Late onset alcoholism

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Abstract

Rather high prevalence rates of alcohol abuse in the elderly have been reported in the literature. However, there is some evidence that many elderly persons with alcohol problems are not identified, probably due to the nonspecificity of alcohol-related presentations in old individuals. Thus, there is an ongoing discussion on appropriate diagnostic criteria for alcohol dependence in elder people who frequently begin to abuse alcohol in late life. This study was aimed to explore whether alcoholics with late onset (beginning after the age of 45) differ from those with an early onset (prior the age of 25). Two hundred and sixty eight subjects consecutively referred to a ward of a general hospital specialized for alcohol detoxification were divided into three groups by the age at onset of harmful alcohol consumption. The duration of harmful drinking was rather similar in all groups. However, alcohol dependence according to the ICD-10 criteria (three or more have to be fulfilled) was diagnosed in 94.1% of the alcoholics with an early onset (≤ 25 years), but only in 62.2% of those with late onset (P < 0.0001). Significant differences between these groups were found for the following criteria: preoccupation with drinking (P < 0.0001), impaired capacity to control drinking (P < 0.01), strong desire to drink alcohol (P < 0.01), and a trend towards a lower rate of lifetime psychiatric comorbidity. The alcoholics with late onset reported fewer previous detoxifications and a lower actual alcohol consumption. Moreover, they showed a higher rate of abstinence in the 12 month follow-up. Regarding the difficulties in comparing groups of different ages at onset of harmful alcohol use our results suggest that the alcoholics with late onset differ in many ways from those with early onset.

Keywords: Alcohol dependence; Old age; Diagnosis; ICD-10; Alcohol markers

1. Introduction

Demographic trends reveal that the proportion of the elderly population grows in all developed countries. Alcoholism is considered to be an important health problem even in the elderly [6]. Estimates of the prevalence of alcoholism in the elderly population varied according to the applied definition of alcoholism and instruments for assessment in European [11] and US surveys [4,19,23,35] yielding prevalence rates ranging from 1.4% to 6% of the general population aged 65 or older. But alcoholism is an ill-defined term. The diagnostic guidelines of the ICD-10 [33] as well as of the DSM-IV [1] differentiate harmful alcohol use or abuse, respectively, and dependence. In this article, the term alcoholism was used as generic term for both harmful use/abuse and dependence. Some studies showed that alcohol abuse is very frequently not diagnosed in older patients [3,7,26]. The detection may be hampered by the nonspecificity of alcohol-related presentations, patient denial, and clinicians’ unawareness to recognize that patients can and do develop alcohol problems in later life.

Some of the problems in the diagnostics may largely attributed to the heterogeneity of alcoholics. It has been suggested that it may useful to differentiate early onset alcoholics (prior the age of 25) from late onset alcoholics [36]. However, up to now the significance of such a distinction has been little explored [4,20]. Dufour and Fuller [10] stated that the signs and symptoms of alcoholism in the elderly may differ from those of younger alcoholics, but they may also be present at lower levels of alcohol consumption. Alcoholism beginning after the age of 45 (late onset alcoholism) is considered to be associated with less family alcoholism and
greater psychological stability[4]. However, there exists only a few studies providing comparisons of early and late onset alcoholics[19,27,31], but Varma et al.[27] set the cut-off at the age of 25 years.

To ascertain current alcohol abuse laboratory parameters (‘alcohol markers’) like gamma-glutamyltransferase (y-GT), mean corpuscular volume of erythrocytes (MCV), and carbohydrate deficient transferrin (CDT) are widely used[5,18,32]. However, relatively little is known about the clinical usefulness of these ‘alcohol markers’ in old age.

This study was aimed to explore whether individuals beginning harmful drinking after the age of 45 differ from alcoholics with an early onset (prior to the age of 25). Moreover, the diagnostic value of biochemical ‘alcohol markers’ should also be evaluated in groups with different ages of onset of harmful drinking.

2. Methods

The sample consisted of consecutive referrals to a ward of a general hospital specialized for the detoxification of alcoholics without acute somatic disorders [Table 1]. Our hospital serves about 200,000 people. Two hundred and sixty eight subjects (196 males and 72 females, mean age 41.6 ± 9.5 years) were included in this study after giving their informed consent. The statistics of the reports of our psychiatric consultation service revealed that the age and sex distribution of 965 other patients with alcohol-related diagnoses referred to other departments of the General University Hospital during the recruitment period (2 years) was rather similar (proportion of females: 26.9% vs. 23.2%, Chi² test n.s.; mean age: 41.6 ± 9.5 vs. 43.4 ± 11.6 years, Mann-Whitney U-test z = –2.0, P = 0.05).

As in some previous studies[2,25] in this investigation cut-off age for late onset was placed at 45 years. So, according to the self-reported age at the onset of harmful alcohol drinking the sample was divided into three groups (beginning prior to the age of 25 (=group A < 25), between the age of 25 and 44 (=group A 25/44), and after the age of 45 (=group A ≥ 45). The drinking history, recent treatments as well as the number of alcohol-related medical complications (liver diseases, pancreatitis, gastritis, gastrointestinal bleedings, polyneuropathy, withdrawal delirium or seizures) and of alcohol-related psychosocial complications (becoming condemned or arrested, divorced or unemployed because of heavy alcohol intake) were assessed by standardized guidelines established by the German Society on Addiction Research and Therapy[8] and by the CIDI[23]. Psychiatric diagnoses were computed according to the ICD-10 criteria[33] using the CIDI data[24]. In a prospective study, abstinence from alcohol was assessed by personal interview at follow-ups 6 and 12 months after completion of the inpatient detoxification programme. All subjects lost during follow-up were rated as relapsers. Details of the follow-up study has already been published elsewhere[16].

Levels of y-GT and MCV were measured by automatised routine methods. CDT was determined bya commercial-ly available RIA (CDTectTM from Kabi Pharmacia, Uppsala, Sweden). CDT-values are only available in 82 patients. The statistical analysis were performed using a SPSS programme package, version 10 (SPSS Inc., Chicago, USA). The applied statistical methods as well as the level of significance are given in the text or in the tables, respectively.

Table 1
Sociodemographic data

<table>
<thead>
<tr>
<th></th>
<th>Group A &lt; 25 onset &lt; 25 years</th>
<th>Group A 25/44 onset between 25 and 44</th>
<th>Group A &gt; 45 onset ≥ 45 years</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>51 (19.0%)</td>
<td>172 (64.2%)</td>
<td>45 (16.8%)</td>
<td></td>
</tr>
<tr>
<td>Females</td>
<td>15.7%</td>
<td>30.2%</td>
<td>26.7%</td>
<td>Chi² = n.s.</td>
</tr>
<tr>
<td>Age (years) at examination</td>
<td>32.2 ± 7.9</td>
<td>40.9 ± 6.5*</td>
<td>54.9 ± 4.8*</td>
<td></td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 9 years</td>
<td>19.6%</td>
<td>16.3%</td>
<td>2.2%</td>
<td>Chi² = n.s.</td>
</tr>
<tr>
<td>Regular school (9 years)</td>
<td>54.9%</td>
<td>53.5%</td>
<td>73.3%</td>
<td></td>
</tr>
<tr>
<td>10 years</td>
<td>19.6%</td>
<td>23.8%</td>
<td>17.8%</td>
<td></td>
</tr>
<tr>
<td>High school (13 years)</td>
<td>3.9%</td>
<td>4.1%</td>
<td>4.4%</td>
<td></td>
</tr>
<tr>
<td>University degree</td>
<td>2.0%</td>
<td>2.3%</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>62.7%</td>
<td>32.6%</td>
<td>6.7%</td>
<td>Chi² = 57.7, d.f. = 6; P &lt; 0.0001</td>
</tr>
<tr>
<td>Married</td>
<td>11.8%</td>
<td>26.7%</td>
<td>40.0%</td>
<td></td>
</tr>
<tr>
<td>Divorced</td>
<td>25.5%</td>
<td>38.4%</td>
<td>33.3%</td>
<td></td>
</tr>
<tr>
<td>Widowed</td>
<td>2.3%</td>
<td>2.3%</td>
<td>20.0%</td>
<td>Chi² = 22.1, d.f. = 4; P &lt; 0.001</td>
</tr>
<tr>
<td>Unemployed</td>
<td>62.7%</td>
<td>45.3%</td>
<td>26.7%</td>
<td></td>
</tr>
<tr>
<td>Retired/housewife-man</td>
<td>9.3%</td>
<td></td>
<td>24.4%</td>
<td></td>
</tr>
<tr>
<td>Income (DM/month)</td>
<td>1419 ± 901</td>
<td>1625 ± 1102</td>
<td>1952 ± 1211*</td>
<td>ANOVA, post hoc Scheffe-tests* P &lt; 0.05 vs. group A &lt; 25</td>
</tr>
</tbody>
</table>
3. Results

It is difficult to make an uncontaminated comparison between alcoholics with different ages of onset, since age is a major potential confounder. However, the reported duration of harmful drinking was rather similar in all three groups (Table 2). Thus, we considered that our results allow an evaluation of differences between alcoholics with various ages of onset.

3.1. Sociodemographic parameters

As expected, the members of group A \( \geq 45 \) were significantly older (54.9 ± 4.8 years) than those with early onset (group A \(< 25\)) (32.2 ± 7.9 years). In contrast to group A \(< 25\) who were predominately singles and unemployed group A \( \geq 45 \) alcoholics more frequently lived in partnership or were widowed (\( \chi^2 = 26.8, \text{ d.f.} = 2, P < 0.0001 \)) and had a job or were retired (\( \chi^2 = 13.9, \text{ d.f.} = 2, P < 0.001 \)). Moreover, they had a significantly higher income.

3.2. Alcohol history

The subjects of group A \( \geq 45 \) differed from the other groups significantly in most investigated items of alcohol history apart from duration of harmful drinking (Table 2). They began to drink alcohol later, showed lower mean daily alcohol consumption, and a lower number of detoxifications. At the follow-up interview 12 months after discharge significantly more group A \( \geq 45 \) alcoholics reported continuous abstinence than group A \(< 25\) alcoholics (31.1% vs. 5.9%).

3.3. Diagnosis according to the ICD-criteria

According to the ICD-10 criteria for alcohol dependence (three or more criteria fulfilled) 94.1% of the people referred for inpatient alcohol detoxification with early onset of harmful drinking, but only 62.2% of group A \( \geq 45 \) were diagnosed as alcohol dependent (\( \chi^2 = 14.4, \text{ d.f.} = 2, P < 0.001 \)). The frequency of the ICD-10 criteria in the different groups is given in Table 3. Significant differences between the groups were found for the following criteria:

- preoccupation with drinking,
- impaired capacity to control drinking in terms of its onset, termination or levels of use,
- a strong desire or sense of compulsion to drink alcohol,
- physiological withdrawal state.

All ICD-10 criteria for alcohol dependence except persistent substance use despite harmful consequences showed a weak age-dependence (Spearman’s rho < –0.3, \( P < 0.02 \)).
The total number of fulfilled ICD-10 criteria was weakly related to the age at the index admission (Spearman’s rho = -0.25, P < 0.001). That number in group A ≥ 45 was significantly lower than in both other groups.

The ICD-10 criteria distinguishes harmful alcohol use from alcohol dependence. Harmful alcohol use is defined by the presence of physical or psychological complications. In our sample, there was evidence of physical or/and psychological alcohol-related complications in all but six subjects. However, in the individuals of group A ≥ 45 the number of psychosocial or medical complications and the rate of injuries was significantly lower than in group A < 25.

### 3.4 Addictive behaviour

The individuals of group A > 45 reported another drinking behaviour than the other groups, i.e. less drinking to avoid withdrawal symptoms and less binge-drinking. Furthermore, they had less current social interactions with alcoholics. Only younger alcoholics had contacts to drug addicts. There is a higher rate of smokers in group A < 25. However, the number of cigarettes smoked per day is rather high in all three groups (mean > 25 cigarettes/d). At 12-months follow-up, group A > 45 showed a higher rate of abstinence than the other group. Furthermore, the rate of lost cases was lower (n.s.).

### 3.5 Alcohol markers

About 37% of patients investigated in our sample show normal CDT values (females ≤ 26 U/l, males ≤ 20 U/l), 25% normal γ-GT (females ≤ 20 U/l, males ≤ 28 U/l), and 40% normal MCV values (≤ 95 fl). There were no group differences. If controlled for alcohol intake per day during the last 3 months, no correlation between age and the values of any of the laboratory ‘alcohol markers’ could be found (Spearman’s rho < 0.1).

### 3.6 Psychiatric comorbidity

The psychiatric comorbidity in lifetime as well as in the last 6 months prior admission were assessed by the CIDI. The groups A < 25 and A ≥ 25/44 showed rather similar rates of lifetime psychiatric comorbidity, while the group A ≥ 45 showed a significantly lower rate of psychiatric comorbidity.

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### Table 4

Psychiatric comorbidity (as assessed by the CIDI)

<table>
<thead>
<tr>
<th></th>
<th>Group A &lt; 25</th>
<th>Group A 25/44</th>
<th>Group A &gt; 45</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime diagnosis of any psychiatric disorder (except nicotine dependence)</td>
<td>43.1%</td>
<td>44.2%</td>
<td>26.6%</td>
<td>Chi² = 3.8, df. = 2, n.s.</td>
</tr>
<tr>
<td>Diagnosis of any psychiatric disorders in the last 6 months (except nicotine dependence)</td>
<td>37.3%</td>
<td>39.5%</td>
<td>20.0%</td>
<td>Chi² = 5.5, df. = 2, P = 0.065</td>
</tr>
<tr>
<td>Lifetime diagnosis of nicotine dependence</td>
<td>62.7%</td>
<td>51.2%</td>
<td>31.1%</td>
<td>Chi² = 6.6, df. = 2, P = 0.04</td>
</tr>
</tbody>
</table>

Chi²: Chi-squared; df: Degrees of freedom; n.s.: Not significant.

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### Table 5

Alcohol-related complications

<table>
<thead>
<tr>
<th></th>
<th>Group A &lt; 25</th>
<th>Group A 25/44</th>
<th>Group A &gt; 45</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence of at least one alcohol-related psychosocial complication*</td>
<td>96.1%</td>
<td>87.8%</td>
<td>60.0</td>
<td>Chi² = 27.6, df. = 2, P &lt; 0.0001</td>
</tr>
<tr>
<td>Number of alcohol-related psychosocial complications</td>
<td>2.4 ± 1.1</td>
<td>2.0 ± 1.2</td>
<td>1.3 ± 1.4*</td>
<td>ANOVA, post hoc Scheffe-tests P &lt; 0.05, * vs. group A &lt; 25, * vs. group A 25/44</td>
</tr>
<tr>
<td>Evidence of at least one alcohol-related medical disorder actually or in history*</td>
<td>88.2%</td>
<td>87.8%</td>
<td>86.7%</td>
<td>Chi² = n.s.</td>
</tr>
<tr>
<td>Number of alcohol-related medical disorders</td>
<td>2.9 ± 2.3</td>
<td>2.3 ± 1.7</td>
<td>1.8 ± 1.2*</td>
<td>ANOVA, post hoc Scheffe-tests, P &lt; 0.05, * vs. group A &lt; 25</td>
</tr>
<tr>
<td>Evidence of at least one alcohol-related injury</td>
<td>47.1%</td>
<td>27.9%</td>
<td>17.8%</td>
<td>Chi² = 10.6, df. = 2, P &lt; 0.01</td>
</tr>
</tbody>
</table>

Chi²: Chi-squared; df: Degrees of freedom; n.s.: Not significant.

### Table 6

Addictive behaviour

<table>
<thead>
<tr>
<th></th>
<th>Group A &lt; 25</th>
<th>Group A 25/44</th>
<th>Group A &gt; 45</th>
<th>Statistics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drink every morning in view of avoiding withdrawal symptoms</td>
<td>55.3%</td>
<td>26.4%</td>
<td>18.6%</td>
<td>Chi² = 17.7, df. = 2, P &lt; 0.001</td>
</tr>
<tr>
<td>Frequent inebriations (&gt; once/week)</td>
<td>61.2%</td>
<td>38.7%</td>
<td>20.5%</td>
<td>Chi² = 16.3, df. = 2, P &lt; 0.001</td>
</tr>
<tr>
<td>Current social interactions with alcoholics</td>
<td>Never</td>
<td>22.2%</td>
<td>35.2%</td>
<td>54.8%</td>
</tr>
<tr>
<td></td>
<td>Seldom</td>
<td>13.3%</td>
<td>18.5%</td>
<td>14.3%</td>
</tr>
<tr>
<td></td>
<td>Frequently</td>
<td>64.4%</td>
<td>46.3%</td>
<td>31.0%</td>
</tr>
<tr>
<td></td>
<td>Currently smoking*</td>
<td>93.5%</td>
<td>86.0%</td>
<td>71.8%</td>
</tr>
<tr>
<td>Mean number of cigarettes smoked a day/last 6 months (only smokers)</td>
<td>27.4 ± 14.7</td>
<td>27.6 ± 12.0</td>
<td>25.2 ± 9.6</td>
<td>ANOVA, post hoc Scheffe-tests n.s.</td>
</tr>
</tbody>
</table>

Chi²: Chi-squared; df: Degrees of freedom; n.s.: Not significant.

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* Definition of alcohol-related complications or disorders see methods.
> 45 had a lower rate (n.s.). The late onset alcoholics also showed less current psychiatric comorbidity (within the last 6 months) than the other groups [Table 3]. Furthermore, they suffered less frequently from nicotine dependence. In only six alcoholics an (alcohol-related) organic brain disorder was diagnosed, thereof four were late onset alcoholics (8.9%).

### 4. Discussion

Alcoholism is one of the major health problems in developed countries. There is much evidence that alcohol abuse is also rather common in the elder populations [2,11,19,23,34] But some studies showed that alcohol abuse was often not recognized in old people [3,7,26] probably due to the nonspecificity of alcohol-related presentations, patient denial, and clinicians’ unawareness of alcohol problems in later life. There is an ongoing discussion, how many elder people begin to abuse alcohol in late life and whether late onset alcoholism differs from that of early onset alcoholism [4,15,36].

‘Late’ onset of alcoholism is difficult to define. As in some previous studies [2,25] cut-off age for late onset was placed at 45 years in this investigation. In our sample of 268 alcoholics consecutively referred for detoxification, about 17% reported that they started harmful drinking after the age of 45 years. Thus far no adequate community incidence surveys exist for alcohol use disorders, so distribution of age at onset is not reliably known. But there is some evidence that onset of the first alcohol problems can also occur after the age of 60 [4,13,34]. The use of self-reports makes our data vulnerable to recall bias and thus the evaluation of the frequency and amount of alcohol consumption as well as the beginning of harmful drinking must be done with some caution. A further crucial methodological problem is the comparison between alcoholics with different ages, because age may be a major potential confounder. Unfortunately, due to the small number of A < 25 individuals older than 44 (n = 3) a group comparison of subjects aged over 45 was impossible.

Despite these methodological problems concerning with the retrospective self-reports, our findings suggest that a considerable proportion of older alcoholics begin to abuse alcohol in late life (after the age ≥45). In view of rather similar duration of harmful drinking in all three groups, we considered that our results allow an estimation of differences between alcoholics with various ages of onset. A crucial factor is the recruitment procedure of the sample. Our sample consists of consecutive referrals to a detoxification ward of a general hospital serving about 200,000 people in the town of Lübeck in northern Germany. However, there may be some selection bias due to the admission policies, but a comparison with the statistical report of our psychiatric consultation service revealed a similar age distribution in the alcoholics referred to other departments of our General University Hospital in the same period (2 years).

Our results showed that individuals beginning alcoholism after the age of 45 (group A > 45) despite of a rather similar duration of harmful alcohol drinking differ in many aspects from those with early onset, in particular:  
- they have a first-degree family pedigree also affected with alcoholism less frequently,  
- they drink lower amounts of alcohol (in the last months prior the index admission),  
- they underwent less detoxifications,  
- they suffered from psychiatric comorbidity less frequently,  
- they showed alcohol-related less physical and psychosocial complications, i.e. they were married or, respectively, widowed more often and had a higher income,  
- they had a better prognosis (higher rate of abstinence after 12 months).

Furthermore, they reported a different addictive behaviour, i.e. lower proportion of smoker, less inebriations, etc. Rather similar profiles were found in elderly problem drinkers with late onset who had been arrested because of driving while alcohol intoxicated [20] and in study comparing alcoholics aged ≥50 years from younger ones [21]. In another study, elderly alcoholics showed less social impairment [31].

In a recent review, the ICD-10 criteria [33] were considered to be a ‘gold standard’ for the assessment of alcohol dependence in the elderly [12]. In our sample individuals beginning harmful drinking after the age of 45 (group A ≥45) fulfilled the ICD-10 criteria for alcohol dependence since they less frequently reported on:  
- preoccupation with drinking,  
- an impaired capacity to control drinking,  
- withdrawal symptoms, or  
- a strong desire or sense of compulsion to drink alcohol.

In another study, late onset alcoholics showed less binge drinking and a lower rate of tolerance development than those with an early onset [31].

The motives for consuming alcohol may change with age at onset. So the group A ≥ 45 alcoholics in our sample reported an addictive behaviour different from that of the other groups, i.e. less drinking in the morning to avoid withdrawal symptoms and lower rates of binge drinking. Furthermore, our results show that the strong desire to drink alcohol decrease with age. This result corresponds well with the low consumption of illegal drugs and the reported addictive behaviour of late onset alcoholics. Probably, also the high proportion of females and the low frequency of comorbidity in late onset alcoholics influenced their drinking behaviour. The good outcome of late onset alcoholics is likely related to the same factors. Some other studies also reported better treatment adherence and outcome in late onset alcoholics if compared with those with an early onset [4,14].

Many possible reasons for problematic drinking among elder individuals are discussed in the literature (for review, see [2]), i.e. relaxation of and to help cope late life losses as well as chronic illness or painful conditions. Until now, there is little support for the stress-reactive hypothesis. However, late onset problem drinkers reported on less drinking related troubles than those with early onset [19]. In our sample,
individuals beginning alcoholism after the age of 45 (group A ≥ 45) described less negative psychosocial complications, and the number of alcohol-related troubles was significantly lower than in the other groups. Similar to another study [21] comparing alcoholics >50 years with those <50 late onset alcoholics did not report more health problems. These results suggest that older alcoholics show the same types of alcohol-related problems, but less so than younger alcoholics. Moreover, the lifetime psychiatric comorbidity as well as the lifetime nicotine dependence were lower in the group A ≥ 45. The results agree with that of Atkinson et al. [4] However, Finlayson et al. [13] found a high rate of organic brain disorders in elder alcoholics. The rather low rate in our sample was probably due to selection bias.

Also biological factors potentially influencing the drinking habits have been investigated only in few studies regarding a possible age dependence. It has been hypothesized that ethanol’s actions on the dopamine system participate in addiction, e.g. in the reward system [9] There is some evidence that the dopaminergic system degenerates with age [30]. So the craving for alcohol may be reduced in elder persons. Moreover, the volume of distribution for alcohol decreases with age because of reduced lean body mass and total body water [22, 28, 29]. The occurrence of maximum serum alcohol concentration following oral intake was significantly delayed in elder persons [22]. However, cognitive and cerebellar functions are more impaired with age after a standard alcohol load, even if controlled for the blood alcohol levels [29]. These results suggest an increasing susceptibility to alcohol toxicity, but a decreasing euphoric effect with age. These effects may be responsible for the lower desire for alcohol and the lower alcohol consumption in the elderly. In a review of the epidemiological literature most studies were found to show a decrease of alcohol consumption with age [17]. Despite the lower alcohol intake in the late onset group, the rate of pathological ‘alcohol markers’ (elevated y-GT, MCV, and CDT values) did not differ between the groups also indicating a higher susceptibility to alcohol in the elderly. (Table 7).

In our sample only 62% of group A ≥ 45, but nearly all of group A < 25 fulfilled the ICD-10 criteria for alcohol dependence [33]. However, most of the investigated subjects of group A ≥ 45 reported severe physical or psychosocial alcohol-related complications, so that they at least qualified the ICD-10 criteria of harmful alcohol use [33]. In this context, the question raises whether the ICD-10 criteria for alcohol dependence are adequate for old persons, especially for individuals beginning alcoholism after the age of 45. Our results showed a weak age-dependence of all the criteria except persistent alcohol use despite harmful consequences. However, the lower rate of alcohol dependence among the late onset alcoholics corresponds well with their different consumption habits (lower drinking frequency and lower amount of alcohol than A < 25).

To conclude, although our findings are limited by methodological considerations (comparison of groups with different ages, self-reports with recall bias) they suggest that individuals beginning alcoholism late in their life differ in many aspects from those alcoholics with early onset, e.g. less preoccupation with drinking, loss of control, craving and psychosocial complications. Moreover, compared to earlier onset cases, late onset alcohol health problems despite cognitive disorders were milder. Our data show that a great proportion of older heavy drinkers were not diagnosed as alcohol dependent by the ICD-10 criteria, but as harmful alcohol user. These results indicate that even elder subjects with this diagnosis should be motivated to participate in an alcohol-specific therapy, since there is clear evidence that old persons with alcohol problems benefit from alcohol-specific treatment.

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