 2 years.

This subject suffered a temporary relapse into her old drinking patterns after this period of abstinence. Subject Three stated that she became "more and more depressed because I thought my life was completely hopeless." Two of her daughters noticed her increased depressed mood and slurred speech over the phone and confronted her with her abuse of alcohol. Although Subject Three did not stop drinking right away, she expressed that it was nice to know that "they really cared a lot about me, so I stopped drinking" eventually. She began attending the Senior Focus Chemical Dependency Group and found the support and friendships of the other members to be

helpful in her recovery. This subject did not find Alcoholics Anonymous to be a significant source of strength. She has found, however, that a big factor in her abstinence is not wanting to have wasted the time and energy of all the people who have worked with her at Senior Focus.

Subject Three still is not a "jovial, happy, on top-of-the-world person with my situation, but I think I'm making about the best of it that anybody could." She continues to have difficulties with her husband's mood and one of her daughters is fighting second stage breast cancer. Subject Three has started putting herself and her needs first in her life and doing things that give her satisfaction. She attends Senior Focus twice a week, is taking an oil painting class, and meets friends or her daughters during the week for lunch or for long walks. She is thinking about getting a dog in the future and taking croquet lessons.

Subject Four

Subject Four reported that she is over 65 and has been married over 40 years. She has two children, seven grandchildren, and has lived in various parts of the United States. Although her mother died when she was 3 years of age, she claimed to have had a "normal girl's type of childhood" while living with her father and two aunts on Long Island. Her interests at that time were swimming and dancing. She stated that she won many awards for swimming and almost made the Olympic team. She did well in school and made some lifelong close friends in her younger years and stated that she had a "very happy life."

Although Subject Four did not drink alcohol while in high school, she remembered her first drink was a highball in college. The subject was a student at New York University and was a member of a sorority during those

years. She claimed that this had a profound effect on her alcohol use, as the college was surrounded by bars which were the "hangout" of the sorority and fraternity members. "We'd have quite the parties," she remembered and recalled getting sick during the very beginning of her drinking experiences because she did not quite know what she was doing and was drinking too much. However, Subject Four was "just doing what everybody else was doing" and in those days there were no lectures or information telling of the dangers of alcohol use. This subject was unable to remember any social engagement from her youth in which alcohol was not involved. She stated, nonetheless, that it never interfered with her classes or schoolwork and so she was able to graduate with a degree and become a sales consultant at an exclusive department store.

Subject Four married soon after graduating from college. Her husband was involved with the film industry, and the couple had many opportunities to go to movie openings and other extravagant social engagements. They also moved around the country with his job and made many acquaintances through the years with whom they often went out to dinner and socialized. The subject also recalled being a member of a church craft guild that would serve alcoholic beverages during its meetings and other church affairs. She stated that she and her husband have always been social drinkers and the people with whom they interacted were also. At times, the subject would stop drinking for years at a time, but a social situation or a party would trigger her drinking. "No one I knew ever discussed alcohol, ever . . . and I never thought a thing about it." She stated that throughout her working years and while raising her children, alcohol never interfered with or compromised her abilities to perform her daily activities.

The subject retired after 26 years as a sales associate for an exclusive department store. Her children were grown and away from home by then but she still had a few charity activities and social events to occupy her time. She stated that she loved to cook and would spend many hours each day in the kitchen. She kept a glass of wine on the counter while she was cooking, constantly refilling it throughout the day. The subject recalled that her son noticed this behavior with more concern than usual but he made no comments to her regarding his thoughts. Last year, the subject decided one day that "I've got to quit drinking wine. I'm gaining weight." She stated that this was her only reason for quitting--weight loss only, not due to interference in her daily life or functioning. However, she stated that she must have been drinking too much because she "went through all the symptoms, all the horrible symptoms" of withdrawal. She, along with her doctor, did not think anything of it and could not discern the source of her physical and emotional complaints following her abstinence. Her son and daughter encouraged her to go to Alcoholics Anonymous meetings, but after finding that this did not work for her she checked into a hospital and was directed to Senior Focus for outpatient treatment in the Chemical Dependency Group.

Subject Four admitted to having been depressed or in low spirits at various times throughout her life. She has seen a psychiatrist and has been diagnosed with depression, for which she is now taking medication. However, she still needs reminding from the staff at Senior Focus to "learn how to love yourself." This subject stated that she has since experienced a great deal of pain and fatigue associated with accomplishing her daily activities. She is able to accomplish a small amount of activity interspersed with plenty of rest, but still does not go out as much as before because she does not feel quite well enough

yet. In addition, she is not allowed to drive due to frequent dizzy spells and blackouts. Her goals are to take on one hobby, attempt to hold a dinner party, ease back into her social groups, and go to parties.

Results According to the Interview Guideline

These four subjects were asked questions regarding their early life and family experiences and about aspects of occupational performance (self-maintenance, work, and leisure) before and during their interactions with alcohol and depression, as well as during the recovery process. The subjects were also interviewed regarding their current functioning and the role that occupational therapy played in their recovery. Finally, these participants in the study were asked for general observations and remarks in reference to their experiences.

Early Life and Family Experiences

The early life and family experiences have been detailed in the preceding section on the subjects' profiles. However, a brief summary of their accounts will be presented here. Three of the subjects spoke of having a normal girl's childhood. Subject One, however, reported that she was lonely and sexually abused during her formative years and had experienced depressive symptoms since childhood. Subject One and Subject Two reported violence in their marriages and/or adult lives. Subject One encountered many difficulties in raising seven children during the 1960s and attempted suicide three times during her life. Alcohol became a coping method for this subject but she was eventually able to hold a job for 25 years and pursue a graduate degree before entering rehabilitation. Subject Two eventually left her husband and raised her three children alone. She endured countless challenges in her life and alcohol also entered early as a method of coping with her problems. Subject

Three and Subject Four, however, recalled unremarkable adult lives and marriages. Subject Three remarked that she was always taking care of everyone else's needs and worked very hard raising her four daughters and caring for her "grumpy" husband until she recently began to put herself first. Subject Four raised two children in a happy marriage and worked for 26 years as a sales consultant in a department store.

Perceptions of Occupational Performance Before Alcoholism and Depression

None of the subjects reported difficulties with or dysfunction in their lives in the areas of self-maintenance, work, and play/leisure before the onset of alcoholism. Subject One stated that although she suffered psychological trauma from loneliness, sexual abuse, and violence in the early years of her marriage, she was always able to take care of her young children and herself and attend to her responsibilities without difficulty. Subject Two also had a violent marriage, spent years fighting off her estranged husband, and suffered a nervous breakdown; yet she also asserted that she was able to put aside her troubles to attend to the everyday needs of herself and her three children. Subject Three reported "nothing spectacular" from her years before alcoholism and instead stated that she always kept very busy with the household chores, raising the children, and caring for her mother and mother-in-law. None of these 3 subjects held a job before the onset of problems with alcohol and they also were unable to describe any leisure activities in addition to raising their families and attending to housework. Subject Four stated that she never had any problems taking care of herself, attending school, or having a good time with friends before her use of alcohol started. It should be pointed out, however, that she started drinking at a young

age and therefore did not have the additional responsibilities and difficulties of adulthood to attend to at that time.

Perceptions of Occupational Performance During Alcoholism

Subject One continued her assertion that despite her difficulties with alcohol, she was always capable of providing for her children, attending to her job, and continuing her education without having the interference of alcohol. She reported interacting with others on a social basis where alcohol was almost always involved. Subject One attempted suicide toward the end of her years of alcohol abuse reportedly due to depression and dissatisfaction with her life. In addition, she felt that retirement and her mother moving into her home required large adjustments in her life at that time and that perhaps she wasn't able to successfully incorporate the accompanying new roles into her life. Subject Two reported that alcohol did not interfere with the other parts of her life concerning work or caring for herself and family. Like Subject One, Subject Two also attempted suicide in response to her depressed state and preoccupation with her family's problems. She, like Subject One, had difficulty discussing leisure activities that did not involve alcohol or were not alcohol-related.

Subject Three stated that her alcohol use "never seemed to affect anything but me." She was otherwise able to attend to her personal needs and the needs of her family and hold a rewarding job for several years. She complained of feeling overworked and that she was taking care of others so much of the time that it made her overtired. She, like the 2 aforementioned subjects, also indicated a lack of leisure and pleasurable activities in her life at that time. Subject Four stated that alcohol "never bothered me." She reported being able to raise her children, to hold a job for 26 years, and to pursue charitable

activities without alcohol interfering or compromising her abilities. She did, however, greatly enjoy cooking for large groups and hosting dinner parties, at which she would drink alcohol for extended periods throughout the event.

Perceptions of Occupational Performance During Recovery
and Current Functioning

All of the subjects shared similar experiences regarding their recovery processes and current functional capabilities, as described in the following section. Subject One stated that since she has stopped frequent drinking (she still will drink on occasion), her depression has taken over and interfered with her accomplishment of daily activities. Her depressive symptoms were so severe that she could do little more than get out of bed each day for 6 months. A typical day for her has been "getting up, eating breakfast, and going back to bed." Although she has begun some new medication which has given her renewed energy and interest in activities, she is hesitant to do very much for fear that she will be unable to continue with what she started. She speaks of restarting some volunteer work and taking a few classes but only recently has been able to help around the house and therefore has no leisure activities or interests as yet.

Subject Two stated that she feels better and is able to take care of all of her needs since the start of her sobriety. Besides attending groups at Senior Focus, she has begun to read, listen to music, and go to plays. A typical day for this subject is taking a walk in the morning, listening to some music or reading, and going out with friends or family. However, right now she's "just going through the motions." She plans on finding a job or some form of meaningful work in the future.

Subject Three reported that she has started to "be more selfish. I try to think of myself first and keep up my spirits. . . . I realized that I had never lived my life just for myself." A typical day for this subject involves preparing meals and watching television on the days after attending Senior Focus, or baking, taking long walks, painting, and meeting her friends or daughters on other days. Although she tries to keep busy with these activities, she still wants to pursue other things such as raising and training a dog.

Subject Four stopped drinking on her own and experienced very painful physical symptoms of withdrawal for months afterward. She suffered from exhaustion and developed depressive symptoms, both of which just recently are beginning to clear up with medication. However, she still refrains from engaging in too much activity. She is able to take care of herself and the most basic housework needs, but refrains from taking on any hobbies or other leisure activities in case she becomes too tired.

Experiences with Depression

Each of the subjects interviewed shared her personal experiences with depression and the relationship that it had to alcohol abuse. Although many of the details are different in each of the subjects' accounts, some of the experiences have similarities, suggesting some common themes for discussion later in the study.

Onset of Depression

Each of the 4 subjects reported her age at the time of onset of depression or depressive symptoms and perceived precipitants to mood changes. Subject One stated that she believes she has been depressed for most of her life "but nobody ever put a label on it until now." She experienced a lonely and abusive childhood and later a violent marriage, both of which she believes reinforced

her already existing depressive state. Subject Two experienced many years of emotional trauma in her younger adult life, yet does not feel that she experienced any depressive symptoms until age 60 (6 years ago) when she began to realize her alcoholism was a problem and her health began to decline. She received a formal diagnosis of depression only recently after several surgeries that she sustained presumably precipitated a "personality change" and she was referred to a psychiatrist for evaluation and treatment. Subject Three also reported that she began to become really depressed in her sixties because of thoughts that "my life was completely hopeless." She stated that she had lived her life always worrying about others and taking care of everyone but herself. These experiences, in addition to the tense relationship she had with her husband, were seen to be the factors that led her toward her depressive state. Subject Four reported that she experienced days of low mood periodically throughout her life just as anyone would, yet after she stopped drinking and went through the withdrawal experience, she was formally diagnosed with depression and has been treated by a psychiatrist for several months.

Relationship Between Alcohol Abuse and Depression

Subject One, who reported that she probably was depressed most of her life, stated that she began using alcohol as a way to relieve her anxieties about the problems that were occurring in her life. She recalled many difficulties with her husband, her children, and her ability to cope, and she reported feeling that her resulting depressed state could be temporarily relieved by drinking alcohol. Her father had told her that drinking would make her feel better. She stated then, "There was nothing I could do except . . . reach for a bottle of cheap wine." Subject Two reflected on similar experiences with alcohol use

and depression. This particular subject stated that she had many fears and worries in her younger years--raising her children, dealing with her husband's mood swings, and sorting out financial difficulties and her own compromised emotional state. She remembered one particular drink she had at that time which made her feel "relieved of all these fears and awful feelings . . . it was a wonderful feeling." From that point on, she indulged herself to relieve her depression and increase her positive feelings in coping with the stresses in her life.

Subject Three stated that it was a combination of her husband's "pretty bad disposition" and the demands that others put on her which led her to start drinking. This subject's mood became increasingly more depressed as she felt that her life was hopeless, yet after having a drink "I'd feel better and so then I'd have another one." This subject used alcohol to boost her mood and help her emotionally through her daily life. Subject Four related that she began drinking in her college years simply because it was what "everybody else was doing." The depressive symptoms emerged later after she quit drinking and alcohol no longer masked her depression. Though she was hard pressed to find a relationship between the two, she believed that "it got bad after I retired. I didn't really have a hobby" or too many other activities in which to involve herself.

One of these 4 subjects, Subject Three, described an alcohol and depression scenario which may apply to others as well as herself. She described the relationship between alcohol and depression as a vicious cycle in which you start drinking because you feel better and then you keep drinking and then you don't feel better - you feel worse and worse and think, well if I

have another drink I'll feel better and at that time you're in a fog and you don't realize that you're not feeling better, you're feeling worse.

In this description, alcohol was used to relieve depression, after which it only served to worsen the depression and the cycle continued.

Perceived Effects of Depression on Performance

Although for 2 of the 4 participants it was a combination of the depression and alcohol abuse that affected their performance, 2 subjects, Subject One and Subject Four, reported distinct effects that their depression had on their ability to carry out everyday activities. Subject One stated that since she has stopped drinking, her depression has been the primary hindrance to her ability to lead a normal life. She said that a typical day is "getting up, eating breakfast, and going back to bed." This subject is becoming increasingly able to help out with small chores, however, is fearful of doing too much or restarting her prior activities in case she falls back into her "black hole" again. Subject Four also reported a similar decreased confidence in her abilities and low motivation to engage in activity. Her daily routine consisted primarily of going to Senior Focus, performing small chores around the house, and watching television in the evenings. In terms of occupational performance, all of the subjects reported low motivation or fear of engaging in leisure activities, though a few of the subjects are making progress in pursuing their interests.

Role of Occupational Therapy in Recovery

It was discovered during the interviews that these subjects had little, if any, contact with occupational therapy or an occupational therapist during their recovery process. It was also discovered from the interviews that the subjects shared a poor understanding of occupational therapy. Subject One

stated that she had told her family and physicians that she would not attend groups at Senior Focus if occupational therapy was to be one of them. She spoke of the group as "kindergarten stuff--cutting papers and pasting them." This subject stated that she would be more inclined to participate in occupational therapy groups if they dealt with something that was of more interest to her, such as learning a new art skill like oil painting, water color, or drawing. Subject Two, after receiving clarification on occupational therapy services from the interviewer, stated that she saw someone before a recent surgery at a local rehabilitation center whom she thought fit the description. She spoke of learning computer skills, taking aptitude tests, and receiving job skills training for future work goals. Subject Three admitted that the chemical dependency group met at the same time as the occupational therapy group and so she, as well as the others in her group, were unable to attend. However, she felt that her oil painting classes and artwork that she does at home were "just like that" and that the occupational therapy group at Senior Focus was just to "keep those people busy." Subject Four said simply that she did not have time to attend the occupational therapy group.

General Observations

All of the subjects agreed that the dangers of alcohol use were not discussed at the time that they began their habitual drinking. The subjects also agreed that they were raised at a time in history when people engaged widely in alcohol use at parties, social engagements, and even in church, and it was not at the time seen as a potentially harmful or addictive substance. Subject One, regarding a tape that she had seen on the effects of alcohol on the body, asserted that "if I could've looked at that, no, I would not have lived the life I lived as far as alcohol is concerned." Subject Three remarked that despite

having visited several doctors while she was depressed and drinking, none of them recognized her symptoms for what they were and even encouraged her to have a few drinks for her health. "It was really strange . . . because that was at a time when I really did get depressed and it wasn't a good time to be drinking, " she remembered. She believed that there should be more awareness in the medical community regarding the abuse of alcohol among elders and the depression that often accompanies it. Subject Four reported that "it was not a problem in those days." However, she concluded that "I know I won't drink again from all the things that I know now and didn't know before."

All of the women agreed that the Senior Focus chemical dependency group was beneficial to their recovery process and has provided support by helping them to set goals for their recovery, promoted interaction with other alcoholics, and facilitated discussion and insight into their problems with drinking and depression. Subject Three stated:

I feel personally that now, if I wanted to drink too much, I'd feel that I couldn't do that because I'd be wasting all of the energy that these people down here have put in--you know, the confidence, caring, and sharing--you know, it's more than you get from the family or anyone.

Research Questions and Results

The data gathered in this study have provided answers to the following research questions.

Question 1: What are the experiences of a sample of older women with prior alcohol abuse and documented depressive symptoms?

The life experiences of four women fulfilling the above criteria were explored through one-time interviews conducted at the Senior Focus Day

Treatment Center. The experiences of these women were varied; yet several common themes emerged which will be discussed briefly in the answer to research question number 4 and in more detail in Chapter 5.

To summarize briefly, the childhood and adult lives of the subjects were filled with varying degrees of goal-accomplishment and achievement, marriage and divorce, sexual and physical abuse, loneliness, domestic violence, impaired family relationships, hard work at the expense of their own happiness, and gratification. Each subject experienced depression as a response to stressful stimuli and began to drink alcohol as a further response to that depression. Subject One, who stated that she was depressed throughout most of her life, felt that her family and marital problems in her late twenties, coupled with the influence of her alcoholic father, led her to drink in order to make herself feel better. Subject Two stated that she began feeling depressed in response to marital and financial troubles and soon found that alcohol served to decrease her anxieties and gave her "a wonderful feeling."

Subject Three realized her depression during her working years, while also attempting to meet the never-ending needs of her family. A drink after work made her feel better and increased her ability to get through the rest of her day. Subject Four began drinking socially as a college student, but the habit progressed and grew to its worst after she retired and realized that she had lost a large part of her life when she left her worker role. Her depression manifested itself at this time and drinking served to facilitate her coping abilities until she sought treatment for her problem.

All of the subjects found that they needed extra help after ceasing their alcohol abuse and, after being referred by their physicians to the program at Senior Focus, they found that support in the chemical dependency group.

Although each woman is at a different stage in her recovery program, each is still dealing with her depression and attempting to manage her life more effectively without alcohol.

Question 2: How do the subjects explain the relationship between their abuse of alcohol and their depressive symptoms?

Although one subject had difficulty defining the relationship between alcoholism and depression according to her experiences, the 3 other subjects explained this relationship in fairly similar terms. The subjects stated that the stresses in their lives initially led to a state of depression or the onset of depressive symptoms including feelings of hopelessness, inability to cope, and general disenchantment with the present state of their lives at the time.

Although driven to drinking by different means, these women found that alcohol was an effective, though unhealthy, means to make themselves feel better in the midst of their problem-filled lives, even if only temporarily. The experience of relief and the seemingly "wonderful" feelings that the alcohol induced served to lessen the subjects' depressive state and increase their ability to cope with their lives. Subject Three stated retrospectively that the relationship between alcohol abuse and depression was an unhealthy one:

you start drinking because you feel better and then you keep drinking and then you don't feel better--you feel worse and worse and think, well if I have another drink I'll feel better and at that time you're in a fog and you don't realize that you're not feeling better, you're feeling worse.

Although alcohol was initially used by the subjects as a means to feel better, the long term effects of continued use only served to worsen their depression and magnify the problems they were facing in their lives. Their perceived

relationship between alcohol abuse and depression was one of alcohol initially relieving the depression, yet eventually becoming a cyclical relationship, each making the other worse as time and abuse went on.

Question 3: What are the subjects' perceptions of the daily effect of alcohol abuse and depression on their occupational performance in areas such as self-maintenance, work, and leisure?

It should be noted that, in surveys of activities of daily living (ADL) performance which is self-reported, the tendency among older adults is to slightly overstate their abilities; yet, when observed, they perform these activities at a lower level than reported (Skruppy, 1993). However, the same research has shown that although self-reported functional abilities are not always accurate in this population, subjects tested are honest about reporting that they do in fact experience limitations and dysfunctions in the areas in which they demonstrate the dysfunction and do not claim to be completely independent in performing an activity when they know they are not (Skruppy, 1993).

Keeping this in mind, the women interviewed for this study all indicated that they never experienced any difficulty performing any of their self-care or work activities, were able to provide for the needs of their family, and deal with the events that arose in their lives without difficulty. This reporting indicated perhaps that their alcohol use served, as Subject Two felt, to increase their ability to cope and survive during the tough times before and during their experiences with depression and alcohol abuse.

One area of occupational performance dysfunction, however, was discovered as a common theme among the subjects' experiences. The subjects

all related a lack of leisure activity and interests combined with a loss of social contacts and support. These women indicated either a decreased ability to pursue leisure activities because of other responsibilities, a declining interest in social and leisure pursuits due to depression, or a loss of resources due to a recent move or retirement as reasons they reduced their involvement in pleasurable activity. Since their cessation of alcohol abuse, they further stated that they lacked the motivation, the energy, and the resources to recommit or pursue activity outside their daily routine. Fear of not being able to fulfill commitments was also a driving factor in the hesitation of these women to involve themselves in volunteer work, clubs, and hobbies.

The precise relationship between their alcoholism, depression, and lack of leisure activity was not clearly defined and limited to the level of honesty and perceptions of the subjects. However, it is evident from their statements that they suffer an imbalance in their occupational performance activity. Physical, psychological, and emotional components of dysfunction all play a role in their inability to function in this area. Possible methods for occupational therapy intervention are discussed in the results of research for Question 5.

Question 4: Are there common themes among a sample of older women with prior alcohol abuse and depressive symptoms, particularly in regard to occupational performance?

It must be noted that despite the fact that these four women were the same approximate age and held similar diagnoses, each subject had a different story to tell regarding early life and family experiences, functional abilities, onset of depression and alcohol abuse, and degree of impairment caused by their

resulting states. However, despite the differences and variety of experiences in their pasts, which had in their individual ways promoted or exacerbated the alcoholism and/or depression, there were several similar ideas or needs discovered among the different accounts.

Five common themes emerged from the experiences of these 4 subjects. Alcohol abuse and depression as a response to stress, interpersonal relationships that supported the abuse of alcohol, imbalance in the occupational performance area of leisure, loss of social contacts and the benefit of a specialized support group were the common themes and experiences shared by the four women.

The degree of impact and duration of each of these areas differed for each woman; yet the research confirmed that there are commonalities among the experiences of women with prior alcohol abuse and depressive symptoms. Chapter 5 provides a more detailed discussion of each of these five themes.

Question 5: What, of the information garnered in this study, could be of use to occupational therapists in their intervention efforts with this population?

All of the subjects interviewed for this study indicated a lack of knowledge about occupational therapy and a general misunderstanding of the services that occupational therapists offer. It was further discovered that, due to attendance by these subjects in the chemical dependency group, they were not left with ample time to participate in the occupational therapy groups held at their facility, therefore they missed receiving the benefits provided by such groups.

A primary concern of occupational therapy is promoting a proper balance between self-maintenance, work, and leisure and to "assist patients in overcoming performance deficits related to living" (Christiansen, 1991, p. 32). It was discovered during this research that the subjects suffered impairments in social and leisure activity resulting in imbalance in occupational performance which proves to be a focal area for intervention for occupational therapy. The subjects in this study stated that lack of motivation and fear of engagement in leisure activities were a major hindrance to their pursuing activities. Subsequently, the common themes of lost social contacts and need for support from others during their recovery were identified by the subjects, thus further promoting feelings of isolation and inhibiting feelings of success in social interaction. The reasons for their fear and lack of motivation varied from fatigue and weakness to a fear of failure and inability to commit to activities and relationships. It was also ascertained that some of the subjects were encountering difficulties identifying and utilizing resources to pursue hobbies or social interests. All are possible explanations of the subjects' fear and dislike of occupational therapy--engagement in such a therapy group may have been too threatening to these women.

Therefore, an important role for occupational therapists in the treatment of this population is promotion of reintegration into a social sphere that can provide support, interaction, and leisure pursuits leading toward a more well-rounded individual in terms of occupational performance. Identifying stressors, teaching more effective coping strategies and strategies for finding and using community resources, and devising groups and methods for increasing self-esteem, problem-solving, and confidence in one's abilities are perhaps the most obvious interventions an occupational therapist can initiate

with a population having the needs identified in this study. The means to accomplish these tasks may vary according to the specific individuals involved and the resources available; however, occupational therapists will want to consider devising strategies with each patient to maximize her physical, psychological, and social abilities toward achieving their goals (Christiansen, 1991).

CHAPTER 5

DISCUSSION, RECOMMENDATIONS, AND SUMMARY

A detailed discussion of the common themes that emerged in this study is presented in this chapter. Recommendations for future research are also discussed. A summary of the study is also provided.

Discussion of Common Themes

This study explored the experiences of four older women who engaged in excessive drinking of alcohol and were also diagnosed with depressive symptoms. Interviews were conducted to gather data. Data analysis yielded five common themes related to the subjects' experiences with alcohol abuse and depression. The themes are alcohol abuse and depression as a response to stress, interpersonal relationships that supported the abuse of alcohol, imbalance in the occupational performance area of leisure, loss of social contacts and the benefit of a specialized support group.

Alcohol Abuse and Depression as a Response to Stress

A common theme in responding to stress with depression and alcohol abuse emerged from the interviews. It is widely acknowledged in the literature that alcohol abuse and depressive states are largely responses to stress (Dufour et al., 1992; Zimberg, 1974); however, it has also been found that more women than men reported higher levels of premorbid anxiety, admitted to being "worriers," and were depressed and alcoholic in response to tension and domestic problems such as family pressures or financial difficulties (Dunne, et al., 1993). The stress in these participants' lives ranged from a change in role status after retirement to dealing with family violence. Although the exact

causes were different for each person, every subject was able to describe stressful events in her life that eventually led to depression and alcohol abuse.

Subject One stated that she "had a lot of reasons to drink" and to be depressed throughout the years. Her stresses started as early as childhood with physical and sexual abuse from her father. She recalled being lonely as a child and being isolated from her family when she was forced to move out of the area to avoid the continuing abuse. She then married a man who was very demanding of her and treated her much the same as her father had. She raised seven children during the 1960s which posed a challenge for her to keep them off the streets and out of jail. Several of her children were taken away at one point and raised in foster homes. All of these stressful facets of her life resulted in a depression, and she found that the use of alcohol became a coping mechanism and made her forget about her troubles for a while. Looking back, she believes that the use of alcohol enabled her to survive through those rough times.

Subject Two endured many stressful situations before the onset of depression and alcoholism. She married a possessive man who could not support the family and was not loyal to her. They had no financial stability and were raising three children. The only way out that she could see was to leave him. She remembered how overwhelming all her anxieties and worries were at that time, but even more she recalled the relief she felt after her first real martini. Her drinking continued from that point, and the drinking of alcohol was used as a crutch for her depression and to enable her to cope with her ex-husband's violence and the distressing situations that were to come.

Subject Three stated that the stresses which were present in her life at the time she started feeling depressed included the health problems of her spouse,

which made his mood swings "unbearable," and the increasing demands placed on her by family members. She remembered being called by her daughters for emergency babysitting early in the morning and often was asked to drop everything and take care of problems in her children's lives. She also began to realize that she had never lived life for herself, and she subsequently fell into a depressed state in which she engaged in little activity and had no pleasures in her life. She found that alcohol enabled her to feel better for a while and relieved her of the worries about everyone else's problems. She realized at the time that she was "definitely drinking too much" but had no support from anyone to stop her addictive habits.

Subject Four stated that her depression and drinking "got to be bad when I retired." Her change in role status, from worker to non-working retired person, left her without an identity to hold on to. She lost a major daily activity, her social circle at work and much of the responsibility she had when she was working. She did not have a hobby and was involved in few activities outside her home. She remembered beginning to feel depressed at the time and realized that she was drinking too much as well.

Interpersonal Relationships that Supported the Abuse of Alcohol

Each of the participants in this study had a close relationship with a man (spouse or father) who was either an abuser of alcohol or other addictive substances or one who participated in the alcohol abuse with the subject. These relationships served to reinforce and often times initiate the addictive behaviors developing in the subjects. One could argue that these women were attempting to place blame on others for their drinking behaviors, instead of owning their actions and accepting responsibility for their alcoholism. However, it is acknowledged in the literature that alcohol-dependent women

"were more likely to have a parent (the father in particular), spouse, or sibling who was alcohol-dependent" (Dunne et al., 1993, p. 98). The issue of blame is one that may have contributed to these subjects' responses; however, the topic requires more inspection than was feasible with this study.

Subject One recalled that her father, after hearing the subject complaining about the problems she was having with her marriage and her children, put a bottle of wine in front of her and said, "have a drink of this--it'll make you feel better." In addition to the influence by her father to begin drinking, this subject also married to a man who shared in her alcohol-drinking, thus supporting this method of coping with her life's stresses. Currently, she states that she enjoys going over to the home of her daughter whose husband "drinks quite a bit," but this atmosphere creates further difficulties in her desire to remain in control of her drinking behavior.

Subject Two stated that her husband was a liquor salesman and together they would host large parties (with alcohol provided) for his clients. He later built a bar in the house for himself and his wife for use in entertaining; however, the subject remembers it as the place where she would go to relieve herself of all the anxieties and worries that she and her family were facing at the time she started drinking heavily.

Subject Three began having a drink or two after work with her husband when her children were in college. She began to take advantage of the good feelings it provided for her and continued her pattern, even after her husband had stopped drinking as much alcohol due to health problems. However, he continued to affect her drinking patterns when it developed into a coping behavior in response to his poor disposition and alleged verbal abuse toward her. Her friends, too, were all drinkers--"everybody drank" alcohol.

In addition, she received advice from her doctors that alcohol was beneficial for her and she should continue having some wine in the evening. The subject stated, "nobody ever said, 'well, why don't you limit yourself to one.' It was like everybody was encouraging me to drink!"

Subject Four started drinking in college when she and her husband-to-be were in a sorority and fraternity, respectively. The bars around their university were the "hangouts" for her and her friends, so it was natural for them to engage in alcohol use when in social situations. This subject and her husband continued this pattern, attending social functions, dinner parties, and work events in which alcohol was always involved. Because her husband continued to drink with her, this woman never questioned her drinking habits and never thought they were a problem.

Imbalance in the Occupational Performance Area of Leisure

All of the subjects in this study reported a low activity level and lack of pleasure in their lives. It is difficult to differentiate whether the lack of activity and pleasure were precursors to their abuse and depression, concurrent with their comorbidity, or life-long patterns; however, this theme was strikingly prominent in all of the subjects' accounts. Each subject experienced a lack of activity and pleasure at some point during their abuse, depression, and recovery periods, and it is interesting to compare the perceived relationships between each of the factors involved.

All of the subjects in this study reported a lack of activity and pleasure in their lives since their initial recovery period. Two of the subjects also stated that they experienced low activity and lack of pleasure prior to their recovery period resulting as factors leading to the pinnacle of their drinking habits. Subject One remarked that she had kept herself very busy with work and

school before her retirement a few years ago. The loss of her worker role combined with her mother moving into her home at the same time left her feeling unfulfilled. Since her hospitalization for alcohol detoxification, she has been unable to do much more than make a meal and sleep due to her severely depressed state, although she is trying to "force" herself to do more activity as she feels better. She stated that she wants to restart a volunteer position with Friends of the Library, an opportunity she had looked into before her hospitalization, but that she is also worried that she may not be able to continue any activity that she starts due to her depression.

Subject Two reported that because she had just recently moved to the area before going into a rehabilitation program, she had not been able to connect with any leisure activities or groups. She stated, "I don't have anything specific going on with me" in the way of hobbies or work and feels that "I need to stop spinning my wheels now . . . and want to do something that I can maybe get a tad bit of pleasure out of." She is looking for volunteer work and to perhaps find a hobby she can pursue.

Subject Three stated that before she stopped drinking she also did not engage in any activity just for herself. She worried about everyone else's problems and busied herself with housework and babysitting with her grandchildren. "I mean, I realize that I had never lived my life just for myself. Now I'm thinking more about it because my husband, if he's going to be happy to sit home all day and not do anything, I won't." Since her recovery she has attempted to increase the time that she spends in the activities she enjoys, such as oil painting and visiting with friends.

Subject Four said that it was after her retirement that her drinking became worse and her depression started. She had had no hobbies before her

retirement and only everyday housework was occupying her time after she retired. One of her goals at Senior Focus was to become involved in a hobby or activity she could do for fun. She stated, however, that "one that I'd wanted to do is garden, but I get awfully tired." She usually goes home, does some house work, fixes dinner, and then watches television before going to bed.

All of these subjects shared an awareness of not being involved in enough activity for their own pleasure, yet many also stated their fear of pursuing something new that they might fail to complete due to their depression and continuing battle with recovery. In terms of occupational performance, one can speculate that perhaps these subjects have concentrated so intensely in recent months on taking better care of themselves and dealing with their alcoholism and depression that they have been left with relatively little time and energy to pursue enjoyable activities. Their areas of occupational performance are in imbalance in the area of play/leisure.

Although each subject stated a desire to pursue an interest, they also share a fear of failure and must struggle to keep themselves involved in the few activities they have chosen. This fear of failure, as stated by the subjects, seems to be based on their experiences during the recovery period. The learned behavior and coping skills that each woman had before her recovery enabled her to effectively participate in all activities without compromising her abilities. However, since the subjects' experiences in recovery with withdrawal, increased depressive states, and losses of energy and interest, the subjects' perceptions of their own abilities have changed. These women have lost confidence in themselves and their sense of control over their actions. Through their recovery and counseling, they have realized that that control was based in their depression and alcohol dependency. With the absence of

these "crutches," the subjects are wary of beginning activities again without the guarantee of success to which they had been accustomed. For these subjects, engaging in activities, regardless of their familiarity, will be like starting something new for the first time.

Loss of Social Contacts

Besides being less active in leisure activities, these women experienced isolation from friends and family members and general loneliness due to the loss of previous social contacts in their lives. In some ways this is related to the imbalance of leisure activity and pleasurable pursuits that each subject experienced, as many personal relationships are rooted in activity and pleasure; however, relationships with others are not always entwined with one's activities. One's psychological well-being and self-esteem is also often intricately related to the number and depth of one's friendships and other interpersonal relationships.

Subject One began to experience more severe depression and alcoholic patterns after she retired from her job. She experienced increased depression and drinking behavior after retiring from her job of 25 years. She not only had been an employee at this facility but also a student, and she had interacted on a daily basis with many people--both in the office and in the classroom. When Subject One stopped working at the junior college, she lost contact with a great many people who had provided her with the necessary social interaction she craved. "I loved getting together with my colleagues and talking about meaty subjects," she remembered. Talking with her mother about the weather, she stated, was not an adequate substitute for the stimulating relationships she previously had.

Subject Two experienced increased social isolation as a result of her move northward to be closer to her children and their families. Although she enjoyed being closer to her children and grandchildren, she left behind many friends and co-workers who had formed this subject's social support group. After her move, she began to feel more unhappy and depressed, thus further inhibiting her from pursuing new friendships. Her drinking then increased to a point that she knew was out of her control.

Subject Three believed that her depression and alcohol use resulted from having lost contact with most of her friends and other people with whom she had previous relationships. She stated that since she has re-established contact with some of these people, she has regained a sense of self and is able to put herself and her needs first. She is increasingly able to engage in activities with friends and family since she has renewed some vital relationships.

Subject Four, like Subject One, said, "I think maybe it got to be bad when I retired." She had worked for 26 years as a sales consultant for an exclusive department store and after her retirement did not have the social contact she once experienced while holding her job. She began to engage in fewer activities and only those which were performed alone--cooking, gardening, and watching television.

The experience of social isolation and loneliness is not uncommon among the elderly. In addition, it is a common trait among depressed people and among alcoholics. For depression, "the most common precipitating events are losses that the elderly must confront: death of a spouse, close relatives or friends; retirement; illness; parenting role; prestige; and independence" (Molinari, 1990, p. 24). In a study of the prevalence of psychologic

impairment in an advanced-age population, "the strongest predictor of low psychologic well-being was low social interaction (Luke et al., 1982). Likewise, alcohol abuse is promoted by retirement with its boredom, change of role status, and loss of income; deaths of close friends and relatives and the knowledge that more will occur; poor health status; and loneliness (Brody, 1982; Schuckit, 1990). The subjects in this study exhibit all three contributing factors (old age, depression, and alcohol abuse), making such outcomes of loneliness and decreased interaction even more predictable.

The Benefit of a Specialized Support Group

All of the women who were interviewed for this study expressed positive feelings about the support they received from the Senior Focus Chemical Dependency Group. Additionally, the subjects told the interviewer that the more traditional mainstream support groups, such as Alcoholics Anonymous (AA), simply were not meeting enough of their needs. Although this disenchantment with AA may be particular to these four women only, it was an agreed upon sentiment by all of the subjects in this study. Subject One remarked that although she attended meetings every night for 9 straight months at one point in her life, she still encounters certain aspects of AA that are "not necessarily true for me." Subject Two reported that she "is not a full-on AA, but I do take certain things from this and use them religiously for me and it's working." Subject Three stated clear reasons for not wanting to participate in traditional dependency meetings:

And then these horrible tales that they tell. You know, you feel like you want to go home and have a drink after listening to all those stories. I found one meeting that I didn't think was too bad, but they didn't speak

personally. They just read from a book but I could do that at home . . . by myself.

Subject Four stated that AA meetings "really didn't do all that much for me, I guess maybe I needed something else."

The literature revealed that most chemical dependency treatment programs are designed primarily according to the needs of men and largely ignore the special needs of women (Dunne, et al., 1993). Some of the distinct characteristics associated with female drinkers are disturbances in married life, high levels of stress, financial difficulties, feelings of low self-worth, suicidal tendencies, isolation, and lack of resources (Davidson & Ritson, 1992; Dunne et al., 1993; Schuckit et al., 1979). Although most of these factors can in some ways affect male drinkers, it has been found that they are more commonly characteristic of women and are the more commonly ignored aspects of alcoholism in women. Adding to this the fact that more female drinkers also present with a comorbid psychiatric diagnosis, female drinkers are in need of specialized services; this includes older women who have distinct needs.

Subject One claimed that much of the progress she has made in recovery has been due to her involvement in the Chemical Dependency Group at Senior Focus. She and the other subjects described the positive attributes of the group in terms of the relaxed and friendly atmosphere, the small size of the program, and most importantly the leader who is an educated and informed moderator. Subject Two stated, "I certainly relate to these older women. . . . I can be honest and I can speak freely." When asked if she has been satisfied with the group, Subject Three answered, "Very much so. I think it was a very good place for me to be." This subject also stated that her greatest reason to refrain from

drinking is to avoid feeling that she has wasted the time and efforts of the caring staff at Senior Focus who aided in her recovery process. Subject Four also agreed that coming to the Senior Focus program has helped her immensely. Although the Senior Focus group is not limited to women, it seemingly has become a woman-focused group due to the lack of men presently in the program. In this way, it has been able to provide these subjects with an intimate, focused, group experience that can deal on a personal level with much sharing and insight from the other members leading to a successful recovery process from alcoholism and depression.

Recommendations for Future Research

The literature review prepared for this study indicated a need for further research regarding older women with comorbid alcoholism and depression. There exists a paucity of knowledge regarding this population which inhibits effective understanding and treatment of the needs of this diagnostic group. Although this study has been able to uncover some of the special characteristics, experiences, and dysfunctions associated with alcohol abuse and depression in these select older women, further research is warranted to give further testimony to the results garnered here.

The continuation of case study data gathering is an excellent method to explore the lives and needs of members of this population. Each of the themes identified and discussed in this study are potential topics for further investigation with other subject samples of different socioeconomic status, age, or gender. By comparing the data and conclusions reached with the sample in this study with the results of other similar studies, one may be able to make a stronger case for the needs of this population, thereby encouraging

clinicians and academicians to increase their research and intervention efforts in this area.

A study including formal observation of the everyday activities and routines of these types of subjects may give additional insight to researchers and occupational therapists into the reality of their abilities and dysfunctions. By interviewing the subjects on their abilities in the areas of occupational performance and following with a detailed demonstration of these activities by the subjects, more concrete evidence of the abilities of the subjects as well as the relationship between perceived ability and actual ability can be provided.

Studies involving the family members of such subjects may also give further credibility to the subjects' perceptions of ability and dysfunctions. Research solely on the children and/or spouses of a person with combined alcohol addiction and depression may in itself be an interesting study to investigate the experiences of being in a relationship or living with a person having such a combination of disorders.

Further research and investigation into the issue of blaming others for addictive tendencies and psychological disturbances also presents itself as an interesting study. Although the subjects in this study did not admit to consciously blaming their fathers and/or spouses for their actions, one might more accurately reach such a conclusion upon further investigation and more detailed interviews with this subject sample. Another topic that did not arise during the interviews yet may have had a significant impact on the subjects' experiences is that of menopause. Research into the role of menopause in the subjects' depression and alcohol abuse might provide another interesting study into the causal relationships between life events and one's actions. Since each of the subjects in this study experienced a peak in their alcohol

abuse and depression around the age at which most women begin experiencing menopausal changes, an overlooked link between body changes and coping strategies may reveal important information regarding the relationships between all of these factors.

A follow-up study on the effectiveness of the teaching of coping strategies on this type of subject's functioning could also yield important data for the occupational therapist. In trying to facilitate more successful methods of dealing with dysfunction and reintegrating the subjects into their social lives, occupational therapists can reach better conclusions regarding the skills that are most effective for optimal functioning of the individual with alcoholism and depression.

Although many studies have been conducted that delineate the effects of alcohol and/or depression on the body, there has been a significant lack of research on the effects of these two factors on the overall life experiences of the people who have lived with them. Only through further exploration of such phenomena will the degree of understanding necessary to intervene and improve the quality of life for such persons be discovered.

Summary

This study has explored the life experiences of four women who have prior alcohol abuse and symptoms of depression. Literature that reviewed the effects of alcoholism and depression in the human being, special characteristics of comorbidity in women, comorbidity among older adults, depression and alcohol abuse in the older woman, limitations in functional performance, the theoretical framework of occupational performance, and case study methodology were presented.

The data were collected through personal interviews with each subject.

The interview format covered the following general areas: early life and family experiences, perceptions of occupational performance before onset of alcoholism and depression, perceptions of occupational performance during the occurrence of alcoholism, perceptions of occupational performance during recovery and current functioning, experiences with depression, the role of occupational therapy in the recovery process and general observations regarding alcoholism and depression.

The experiences of each subject regarding alcoholism and depression were discussed, as was each subject's perception of their effect on her occupational performance areas of self-maintenance, work, and leisure. The subjects also attempted to describe the relationship between their alcohol abuse and depressive symptoms, their responses indicating that both factors were in response to stress and a general disenchantment with their lives. The role that occupational therapy played in their recovery process was identified and possible intervention recommendations, including providing a solid base of physical, psychological, and social confidence toward the promotion of leisure activity and social interaction, were discussed.

Although the subjects each had very different lives and a large variety of experiences in their pasts which have in their individual ways promoted or exacerbated the alcoholism and/or depression, five common themes were discovered between the subjects' accounts. These common themes were alcoholism and depression as a response to stress, interpersonal relationships that supported the abuse of alcohol, imbalance in the occupational performance area of leisure, loss of social contacts and the benefit of a

specialized support group. These themes were each discussed individually and related to occupational therapy theory as appropriate.

Suggestions for further research opportunities were given. These included studies involving actual demonstration of functional abilities as compared to reported self perceptions of ability as well as studies including or focusing on the experiences of the family members of a person who abused alcohol and had depressive symptoms. There still exists a large research gap regarding the effects of alcohol abuse and depression on the life experiences of an older woman utilizing these two criteria. Further research in this area is warranted to increase the understanding and special characteristics of this group if occupational therapy is to be successful in its intervention efforts with this population.

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APPENDICES

APPENDIX A
INTERVIEW GUIDELINE

Interview Guideline

All information gained through this interview is anonymous.

Age:

Age at onset of alcohol abuse:

Marital status:

Age at onset of Depression or depressive symptoms:

Introduction

- Tell me about yourself. Who is (subject's name)?
- Have you ever been married? Are you now? How was that experience for you?
- Do you have any children/other family members that you are close to or are influenced by? Tell me about your current relationship with them.
- What is/was your occupation? Tell me about it.

Your Early Life/Family

- Do you know/do you think that there was anything in the earlier years of your life which may have influenced your alcohol abuse or depression? What were those things?
- Have you had any other experiences with alcohol abuse or depression/depressive symptoms?
- What role did your family play in your abuse of alcohol?
- How did they help/hinder your realization of your problem and/or your recovery process?

Pre-alcoholism

- What was your life like before you began abusing alcohol/experiencing depression?

Occupational performance

- How did you perform in your **work** capacity? How did you feel about your job?
- How did you spend your **leisure** time? What did you do for fun?
- How were you able to take **care** of yourself and your daily needs?
- Were you experiencing any other area of dysfunction in your life at this time?

Onset of alcoholism

- What was happening in your life when you started abusing alcohol? What was your life like during this time?
- What kinds of stresses were you facing? (Loss, loneliness, health, aging, etc.)

Occupational performance

- How did you perform in your **work** capacity? How did you feel about your job?
- How did you spend your **leisure** time? What did you do for fun?
- How were you able to take **care** of yourself and your daily needs?

- How did you feel about your life/yourself during this time (self-esteem, self awareness, etc.).
- What was it that made you realize that your use of alcohol was a problem?
- When did you finally seek help?
- Where did you turn for help? Are you an Alcoholics Anonymous member?

Post-alcoholism

- What is your life like now that you are in recovery and treatment?
- What kinds of stresses are you facing now? (Loss, loneliness, health, aging, etc.) How are you dealing with them?

Occupational performance

- How are you performing in your **work** capacity? How do you feel about work?
- How do you spend your **leisure** time? What do you do for fun?
- How are you able to take **care** of yourself and your daily needs?
- How do you think alcohol played a role in your daily functioning?
- What is different about your life now?
- How do you see yourself improving (daily progress, etc.)
- How has your view of yourself changed since your days of abuse?

Depression

- When did you start becoming depressed/experiencing depressive symptoms?
- What do you believe precipitated this mood change?
- Do you feel that you experienced depression in relation to your alcohol abuse? What do you think is the relationship between the two - in **your** life?
- How does your depression affect your daily functioning? How do you deal with this?

Current Functioning

- Describe a typical day for you.
- Tell me how you perform your daily activities.
- What kinds of difficulties do you face in your daily activities and in your daily life?
What kind of pleasures do you face/enjoy in your daily activities and in your daily life?

The Role of Occupational Therapy in your Recovery Process

- Tell me about your experiences with Occupational Therapy.
- How has Occupational Therapy impacted your recovery process/therapy?
- What are your current goals in Occupational Therapy?
- Do you agree with these goals? Were they set for you or did you participate in setting them? Are there other goals that you would prefer?
- What else would you like Occupational Therapy to do for you in your recovery/therapy?

Conclusion

- What are some general impressions that you have about your experience with alcohol abuse and depression?

- What other questions should I be asking you? Is there anything you would like to say/discuss that we haven't yet addressed?

APPENDIX B
FACILITY CONSENT LETTER

April 22, 1994

Gretchen Goebel
333 S. 14th Street
San Jose, CA 95112

Dear Ms. Goebel:

This letter is to confirm your request to do research at our facility. It is my understanding that your project entails interviews with clients, and that these interviews will be conducted in a confidential manner and on a voluntary basis, and that the results of these interviews will be kept confidential and utilized in summary or anonymous format only. There is no experimental intervention. These interviews are to be conducted at the Senior Focus program.

Should you or your advisor at San Jose State University have questions, please do not hesitate to contact me at 415-696-4525.

Sincerely,

Barbara Gale, MS, OTR
Manager, Occupational Therapy Department

APPENDIX C
SUBJECT CONSENT FORM

College of Applied Sciences and Arts • Department of Occupational Therapy
One Washington Square • San Jose, California 95192-0059
Main Office: 408/924-3070 • Fieldwork Office: 408/924-3078 • FAX: 408/924-3088

Subject Consent Form

Responsible Investigator: Greichen A. Goebel

Title of Protocol: The Experience of Depression and Alcohol Abuse Among
Older Women

1. I have been asked to participate in a research study investigating the experiences of older women with concurrent diagnoses of depression and alcohol use.
2. I will be asked to answer interview questions and engage in discussions regarding my experiences with depression and alcohol. These interviews will take place either in my place of residence or in a setting that is comfortable to me, and the researcher will be responsible for asking the questions from a pre-approved interview questionnaire and for recording my responses. These interviews will be approximately forty-five minutes in length and the need for more time or a second interview will be assessed at the end of that time period. I understand that my responses will be recorded and later transcribed by the interviewer for use in the research process.
3. No present or future risks to my well-being are anticipated with this research.
4. I understand that the results of this study, though perhaps not directly beneficial for me, may be utilized by health care personnel for greater understanding of depression and alcohol use in older women and therefore lead to better intervention in this population. The results of this research will be presented to the Department of Occupational Therapy at San Jose State University and later submitted for publication in a national, professional journal.
5. My name will not be used in the data analysis. The results of this study may be published, but no information that could identify me as a subject in this research will be included.
6. No compensation will be awarded to me for my participation in this study.

Initialed by Subject

Initialed by Researcher

College of Applied Sciences and Arts • Department of Occupational Therapy
One Washington Square • San Jose, California 95192-0059
Main Office: 408/924-3070 • Fieldwork Office: 408/924-3078 • FAX: 408/924-3088

7. Questions about this research may be addressed to the principal investigator: Gretchen Goebel, (408) 738-5685. Complaints about the research may be presented to the respective Department Chair: Amy Killingsworth, (408) 924-3070. Questions or complaints about research, subjects' rights, or research-related injury may be presented to Serena Stanford, Ph.D., Associate Vice-President of Graduate Studies and Research, at (408) 924-2480.
8. No service of any kind, to which I am otherwise entitled, will be lost or jeopardized if I choose not to participate in this study.
9. My consent to participate in this study is voluntary. I may refuse to participate in this study or in any part of the study. If I choose to participate in this study, I am free to withdraw at any time without prejudice to my relations with San Jose State University.
10. I have received a signed and dated copy of this consent form.

BY SIGNING THIS FORM I AM GIVING MY VOLUNTARY CONSENT TO PARTICIPATE
IN THIS STUDY AND HAVE READ AND UNDERSTAND THE ABOVE INFORMATION.

Signature of a subject on this document indicates agreement to participate in the study.
Signature of a researcher on this document indicates agreement to include the above named
subject in the research and attestation that the subject has been fully informed of his
or her rights.

Subject's Signature _____

Investigator's Signature _____ Date _____